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**UNCLASSIFIED**

**UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D. C. 20523**

JAMAICA

**PROJECT PAPER**

DRUG ABUSE PREVENTION

AID/LAC/P-487

Project Number: 532-0161

**UNCLASSIFIED**

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT DATA SHEET**

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete)  
Amendment Number: \_\_\_\_\_ DOCUMENT CODE: **3**

COUNTRY/ENTITY: **USAID Jamaica**

3. PROJECT NUMBER: **532-0161**

4. BUREAU/OFFICE: **Latin America & Caribbean 05**

5. PROJECT TITLE (maximum 40 characters): **Drug Abuse Prevention**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY **01 21 09 14**

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)  
A. Initial FY: **89** B. Quarter: **4** C. Final FY: **93**

8. COSTS (5000 OR EQUIVALENT \$) =

A. FUNDING SOURCE	FIRST FY 89			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total	75	68	143	220	280	500
(Grant)	( 75 )	( 68 )	( 143 )	( 220 )	( 280 )	( 500 )
(Loan)	( 0 )		( 0 )	( 0 )	( 0 )	( 0 )
Other 1.						
U.S. 2.						
Hait Country		29	29		137	137
Other Donors)		13	13		67	67
TOTALS	75	110	185	220	484	704

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
			1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) EHRD	680	690	-	-	500		500	
(2)								
(3)								
(4)								
TOTALS					500		500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): **560**

11. SECONDARY PURPOSE CODE: **510**

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	B. Amount
PVON	140
TNG	292

13. PROJECT PURPOSE (maximum 480 characters):  
 To improve the capability of the Jamaican public and private sectors to develop and implement drug abuse prevention programs aimed at high risk target groups, primarily youth between 12 and 25 years of age.

14. SCHEDULED EVALUATIONS

Interim	Final
MM YY: 08 92	MM YY:

15. SOURCE/ORIGIN OF GOODS AND SERVICES  
 000  941  Local  Other (Specify) \_\_\_\_\_

16. AMENDMENT SIGNATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP amendment)  
 Mission Controller has reviewed and concurs with the methods of implementation and financing included herein.

*Robert Leonard*  
 Robert Leonard, Controller

17. APPROVED BY: **William R. Joslin**  
 Title: **Director, USAID/Jamaica**  
 Date Signed: **09 21 89**

18. DATE DOCUMENT RECEIVED IN AID/... OR FOR AID/... DOCUMENTS. DATE OF DISTRIBUTION:  
 MM DD YY: | | | |

**PROJECT AUTHORIZATION**

**Name of Country:** Jamaica  
**Name of Project:** Drug Abuse Prevention  
**Number of Project:** 532-0161

1. Pursuant to Sections 104 and 105 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Drug Abuse Prevention Project for Jamaica involving planned obligations of not to exceed \$500,000 United States Dollars (US\$500,000) in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB allotment process, to help in financing foreign exchange and local currency costs of the Project. The planned Life of Project is approximately five years from the date of initial obligation.

2. The Project will provide funding for a number of activities designed to improve the capability of the Jamaican public and private sectors to design and implement drug abuse prevention programs aimed at high risk target groups, primarily youth between 12 and 25 years of age. The Project will include three core activities: 1) developing human resources, 2) community based secondary and tertiary prevention activities, and 3) improvement in drug abuse prevention information.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with AID regulations and Delegations of Authority, shall be subject to the following essential terms, together with such other terms and conditions as A.I.D. may term appropriate.

4.a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in Jamaica or in the United States except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have Jamaica or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing.

4.b. Ocean Shipping

Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.



---

William R. Joslin  
Director  
USAID Jamaica

9.21.89

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Date

List of Important Acronyms

AAO	Addiction Alert Organization
EEC	European Economic Community
GOJ	Government of Jamaica
MOH	Ministry of Health
MYCD	Ministry of Youth and Community Development
NAU	U. S. Embassy Narcotics Affairs Unit
NCDA	National Council on Drug Abuse
NGO	Nongovernmental organization
NIAAA	National Institute on Alcohol Abuse and Alcoholism (USG)
NIDA	National Institute on Drug Abuse (USG)
OPM	Office of the Prime Minister
OSAP	Office of Substance Abuse Prevention (USG)
PAHO	Pan American Health Organization
PVO	Private voluntary organization
USAID	U. S. Agency for International Development
USIS	U. S. Information Service

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## I. SUMMARY AND CONCLUSIONS

### A. Project Summary

This project addresses a gap in the spectrum of drug abuse prevention by focusing on secondary and tertiary prevention activities (i.e., programs directed toward high risk groups). Although few such activities are currently underway in Jamaica, there is a clear need for them in view of the indications of drug abuse in the country, and in particular in view of the growing problem of cocaine and crack availability and use. Further, the project is seen as necessary and appropriate in view of the following:

- 1) Jamaica has a serious and growing problem of drug abuse; of particular concern is the significant increase in availability and use of crack among all socioeconomic groups. Also, drug abuse has significant socioeconomic costs which can be averted through targeted secondary and tertiary prevention programs.
- 2) While there are few identified secondary and tertiary drug abuse prevention projects in Jamaica, there have been and continue to be primary prevention projects (both public awareness activities and school based drug education programs). Thus, this project would fill a defined gap in prevention strategies.
- 3) The recent relative success of targeted secondary and tertiary prevention programs, as compared with general public awareness campaigns, in the U.S. and elsewhere, points to adapting strategies that make maximum use of GOJ, private sector, and donor resources.
- 4) As presently envisioned, the project components will have important multiplier effects (e.g., trained community workers can implement prevention activities at a variety of levels and can train others in the community; trained nurses and social workers can carry out detection and screening as well as tertiary prevention activities); technical assistance to the National Council on Drug Abuse (NCDA) can guide this organization in policy planning and development which would be useful for all segments of its program.
- 5) Drug abuse has significant socioeconomic costs which can be averted through targeted secondary and tertiary prevention programs.

For purposes of the project, prevention activities will be designed to recognize co-dependencies (i.e., the relationship between abuse of multiple drugs) and at the same time to take into account the different use patterns by socioeconomic groups and other factors.

The goal of the project is: to prevent further significant increases in the abuse of drugs of all types among high risk groups in Jamaica during the life of the project. The project purpose is to improve the capability of the Jamaican public and private sectors to develop and implement drug abuse prevention programs aimed at high risk target groups, primarily youth between 12 and 25 years of age.

An important aspect of the project will be the linkages that will be established both with ongoing prevention programs and with those that are in the planning stages, including those of the public and the private sector. The five year project will include three core activities: 1) developing human resources, 2) community based secondary and tertiary intervention activities, and 3) improving drug abuse prevention information.

USAID funding in the amount of US\$500,000 will be made through a bilateral grant agreement with the GOJ, with the National Council on Drug Abuse serving as the primary implementing agency. The NCDA is the GOJ agency with primary responsibility for developing and coordinating public policy and programs regarding both supply of and demand for drugs. A subgrant will be made to a nongovernmental organization (or a private voluntary organization) to manage the community based prevention component of the project, which will constitute small grants to grassroots organizations to undertake secondary and tertiary prevention activities directed toward high risk populations. USAID funds will finance short term technical assistance, short term training, limited commodity support, and small grants to the community based organizations undertaking prevention activities.

#### B. Summary Findings

Based on the analyses contained in Part IV. Cost Estimates and Financial Plan, and Part VII. Summary of Project Analyses, the Project has been determined to be technically, administratively, economically, and socially sound and ready for implementation. Annex F presents the report of the consultant, which summarizes the status of drug abuse in Jamaica, its social and economic implications, and public and private sector responses.

The Project meets all the statutory requirements (See Annex C).

C. Project Paper Design Team

The Drug Abuse Prevention Project was designed by the following USAID/Jamaica staff, who are members of the Project Design Team:

Ms. Nancy Hardy, OPEP  
Mr. Louis Coronado, OPPE/PDSD  
Mr. Robert Leonard, Controller  
Ms. Rebecca Cohn, OHNP  
Mr. William Charleson, OEHR  
Ms. Yvonne Johnson, OEHR  
Mr. Walter Coles, OPPE/PED  
Ms. Denise Rollins, OPPE/PED

The project was developed in conjunction with the Government of Jamaica, and with the assistance of Policy Research Incorporated.

This and earlier versions of the Project Paper were reviewed by the Deputy Chief of Mission, the Drug Enforcement Agency Country Attache, the Narcotics Affairs Officer, and the U. S. Information Service Public Affairs Officer. Their suggestions and comments have been incorporated herein.

## II. PROJECT RATIONALE AND DESCRIPTION

### A. Rationale

#### 1. Background: Defining Drug Abuse and Understanding Related Issues

The abuse of drugs of all types is a societal problem of immense proportions in many countries. The personal, familial, social, health and economic impact of such abuse, and of the concomitant problems associated with illegal drug use, are, in many ways, incalculable. Complicating the ability of the public and private sectors to mount effective programs to combat drug abuse are the divergent theories regarding causal factors of drug use itself, and approaches to prevention and treatment. Theories of drug use range from its being natural to use drugs of any type to relieve physical and psychological pain to its being an inherited "defect" which is incurable.

Even the appropriate terminology used to describe programs aimed at the problem is controversial. For some time, the most common term has been "drug abuse"; more recently, some programs have been titled "substance abuse". Few programs still use "narcotics abuse"; those which do so relate, for the most part, to narcotic substances only, not to all drugs. The issue which is at the heart of the discussion regarding program titles is the inclusion of certain types of substances in a classification of drugs. There is some degree of agreement that a drug is any substance which is mind altering, including alcoholic beverages, narcotics, and prescription drugs. However, often alcohol is not considered as a drug of abuse because of its generally accepted and legal use in many societies.

This is a partial reason for the historical distinction between alcohol and drug abuse programs. Another is that, in the late 1960s, when a massive infusion of funds was put into narcotics programs (primarily heroin prevention and treatment in the U.S. and Europe), those in the field of alcohol abuse in the U.S. were concerned that, if their programs merged with those of narcotics and other drugs, there would be scant attention paid to alcohol abuse. The inclusion of tobacco use in substance abuse programs is considered by some in the field of drug abuse to unnecessarily complicate the drug abuse issue, and by others as a necessary component of a comprehensive program of health promotion and disease prevention.

Notably, when the U.S. Office of Substance Abuse Prevention was created in 1982, there was, and continues to be, a dispute regarding the appropriateness of the title. On the one hand, some experts in the field believe that it is important to ensure that all possible substances of abuse are included in any prevention program. On the other hand, there are those who say that the title is inclusive, but meaningless to a large

segment of the population, including those at whom prevention programs may be directed. These discussions regarding program title -- and the approaches to the problem that underlie the discussions -- have taken place in many countries in which prevention and treatment programs have been implemented on a national level. In Jamaica, the GOJ determined that it would be most appropriate for the Jamaican context to utilize the term drug abuse. Hence, the creation of the National Council on Drug Abuse, which includes alcohol and other drugs in its purview.

Definitions of abuse also vary; generally, specific definitions of abuse are used for distinct types of drugs. For example:

alcohol abuse is construed as psychological or physical dependence (including binge drinkers and habitual abusers);

for illicit drugs such as heroin, any use which is not part of an approved research or treatment program is considered abuse;

for prescription drugs, any non-medical use is considered abuse. For these drugs, physical or psychological dependence (abuse) can also result from use authorized by a physician.

For alcohol abuse, there are several levels of alcohol consumption that are usually used in epidemiological research; these are based on amount and type of alcohol consumed, on drinking patterns, and on the impact of alcohol use on the ability to normally function in society.

Drug abuse prevention is considered to consist of three levels of activities:

Primary prevention, with programs addressing the general population without regard to degree of risk for drug abuse, and which focuses on preventing new cases; that is, on reducing the incidence of abuse. These programs include, for example, public awareness or mass media campaigns, and some school based programs.

Secondary prevention, which addresses more defined populations who are perceived as having some risk factors for drug abuse, and which is directed at reducing prevalence of drug abuse, or total numbers of cases in a society. These programs include, for example, drop-in centers offering crisis intervention (early detection and screening, preliminary counseling and referral for treatment) services to youth in high risk areas; and multipurpose programs directed toward high risk populations, including services designed to recognize cofactors related to drug use (e.g., job counseling and referral, family counseling, peer group support).

Tertiary prevention, which attempts to prevent increased, continued, or expanded abuse (e.g., use of additional drugs) among identified populations or individuals, and which is also directed toward reducing prevalence. Tertiary prevention programs include, for example, crisis intervention centers located in areas of known widespread availability and/or use).

In practice, the boundaries between secondary and tertiary prevention, and between tertiary prevention and treatment of drug abusers are difficult to distinguish. In part this results from the fact that within geographic areas or population groups to which programs are targeted there may be both high risk non users and high risk experimenters or early users. In addition, certain types of basic counseling that are appropriate for crisis intervention as part of a tertiary prevention program can also be used as part of treatment. However, tertiary prevention usually excludes inpatient, medically based treatment. Some classifications of drug abuse programs consider both secondary and tertiary prevention to be intervention.

## 2. The Problem

### a. Extent of Drug Abuse in Jamaica

The first survey of drug abuse in Jamaica was conducted in 1966; that survey related exclusively to alcoholism and found that 5% of the population 18 years and older were alcoholics or potential alcoholics.(1)\* In 1985, the World Health Organization supported a study of per capita consumption of alcohol, which showed a substantial increase during the period 1973 to 1981: from 22 liters to 27 liters per capita. (2)

If the 1981 figure is accurate and has not changed substantially, that would make the Jamaican population the highest per capita consumers of alcoholic beverages of 48 countries studied in 1985, the most recent year for which data are available. In that year, the country with the highest per capita consumption of those studied was Luxembourg, with 16 liters per capita; next was France, with 13.3 liters per capita. The U.S. per capita consumption was 8.0 per capita. (3)

The only large scale studies of drug abuse in Jamaica have been the national household and school surveys conducted by the NCDA with the assistance of the Pan American Health Organization (PAHO) and funded by USAID. They were conducted over the period 1985-1989, with the data being collected in 1987. The report of the School Study was issued in 1989. The draft

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\*For citation references, please see Annex A

report of the National Household Survey is in limited circulation for review purposes only. The NCDA and USAID have determined that the preliminary analyses included in the draft report could be included in the Project Paper, as they are the only national baseline data available.

Planning for both the National Household Survey and the School Survey was initiated in 1985. The household survey was the largest of its kind undertaken in Jamaica, and the sample (6,007 Jamaicans 12 years and older) represented a much larger proportion of the population than that of comparable surveys undertaken in the U.S. (4) The survey of drug use in schools (post-primary) included a total of 8,886 students in grades 9-13. (5)

The findings from both of these studies confirmed the generally held belief that use of marijuana or "ganja" as it is known in Jamaica is endemic, and that alcohol use -- if not abuse -- is a significant problem as well. In the draft report of the household survey, for example, results indicated that 30% of male respondents and 6% of females reported that they had ever used ganja and 26% of males and 6% of females reported taking five or more drinks on the same occasion during the two weeks prior to the survey. Sixty-two percent of males and 45% of females reported that they had close friends who had ever used ganja. Twenty-four percent of males and 34% of females reported that they strongly disapprove of occasional ganja use. The school survey also confirmed the extensive use of ganja and alcohol: 76% of students reported ever having used alcohol, and 34% reported having used ganja in the previous month. Thirty-nine percent of students reported ever having used ganja, and nearly 10% reported having used it in the previous month.

Notably, in the household survey, nonmedical use of analgesics was reported by nearly as many men (23%) and by far more women (30%) than the use of ganja. The survey reported low rates (1% or less) of use of inhalants, LSD, PCP, and heroin. Similarly, less than 1% of males and females reported ever having used tranquilizers, barbiturates or amphetamines other than for medical reasons. The students reported somewhat higher abuse of other drugs than did the adults in the household survey. For example, 3% reported nonmedical use of tranquilizers in their lifetime, and 2% reported nonmedical use of amphetamines. Sixteen percent had used inhalants at least once. With regard to recent use of other drugs, 1.8% of students had used tranquilizers in the previous month; the same figures for amphetamines were 1.7% and 0.7% respectively, and for inhalants were 16% and 10.2%. For opiates the rates were 1.2% for lifetime prevalence and 0.9% for previous month's use of psychedelics.

The two surveys seemed to indicate surprisingly little use of cocaine and crack in 1987, particularly in view of recent reports that both drugs were available in Jamaica at the time the two studies were conducted. (6) For example, in the household survey, only 0.3% of males and no females reported ever having used cocaine, and 1.0% of males and 0.1% of females reported ever having used crack. The study's authors hypothesize that these findings - i.e., that there is higher reported use of crack than cocaine - may result from the order of the questions in the survey. In fact, respondents reported that both cocaine and crack were difficult to obtain: only 6% of males and 2% of females reported that cocaine was easily available, and 3.6% of males and 1.3% of females reported that crack was easy to obtain. More than half (56% of males and 61% of females) reported that they strongly disapprove of trying cocaine, and 59% of males and 62% of females reported that they strongly disapprove of trying crack.

Students participating in the school survey reported minimal use of cocaine and crack, although the figures are higher than for adults: 2% of students reported ever having used cocaine, and 1% reported having used it in the previous month; 1.5% reported ever having used crack, and .8% reported having used it in the previous month. (7)

These figures can be compared with the results of the 1988 National Household Survey on Drug Abuse in the United States, the preliminary results of which have recently been released. The results showed that an estimated 33% of the population age 12 and over has ever tried marijuana, and 6% had used it in the previous month. Eleven percent of the population had ever used cocaine, and of those 2.9 million who had used it in the previous year, 11% used it once a week or more, and 4% of these users -- or 328,000 persons -- used it daily. For crack, the lifetime prevalence was 1%, and less than 1% (484,000) were current users. Disturbingly, 4.8% of high school seniors had used crack in the previous month. Unfortunately, the preliminary results do not distinguish between moderate and heavy use of alcoholic beverages, so it is difficult to discern abuse patterns. They do show that 25% of youth 12-17 had used alcohol at least once in the previous month (down from 31% in 1985), and that an estimated 47 million Americans drank once a week or more often in 1988. (8)

The Jamaican surveys, while providing information that helps to describe part of the picture, need to be considered in light of information that is available from other sources as well. Unfortunately, other types of studies that are generally used to complete the picture of drug abuse in a country or geographic area (e.g., community surveys of drug use, analysis

of drug-related diagnoses from medical records, and review of national drug-related mortality and morbidity data) have not been conducted or are not available. However, informed sources report that cocaine has been available (though until recently relatively expensive) in Jamaica for at least ten years and that crack has been available for at least three years. More importantly, the availability and use of cocaine has been significantly increasing for at least three years, and availability and use of crack has increased over the past 12-18 months. A further indication of the availability of crack is the fact that a representative of Narcotics Anonymous reports that they receive 10-15 calls each day from individuals identifying themselves as having a serious drug abuse problem and seeking treatment; in the past ten months, most of these callers have reported that they are addicted to crack.

Unfortunately, crack is relatively inexpensive, even by standards of the Jamaican economy. The price varies by geographic area and clientele, but ranges from J\$10 (or less) for a "rock" (a single use) in parts of Kingston to J\$20-J\$40 for the same amount on the North Coast. The latter differential is undoubtedly due to the influx of tourists, which raises the price of commodities in general. Numerous individuals have reported that, as in the U.S. and elsewhere, crack is also being offered gratis in social settings, including private parties and public establishments. This is a standard means of early distribution. Notably, the price of a bottle of beer is approximately J\$3, and of a bottle of rum is J\$30. The price of cocaine is less variable than that of crack, and still rather high: generally, it sells for J\$100 per gram.

The pattern of public perception of cocaine and crack use in Jamaica has paralleled that of the U.S. and elsewhere, with the generally held belief that cocaine is a drug of the upper and upper middle classes, and crack a drug of the lower class ghettos and middle classes. That perception has changed over the last few years in the U.S., particularly with regard to crack, and there is now the recognition that the problem is, or should be, of importance for the general population, and of priority for public and private sector policy.

The perception is also changing in Jamaica; there is an increasing awareness of rapidly changing trends in drug abuse. Informed sources report that, as a result of availability and low price, use of crack in Jamaica now cuts across socioeconomic strata, with youth 15-25 the heaviest users in the lower economic groups and young adults 18-40 the heaviest users in the middle and upper income groups. Crack is reportedly available in public and private schools, and in some of the poorest areas of Kingston in which unemployed youth who

are out of school are reportedly involved both in the distribution of crack and its use. Sources have estimated that in poorer parts of Kingston, for example, children as young as 12 are distributing and using crack; as many as 25% to 50% of youth in these areas may have experimented with crack.

The lack of substantive information hinders the ability to clearly define high risk groups, and clearly they vary by type of drug. However, based on the results of the two national surveys, on more recent information regarding drug abuse in Jamaica, and on trends in other countries, the following preliminary high risk groups can be described:

- Alcohol:           general population, and in particular youth to which advertisements are increasingly targeted
- Marijuana:        general population, and in particular youth
- Cocaine:          youth 15-25 and young adults 26-40 who are in middle and upper middle income populations
- Crack:            youth 12-25 of all socioeconomic strata, particularly low income populations
- Prescription  
Drugs:            general population, in particular young adults 25-40

The degree of susceptibility to drug abuse is often considered based on "additive" cofactors; that is, the more cofactors for abuse that pertain to an individual or population, the more likely that abuse will occur. For example, if one is uneducated, unemployed, a child of a dysfunctional family, and lives in an area in which drugs are widely available and relatively inexpensive, the probabilities are higher than average that abuse will occur. Similarly, if one lives in an upper class family environment in which risk taking and experimenting are accepted, parental supervision is minimal, and the family is dysfunctional, the probabilities are also higher that abuse will occur. The socioeconomic factors that make those in the lower socioeconomic strata at risk for drug abuse also pertain to their recovery, when they are trying to refrain from use. For example, the poor and disaffected groups are more vulnerable for involvement in distribution networks, and therefore for consequential abuse. Further, it is more difficult to design successful prevention strategies for these populations because of such factors as illiteracy.

b. Drug Abuse Prevention and Rehabilitation Programs in Jamaica

The GOJ has targeted drug abuse as a priority area of concern, and the Prime Minister has appointed an interministerial committee, with the Minister Without Portfolio and Minister for Parliamentary Affairs as Chair of this committee. Drug abuse prevention programs were initiated in Jamaica in the early 1980's. The National Council on Drug Abuse, established in 1984, is the administrative vehicle for conduct of projects.

With funding primarily from USAID, since 1984 the NCDA has, in addition to developing a five year plan and household and school surveys referenced previously, sponsored various drug awareness activities throughout Jamaica.

Other parts of the public sector have been involved in drug abuse prevention as well over the past five years, including the following:

- \* Ministry of Education, which, with UN funding, developed and implemented a school based drug abuse education project in 1985 which has been evaluated and which is planned for revision by the end of 1989; the MOE has also produced 30-minute programs that are broadcast over the Educational Broadcasting Service weekly;
- \* the Jamaica Broadcasting Corporation, which has developed and broadcast a number of drug prevention programs;
- \* the Jamaican Information Service, which has produced and broadcast drug prevention spots for its daily and weekly programs, and which is currently planning an anti-drug trafficking campaign; and
- \* Ministry of Youth and Development, which has operated a Family Life Education project since 1982; this project includes a strong peer training and leadership component, and focuses on health issues, including drug abuse.

Nongovernmental organizations involved in drug prevention activities include the following:

- \* University of West Indies, which directed the public awareness component of the NCDA's U.N. funded Narcotics Awareness Project, working directly with community councils at the parish level and with the Ministry of Education on parenting skills;

- \* Narcotics Anonymous, which was founded in 1984, and which, in conjunction with the Addiction Alert Organization, provides speakers (recovering drug abusers) on request for schools, health care facilities, churches, and other organizations;
- \* the Private Sector Organization of Jamaica (PSOJ), which has initiated plans for prevention (and rehabilitation) activities that could be supported in a variety of ways by the organization as a whole, and by individual member companies through financial contributions (the PSOJ is a member of the NCDA and is initiating collaboration with it on these activities); and
- \* The Scout Association of Jamaica, which in collaboration with Guides, Rangers, Red Cross, 4-H, Girls' and Boys' Brigades, Cubs, Brownies and Cadets has recently initiated a prevention campaign (Amplified Drug Abuse Prevention for Scouts - ADAPTS), which will include rallies, video messages, and training of youth for peer counseling and other activities.

In addition, organizations which have expressed an interest in drug prevention activities include Jamaica/Western New York Partners of the Americas, the Anglican Diocese of Jamaica, the Salvation Army, and Southern University, which was contracted to provide technical assistance to the Ministry of Education for the USAID funded Primary Education Assistance project. Importantly, the NCDA includes more than 20 private sector organizations in its general assembly.

While there is increasing interest on the part of private sector employers in establishing Employee Assistance Programs patterned on those in the U.S., they are keenly aware that to do so without the availability of rehabilitation services would be fruitless and unfair for those who would self-identify as drug abusers seeking treatment. There are no known employers who have attempted to set up counseling programs in their organizations.

Drug abuse rehabilitation services are scarce in Jamaica. In fact, there is only one free-standing program for the residential treatment of drug abuse -- a small private practice facility operated by a physician in Montego Bay. For short term detoxification, alcoholics and other drug abusers may seek treatment in a public or private hospital (e.g., the University of the West Indies hospital's 15-bed psychiatric unit), which have no health care providers specifically trained in treat-

ment of drug dependencies. Moreover, psychiatric units at the private hospitals are reportedly reluctant to admit drug abusers, maintaining, as do the public facilities, that their staff are not trained to care for the special problems of drug abusers. Upper and upper middle class Jamaicans who seek treatment do so in the United States; they may also seek treatment in Jamaica, with a private psychiatrist or other physician. However, it is reported that few such physicians are willing to provide such care.

Both Alcoholics Anonymous and Narcotics Anonymous (and their affiliate organizations such as Alateen and Alanon) have groups which meet weekly throughout the island; it has been estimated that approximately 200 Jamaicans are regular members of one or both of these self-help organizations. Volunteer members of these organizations will provide individual counselling to all those who seek it on an as needed basis. Some abusers reportedly attempt to self-treat, with no medical assistance. Several churches in Kingston, Mandeville, and the north coast operate community based counseling services provided voluntarily by church members who are health care providers, teachers or other professionals, some of whom have received some training in counseling methods. Reportedly, drug abusers have received counseling through these sources.

Mental health services have in other countries served as the basis for drug abuse rehabilitation, but in Jamaica the availability of such services is minimal. The MOH operates no specialized outpatient mental health facilities; however, the Ministry has 20 positions for mental health counselors at community health centers (these are nurses trained in mental health counseling). The MOH has one public psychiatric hospital, which also provides some outpatient care. (9) The UWI hospital has a psychiatric ward, as does St. Joseph's hospital. Reportedly, 15 psychiatrists practice in Jamaica; there are no figures for the number of psychologists who practice in the country.

The Addiction Alert Organization (AAO) has developed a proposal for a 30-bed in-patient treatment facility. AAO has been actively seeking private sector funding and has suggested that the GOJ underwrite 10 of the 30 beds. The treatment modality would follow the 28-day model developed in the U.S. and used in rehabilitation facilities throughout the world. The Richmond Foundation (based in England, with a Jamaican affiliate) also has a proposal for an inpatient rehabilitation facility. The NCDA is planning to incorporate both proposals, and plans from the MOH, as part of a comprehensive package of public and private sector plans for rehabilitation services in Jamaica for which they are seeking funding from the EEC and other donors.

### 3. Strategy

This project is designed to address a gap in the spectrum of public and private sector drug abuse prevention programs in Jamaica by focusing on secondary and tertiary prevention. As described previously, these levels of prevention target those individuals and groups most at risk for abusing drugs. This has been determined to be the area of focus for this project for the following reasons:

- 1) Jamaica appears to have a serious and growing problem of drug abuse; of particular concern is the significant increase in availability and use of crack among all socioeconomic groups. Also, drug abuse has significant socioeconomic costs which can be averted through targeted secondary and tertiary prevention programs.
- 2) While there were few identified secondary and tertiary drug abuse prevention projects in Jamaica, there have been and continue to be primary prevention projects (both public awareness activities and school based drug education programs). Thus, this project would fill a defined gap in prevention strategies.
- 3) The recent relative success of targeted secondary and tertiary prevention programs, as compared with general public awareness campaigns, in the U.S. and elsewhere, points to adapting strategies that make maximum use of GOJ, private sector, and donor resources.
- 4) As presently envisioned, the project components will have important multiplier effects (e.g., trained community workers can implement prevention activities at a variety of levels and can train others in the community; trained nurses and social workers can carry out detection and screening as well as tertiary prevention activities); technical assistance to the NCDA can guide this organization in policy planning and development which would be useful for all segments of its program.
- 5) Drug abuse has significant socioeconomic costs which can be averted through targeted secondary and tertiary prevention programs.

While this is the first drug abuse prevention project to be undertaken by USAID/Jamaica, project design builds upon activities previously financed by USAID under the NCDA/PAHO grant, related USAID projects involving assistance to community based organizations in the health and education sectors, and US Mission experience to date. The proposed project also builds upon drug abuse prevention activities planned and/or implemented by the public and private sectors in Jamaica, and on the limited experience of AID in general in the field of drug abuse.

For purposes of the project, prevention activities will be designed to recognize co-dependencies (i.e., the relationship between abuse of multiple drugs) and at the same time to take into account the different use patterns by socioeconomic group and other factors.

a. Overview of Project Strategy

An important aspect of the project will be the linkages that will be established both with ongoing prevention programs and with those that are in the planning stages, including those of the public and the private sector. The five year project will include three core activities: 1) developing human resources, 2) community based secondary and tertiary prevention activities, and 3) improvement in drug abuse prevention information.

Funds will be provided under a bilateral grant agreement with the GOJ. The National Council on Drug Abuse, through the Office of the Prime Minister, is the primary implementing agency in view of the fact that the NCDA has responsibility for developing and coordinating public policy and programs regarding both supply and demand for drugs, and it presently falls under the purview of the OPM. A subgrant will be made to a Jamaican nongovernmental organization (or private voluntary organization), to manage the community based secondary and tertiary prevention component of the project. This will consist of small grants to grassroots community organizations to undertake prevention activities directed toward high risk populations.

Intermittant local and expatriate technical assistance will be funded by USAID and provided to both the NCDA and the NGO (or PVO) as well as to the small grant recipients, as deemed appropriate and necessary. Funds will also be used for training, limited commodity support, and small grants to community based organizations undertaking secondary and tertiary prevention activities.

b. Relationship to USAID/Jamaica's Country Development Strategy and Current Projects.

The proposed project is consistent with AID's strategy to improve the development of human resources and health status of the Jamaican population, and with AID's interest in drug abuse prevention specifically. Further, it is consistent with the Department of State's 1989 International Narcotics Control Strategy Report which stresses the need for a comprehensive drug abuse prevention program in Jamaica, aimed at preventing an increase in cocaine abuse.

Although the Drug Abuse Prevention project is the first discrete project in the area of drug abuse awareness for USAID/Jamaica, the Mission, beginning in FY 1985, has funded drug abuse prevention and research activities in Jamaica, including the national household and school surveys of drug abuse and a public information component to further public awareness of the problem of drug abuse. These activities were undertaken by the NCDA, with the Pan American Health Organization (PAHO) serving as the executing agency. The USAID Population and Family Planning Project has a Family Life Education component covering a number of health and family planning issues, including drug education. The AIDS/STD Project also has a small drug abuse education component designed to address the linkage between AIDS and drug use. In addition, in 1988 USAID provided funds to JAMPRO for preparation and production of 5,000 brochures describing methods to secure packaging of exports as a means of narcotics control. The proposed FY 1990 Primary Education Project may also include a limited amount of funds for development and distribution of supplementary materials related to drug abuse awareness.

The Narcotics Affairs Unit of the American Embassy (under a bilateral agreement with the GOJ) and the United States Information Service in Jamaica have provided funds for long term training in the U.S., public awareness campaigns, workshops and other activities related to drug abuse prevention. The Drug Enforcement Agency also participates in drug abuse awareness activities, including providing speakers for schools, service clubs, and other organizations. All of these activities, as well as the drug prevention activities of USAID, are undertaken with the guidance of the U.S. Mission Narcotics Coordinator, the Deputy Chief of Mission.

c. Relationship to GOJ's Drug Abuse Policy and Programs

The Government of Jamaica has expressed urgent concern for the problem of illicit drug distribution and drug abuse and has indicated that it intends to take steps to reduce both demand for and supply of illicit drugs.

As evidence of this concern, the Prime Minister designated the Minister Without Portfolio and Minister for Parliamentary Affairs as the senior GOJ official responsible for overseeing all drug related matters. Reporting directly to the Prime Minister, this Minister chairs an interministerial committee comprised of five ministers: Minister of Health, Minister of Education, Minister of National Security, Minister of Agriculture, and Minister of Youth and Community Development. This committee coordinates national policies involving demand and supply of drugs. The National Council on Drug Abuse (NCDA) is a quasi-governmental advisory body operating out of the Office of the Prime Minister since 1985. For the first time in its existence, the operating costs of the NCDA have been included as a line item in the GOJ budget (J\$1.698 million for JFY 1989/90 to cover primarily salary and administrative expenses for a fulltime staff of 13). Legislation is in process to establish the NCDA as a Statutory Body; it is expected that this will be enacted in the next few months.

The NCDA has a 15-member Advisory Board comprised of representatives of the key related ministries (e.g., Ministry of Health, Ministry of Education, Ministry of National Security, Ministry of Youth and Community Development), as well as representatives of the private sector. In addition, there is a 60-member General Council comprising representatives of other public agencies and a wide range of private sector organizations. The NCDA is organized into 8 standing committees, six of which relate to programmatic areas (e.g., Public Education, Medicine/Research), and two of which relate to broader concerns: the Coordinating Committee and the International Cooperation Committee.

Recently, the NCDA has developed a five year Plan for Prevention and Control of Drug Abuse; this plan has served as one of the primary bases for development of this project. Project areas identified in the National Plan are: research and development, community based institutional strengthening, public education, schools education, coordination and dissemination of information, legal reform, security (supply and distribution of drugs), rehabilitation, alternative occupations, and international cooperation. Specific descriptions of priority projects for each of these areas are currently being defined by the NCDA based on proposals prepared by the standing committees over the past 2 1/2 years.

d. Current and Potential Donor Support for Drug Abuse Programs

There has been increasing interest in supporting drug abuse prevention and rehabilitation projects in Jamaica on the part of donors other than AID. For example, in addition to serving as the executing agency for the two AID funded surveys of drug abuse in Jamaica, PAHO has provided technical assistance and training to the GOJ for both public awareness and research programs. United Nations agencies (UNFDAC and UNDP) have

funded various activities of the NCDA. Other donors which have expressed an interest in funding drug abuse prevention or rehabilitation efforts in Jamaica include:

the European Economic Commission (EEC) (which may provide US\$500,000 for development and implementation of rehabilitation services), and

the Organization of American States (OAS) (which may provide an unspecified amount of funding for educational activities).

The NCDA and private sector organizations are in the process of preparing proposals for submission to funding sources, and in some cases have initiated negotiations with them. The NCDA is endeavouring to ensure that some level of funding is available for all three strategic areas of its policy agenda: control (supply), prevention (including general public awareness and targeted projects), and rehabilitation, as well as for institutional strengthening (including training and information systems development, for example).

### III. PROJECT DESCRIPTION

The Logframe, including quantification of project outputs and inputs, is included as Annex B to the Project Paper.

#### A. Goal, Purpose, Inputs and Outputs

##### 1. Project Goal and Purpose

The goal of the project is:

to prevent further significant increases in the abuse of drugs of all types among high risk groups in Jamaica during the life of the project.

The project purpose is to

improve the capability of the Jamaican public and private sectors to develop and implement drug abuse prevention programs aimed at high risk target groups, primarily youth between 12 and 25 years of age.

## 2. Project Outputs

Anticipated outputs of the Project include:

- \* 40 individuals having received short term training overseas and 500 having received local short term training locally in the design and implementation of secondary and tertiary prevention projects, drug abuse information systems, and related areas of drug abuse prevention (this includes, for example, community based paraprofessionals and professionals, health care providers, and public and private sector managers)
- \* establishment of at least five secondary and tertiary drug abuse prevention projects within existing community facilities in geographic areas identified as high risk and/or serving high risk population groups
- \* four training manuals and handbooks adapted and used by secondary and tertiary prevention and for facility level evaluation of such programs
- \* at least two short term, targeted epidemiological studies

## 3. Project Inputs

USAID funded project inputs include:

- \* Approximately 20 person months of local short term technical assistance and 3.5 person months of expatriate short term technical assistance to the GOJ and the NGO (or PVO);
- \* Approximately 15 person months of overseas training and approximately 20 local training sessions for personnel engaged in drug abuse prevention activities in the public and private sectors;
- \* Local costs for community based secondary and tertiary prevention activities, short term, targeted epidemiologic and evaluation studies; and
- \* Limited commodity procurement, including microcomputers and educational materials.

B. Description of Project Elements

1. Developing Human Resources for Drug Abuse Prevention

Few Jamaicans have received specific training in drug abuse prevention or research, or even in general drug abuse policy and program issues. The NCDA, which identified training of human resources as a critical part of its strategy to strengthen the capability of Jamaican institutions to respond to the drug problem, will be supported in this endeavour through this project. In the five year plan referenced previously, the NCDA linked training and human resource development to both prevention and rehabilitation, and included both public and private sector participants. Examples of the specific personnel to be trained include medical and health care practitioners, social workers, counselors, and managers and employee representatives of private firms.

This USAID funded project would provide support to the NCDA for short term incountry and overseas training. Training will be provided in order to meet the urgent need for personnel who can identify those with drug abuse problems, refer them for appropriate health and social services, and provide basic counseling prior to referral for rehabilitation. In some cases, because of the paucity of rehabilitation services available in Jamaica at present, the basic counseling and related social support services provided by those trained through this project may be the only rehabilitation services available. As the rehabilitation programs being coordinated by the NCDA are implemented, it will be important to ensure that the appropriate referrals are made to either public or private facilities, as available. Training of existing frontline personnel who already have some basic, appropriate skills either in health services delivery or in social action programs ensures that the maximum possible use is made of scarce resources available to Jamaica for its drug abuse program, and at the same time recognizes the importance of training those who are most in contact with persons at risk.

NCDA will have a fulltime project coordinator (not funded through this project) whose duties will include coordination of training programs and activities. During the first six months of the project, this person will develop a training needs assessment and plan, based largely on needs identified through

its project development process, which is currently underway. This needs assessment will include:

- \* identification of the types of personnel currently providing drug abuse prevention and treatment services,
- \* the types of training programs which have been implemented within the past five years, and the numbers and types of persons trained (e.g., physicians, social workers, teachers, youth workers),
- \* the numbers and types of personnel required to provide services identified through the project development process (i.e., the specification of the priority projects described in the National Plan), and
- \* the type of training appropriate for each category of personnel.

This Training Needs Assessment and Plan will then be used as the basis for setting priorities for training, for identifying the most appropriate existing local and overseas training programs, and for designing new programs to meet current needs. The Plan is expected to be reviewed and updated each yearly to ensure that it reflects changes in human resource needs.

Based on the list of personnel presented in the NCDA five year plan, and discussions with NCDA and others, the following is a list of the types of categories of participants in short term training, together with the types of training they would receive:

- NCDA staff, Board and General Assembly members (workshops and short term training in drug abuse policy and program issues in general, selecting, adapting, designing and evaluating secondary and tertiary prevention approaches, and designing and implementing drug abuse information systems);
- professionals and non-professionals working at the community level in public and private sector organizations, including but not limited to those working in the community based organizations receiving grants through this project, e.g., churches, Youth Clubs, service clubs, and other community based organizations (short term training focusing on crisis intervention, referral approaches, and means of developing secondary and tertiary prevention activities appropriate for specific high risk groups);

- physicians, nurses and social workers involved with programs, primarily focusing on those who directly serve high risk populations such as social workers assigned to juvenile detention centers (short term training focusing on early detection and screening, referral approaches, and basic counseling); and
- personnel managers and occupational health staff of private industry (short term training focusing on identification of those with drug problems and referral approaches).

Importantly, the project will make maximum use of short term training programs operated by U.S. and Caribbean organizations at minimal or no cost. These include, for example, U.S. Office of Substance Abuse (OSAP) training and workshops which require no fee, and the University of the Virgin Islands Caribbean Institute for Alcoholism and Drug Abuse, which has low cost workshops and seminars. Further, training materials which have been produced in the U.S. using USG funds, and which are therefore in the public domain (i.e., at minimal or no cost), will be adapted for use in Jamaica where possible. Such materials can be identified from OSAP (perhaps with assistance from USIS). Further, because of the extensive funding that is available in the U.S. for drug abuse prevention activities, there are numerous opportunities to take part in low cost (or gratis) training, either through structured training programs, or through participation in USG-sponsored (primarily OSAP, NIDA and NIAAA) conferences and workshops at which prevention strategies are presented and discussed. As appropriate, arrangements will be made to involve Jamaican participants in these training opportunities.

## 2. Community Based Secondary and Tertiary Prevention Activities

Several private sector organizations have initiated activities which, while not necessarily explicitly designed as secondary or tertiary drug abuse prevention, can serve as the basis for such programs. Such activities include referral networks for drug abuse counseling, community based counseling services for the general public, activities for unemployed and low income youth, and sports activities for youth in general.

Organizations which have initiated such activities include churches (e.g., Bethel Baptist Church and First Missionary Church in Kingston), service clubs (e.g., Kiwanis), grassroots social service or development organizations, and other nongovernmental, voluntary organizations (e.g., self-help groups such as Alcoholics and Narcotics Anonymous, Boy Scouts, 4-H Clubs).

In order to both use the opportunity to expand rapidly secondary and tertiary prevention efforts, and build upon this base of private sector initiatives, the USAID project will provide funds for, at a minimum, five community based small grants to support activities in centers or programs that already exist and which are providing related services. In order to help ensure a more coordinated effort and make maximum use of the resources available, it is preferable to provide support to these groups through a Jamaican nongovernmental or private voluntary organization. Involving an intermediary NGO or PVO will also make it possible to ensure the closest possible links with and among grassroots organizations which have direct contact with high risk populations. This is true because, when implementing prevention projects related to illicit drugs, direct financial arrangements with either a GOJ agency (e.g., the NCD), or with a US agency (USAID) may be seen by grassroots organizations which are potential grantees as a barrier to effective prevention.

The types of activities that could be supported through these small grants include:

- \* peer leadership programs operated through community centers or youth clubs (including, e.g., individual and group discussion of drug abuse and workshops on self-esteem);
- \* development of drug awareness materials (including, e.g., plays, music, posters and videos) by high risk group members themselves with consultation from voluntary professionals;
- \* cultural and sports activities for high risk youth and young adults, coupled with drug prevention and healthy lifestyle education (including voluntary involvement of Jamaican cultural and sports figures, and with reference to use of steroids, in the case of sports activities);
- \* peer tutoring of high risk youth to enhance basic skills and encourage completion of formal schooling; and
- \* referral linkages between community centers and other support systems such as training and employment programs, and with rehabilitation services.

The NCDA will cooperate with the NGO or PVO to identify and obtain descriptions of community based prevention projects in the U.S. which are directed toward comparable high risk groups, and which have been shown to be effective. This organization, working with the community groups, can then adapt from these strategies those which may be applicable to the Jamaican context.

An important linkage among the project components is the short term training that will be provided through the NCDA to staff and volunteers of the community organizations which are carrying out the prevention projects. Such short term training, which will include participation in local workshops designed for larger audiences as well as those specifically designed for the community grants projects, will include, for example:

- \* designing and putting into place specific prevention strategies targeted to high risk populations,
- \* organizing communities for drug abuse prevention activities
- \* appropriate management and evaluation systems (including, for example, maintaining records for service provision), and
- \* referral networks for linkages between the prevention programs and existing social support projects (e.g., skills training) and rehabilitation services.

In addition, technical assistance will be provided to the community based organizations through the umbrella implementing agency for planning and implementation. To the maximum extent possible, the NGO or PVO will identify voluntary technical assistance.

Such technical assistance can include, for example, fiscal management (simple accounting and recordkeeping), preparing of project designs, and design and preparation of multi media prevention messages.

In addition to training available through the NCDA, staff and volunteers of those organizations involved in the community based small grants will be provided with training and prevention materials. In addition, USAID will assist in the financing of manuals for use in the evaluation of secondary and tertiary drug abuse prevention programs. These evaluation manuals may be adapted to meet AID's reporting needs and also to be used directly by the programs and by the GOJ for planning and management purposes.

In order to improve the capability of community based programs to identify critical needs, plan for prevention programs designed to meet those needs, and evaluate the effectiveness of those programs, the USAID project will provide appropriate staff with training in recordkeeping and program evaluation.

### 3. Improvements in Drug Abuse Prevention Information

Technical assistance will be provided to NCDCA in the ongoing collection and analysis of information (gender disaggregated when feasible) useful for decision makers at all levels of the public and private sector to:

- 1) determine the extent and type of drug abuse in Jamaica (i.e., community level epidemiology), and
- 2) determine changes in the need and demand for secondary and tertiary prevention (to assist the GOJ and private sector in planning comprehensive drug abuse policy and programs).

Short term technical assistance will also be provided to the NCDCA in the design and implementation of small scale epidemiologic studies (e.g., community based studies of cocaine and crack use, review of hospital medical records and emergency room observation). As appropriate, funds will be provided through the training component of the project (see above) to arrange for those responsible for developing and maintaining the NCDCA information system and those responsible for drug abuse research, and others as appropriate, to participate in short term training regarding their respective areas of responsibility.

To further assist the NCDCA in improving its information base, it will be provided with a microcomputer and peripherals which will have sufficient hard disk capacity to store and analyze epidemiologic, financial, services and other data. In addition, the umbrella NGO (or PVO) will receive a microcomputer and peripherals for use in compiling needs and service information provided by the small grant programs.

In order to ensure that current information is available regarding use and availability of drugs, short term, small scale, community based epidemiologic studies will be funded through the project. While all such studies will be coordinated with the Research and Development Committee of the NCDCA, it may be appropriate for USAID to contract for and fund several such projects directly.

### C. Project Beneficiaries

The training of public and private sector health and social service personnel and the provision of support for community based services are seen as mechanisms for beginning to meet the needs of those most at risk for drug abuse among the population of Jamaica. The direct beneficiaries of this project will include:

- 1) those participating in short term training programs and receiving technical assistance, including those providing direct services at the community level, health and social service professionals and paraprofessionals, and public and private sector officials and staff responsible for drug abuse policy and programs, and
- 2) those receiving services from the five secondary and tertiary community based prevention centers, specifically groups within those communities most at risk for drug use (see Section II for specific categories by type of drug).

Although the national school and household surveys indicate relatively lower levels of drug abuse among Jamaican women, there are indications from informal reports that, with such surveys in the U.S. and elsewhere, abuse among females is consistently under-reported in such surveys. Further, in other countries, women are much less likely to seek preventive counselling and support than are men; this may be true for Jamaica as well, although there are no data available to support or disprove this hypothesis. However, the project will be designed to pay attention to this possibility by generating gender disaggregated data and involving women in planning for the community based prevention centers, training women in secondary and tertiary drug abuse prevention, including specific sections regarding women and drug abuse in training curricula, and ensuring that outreach programs are designed to take this issue into consideration.

## IV. COST ESTIMATES AND FINANCIAL PLAN

### A. Overview

The total estimated cost of the five year Drug Abuse Prevention Project is US\$704,000. Of this total, USAID will contribute \$500,000, the GOJ \$137,000, and the NGO community \$67,000. Estimated expenditures for USAID for the first year of the Project are \$143,000. Approximately 74% (US\$370,000) of USAID funding will be reserved to implement NCA activities related to training, technical assistance and commodities. The

remaining funds (US\$130,000) will be provided through the GOJ to the umbrella NGO or PVO and community based organizations for small, targeted secondary and tertiary prevention activities.

In addition it is expected that complementary funds will be available from the U.S. Embassy's Narcotics Affairs Unit and United States Information Service for drug abuse public awareness activities, small scale studies of availability and use of selected drugs (to supplement those to be carried out through this project), overseas and incountry training, and some technical assistance. Over the five year life of the project, these funds are estimated to total approximately \$500,000. USAID will coordinate closely the activities of this project with those of NAU and USIS.

The project will be carried out through the following implementation arrangements:

- \* AID direct contracts for short term US and local technical assistance, including buy-in arrangements for short term technical assistance and training through projects such as the proposed AID centrally funded project on drug abuse.
- \* Host country contracts to Jamaican and US contractors, including nongovernmental and nonprofit organizations for specific project activities, including for example, the subgrant to NGO or PVO for the community based small grant prevention program, short term contracts for the design and conduct of short term training programs and workshops and design and implementation of short term community based epidemiologic studies;

## B. Funding

The AID grant funding of \$500,000 will be obligated in a Bilateral Grant Agreement with the Government for all expenditures. All funds will be earmarked in the form of Project Implementation Letters (PILs) addressed to the Government of Jamaica and Project Implementation Orders issued by USAID for direct procurement of goods and services. Funds will be committed by PILs or AID direct contracts, depending on the activity. Funds requiring US dollar expenditures will be committed by Host Country or AID direct contracts, wherein AID is named in all cases as the paying agent. There will be six separate budget elements as follows:

Element 1	Development of Human Resources
Element 2	Community based Secondary and Tertiary Prevention Small Grants Program
Element 3	Improvements in Drug Abuse Prevention Information
Element 4	Evaluation/Audit
Element 5	Administration
Element 6	Contingency/Inflation

Element 1: Development of Human Resources. AID funds will be used primarily for short term local and overseas training in drug abuse and in skills related to implementation of drug abuse prevention programs. In addition, funds will support the use of local and expatriate technical assistance to assist the NCDCA in identifying appropriate overseas training programs, and in designing, implementing and evaluating in-country training programs, as appropriate. For overseas training, the Government of Jamaica will be expected to contribute the costs of international airfare for public sector participants. For private sector participants, the organizations which these individuals represent will be expected to contribute the cost of international airfare. In the event that a proposed participant would be unable to attend an overseas training course because of the lack of demonstrable funding for travel, AID will consider funding such costs. AID funds will be used for other costs associated with U.S. or third country training, including course registration fees and maintenance allowances. Commodities to be purchased or produced through this component are limited to informational and educational materials, including print and audiovisual materials (e.g., books, pamphlets, training guides, videotapes).

Element 2: Community based Secondary and Tertiary Prevention Small Grants Program. AID funds will be used for management costs of the NGO or PVO umbrella agency, and for a minimum of five secondary and tertiary prevention grants to be operated by community based organizations. These organizations will receive up to \$5,000 each to operate programs for a three year period. These funds will be used for staff, supplies, transportation (but not purchase of vehicles), and other expenses as appropriate for community based prevention activities. This component also includes funds for US and local technical assistance and for local and US short term training. These funds are intended to supplement the training activities that will be coordinated by the NCDCA, and in which the small grant recipients can also participate.

Element 3: Improvements in Drug Abuse Prevention Information. AID funds will be used for local and overseas technical assistance to provide initial consultation to the NCDA in developing a national drug abuse information system, with a focus on epidemiologic data. Funds will also be used for contracting by the NCDA (and, where appropriate, directly by USAID) for the conduct of small scale epidemiologic studies. In addition, funds will be used to purchase two microcomputers and related peripherals, one for the NCDA and one for the NGO or PVO which manages the small grants program.

Element 4: Evaluation and Audit. AID funds will be used for hiring of local and U.S. consultants to perform an evaluation of the project during the third year of implementation. The GOJ and NGO (or PVO) will contribute to this element in the form of counterpart input to the evaluation; \$15,000 will be used to audit the NCDA and the NGO or PVO subgrantee for financial capability and for other audit requirements.

Element 5: Administration. The GOJ will contribute a minimum of US\$75,000 over the life of the project in the form of NCDA staff time and other inkind contributions for administration of this project and for activities to be carried out related to components 1 and 3 (training and information improvement).

Element 5: Contingency/Inflation. Funds for contingency and inflation are figured at 3.5% of the project budget, and will be earmarked and committed over the course of the project as needed to adjust for circumstances not seen during the project design. The percentage of funds allocated for this element is low, and any shortfalls will require the shifting of funds from other elements, thereby reducing planned inputs.

### C. Cost Summary

Table 1 presents the Summary Cost Estimate and Financial Plan subdivided by inputs and financial sources.

Table 2 describes the relationship between costing of project inputs and project outputs.

Table 3 presents a detailed estimate of project expenditures over the life of the project. These figures are subdivided by budget element and source of funds for each project year.

It should be noted that GOJ and NGO contributions to training include staff time and fringe benefits of employees on leave for training.

TABLE 1 - SUMMARY COST ESTIMATE AND FINANCIAL PLAN  
(In Thousands)

INPUTS BY COMPONENT		AID			GDJ		NGD		TOTAL		GRAND
		FX	LC	TOTAL	LC	LC	FX	LC	LC	TOTAL	
1. Human Resource Devp.	Local Training	0	130	130	38	0	0	168	168		
	US Training	92	0	92	14	12	92	26	118		
	Other (3rd country) Training	15	0	15	6	5	15	11	26		
	TA - Short Term	25	10	35	0	0	25	10	35		
	Commodities	10	0	10	0	0	10	0	10		
Subtotal		142	140	282	58	17	142	215	357		
2. Community Based Prevention Activities	Sub-grant	0	85	85	0	41	0	126	126		
	US TA Short term	25	0	25	0	0	25	0	25		
	U.S. Training	24	0	24	0	3.5	24	3.5	27.5		
	Local Training	0	6	6	0	1.5	0	7.5	7.5		
Subtotal		49	91	140	0	46	49	137	186		
3. Imp. Drug Abuse Prevention Inform.	Local TA	0	15	15	0	0	0	15	15		
	US TA	15	0	15	0	0	15	0	15		
	Commodities	0	6	6	0	0	0	6	6		
Subtotal		15	21	36	0	0	15	21	36		
4. Evaluations & Audit	Short term TA	6	19	25	0	0	6	19	25		
5. Administrative Support	J Staff	0	0	0	75	0	0	75	75		
6. Contingency/Inflation (@ 3.5%)		7	10	17	4	4	7	18	25		
TOTAL		219	281	500	137	67	219	465	704		

TABLE 2  
COSTING OF PROJECT INPUTS/OUTPUTS  
(in U.S. \$ (000's))

INPUTS BY COMPONENT

	TRAINED PERSONNEL		COMMUNITY PREVENTION ACTIVITIES		TRAINING HANDBOOKS		EPIDEMIOLOGIC STUDIES		TOTALS	
	AID	GOJ/ NGO	AID	GOJ/ NGO	AID	GOJ/ NGO	AID	GOJ/ NGO	AID	GOJ/ NGO
<b>1. Human Resource Development</b>										
Local Training	75	48	25	0	15	0	15	0	130	48
Overseas Training	60	22	37	10	0	0	10	5	107	37
US TA	15	0	5	0	10	0	5	0	35	0
Commodities	10	0	0	0	0	0	0	0	10	0
Subtotal	160	70	67	10	25	0	30	5	262	85
<b>2. Community Based Prev. Activities</b>										
Sub-grant to Local NGO	0	0	25	25	0	0	0	0	25	25
Small grants	0	0	60	16	0	0	0	0	60	16
US TA	5	0	20	0	0	0	0	0	25	0
US Training	4	0.5	20	3	0	0	0	0	24	3.5
Local Training	1	0.5	5	1	0	0	0	0	6	1.5
Subtotal	10	1	130	45	0	0	0	0	140	46
<b>3. Imp. Drug Abuse Prev. Information</b>										
Local Consultants	0	0	0	0	0	0	15	0	15	0
US TA	0	0	0	0	0	0	15	0	15	0
Commodities	0	0	3	0	0	0	3	0	6	0
Subtotal	0	0	3	0	0	0	33	0	36	0
<b>4. Evaluation/Audit</b>										
	13	0	9	0	2	0	1	0	25	0
<b>5. Administration</b>										
	0	50	0	5	0	15	0	5	0	75
<b>6. Contg./Inflation</b>										
	9	4	5	2	1	1	2	1	17	8
-----										
TOTALS	192	125	214	62	28	16	66	11	500	214

TABLE 3 - Projection of Expenditures By Fiscal Year (US 000s)

COMPONENT	YEAR 1			YEAR 2			YEAR 3			YEAR 4			YEAR 5			TOTAL			GRAND
	AID	GOJ	NGO	AID	GOJ	NGO	AID	GOJ	NGO	AID	GOJ	NGO	AID	GOJ	NGO	AID	GOJ	NGO	TOTAL
<b>1. Human Resource Devel.</b>																			
Overseas Per Partic. (1)																			
U.S. @ \$2,000	10	2	2	10	2	2	4	1	1	4	1	1	4	1	1	32	7	7	46
U.S. @ \$3,000	15	2	1	15	2	1	9	1	1	12	1	1	9	1	1	60	7	5	72
UVI/CARIAD @ \$1,000	5	2	2	5	2	2	5	2	1	0	0	0	0	0	0	15	6	5	26
Local Per Partic. (2)																			
@ \$1000	20	2	0	15	2	0	10	2	0	0	2	0	10	1	0	55	9	0	64
@ \$500	5	2	0	5	2	0	5	2	0	5	2	0	5	1	0	25	9	0	34
@ \$250	5	2	0	5	2	0	5	2	0	5	2	0	5	2	0	25	10	0	35
@ \$100	5	2	0	5	2	0	5	2	0	5	2	0	5	2	0	25	10	0	35
Educ/Trng.Materials	2	0	0	2	0	0	2	0	0	2	0	0	2	0	0	10	0	0	10
US Tech. Assis.	15	0	0	15	0	0	5	0	0	0	0	0	0	0	0	35	0	0	35
<b>Sub-total</b>	<b>82</b>	<b>14</b>	<b>5</b>	<b>77</b>	<b>14</b>	<b>5</b>	<b>50</b>	<b>12</b>	<b>3</b>	<b>33</b>	<b>10</b>	<b>2</b>	<b>40</b>	<b>8</b>	<b>2</b>	<b>282</b>	<b>58</b>	<b>17</b>	<b>357</b>
<b>2. Community Based Prevention Activities</b>																			
NGO/PVO & Small Grants	15	0	7	15	0	7	20	0	10	20	0	10	15	0	7	85	0	41	126
U.S. Tech. Assis.	10	0	0	10	0	0	5	0	0	0	0	0	0	0	0	25	0	0	25
U.S. Training	10	0	1	5	0	1	3	0	0.5	3	0	0.5	3	0	0.5	24	0	3.5	27.5
Local Training	0	0	0	0	0	0	2	0	0.5	2	0	0.5	2	0	0.5	6	0	1.5	7.5
<b>Sub-total:</b>	<b>35</b>	<b>0</b>	<b>8</b>	<b>30</b>	<b>0</b>	<b>8</b>	<b>30</b>	<b>0</b>	<b>11</b>	<b>25</b>	<b>0</b>	<b>11</b>	<b>20</b>	<b>0</b>	<b>9</b>	<b>140</b>	<b>0</b>	<b>46</b>	<b>186</b>
<b>3. Imp. Drug Abuse Prevention Inf. Sys.</b>																			
Local Consultant (2US200/DAY)	5	0	0	5	0	0	5	0	0	0	0	0	0	0	0	15	0	0	15
U.S. Tech. Assis.	10	0	0	5	0	0	0	0	0	0	0	0	0	0	0	15	0	0	15
Commodities (2 Micro computers & peripherals)	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	6
<b>Sub-total</b>	<b>21</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>36</b>	<b>0</b>	<b>0</b>	<b>36</b>							
<b>4. Evaluations And Audit</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>25</b>	<b>0</b>	<b>0</b>	<b>25</b>
<b>5. Administrative Support</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>75</b>	<b>0</b>	<b>75</b>
<b>TOTAL</b>	<b>143</b>	<b>29</b>	<b>13</b>	<b>122</b>	<b>29</b>	<b>13</b>	<b>95</b>	<b>27</b>	<b>14</b>	<b>58</b>	<b>25</b>	<b>13</b>	<b>65</b>	<b>23</b>	<b>10</b>	<b>483</b>	<b>133</b>	<b>63</b>	<b>679</b>
<b>6. Contingency (approx. 3.5%)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>1</b>	<b>1</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>17</b>	<b>4</b>	<b>4</b>	<b>25</b>
<b>GRAND TOTAL</b>	<b>143</b>	<b>29</b>	<b>13</b>	<b>128</b>	<b>30</b>	<b>14</b>	<b>100</b>	<b>28</b>	<b>15</b>	<b>61</b>	<b>26</b>	<b>14</b>	<b>68</b>	<b>24</b>	<b>11</b>	<b>500</b>	<b>137</b>	<b>67</b>	<b>704</b>

D. Methods of Financing

The methods of implementation and financing listed in Table 4 are all in accordance with the Agency's payment verification guidelines. The NCDA through the OPM, will be the GOJ implementing agent and will be responsible for all host country accounting, financial reporting and contracting for goods and services. USAID will provide detailed guidance in host country procurement practices through project implementation letters and direct assistance by the Project Officer and other USAID personnel.

After the NCDA is established as a Statutory Body, USAID will have a Chartered Accounting Firm conduct a review of their capabilities to carry out the functions addressed above. The findings of the review will be addressed before any project funds are advanced. Funds are also budgeted to conduct additional audit reviews if required during the course of project implementation.

V. IMPLEMENTATION ARRANGEMENTS

A. Overview

The Implementation Schedule in Table 5 presents the five year plan of activities and responsible parties for the project components as outlined in Section IV. Necessarily, only minimal detail can be provided for activities in the last three years of the project, as they are largely dependent on changes in the epidemiologic patterns of drug use, on the relative success of the community based programs, and on changes in technologies available to prevent and treat drug abuse.

TABLE 4 - METHODS OF IMPLEMENTATION AND FINANCING  
(IN THOUSANDS)

COMPONENTS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	AMOUNT
1. Human Resource Development			
Local Training	H/C Contracts/POs	Adv/Reimbursement	130
U.S. training	PIO/Ps & Travel/Auth	Transfer of Funds/Dir Payment	92
Third Country Training	PIO/Ps	Direct Payment	15
Short Term TA (US)	Direct Contract	Direct Payment	25
Short Term TA (Local)	H/C Contract	Adv/Reimbursement	10
Commodities	Direct Contract	Direct Payment	10
2. Community Based Prevention Activities			
Grants	H/C	Adv/Reimbursement	85
Short Term TA (U.S)	Direct Contract	Direct Pay	25
U.S. Training	PIO/P/Travel Auth	Transfer of Funds/Dir. Payment	24
Local Training	H/C Contract/FC	Advance Reimbursement	6
3. Imp. Drug Abuse Prevention Info			
Short Term TA (U.S)	H/C Contract	Adv/Reimbursement	15
" " (Local)	Direct Contract	Direct Payment	10
Commodities	AID Direct	Direct Pay	6
4. Evaluation/Audit	Direct Contract	Direct Payment	25
5. Contingency/Infl.			17
			-----
			500

TABLE 5  
IMPLEMENTATION SCHEDULE

ACTIVITIES	MONTHS					
	1-6	7-12	13-24	25-36	37-48	49-60
<b>MANAGERIAL ACTIVITIES/MILESTONES</b>						
--Signing of Project Agreement	x					
--Signing of Sub-grant Agreement	x					
--NCDA becomes statutory body	x					
--NCDA is certified by USAID for fiscal responsibility		x				
<b>1. Human Resources Development</b>						
-- Training Plan Developed by NCDA	x					
-- Selection of Priorities for Year 1	x					
-- Logistical arrangements for overseas training	x	x	x	x	x	x
-- Design/arrangements for local training	x	x	x	x	x	x
-- Overseas training		x	x	x	x	x
-- Local training		x	x	x	x	x
<b>2. Community Based Prevention Strategies</b>						
-- Selection of/negotiations with community organizations	x					
-- Implementation of at least 5 projects		x				
-- On-going monitoring/evaluation of projects			x	x	x	x
-- Selection of additional projects					x	x
<b>3. Improvements in Drug Abuse Prevention Information</b>						
-- Initial design of drug abuse information system	x	x				
-- Procurement of micro-computers	x					
-- conduct of community based epidemiological studies		x	x	x	x	x
<b>4. Evaluations &amp; Audit</b>						
		x		x		x

## B. Components

The implementation of the Drug Abuse Prevention Project will be a joint public and private sector effort which will be closely coordinated with the overall policies and programs of the NCDA. The NCDA is currently in the process of designing specific plans for the priority project areas defined in its five year plan; therefore, as these specific projects are described in more detail, the related components of this USAID funded projects will be clarified. For example, USAID can coordinate with the NCDA to further identify priority categories of participant trainees and the types of community epidemiological studies that are most critically needed. The implementation plans and schedule described below take into account the development of the NCDA's priority projects, as well as other critical scheduling factors.

1. Development of Human Resources. Within the first six months of the project, the NCDA will have prepared a Training Needs and Assessment Plan which can be used as the basis for determining the priority categories of training participants, training content, and sources of such training. The NCDA staff will work closely with its appropriate standing committees (e.g., the Coordinating Committee and the Public Education Committee), as well as with other representatives of its Advisory Board and General Council, to identify personnel as candidates for training. Within the first year of the project, it is expected that approximately 11 participants will have received overseas training, and 100 will have received local training. Over the course of the project, decreasing numbers will be trained overseas, as local capability for short term training in drug abuse has been expanded through training of trainers programs. By the end of the project, approximately 40 individuals will have received overseas training, and 500 will have received local training.

### 2. Community based Secondary and Tertiary Prevention Small Grants Program.

Within the first three months of the project, the GOJ will award a subgrant to a NGO (or PVO) to initiate, manage, and implement the small community based prevention grants. Selection and award of the subgrant will be in accordance with competitive procedures outlined in AID Handbooks 1B and 11.

The organization selected for management of the small grant prevention projects should:

- \* Be a nongovernmental or voluntary organization with strong ties to public and private sector organizations representing a broad cross section of the Jamaican population, including grassroots organizations serving high risk populations
- \* Have demonstrated experience in managing and implementing projects related directly or indirectly to drug abuse prevention
- \* Have demonstrated experience in implementing projects which have as target groups the populations defined as at high risk for drug abuse
- \* Preferably have experience in managing donor financed projects
- \* Involvement in public and/or private sector policy and program development regarding drug abuse, either through organizational or individual membership on the NCDA

Within the first three months after execution of the subgrant, the subgrantee will: 1) develop a set of project design materials for use by the potential small grant recipients in preparing their proposals, 2) conduct a two day workshop to assist the potential grantees in consideration of alternative drug abuse prevention strategies appropriate for the Jamaican high risk groups, and 3) select the recipients of the first small grants. It is anticipated that at a minimum, five such projects will have been initiated by the end of the first year of the project.

For a number of reasons (e.g., to encourage interest in community based drug abuse prevention activities and for consideration of the most appropriate and low cost prevention strategies), it would be useful to fund as many as possible community based prevention projects in the initial years of the project, with decreased numbers of grants (or increases in grant awards) for the remaining two years of the project. This would allow for maximum flexibility in this important component of the project, in particular in view of the fact that such prevention projects are relatively new to Jamaica. Each project would receive no more than US \$5,000 for the life of the grant. These funds would be used to partially support staff, materials, activities (e.g., costs of participation in sports events, conduct of community education workshops) and purchase of educational materials not already available through the NCDA or other sources.

In order to ensure that the small grants are directly meeting the needs of high risk groups, criteria have been developed to use in selection of the organizations that would receive the grants. These criteria are:

- \* sufficient experience in conduct of successful community based activities (5 years or more, preferably having been evaluated by an external organization);
- \* evidence of commitment to drug abuse prevention, including voluntary educational activities, participation in public or private sector prevention programs;
- \* direct experience with providing services to high risk groups;
- \* clearly defined approach to secondary and tertiary prevention, and understanding of drug abuse prevention issues (which can be determined after the workshop described above) and
- \* demonstrated knowledge of community problems and concerns, particularly drug abuse.

### 3. Improvements in Drug Abuse Prevention Information

During the first two years of the project, local and expatriate technical assistance will be provided to the NCDA to assist in the design and implementation of a national drug abuse information system. The funding level of the project does not allow for this to be a major component. Therefore, establishment of a drug abuse information system has not been identified as a verifiable indicator for the Logframe. However, because efforts will be made to assist the NCDA in identifying other sources of support that can be used to provide additional technical assistance as necessary, improved information regarding drug use and availability is a verifiable indicator. As envisioned, the NCDA drug abuse information system to which this USAID project will partially contribute will be designed to have integrated subsystems, including for example:

- \* epidemiologic information from a variety of sources (e.g., the two national surveys, short term studies, hospitals and other health facilities),

- \* service statistics from the public and private sectors (including diagnoses, procedures, resources used),
- \* impact data (including drug-related motor vehicle accidents and crime), and
- \* other information as appropriate.

The NCDA is planning to design a system that could use a microcomputer with sufficient capacity to sort and analyze data, as necessary when linked with a mainframe computer, and to use off the shelf programs where possible (e.g., LOTUS123, SYSTAT, DBaseIV or Paradox).

Because the NCDA urgently needs to have available a microcomputer for the initial development of this system, and for inputting data which are currently available, USAID will work closely with the NCDA over the first three months of the project to develop specifications for a microcomputer and related peripherals to be purchased as soon as possible. In addition, a microcomputer and peripherals will be procured for the NGO or PVO managing the small grants program.

As information gaps regarding use and availability become apparent, through the information system and other sources, the NCDA will commission short term community based epidemiologic studies. These studies may, for example, be used to identify current use patterns in a specific geographic area, or use patterns of a particular drug (e.g., alcohol or crack). When it is deemed appropriate to do so, USAID may contract directly for such studies, contracting for them in such a manner that confidentiality of sources of information would be protected. To the maximum extent possible, the information system will generate and incorporate gender disaggregated data.

#### C. Institutional Arrangements.

The NCDA is the GOJ agency with primary responsibility for developing and coordinating public policy and programs regarding both supply and demand for drugs. However, that agency is not yet a statutory body (enacting legislation is expected to be in place in upcoming months), and financial accounting systems are not currently in place. Therefore, USAID funding will be provided through a bilateral grant agreement with the Ministry of Finance, with the NCDA, operating through the Office of the Prime Minister, serving as the primary implementing agency. When the NCDA has financial

and management auditing systems in place which have been reviewed and approved by AID as being adequate for accountability of AID funds, consideration will be given to assigning full implementation responsibility to the NCDA, which will be the GOJ entity with direct responsibility for drug abuse policy and programs. It is expected that this will take place within the first year of the project.

For the interim period, the Permanent Secretary for the Office of the Prime Minister will be responsible for monitoring the project, with day to day monitoring with respect to policy issues resting with the Executive Chairman of the NCDA, and with project implementation issues resting with the Executive Director of the NCDA. When and if the project can be directly assigned to the NCDA, the GOJ person responsible will be the Executive Chairman of the NCDA, with day to day responsibility for project implementation residing with the NCDA Executive Director.

A subgrant will be made to a nongovernmental or private voluntary organization to manage the small grant program for community based prevention projects. Prior to any grant award, the USAID Controller's Office will certify the capability of the selected organization to fiscally manage the project.

The specific tasks to be undertaken as part of the subgrant will be specifically defined prior to award of the subgrant (during the first two months of the project). They will include, for example:

- \* providing guidance to the potential grant recipients in identification of appropriate prevention strategies and preparation of project proposals;
- \* review of proposals submitted by the community based organizations, and selection of grantees in consort with the NCDA and USAID;
- \* monitoring of project progress;
- \* provision of voluntary technical assistance; and
- \* ensuring necessary linkages with other aspects of the USAID funded project (e.g., training of staff and volunteers) and with other public and private sector drug prevention programs in Jamaica.

The organizations which have been identified as potential recipients of the initial small grants are listed in Table 6, with a brief description of their current activities and the types of drug abuse prevention activities that they would undertake.

TABLE 6: POTENTIAL COMMUNITY GRANT RECIPIENTS AND THEIR ACTIVITIES

ORGANIZATION	CURRENT RELATED ACTIVITIES	TYPE OF DRUG ABUSE PREVENTION GRANT ACTIVITIES	CATEGORY OF POSSIBLE SUPPORT	COMMENTS
1. First Missionary Church	Recreational and extra curricular educational activities with high risk youth	Implement peer leadership programs Educational activ. designed by the community	Educational materials Staff support Funds for sports, cultural activities	Located in high risk area; serve high risk youth
2. Bethel Baptist	Provides counseling services, but not specifically drug related	Youth outreach	Educational materials Staff support Funds for sports, cultural activities	Serves high risk population
3. Webster Memorial (Mel Nathan Inst. for Devp. & Social Research)	Reportedly provides drug abuse counseling services	Provide after school activities for youth 12-17	Educational materials Staff support Funds for sports, cultural activities	Serves high risk population
4. Law Street Trade and Training Center	Provides counseling services, operates training program and social service projects	Educational activities linked to training Serve as local clearinghouse for area Personal financial mgmt. (savings, planning)	Educational materials Staff support Funds for sports, cultural activities	High risk area, serves high risk youth
5. HEAT	Organization comprised primarily of recovering who volunteer time for community based prevention & rehabilitation services (focused on low, middle income populations, and on creative activities, e.g., street theater), has good association with NEDA	Expand capability to develop & implement creative prevention strategies (e.g., theater, multimedia presentations, music), with involvement of target audiences in such development Personal financial mgmt. (savings, job planning)	Staff support Transportation to events Materials for theater productions, educational & audiovisual materials	High risk area, serves high risk youth (rural & urban)
6. Addiction Alert Organization	Associated with AA, NA and self-help groups; provide voluntary support for rehab. referral and speakers for various groups	Increase capability of self help groups to provide services to members, to increase membership, and to perform outreach tertiary	Educational materials Staff support to work with existing groups and help initiate new ones	Serves high risk population
7. Youth Club or organization - e.g., Jamaica 4-H Clubs, Shona Youth Club, Sheffield All-Age Youth Club	Activities focus on educ., sports, cultural events, peer leadership, and/or small scale enterprise	Implement peer leadership programs Educational activ. designed by youth members and others in the community Youth outreach Identify high risk youth and refer for counseling Coordinate drug educ. with social service support (e.g., skills training)	Educational materials Staff support Support for sports, arts activities Transportation to events	Serves high risk youth (In the case of Shona Youth Club, located in high risk area)

ORGANIZATION	CURRENT RELATED ACTIVITIES	TYPE OF DRUG ABUSE PREVENTION GRANT ACTIVITIES	CATEGORY OF POSSIBLE SUPPORT	COMMENTS
8. Sistren	Women's Center with arts, educational, community outreach programs (including popular theater group)	Outreach to high risk women Educational, arts activities directed toward women, particularly high risk groups (e.g., prostitutes) Personal financial mgmt. (savings, job planning)	Educational materials Staff support Materials for theater productions, educational & audiovisual materials	Access to high risk population; urban & rural
9. Jamaica Amateur Athletic Association	Training, counseling and organizing youth 14--15 years in track & field events Has been involved with Just Say No Campaigns in Jamaica	Drug education and other prevention strategies for high risk youth; peer leadership	Educational materials Staff support Support for sports activities Transportation to events	Access to high risk population; urban & rural
10. Legal Aid Clinic	Provides a full range of legal advice & assistance to Jamaicans in need.	Early detection & screening, drug education for high risk youth who seek legal advice	Educational materials	Serves high risk population Located in high risk areas

D. USAID/Jamaica Organizational Responsibilities

Implementation and monitoring responsibility within USAID will primarily rest with the Office of Education and Human Resources. The USAID Project Officer will be responsible for preparing all earmarking and committing documentation, drafting all Project related correspondence, preparing AID semi-annual reports, and assisting the NCDA and NGO or PVO in making all arrangements for technical assistance and training. USAID will also review and approve all contracts and subgrant proposals submitted for funding. Additional Mission support will be provided by other USAID offices as appropriate (i.e., to include the Office of Health Nutrition and Population, Office of Program and Project Development, Executive Office, and Controller's Office) and the USAID/Jamaica Narcotics Coordinator.

The Project Committee, which has been in place since the initial plans for the project were developed, will continue to monitor project progress.

In the case of the subgrant and contracts, the Office of the Prime Minister (OPM) and NCDA, with assistance from USAID/Jamaica, will prepare necessary documentation for approval by USAID and relevant GOJ agencies. In general, the simplest, most expeditious and most cost-efficient form of committing mechanisms and documentation will be utilized. The specific committing document to be used will depend on the activity being funded, and may include a PIO/T, PIO/P, PIO/C, Project Implementation Letter, Subgrant Agreement, contract, or travel authorization. USAID will review and concur with all contracts and subgrants made through the project.

E. Procurement Plan

During the first three months of the project, USAID, with assistance from NCDA and the NGO (or PVO), will prepare documentation (in line with A.I.D. Handbook 14) for purchase of the following commodities:

- 2 Microcomputers and peripherals
- 2 Standard Printers

These will be procured by AID for the NCDA and the NGO (or PVO) using competitive procedures.. It may be possible to procure these items off the shelf locally, in which case Handbook 15 procedures would be followed.

Training materials required for use in the short term workshops and seminars will be identified both as part of the training plan, and throughout the duration of the project. Lists of booklets and audiovisual materials have already been made available to NCDA; these could be used as a partial basis for selection of materials appropriate to Jamaica. In addition, some funds would be used for the adaptation of such materials for the Jamaican context. Contracts for such adaptation or purchase of materials would be prepared by the NCDA and reviewed by USAID prior to award.

Contracts for US and Jamaican technical assistance would be prepared by the NCDA and reviewed by USAID prior to award. In addition, some US and local TA would be contracted directly by USAID (e.g., for conduct of community epidemiologic studies). It may also be preferable to secure assistance through buy-in arrangements under AID's centrally funded drug abuse prevention project.

Within the first three months of the project, a subgrant will be made to a nongovernmental or private voluntary organization in Jamaica to manage the small grant program for community based prevention projects. Selection and award of the subgrant will be in accordance with competitive procedures outlined in AID Handbooks 1B and 11.

## VI. MONITORING AND EVALUATION ARRANGEMENTS

### A. Monitoring and Reporting

Monitoring of the Project will be carried out by both the OPM/NCDA and USAID/Jamaica in order to: (a) assure that the inputs are being provided in a timely manner, (b) determine the extent to which planned outputs are being achieved, and (c) take timely corrective action when necessary. Project personnel will periodically meet with other donors, representatives of NAU and USIS, and the DCM to ensure coordination of drug abuse program efforts.

In terms of USAID/Jamaica's monitoring arrangements, the Project Officer will have primary responsibility. Annually, the Project Officer will compile and summarize quarterly financial and managerial reports from the OPM/NCDA and the NGO. Additionally, the USAID Project Committee will conduct regular assessments of Project progress through the Mission's semi-annual review process. Project progress will also be monitored through the close collaboration of the Project Officer and the USAID Controller's Office.

## B. Evaluation

It is anticipated that the Drug Abuse Prevention Project will be evaluated during the third year of the project. The evaluation will focus on implementation issues, including determination of progress toward achievement of indicators related to each project component; e.g.:

A minimum of 5 small grant prevention projects are operational,

NCDA has improved information base as a partial result of community epidemiologic studies and operational information system,

100-200 individuals have received short term training.

This information will enable USAID and the NCDA to determine what action would be necessary to ensure that project indicators are likely to be reached by the end of the project, and whether or not project activities are on track.

This evaluation will be carried out by external evaluators over a two week period. The evaluators should have specific expertise in drug abuse prevention programs.

## VII. SUMMARIES OF ANALYSES

### A. Technical Analysis

There are several ways to consider the priorities in drug abuse prevention, and care has been taken in the project design not to make hard and fast delineations (and project limitations) prior to availability of more information regarding use patterns, relative success of existing programs, and other factors. In developing the training plan, and working with the community groups to design the community based prevention programs, the GOJ, the NGO or PVO, and USAID will take into consideration the target groups and areas at which such activities will be directed. These include definitions of high risk groups (see the background section for preliminary identification of such groups), and geographic areas, such as low income areas of Kingston and the North Coast. The latter is important because, although it is known as a center for drug trade among tourists, the local population is increasingly a client group for the trade.

1. Drug Abuse Prevention Program Strategies in the United States.

Jamaica has minimal experience with secondary and tertiary prevention programs, and thus little experience based knowledge that is specific to the Jamaican context can be brought to bear on this project design. However, experience in the U.S., which has a lengthy history of design, implementation and evaluation of such programs, can inform this project design.

For some time, drug abuse prevention programs in the U.S. were seen as having little success, as evidenced by ever increasing incidence and prevalence statistics, and by other use patterns such as teenagers' expanding the types of drugs with which they would experiment (e.g., crack in addition to alcohol and marijuana). Recently, however, experimentation among the general population seems to be on the wane. (10)

Preliminary findings from the U.S. Office of Substance Abuse Prevention's (OSAP) evaluation of its community based grants programs, and from other U.S. government sources, indicate that involvement of the community in drug abuse prevention efforts over the past five years or so has played an important part in this decline. The types of factors that seem now to consistently indicate the likelihood of program success include the following, which have adapted from a number of sources (11):

- \* clearly delineated plans, and involvement of as representative a group as possible in the process of planning for the project,
- \* clearly delineated goals and objectives which have been developed based on a community needs assessment,
- \* use of multiple prevention strategies which are culturally sensitive and which have been shown to be applicable to comparable populations, but which are adapted specifically for the target population (or, in the case of newly designed strategies, which are likely to be applicable, given comparable approaches), taking into account cultural, ethnic, socioeconomic and gender factors,
- \* involvement of the broader health and social support system, including the public and private sectors, and linkages with intervention, referral, treatment and aftercare components of the local or national drug abuse program,

- \* community involvement in the implementation and evaluation of the program as well as in the planning (this creates a vested interest in the success of the project),
- \* recognition that the problem is a long term one, with integration of related prevention activities into the education, work and social lives of the community, and
- \* explicit and well publicized interest and commitment (including financial resources) on the part of national and local leaders and role models in the public and private sector (including but not limited to musicians, athletes, artists, elected and appointed officials).

In working with community organizations to design and implement their prevention activities, the NGO or PVO managing the community based small grants program, will ensure that these factors are taken into account. Moreover, it will be important for the NCDA to continue its efforts to ensure that as representative a group as possible is involved in planning and implementing prevention programs. The General Council's broadbased representation augers well for this involvement. Additionally, representatives of the Rastifarian community and of popular entertainment groups which have publically taken a position against drug abuse might be involved.

Additionally, it will be important to ensure that other projects in the USAID/Jamaica portfolio (e.g., the Primary Education Project, Basic Skills Training, CLASP II, Population and Family Planning, and Health Sector Initiatives) are linked in the most appropriate and feasible manner possible.

One technical problem with regard to drug abuse prevention has been the tendency for the public and private sectors to (usually unwittingly) fund or otherwise sponsor mixed messages. This results in considerable confusion for the target audience, and has been shown to be counterproductive. (In fact, in the U.S. it resulted in a temporary moratorium on federally funded drug abuse prevention programs in the early 1970's.) Currently, NCDA has a planned mechanism, through its committee structure, to ensure that information/educational materials use are most appropriate and cost effective for the Jamaican population. The review procedure is also designed to ensure that, for example with regard to education, different

"messages" are not being provided by the same organization (e.g. MOE), or by different organizations that serve the same target population (e.g., MOE and MYCD).

Short term training represents a substantial proportion of this project, with nearly 40 participants receiving training overseas, and 500 locally. The types of training envisioned, and the schedule of training, ensure that the participants can be trained within the LOP, as planned.

## 2. AID Funded Drug Abuse Prevention Programs.

Prior to this project, USAID funded drug abuse activities in Jamaica have been the school and household surveys, and public awareness component, the small JAMPRO activity, and the Family Life Education component of the Population and Family Planning Services project. This project does not include funds for surveys on the scale or of the type conducted previously.

The only known assessments of the USAID and UN funded NCDA public education activities are 1) that conducted by the Ministry of Education on the primary education materials (the report is yet to be formally issued), and 2) the recently issued evaluation of the NCDA Narcotics Awareness Project. (12)

This evaluation indicates that, of the community based projects initiated through the project, 8 of the 13 parish level committees are active. An internal review of the various training and workshop activities showed that constraints to successful implementation included lack of continuity among groups and individuals involved, and need for increased support from a coordinated national agency. There has been no external evaluation of drug abuse prevention projects in Jamaica.

There is no clear AID guidance on the definition of which activities or elements are considered to be included in drug abuse prevention, and on what is considered tertiary prevention rather than treatment. The most recent official AID/W policy directive (AID Narcotics Policy Paper, 1981) focuses on crop substitution, and provides no direction regarding demand side activities, including prevention and rehabilitation. However, a LAC Bureau cable addressed to USAID/Bolivia (13), which was sent in response to a request for policy clarification, advised that the utilization of limited AID resources for treatment is discouraged. Lack of guidance therefore hampers the ability of USAID/Jamaica to develop a project design that can effectively make use of USAID and Jamaican resources and take into account Jamaican needs.

There is a related technical issue in this regard. Unless or until there are at least minimal rehabilitation services available, it would be unreasonable (and unethical) to implement public awareness campaigns that create a demand for such services. Even in the case of a telephone hotline unless the operators were trained to provide emergency counselling and it were made clear that rehabilitation services are not currently available, ethical issues arise. However, this issue has been factored into project design in that this project will assist in developing the human resource base necessary for comprehensive drug abuse prevention, and the NCDA is actively seeking funding from other donors for drug treatment facilities.

Several USAID missions in the Latin American and Caribbean region have funded drug abuse prevention projects over the past four years; these include projects in Bolivia, Panama, Peru, Colombia, Haiti, Belize and Mexico. The projects have included such components as:

- \* public awareness campaigns,
- \* school based education (including teacher training),
- \* education and training of parents, youth leaders, religious groups, and health care professionals,
- \* conduct of research projects, and
- \* support for hotlines.

The evaluations of only two of these projects (in Peru and in Belize) were available at the time of the preparation of this Project Paper. (14) The following is a compilation of findings from those two evaluations.

- \* There must be broad representation in the planning, implementation and evaluation process, including at the community level.
- \* It is essential to identify and address the immediate concerns of the population in order to ensure their cooperation in addressing issues of more general concern.
- \* There must be commitment on the part of all concerned to ensure that any strategies and materials are reflective of cultural diversity in the population served.

- \* Insofar as possible, training of trainer models should be used.
- \* It is essential to work with a small group of concerned individuals and groups who will be willing to devote time and effort to the project.
- \* It is essential to secure voluntary support from the private sector, including mass media time and resources, time commitments from sports and cultural figures, and others.
- \* The drug abuse prevention policies and programs must be those of the host country, and not dominated by the U.S.

In addition, several Jamaican public sector programs exist on which community based activities could be built. These include the Ministry of Youth and Development's Youth Clubs and the Ministry of Education's SCOPE project. The latter has generated interest and capability on the part of local community advisory councils with regard to school vandalism. Local groups which have participated in both public and private sector projects, which are located in high risk areas for drug abuse, and which have demonstrated success in related activities (e.g., Youth Clubs and local SCOPE councils) could be encouraged to participate in the drug abuse prevention project, both through NCDA training activities and by participating as one of the small grant recipients (see below).

#### B. Economic Analysis

Drug abuse has well documented and significant economic impacts. The type of impact can vary by the type of drug abused (e.g., alcohol abuse and drunk driving, cocaine or crack abuse and related illicit crime), but many indicators cross classes of drugs; these include, for example: decreased productivity, industrial accidents, related health effects which require increased utilization of the health care system. Having considered available information regarding the extent of the problem in Jamaica, and the availability of prevention programs, USAID/Jamaica reviewed alternative approaches to select that which is likely to be most cost-effective in Jamaica.

First and foremost, a null approach (i.e., not to support prevention) is not cost-effective because it ignores the severity and socioeconomic cost of drug abuse. Primary prevention activities have been implemented at least

minimally, in Jamaica, and such untargeted approaches are not generally considered cost-effective in preventing drug abuse. Most studies of secondary and tertiary prevention programs in the U.S. and Europe have shown that well designed, targeted secondary and tertiary programs can be cost-effective. (15) The factors that are correlated with improved cost efficiency are analogous to those listed previously from the US prevention projects, and include involvement of the target audience in the project planning and implementation, adaptation of strategies to the particular social, economic and cultural context of the project (rather than de novo development), use of voluntary support where possible, and strong linkages with health and social support systems, and ongoing monitoring to ensure that the project is on track and that funds are being appropriately allocated.

It should be noted that most studies of the cost and effectiveness of prevention projects have been limited to assessments during the operation of the project, rather than to determination of the durability of success. It has been difficult to evaluate long term success of projects because funds for post-project evaluation are rarely allocated, and because of methodological problems inherent in evaluating such programs.

Because secondary and tertiary drug abuse prevention programs are relatively new to Jamaica, it is not possible to generalize from these findings. However, a simple assessment of the estimated economic impact of drug abuse in Jamaica, based only on data readily available, shows the following:

- \* Annual lost wages due to alcohol abuse total  
J\$29,240,000 (US\$5.4 million)

Estimated number of alcoholics: 10% of the 170,000 persons, estimated from the draft National Household survey to have consumed 5 or more drinks on one occasion in the month prior to the survey

Average wage/month: J\$430

Average number of months unable to function per year: 4

- \* Annual hospital costs due to treatment of alcoholism and alcohol-related medical and psychological illnesses: J\$21,500,000 (US\$3.9 million)

10% of total hospital costs in 1988: J\$215.7 million (This is a conservative estimate; there have been no empirical studies of the cost of treating alcohol-related illnesses in Jamaica. The estimate for the U.S. and for many European countries is 20-30%.)

\* Annual lost wages due to crack addiction: J\$2.5 Million (U.S. \$466,311)

Estimated number of those addicted to crack: 25% of those who are estimated from the National Household survey to have ever used crack: 1464

Average wage/month: J\$430 (It may actually be higher for the crack user than for the alcoholic.)

Average number of months unable to function per year: 4

The estimated cost of lost wages due to ganja abuse cannot be calculated without additional data regarding levels of use. The draft results of the National Household Survey do not provide data regarding debilitating effects of drug use, but rather frequency of use. This can be used to estimate effects of alcohol, cocaine and crack use, but not ganja, as frequency is not an indicator of debilitating effects.

Other costs which are usually included in calculations of the economic impact of drug abuse, and which are not available at this time in Jamaica, include: costs of automobile accidents, workplace accidents, decreased productivity while on the job, treatment of physical and psychological abuse inflicted in family members and others as a result of drug abuse, economic instability in a community (e.g., loss of productive workers to "employment" in the drug trade), crime against person and property.

However, even given the limited assessment of the economic impact of drug abuse in Jamaica, the financial costs are high, and the potential benefits from this USAID funded project are substantial. For example, given a 10% success rate in reducing the prevalence of drug abuse, and other measures taken by the GOJ (e.g., imposition of strict driving while intoxicated laws), there could be an annual savings of US\$930,000 after the first year for alcohol abuse costs alone.

Using the numbers of individuals expected to be served directly by the project, the following is a minimum estimate of the economic costs which may be averted over the life of the project, as a result of secondary and tertiary prevention activities supported by the project;

250 high risk youth who are employed	X	J\$1,720 (lost wages) +	X 5 years
		J\$1,200 (hospital costs)	

Total: J\$3,600,000 (\$663,636)

An additional benefit roughly equal to this amount (\$700,000) would result from the project if half of these youth remained drug free for the remainder of their working years, based on the present value of their added earnings as a result of drug avoidance.

During the course of the project, the NCDA will be provided with technical assistance to assist in determining economic costs of drug abuse which will allow for a more thorough cost benefit analysis of this project and other public and private sector prevention strategies.

### C. Social Soundness Analysis

#### 1. Social and Cultural Context

There is clear evidence that the abuse of drugs is increasingly crossing socioeconomic strata in Jamaica, and as affecting Jamaican youth in particular, principally those between low and lower middle income youth between 15 and 25 years of age.

The use of ganja is endemic in Jamaica, with widespread use beginning in the late 1960's. Some Jamaicans indicate that its use has diminished among school children in recent years; the explanations for this possible decrease are varied and conflicting. Use of ganja is considered acceptable by Rastafarians, for whom it is part of a cultural and religious norm. Importantly, ganja use has crossed socioeconomic strata, and continues to do so. The same is true for alcohol. For example, weekly use of white rum by rural males - often to the point of inebriation - is considered an appropriate ending for a week of hard labor, and heavy drinking has been known to be widespread among the middle and upper urban classes since the mid-1960s.

Cocaine and crack are increasingly seen as drugs introduced to the Jamaican population by outside forces, as a foreign menace that has the potential to be destructive of Jamaican society.

There is concern that Jamaica could become "another Colombia or Washington, D.C." in the words of many, with local (and in the worst case, national) economies heavily dependent on cocaine and crack. As has been the case in most other countries, because of its expense, use of cocaine predominated among the upper middle and upper classes when it was originally introduced, but the decline in cost in recent years, as well as other factors, has resulted in its being increasingly used by the middle class. Crack, on the other hand, has since its introduction been relatively inexpensive (a daily supply can cost as little as J\$10); its use, therefore, permeates socioeconomic strata.

Poverty, unemployment, low educational levels, disaffection, and inadequate social support systems, are known to be factors that increase susceptibility to drug abuse in an individual and in communities. Indicators of these variables place Jamaica at high risk for abuse of drugs among its population, particularly the lower socioeconomic groups. For example, in 1988 the unemployment rate was 8.5% among job seekers (16), and only 64% of the eligible population (ages 12-17) was enrolled in secondary schools. (17)

Conversely, the social and economic costs of drug abuse are well-documented in other countries, and are known anecdotally in Jamaica. Drug abuse is a causal factor in spouse and child abuse, dissolution of marriages or couples, violent behavior (including rape, armed assault, and murder), decreased productivity, and physical and psychological illnesses (including chronic obstructive pulmonary disease, liver cirrhosis, AIDS and STDs), motor vehicle accidents, and local and national political destabilization. These are consequences that Jamaica can ill afford. Unfortunately, there are scant data available in Jamaica to demonstrate these consequences of drug abuse. The NCDA is keenly interested in developing an information system that would be used in part to compile and analyze such data, and use it as the basis for developing national strategies.

During the development of the project, discussions have been held with senior GOJ officials responsible for drug abuse policy and programs, and with NGO representatives having an interest in or involvement with drug abuse prevention activities. The draft PID and PP were reviewed by and comments received from representatives of the GOJ, including the OPM, NCDA and the Planning Institute of Jamaica.

One of the three components of the project, Community Based Prevention Activities, focuses on developing and implementing projects at the community level, with participation on the part of target groups insofar as possible. The NGO or PVO umbrella agency under which these grants will be managed will provide technical assistance throughout the terms of the grants to assist the local organizations in applying community organization techniques to ensure maximum community and target group participation in project planning and implementation.

With regard to sociocultural feasibility, it must be acknowledged that few drug abuse prevention projects have been shown to have been successful in substantially reducing the incidence or prevalence of drug abuse. Notwithstanding the apparent positive trends reported recently in the U.S., it should be noted that while casual experimentation has been somewhat reduced, it is nonetheless at a very high level, and that abuse and addiction (particularly of crack) continues to increase. Prevention strategies directed toward low income populations are particularly difficult to design and implement, in part because poverty, low levels of education and disaffection are themselves cofactors in drug abuse (see discussion above). For example, it is often a futile task to convince a young adult who sees himself or herself as having few options in life that distributing and using crack is harmful to his or her health, and destructive of life choices.

However, this project has been designed to make the most effective use of technologies that have in the recent past been shown to have some effect in minimizing the consequences of drug abuse: train frontline personnel in identification, referral and initial intervention techniques, improve the information base to enable decision makers to develop more targeted strategies at the national and local levels, and develop the capacity for local organizations to utilize their resources to carry out prevention activities. At the same time, the general awareness of and knowledge regarding drug abuse will significantly increase at the national and local levels, and within the public and private sectors.

#### D. Administrative Analysis

The project will be implemented under a bilateral grant with the GOJ Ministry of Finance, with implementation initiated with the NCDCA, operating through the OPM. A subgrant will be provided to a nongovernmental organization or private voluntary organization, as described previously. The project is designed

to assist in the institutional strengthening of the NCDA, which will shortly become a statutory body with recurrent costs covered through the GOJ budget, and also to expand the capability of the private sector in managing and implementing community based prevention activities. The advantages and disadvantages of involving these implementing agencies are summarized below.

NCDA. Within the next few months, the NCDA is expected to become a permanent agency within the GOJ, with substantial coordinating responsibility and authority. Its 15-member Advisory Board includes key relevant Ministers (e.g., from the MOE, the MOH and the MYCD), and representatives of key organizations in the private sector selected from the organizations represented on the 60-member General Council. Importantly, the NCDA is bipartisan and includes a wide range of private sector organizations. The NCDA has planned a staff including 13 professionals who will work with 8 committees to design and implement projects through the Ministries and the private sector. In order to help ensure the effectiveness of this organization, USAID has focused this project on needs identified in the NCDA five year plan which relate to long term strengthening of the capability of the GOJ to design and implement effective drug prevention policies and programs.

The NCDA staff complement includes an executive director, an internal auditor, 4 accountants, senior secretary, 3 secretaries, personnel officer, office manager, financial controller, secretary, and for each of three geographic zones in Jamaica: a deputy director and 2 field officers. These deputy directors would also have responsibility for programmatic areas (e.g., education, health, interdiction). In addition, there will be a research officer and a research librarian. The Executive Director, and a full time consultant with responsibilities for liaison with the Coordinating Committee, and two secretaries are currently on staff. The full complement of staff is expected to be in place by the end of 1989.

A disadvantage of working through the NCDA is that at the time of project design finalization, it does not yet have a full complement of staff, and is not likely to have such for several months. Further, the volatile nature of drug abuse issues in any country calls for combined public and private sector involvement. While the NCDA General Council includes representatives from the private sector, the organization is nonetheless governmental.

The NCDA has initiated coordination of the drug abuse activities of the various ministries which have representatives on its Board, and with private sector organizations (e.g., the Medical Association of Jamaica) to the maximum extent possible. This coordination is intended to include, for example, review and comment on all public awareness education material and training being proposed or considered by the public sector. This should considerably enhance the probability that resources will be appropriately allocated and decrease the probability that "mixed messages" will be provided to the public, school children in general, and high risk groups specifically.

A non-governmental organization (or private voluntary organization). Involving the private sector through an NGO or PVO is seen as a mechanism for ensuring that some activities can take place outside of this structure. Importantly, however, these will be coordinated with those of the NCDA to ensure that they are complementary rather than duplicative, and that they relate to priorities of the NCDA's national plan.

Criteria for the selection of the umbrella organization has been listed earlier. It is, however, important to note that such an organization can provide an important networking device for the grassroots community organizations and it will help identify and provide voluntary technical assistance to the small grant recipients. Also, in implementing prevention projects related to illicit drugs, direct financial arrangements with either a GOJ agency or with a US agency may be seen by grassroots organizations which are potential grantees as a barrier to effective prevention.

There is precedent for private sector involvement in health education directed toward high risk populations: the ACOSTRAD teenage pregnancy and AIDS/STDs activities have received USAID funding, the first indirectly through United Way and the second directly as part of the USAID funded AIDS/STD Project.

#### E. Environmental Concerns

The Initial Environmental Examination prepared by the Mission recommended a Categorical Exclusion for the Drug Abuse Prevention project. The LAC Bureau Environmental Officer concurred with this recommended threshold decision (Annex E).

### VIII. CONDITIONS AND COVENANTS

There are no special conditions precedent or covenants associated with this project.

## ANNEX A

### References

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16. Economic and Social Indicators 1988, p. xv
17. Economic and Social Indicators 1988, op cit, p. 18.6

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<b>Project Goal:</b>			
To prevent further significant increases in the abuse of drugs of all types among high risk groups in Jamaica between 1989-1994	Reduction in reported use of illicit drugs, non-medical use of prescription drugs, and abuse of alcohol	Surveys of target population  Health facility records, MOH reports of drug related disorders	Funding secured from other donors to increase and improve treatment facilities
<b>Project Purpose</b>			
To improve the capability of Jamaican public and private sectors to develop and implement drug abuse prevention activities aimed at high risk target populations, primarily youth aged 12 to 25	300 urban high risk youth having participated in secondary or tertiary prevention activities	Project records	GOJ and private sector groups continue commitment to stemming drug abuse
	200 rural high risk youth having participated in secondary or tertiary prevention activities	Project records	
	Improvements in knowledge, attitudes and behavior regarding drug use on the part of participating high risk youth	Project records & followup interviews	
<b>Project Outputs:</b>			
1. Trained professional and community based personnel	540 trained community leaders, physicians, nurses, gatekeepers, and others in drug abuse prevention	Project records (for process indicators) Pre and post followup surveys for KAP	Willingness and interest of NGO or PVO and grassroots community groups to participate in project  Sufficient numbers of personnel available for training
2. Prevention training manuals	4 training manuals and handbooks adapted and used for secondary and tertiary prevention and for evaluation of such programs	Project records	
3. Community prevention projects	5 in place end of 1994	Project records	
4. Improved information base	2 community epidemiology studies Improved data available to NCDA	NCDA Information System operational, including project data	
		NGO/PVO community based small grant program information system established	

**Project Inputs**

<b>1. Technical assistance</b>	<b>Project Budget</b>	<b>Project records</b>	<b>Inputs are appropriate and are provided/available on a timely basis</b>
US Technical Assistance			
Local Tech. Assistance			
<b>2. Training</b>			
Overseas			
Local			
<b>3. Small Grants</b>			
<b>4. Commodities</b>			

## 5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes. Country Checklist completed with FY PAAD 11/88.  
Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?

CN sent on 8/1/89  
and expired without  
objection 8/15/89.

2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

N/A

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No;

N/A

7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

Only (b) is applicable to this project. The project is designed to foster the development and implementation of drug abuse prevention activities by private sector groups.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. Jamaica is contributing 25% of the total cost of the project in local currency and in kind
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? The U.S. does not own excess foreign currency.
11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other a) No  
b) No  
c) No  
d) No

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A

15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A

16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? If assistance is made available to a PVO, that organization will be requested to provide auditing information as necessary. The PVO or NGO is yet to be determined

17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N/A

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). Will be done as soon as signed.

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B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1989 Appropriations Act Sec. 548  
 (as interpreted by conference report  
 for original enactment). If  
 assistance is for agricultural  
 development activities (specifically,  
 any testing or breeding feasibility  
 study, variety improvement or  
 introduction, consultancy,  
 publication, conference, or  
 training), are such activities (a)  
 specifically and principally designed  
 to increase agricultural exports by  
 the host country to a country other  
 than the United States, where the  
 export would lead to direct  
 competition in that third country  
 with exports of a similar commodity  
 grown or produced in the United  
 States, and can the activities  
 reasonably be expected to cause  
 substantial injury to U.S. exporters  
 of a similar agricultural commodity;  
 or (b) in support of research that is  
 intended primarily to benefit U.S.  
 producers?

N/A

b. FAA Secs. 102(b), 111, 113, 281(a).  
 Describe extent to which activity  
 will (a) effectively involve the poor  
 in development by extending access to  
 economy at local level, increasing  
 labor-intensive production and the  
 use of appropriate technology,  
 dispersing investment from cities to  
 small towns and rural areas, and  
 insuring wide participation of the  
 poor in the benefits of development  
 on a sustained basis, using  
 appropriate U.S. institutions;  
 (b) help develop cooperatives,  
 especially by technical assistance,  
 to assist rural and urban poor to  
 help themselves toward a better life,  
 and otherwise encourage democratic  
 private and local governmental

a) Low income groups will be  
 involved in the planning and  
 implementation of community  
 based prevention projects; some  
 will also participate in short  
 term training.

b) N/A

c) The project is designed to  
 improve the capability of the  
 Jamaican public and private  
 sectors to plan and implement  
 drug abuse prevention activities.

d) Women will be involved in  
 the planning and implementation  
 of drug abuse prevention  
 activities, through their  
 participation at the national  
 and community levels in organi-  
 zations undertaking such  
 activities.

66'

institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

a) The implementing agency cooperates with other countries in the region in curbing drug abuse, and continued cooperation is encouraged.

- c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used? Yes
- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A
- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes

- g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

Project was developed jointly with GOJ representatives and includes local technical assistance and training
  
- h. FY 1989 Appropriations Act Sec. 536. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No

  

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No

  

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No
  
- i. FY 1989 Appropriations Act. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No

  

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

N/A

j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? To the maximum extent possible, such organizations which have recognize capability in drug abuse prevention will be considered for short term US training and US TA.

l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase Yes

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production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

- m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

- n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? No
- o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? No
- p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA; N/A

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(c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa;

(d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups;

(e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

9. FY 1989 Appropriations Act Sec. 515.  
If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified?

N/A



ANY REPLY OR SUBSEQUENT REFERENCE TO THIS COMMUNICATION SHOULD BE ADDRESSED TO DIRECTOR GENERAL, PLANNING INSTITUTE OF JAMAICA, 39-41 BARBADOS AVENUE.

PIOJ  
012866

PLANNING INSTITUTE OF JAMAICA  
TELEX 3529, PLANJAM JA  
P.O. BOX 634,  
KINGSTON,  
JAMAICA.

FAX #92-64670  
C-18-15-1-1

4th September 1989

Mr. William Joslin  
Mission Director  
United States Agency for International  
Development  
6B Oxford Road  
Kingston 5.

Dear Mr. Joslin,

Re: Drug Abuse Prevention Project

This letter constitutes the formal request of the Government of Jamaica to the United States Agency for International Development (USAID) for funding to implement the Drug Abuse Prevention Project.

The project seeks to prevent further significant increases in the abuse of all types among high risk groups in Jamaica between 1989 and 1994. In order to achieve this the project will establish the capability to develop and implement drug abuse prevention programmes primarily aimed at high risk target groups, that is youth between 12 and 25 years. The project will also establish linkages between on-going prevention programmes and those in the planning stages in the public and private sector. The core activities of this five-year project will be 1) human resource development 2) improvement in drug abuse prevention information, and 3) community-based secondary and tertiary intervention activities.

USAID is being requested to make available the sum of US\$500,000 on a grant basis to finance the project.

Yours sincerely,

*Denise Irving*  
Denise Irving (Miss)  
for Director General

DATE RECEIVED <i>9/8</i>	ACTION OFFICER: <i>C.P.E.P.</i>	INFO TO: DIR - ARDO D/DIR - OHNP OPEP - GEHR OPDS - OPED OEEE - OCM EXQ/... - RHUDO CONT - R.F.	DUE BY: <i>9/8</i>	ACTION: <i>[Signature]</i>
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*10/9/89*

AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

LAC-IEE-89-65

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Jamaica  
Project Title : Drug Abuse Prevention Project  
Project Number : 532-0161  
Funding : \$500,000  
Life of Project : 5 years  
IEE Prepared by : Charles R. Mathews  
Mission Environmental Officer  
Recommended Threshold Decision : Categorical Exclusion  
Bureau Threshold Decision : Concur with Recommendation  
Comments : None  
Copy to : Willian Joslin, Director  
USAID/Kingston  
Copy to : Andre DeGeorges, RDO/C  
Copy to : Charles Mathews, USAID/Kingston  
Copy to : Dianne Blane, LAC/DR/CAR  
Copy to : IEE File

James S. Hester Date SEP - 1 1989

James S. Hester  
Chief Environmental Officer  
Bureau for Latin America  
and the Caribbean

AN OVERVIEW OF DRUG ABUSE IN JAMAICA

Report Prepared for USAID/Jamaica

by:

Policy Research Incorporated  
5740 Trotter Road  
Clarksville, Maryland 21029

August, 1989

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## 1. BACKGROUND: DEFINING DRUG ABUSE AND UNDERSTANDING RELATED ISSUES

### 1.1 Defining Drug Abuse

The abuse of drugs of all types is a societal problem of immense proportions in many countries. The personal, familial, social, health and economic impact of such abuse, and of the concomitant problems associated with illegal drug use, are, in many ways, incalculable. Complicating the ability of the public and private sectors to mount effective programs to combat drug abuse are the divergent theories regarding causal factors of drug use itself, and approaches to prevention and treatment. Theories of drug use range from its being natural to use drugs of any type to relieve physical and psychological pain to its being an inherited "defect" which is incurable.

Even the appropriate terminology used to describe programs aimed at the problem is controversial. For some time, the most common term has been "drug abuse"; more recently, some programs have been titled "substance abuse". Few programs still use "narcotics abuse"; those which do so relate, for the most part, to narcotic substances only, not to all drugs. The issue which is at the heart of the discussion regarding program titles is the inclusion of certain types of substances in a classification of drugs. There is some degree of agreement that a drug is any substance which is mind altering, including alcoholic beverages, narcotics, and prescription drugs. However, often alcohol is not considered as a drug of abuse because of its generally accepted and legal use in many societies.

This latter fact is a partial reason for the historical distinction between alcohol and drug abuse programs. Another is that, in the late 1960s, when a massive infusion of funds was put into narcotics programs (primarily heroin prevention and treatment in the U.S. and Europe), those in the field of alcohol abuse in the U.S. were concerned that, if their programs merged with those of narcotics and other drugs, there would be scant attention paid to alcohol abuse. The inclusion of tobacco use in substance abuse programs is considered by some in the field of drug abuse to unnecessarily complicate the drug abuse issue, and by others as a necessary component of a comprehensive program of health promotion and disease prevention. Definition of abuse also vary; generally, specific definitions of abuse are used for

distinct types of drugs. For example:

alcohol abuse is construed as psychological or physical dependence (including binge drinkers and habitual abusers);

for illicit drugs such as heroin, any use which is not part of an approved research or treatment program is considered abuse;

for prescription drugs, any non-medical use is considered abuse. For these drugs, physical or psychological dependence (abuse) can also result from use authorized by a physician.

For alcohol abuse, there are several levels of alcohol consumption that are usually used in epidemiological research; these are based on amount and type of alcohol consumed, on drinking patterns, and on the impact of alcohol use on the ability to normally function in society.

## 1.2 Drug Abuse Prevention Strategies

Drug abuse prevention is considered to consist of three levels of activities:

Primary prevention, with programs addressing the general population without regard to degree of risk for drug abuse, and which focuses on preventing new cases; that is, on reducing the incidence of abuse. These programs include, for example, public awareness or mass media campaigns, and some school based programs.

Secondary prevention, which addresses more defined populations who are perceived as having some risk factors for drug abuse, and which is directed at reducing prevalence of drug abuse, or total numbers of cases in a society. These programs include, for example, drop-in centers offering crisis intervention (early detection and screening, preliminary counseling and referral for treatment) services to youth in high risk areas; and multipurpose programs directed toward high risk populations, including services designed to recognize cofactors related to drug use (e.g., job counseling and referral, family counseling, peer group support).

Tertiary prevention, which attempts to prevent increased, continued, or expanded abuse (e.g., use of additional drugs) among identified populations or individuals, and which is also directed toward reducing prevalence. Tertiary prevention programs include, for example, crisis intervention centers located in areas of known widespread availability and/or use).

The latter two levels of prevention can also be classified as intervention. The way in which the program goals and activities are interpreted and emphasized often determines the way in which a particular strategy is defined, that is, whether it is classified as prevention (and in which level) or intervention.<sup>1</sup> In practice, the boundaries between secondary and tertiary prevention, and between tertiary prevention and treatment of drug abusers are difficult to distinguish. In part this results from the fact that within geographic areas or population groups to which programs are targeted there may be both high risk non users and high risk experimenters or early users. In addition, certain types of basic counseling that are appropriate for crisis intervention as part of a tertiary prevention program can also be used as part of treatment. However, tertiary prevention usually excludes inpatient, medically based treatment.

#### 1.2.1 Success Factors in Drug Abuse Prevention Program Strategies

Drug abuse prevention program experience in the U.S. can inform discussions of prevention strategies that may be appropriate for the Jamaican context.

For some time, drug abuse prevention programs in the U.S. were seen as having little success, as evidenced by ever increasing incidence and prevalence statistics, and by other use patterns such as teenagers' expanding the types of drugs with which they would experiment (e.g., crack in addition to alcohol and marijuana). Recently, however, experimentation among the general population seems to be on the wane.<sup>2</sup>

Preliminary findings from the U.S. Office of Substance Abuse Prevention's (OSAP) evaluation of its community based grants programs, and from other U.S. government sources, indicate that involvement of the community in drug abuse prevention efforts over the past five years or so has played an important part in this decline. The types of factors that seem now to consistently indicate the likelihood of program success include the following, which have adapted from a number of sources<sup>3</sup>:

- \* clearly delineated plans, and involvement of as representative a group as possible in the process of planning for the project,

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- \* clearly delineated goals and objectives which have been developed based on a community needs assessment,
- \* use of multiple prevention strategies which are culturally sensitive and which have been shown to be applicable to comparable populations, but which are adapted specifically for the target population (or, in the case of newly designed strategies, which are likely to be applicable, given comparable approaches), taking into account cultural, ethnic, socio-economic and gender factors,
- \* involvement of the broader health and social support system, including the public and private sectors, and linkages with intervention, referral, treatment and aftercare components of the local or national drug abuse program,
- \* community involvement in the implementation and evaluation of the program as well as in the planning (this creates a vested interest in the success of the project),
- \* recognition that the problem is a long-term one, with integration of related prevention activities into the education, work and social lives of the community, and
- \* explicit and well-publicized interest and commitment (including financial resources) on the part of national and local leaders and role models in the public and private sector (including but not limited to musicians, athletes, artists, elected and appointed officials).

Of the few studies of cost effectiveness of secondary and tertiary prevention programs in the U.S. and Europe, most have shown that well-designed, targeted secondary and tertiary programs can be cost-effective.<sup>4</sup> However., it should be noted that most studies of the cost and effectiveness of prevention projects have been limited to assessments during the operation of the project, rather than to determination of the durability of success. It has been difficult to evaluate long term success of projects because funds for post-project evaluation are rarely allocated, and because of methodological problems inherent in evaluating such programs.

Because secondary and tertiary drug abuse prevention programs are relatively new to Jamaica, it is not possible to generalize from these findings.

What types of drug abuse prevention programs are most successful in developing countries in the Latin America/Caribbean region? The U.S. Agency for International Development has funded several drug abuse prevention projects in the region over the past four years; these include projects in Bolivia, Panama, Peru, Colombia, Belize and Mexico. The projects have comprised such components as: public awareness campaigns, school-based education (including teacher training), education and training of parents, youth leaders, religious groups, and health care professionals, conduct of research projects, and support for hotlines.

The evaluations of only two of these projects (in Peru and in Belize) were available at the time of the preparation of this report.<sup>5</sup> The following is a compilation of findings from those two evaluations.

- \* There must be broad representation in the planning, implementation and evaluation process, including at the community level.
- \* It is essential to identify and address the immediate concerns of the population in order to ensure their cooperation in addressing issues of more general concern.
- \* There must be commitment on the part of all concerned to ensure that any strategies and materials are reflective of cultural diversity in the population served.
- \* Insofar as possible, training of trainer models should be used.
- \* It is essential to work with a small group of concerned individuals and groups who will be willing to devote time and effort to the project.
- \* It is essential to secure voluntary support from the private sector, including mass media time and resources, time commitments from sports and cultural figures, and others.
- \* The drug abuse prevention policies and programs must be those of the host country, and not dominated by the U.S.

## 2. DRUG ABUSE AND RELATED FACTORS IN JAMAICA

### 2.1 Drug Abuse in Jamaica

The first survey of drug abuse in Jamaica was conducted in 1966; that survey related exclusively to alcoholism and found that 5%

of the population 18 years and older were alcoholics or potential alcoholics.<sup>6</sup> In 1985, the World Health Organization supported a study of per capita consumption of alcohol in Jamaica, which showed a substantial increase during the period 1973 to 1981: from 22 liters to 27 liters per capita.<sup>7</sup>

The most recent year for which comparable international data are available regarding alcohol consumption per capita is 1985; 48 countries other than Jamaica were included in that survey. However, if the 1981 figure for Jamaica (27 liters per capita) is accurate, and did not change substantially by 1985, that would make the Jamaican population among the highest per capita consumers of alcoholic beverages. In that year, of the countries surveyed, that with the highest per capita consumption was Luxembourg, with 16 liters per capita; next was France, with 13.3 liters per capita. The U.S. per capita consumption was 8.0/capita.<sup>8</sup>

The only large scale studies of drug abuse in Jamaica have been the national household and school surveys conducted by the NCDA with funding from USAID. They were conducted over the period 1985-1989, with the data being collected in 1987. The report of the School Study was issued in 1989. The draft report of the National Household Survey is in limited circulation for review purposes only. The NCDA and USAID have determined that the preliminary analyses included in the draft report could be included in this report, as they are the only national baseline data available.

Planning for both the National Household Survey and the School Survey was initiated in 1985. The Household survey was the largest of its kind undertaken in Jamaica, and the sample (6,007 Jamaicans 12 years and older) represented a much larger proportion of the population than that of comparable surveys undertaken in the U.S.<sup>9</sup> The survey of drug use in schools (post-primary) included a total of 8,886 students in grades 9-13.<sup>10</sup>

The findings from both of these studies confirmed the generally held belief that marijuana (ganja) use is endemic in Jamaica, and that alcohol use -- if not abuse -- is a significant problem as well. In the draft report of the household survey, for example, results indicated that 30% of male respondents and 6% of females reported that they had ever used ganja and 26% of males and 6% of females reported taking five or more drinks on the same occasion during the two weeks prior to the survey. Sixty two percent of males and 45% of females reported that they had close friends who had ever used ganja. Twenty four percent of males and 34% of females reported that they strongly disapprove of occasional ganja use. The school survey also confirmed the extensive use of ganja and alcohol: 76% of students reported ever having used alcohol, and 34% reported having used ganja in the previous month. Thirty-nine percent of students reported

ever having used ganja, and nearly 10% reported having used it in the previous month.

Notably, in the Household Survey, non-medical use of analgesics was reported by nearly as many men (23%) and by far more women (30%) than the use of ganja. The survey reported low rates (1% or less) of use of inhalants, LSD, PCP, and heroin. Similarly, less than 1% of males and females reported ever having used tranquilizers, barbiturates or amphetamines other than for medical reasons. The students reported somewhat higher abuse of other drugs than did the adults in the household survey. For example, 3% reported non-medical use of tranquilizers in their lifetime, 2% reported non-medical use of amphetamines, and 16% had used inhalants at least once in their lifetime. With regard to recent use of other drugs, 2% of students had used tranquilizers in the previous month, 1% had used amphetamines, and 10% had used inhalants. One percent of the student respondents indicated that they had ever used opiates; the study report does not present data for previous month's use of opiates.

The two surveys seemed to indicate surprisingly little use of cocaine and crack in 1987, particularly in view of recent reports that both drugs were available in Jamaica at the time the two studies were conducted.<sup>11</sup> For example, in the household survey, only 0.3% of males and no females reported ever having used cocaine, and 1.0% of males and 0.1% of females reported ever having used crack. The study's authors hypothesize that these findings - i.e., that there is higher reported use of crack than cocaine - may result from the order of the questions in the survey. In fact, respondents reported that both cocaine and crack were difficult to obtain: only 6% of males and 2% of females reported that cocaine was easily available, and 3.6% of males and 1.3% of females reported that crack was easy to obtain. More than half (56% of males and 61% of females) reported that they strongly disapprove of trying cocaine, and 59% of males and 62% of females reported that they strongly disapprove of trying crack.

Students participating in the school survey reported minimal use of cocaine and crack, although the figures are higher than for adults: 2% of students reported ever having used cocaine, and 1% reported having used it in the previous month; 1.5% reported ever having used crack, and .8% reported having used it in the previous month.<sup>12</sup>

These figures can be compared with the results of the 1988 National Household Survey on Drug Abuse in the United States, the preliminary results of which have recently been released. The results showed that an estimated 33% of the population age 12 and over has ever tried marijuana, and 6% had used it in the previous month. Eleven percent of the population had ever used cocaine, and of those 2.9 million who had used it in the

previous year, 11% used it once a week or more, and 4% of these users -- or 328,000 persons -- used it daily. For crack, the lifetime prevalence was 1%, and less than 1% (484,000) were current users. Disturbingly, 4.8% of high school seniors had used crack in the previous month. Unfortunately, the preliminary results do not distinguish between moderate and heavy use of alcoholic beverages, so it is difficult to discern abuse patterns. They do show that 25% of youth 12-17 had used alcohol at least once in the previous month (down from 31% in 1985), and that an estimated 47 million Americans drank once a week or more often in 1988. <sup>13</sup>

The Jamaican surveys, while providing information that helps to describe part of the picture, need to be considered in light of information that is available from other sources as well. Unfortunately, other types of studies that are generally used to complete the picture of drug abuse in a country or geographic area (e.g., community surveys of drug use, analysis of drug-related diagnoses from medical records, and review of national drug-related mortality and morbidity data) have not been conducted or are not available. However, informed sources report that cocaine has been available (though until recently relatively expensive) in Jamaica for at least 20 years and that crack has been available for at least five years. More importantly, the availability and use of cocaine has been significantly increasing for at least three years, and availability and use of crack has increased dramatically over the past 12-18 months. This may result from a significant new development; according to sources, crack began to be processed in Jamaica some 18-24 months ago. A further indication of the availability of crack is the fact that a representative of Narcotics Anonymous reports that they receive 10-15 calls each day from individuals identifying themselves as having a serious drug abuse problem and seeking treatment; in the past ten months, most of these callers have reported that they are addicted to crack.

The price of cocaine varies from J\$100-J\$200 per gram, and has decreased in the last five years. Unfortunately, crack is relatively inexpensive, even by standards of the Jamaican economy. The price varies by geographic area and clientele, but ranges from J\$20 (or less) for a "rock" (a single use) in parts of Kingston to J\$20-J\$40 for the same amount on the North Coast. The latter differential is undoubtedly due to the influx of tourists, which raises the price of commodities in general. Importantly, in Jamaica as elsewhere, the per use cost to the purchaser is raised over time; that is, the initial cost is often minimal, but is raised by the seller as the individual becomes addicted.

Numerous individuals have reported that, as in the U.S. and elsewhere, crack is also being offered gratis in social settings, including private parties and public establishments. This is a standard means of early distribution. Notably, the price of a bottle of beer is approximately J\$3, and of a bottle of rum is

J\$30. The price of cocaine is less variable than that of crack, and still rather high: generally, it sells for J\$100 per gram. The pattern of public perception of cocaine and crack use in Jamaica has paralleled that of the U.S. and elsewhere, with the generally held belief that cocaine is a drug of the upper and upper middle classes, and crack a drug of the lower class ghettos and middle classes. That perception has changed over the last few years in the U.S., particularly with regard to crack, and there is now the recognition that the problem is, or should be, of importance for the general population, and of priority for public and private sector policy.

The perception is also changing in Jamaica; there is an increasing awareness of rapidly changing trends in drug abuse. Informed sources report that, as a result of availability and low price, use of crack in Jamaica now cuts across socioeconomic strata, with youth 15-25 the heaviest users in the lower economic groups and young adults 18-40 the heaviest users in the middle and upper income groups. Crack is reportedly available in public and private schools, and in some of the poorest areas of Kingston in which unemployed youth who are out of school are reportedly involved both in the distribution of crack and its use. Sources have estimated that in poorer parts of Kingston, for example, children as young as 12 are distributing and using crack; as many as 25% to 50% of youth in these areas may have experimented with crack.

The lack of substantive information hinders the ability to clearly define high risk groups, and clearly they vary by type of drug. However, based on the results of the two national surveys, on more recent information regarding drug abuse in Jamaica, and on trends in other countries, the following preliminary high risk groups can be described:

Alcohol:	general population, and in particular youth to which advertisements are increasingly targeted
Marijuana:	general population
Cocaine:	youth 15-25 and young adults 26-40 who are in middle and upper middle income populations
Crack:	youth 12-25 and young adults 26-40 of all socio-economic strata, particularly low income populations
Prescription Drugs:	general population, in particular young adults 25-40

The degree of susceptibility to drug abuse is often considered based on "additive" cofactors; that is, the more cofactors for abuse that pertain to an individual or population, the more likely that abuse will occur. For example, if one is uneducated, unemployed, a child of a dysfunctional family, and lives in an area in which drugs are widely available and relatively inexpensive, the probabilities are higher than average that abuse will occur. Similarly, if one lives in an upper class family environment in which risk taking and experimenting are accepted, parental supervision is minimal, and the family is dysfunctional, the probabilities are also higher that abuse will occur. The socio economic factors that make those in the lower socio-economic strata at risk for drug abuse also pertain to their recovery, when they are trying to refrain from use. For example, the poor and disaffected groups are more vulnerable for involvement in distribution networks, and therefore for consequential abuse. Further, it is more difficult to design successful prevention strategies for these populations because of such factors as illiteracy (which makes use of written materials of little utility) and unemployment (which eliminates an access point for prevention strategies).

In order to improve its information base, so as to increase the ability of public and private sector projects to be targeted as specifically as possible, the National Council on Drug Abuse is currently planning to develop a national drug abuse information system. As envisioned, the NCDCA drug abuse information system will be designed to have integrated sub-systems, including for example:

- \* epidemiologic information from a variety of sources (e.g., the two national surveys, short term studies, hospitals and other health facilities),
- \* service statistics from the public and private sectors (including diagnoses, procedures, resources used),
- \* impact data (including drug-related motor vehicle accidents and crime), and
- \* other information as appropriate.

## 2.2 Relevant Social Factors

There is clear evidence that the abuse of drugs is increasingly crossing socio-economic strata in Jamaica, and as affecting Jamaican youth in particular, principally those between low and lower middle income youth between 15 and 25 years of age.

The use of ganja is endemic in Jamaica, with widespread use among certain ethnic populations (primarily, Chinese and Indians), and in rural areas, for at least 100 years. Use of ganja is considered acceptable by Rastafarians, for whom it is part of a

cultural and religious norm. Moreover, it is used by some Jamaicans as a folk medicine (in the form of tea or being steeped in rum).<sup>14</sup> Beginning in the 1970s, use spread to the urban middle class, in part as a result of imitation of the Rastafarian culture. Importantly, ganja use has crossed socio-economic strata, and continues to do so. Some Jamaicans indicate that its use has diminished among school children in recent years; the explanations for this possible decrease are varied and conflicting.

Abuse of alcohol also crosses socioeconomic strata in Jamaica, as it does in most countries. For example, weekly use of white rum by rural males - often to the point of inebriation - is considered an appropriate ending for a week of hard labor. An important social factor in Jamaica is the societal and familial accommodation of the heavy drinker. This has made it difficult to convince the public that alcoholism is a problem; there has been no real concept of alcohol abuse, except among the Rastafarians, whose religion proscribes abuse of alcoholic beverages.

Cocaine and crack are increasingly seen as drugs introduced to the Jamaican population by outside forces, as a foreign menace that has the potential to be destructive of Jamaican society. There is concern that Jamaica could become "another Colombia or Washington, D.C." in the words of many, with local (and in the worst case, national) economies heavily dependent on cocaine and crack. As has been the case in most other countries, because of its expense, use of cocaine predominated among the upper middle and upper classes when it was originally introduced, but the decline in cost in recent years, as well as other factors, has resulted in its being increasingly used by the middle class. Crack, on the other hand, has since its introduction been relatively inexpensive (a single use can cost as little as J\$20); its use, therefore, permeates socio-economic strata.

Poverty, unemployment, low educational levels, disaffection, and inadequate social support systems, are known to be factors that increase susceptibility to drug abuse in an individual and in communities, as well as to drug trafficking. According to a recent study:

"in a very real sense, the problem of drug abuse in much of the Caribbean Region is a complex psycho/socio-economic phenomenon evidenced, on the one hand, by the continuing dislocation of national economies occasioned by the symmetrical structure and orientation of the international economic system. Debt burdens of many developing countries and the consequent inability of their governments to provide normal social services and employment opportunities, have conspired to create a congenial environment for drug traffickers whose sophisticated modes of operation have aggravated

difficulties of supply management and this has impacted on the incidence of drug abuse." <sup>15</sup>

Three indicators of social cofactors for drug abuse are examples of factors which place Jamaica at high risk for abuse of drugs among its population, particularly the lower socio-economic groups:

- \* in 1988 the unemployment rate was 19% <sup>16</sup>,
- \* only 64% of the eligible population (ages 12-17) was enrolled in secondary schools, <sup>17</sup> and
- \* using constant 1974 dollars, the per capita income actually declined between 1977 and 1987, from J\$953 to J\$835, and depending on the definition of low-income used, either 70% or 85% of Jamaican households were in the low income category in 1984. <sup>18</sup>

Conversely, the social and economic costs of drug abuse are well-documented in other countries, and are known anecdotally in Jamaica. Drug abuse is a causal factor in spouse and child abuse, dissolution of marriages or couples, violent behavior (including rape, armed assault, and murder), decreased productivity, and physical and psychological illnesses (including Fetal Alcohol Syndrome (FAS), newborn addiction to cocaine and crack, chronic obstructive pulmonary disease, liver cirrhosis, AIDS and STDs), motor vehicle accidents, and local and national political destabilization. In particular, violent crime, including robbery and murder, is associated with crack use in the U.S., and more recently in Jamaica. These are consequences that Jamaica can ill-afford.

Unfortunately, there are scant data available in Jamaica to demonstrate these consequences of drug abuse. The NCDA is keenly interested in developing an information system that would be used in part to compile and analyze such data, and use it as the basis for developing national strategies. In the meantime, Table 1 presents a minimal estimate, based on data included in the draft national household survey, of the numbers of individuals who are current users of four types of drugs; these numbers help to place the statistics in human perspective.

Table 1

## Estimated Number of Jamaicans Who Are Abusing Four Types of Drugs

<u>Type of Drug</u>	<u>Males</u>	<u>Females</u>	<u>Estimated # of Abusers*</u>
Alcohol (5 or more drinks on one occasion in past 30 days)	138,000	32,000	17,000
Cocaine (use in past 30 days)	1,593	500*	523
Crack (use in past 30 days)	5,309	547	1,464
Ganja (use in past 30 days)	90,000	11,400	10,100

\* Defined as: alcohol (10% of 170,000), cocaine (25% of 2,093), crack (25% of 5,856), ganja (10% of 101,400). These estimates are very general, as no research study has been made of physical and psychological conditions indicative of drug abuse in Jamaica. The population denominator was derived from 1988 sex and age disaggregated estimates published in Economic and Social Indicators, op cit.

\*\* The national household survey reported no use of cocaine by females, but this is known, based on first-hand report, not to be true. The estimate of 500 is based on: calls to Narcotics Awareness, known cocaine users, and estimates provided by knowledgeable sources.

According to these estimates, nearly 30,000 individuals in Jamaica are being physically or psychologically impaired by drug abuse, and are likely causing social and economic consequences for their families and for society in general. In considering "cocaine babies" alone, if the estimated number of females who are currently using cocaine or crack is accurate, then of these nearly 2,000 women, approximately 10% -- or 200 -- could be expected to give birth each year to an infant affected by cocaine. Even one use of cocaine during pregnancy, particularly during the first trimester, can result in serious medical consequences for the newborn. The immediate medical care of these infants is expensive (often they require lengthy stays in neonatal intensive care units) and complicated, and they often have effects that require subsequent longterm term care. Moreover, the mothers of these babies are themselves ill equipped to care for their children at home.

## 2.4 Economic Cost of Drug Abuse in Jamaica

Drug abuse has well-documented and significant economic impacts. The type of impact can vary by the type of drug abused (e.g., alcohol abuse and drunk driving, cocaine or crack abuse and related illicit crime), but many indicators cross classes of drugs; these include, for example: decreased productivity, industrial accidents, related health effects which require increased utilization of the health care system.

As yet, there has been no study of the economic impact of drug abuse in Jamaica, and the lack of data hampers such an analysis. However, in order to begin to determine the cost of drug abuse to Jamaican society, the following simple assessment, based only on data readily available, is presented:

- \* annual lost wages due to alcohol abuse total  
J\$29,240,000 (US\$5.4 million)
- Estimated number of alcoholics: 10% of the 170,000 persons, estimated from the draft National Household survey to have consumed 5 or more drinks on one occasion in the month prior to the survey
- Average wage/month: J\$430
- Average number of months unable to function per year: 4
- \* annual hospital costs due to treatment of alcoholism and alcohol-related medical and psychological illnesses: J\$21,500,000 (US\$3.9 million)
- 10% of total hospital costs in 1988: J\$215.7 million (This is a conservative estimate; there have been no empirical studies of the cost of treating alcohol-related illnesses in Jamaica. The estimate for the U.S. and for many European countries is 20-30%.)
- \* Annual lost wages due to crack addiction: J\$2.5 Million (U.S. \$466,311)
- Estimated number of those addicted to crack: 25% of those who are estimated from the National Household survey to have ever used crack: 1464
- Average wage/month: J\$430 (It may actually be higher for the crack user than for the alcoholic.)
- Average number of months unable to function per year: 4

The estimated cost of lost wages due to ganja abuse cannot be calculated without additional data regarding levels of use. The draft results of the National Household Survey do not provide data regarding debilitating effects of drug use, but rather frequency of use. This can be used to estimate effects of alcohol, cocaine and crack use, but not ganja, as frequency is not an indicator of debilitating effects.

Other costs which are usually included in calculations of the economic impact of drug abuse, and which are not available at this time in Jamaica, include: costs of automobile accidents, workplace accidents, decreased productivity while on the job, treatment of physical and psychological abuse inflicted in family members and others as a result of drug abuse, economic instability in a community (e.g., loss of productive workers to "employment" in the drug trade), crime against person and property.

However, even given the limited assessment of the economic impact of drug abuse in Jamaica, the financial costs are high, and the potential benefits from this USAID funded project are substantial. For example, given a 10% success rate in reducing the prevalence of drug abuse, and other measures taken by the GOJ (e.g., imposition of strict driving while intoxicated laws), there could be an annual savings of US\$930,000 after the first year for alcohol abuse costs alone.

### **3. DRUG ABUSE PREVENTION AND REHABILITATION PROGRAMS IN JAMAICA**

#### 3.1 Public and Private Policy with Regard to Drug Abuse in Jamaica

The Government of Jamaica has expressed urgent concern for the problem of illicit drug distribution and drug abuse and has indicated that it intends to take steps to reduce both demand for and supply of illicit drugs. As evidence of this concern, the Prime Minister designated the Minister Without Portfolio and Minister for Parliamentary Affairs as the senior GOJ official responsible for overseeing all drug related matters. Reporting directly to the Prime Minister, this Minister chairs an inter-ministerial committee comprised of five ministers: Minister of Health, Minister of Education, Minister of National Security, Minister of Agriculture, and Minister of Youth and Community Development.

Drug abuse prevention programs were initiated in Jamaica in the early 1980s. The National Council on Drug Abuse (NCDA), established in 1984 as a quasi-governmental organization, has been the administrative vehicle for conduct of projects. With funding primarily from USAID and UNDP, since 1984 the NCDA has developed the five year plan, conducted the household and school surveys referenced previously, and sponsored various drug awareness

activities throughout Jamaica. Since March of 1989, the NCDA has been reactivated and strengthened. The Committee will, in cooperation with the Interministerial Committee, coordinate national policies involving both the demand and supply of drugs. Specifically, its function is:

"to focus national attention on drug abuse by bringing together representatives of all major national institutions, organizations, groups and special individuals, to study, advise, coordinate, evaluate and take specific actions on the problem as indicated." <sup>19</sup>

For the first time in its existence, the operating costs of the NCDA have been included as a line item in the GOJ budget (J\$1.698 million for JFY 1989/90 to cover primarily salary and administrative expenses for a fulltime staff of 13). Legislation is in process to establish the NCDA as a Statutory Body; it is expected that this will be approved by November, 1989.

The NCDA has a 15-member Advisory Board comprised of representatives of the key related ministries (e.g., Ministry of Health, Ministry of Education, Ministry of National Security, Ministry of Youth and Community Development), as well as representatives of the private sector. In addition, there is a 60-member General Council comprising representatives of other public agencies and a wide range of private sector organizations. Importantly, the NCDA Advisory Board and General Council are bi-partisan, and the new Executive Chairman and Vice Chairman have both initiated efforts to ensure a broad involvement on the part of grassroots organizations and representatives of a cross section of Jamaican society (e.g., the Rastafarian community and of popular entertainment groups which have publicly taken a position against drug abuse).

The NCDA staff works with 8 standing committees comprised of representatives of the Advisory Board and General Council; six of these committees relate to programmatic areas (e.g., Public Education, Medicine/Research), and two relate to broader concerns: the Coordinating Committee and the International Cooperation Committee.

The NCDA has planned a staff of 13 professionals who will work with the committees to design and implement projects through the Ministries and the private sector. The NCDA staff complement includes an executive director, an internal auditor, 4 accountants, senior secretary, 3 secretaries, personnel officer, office manager, clerical officer, financial controller, secretary, and for each of three geographic zones in Jamaica: a deputy director and 2 field officers. These deputy directors would also have responsibility for programmatic areas (e.g., education, health, interdiction). In addition, there will be a research officer and a research librarian. The Executive Director, a full-time

consultant with responsibilities for liaison with the Coordinating Committee, and two secretaries are currently on staff. The full complement of staff is expected to be in place by the end of 1989.

In mid-1988, the NCDA drafted the five-year Plan for Prevention and Control of Drug Abuse; this plan has served as one of the primary bases for development of this project. The project areas which were identified in the National Plan are: research and development, community based institutional strengthening, public education, schools education, coordination and dissemination of information, legal reform, security (supply and distribution of drugs), rehabilitation, alternative occupations, and international cooperation. Specific descriptions of priority projects for each of these areas are currently being defined by the NCDA based on proposals prepared by the standing committees over the past 2 1/2 years.

One technical problem with regard to drug abuse prevention has been the tendency for the public and private sectors to (usually unwittingly) fund or otherwise sponsor mixed messages. This results in considerable confusion for the target audience, and has been shown to be counter productive. (In fact, in the U.S. it resulted in a temporary moratorium on federally funded drug abuse prevention programs in the early 1970s.) Currently, NCDA has a planned mechanism, through its committee structure, to ensure that information/educational materials used are most appropriate and cost effective for the Jamaican population. The review procedure is also designed to ensure that, for example with regard to education, different "messages" are not being provided by the same organization (e.g. the Ministry of Education), or by different organizations that serve the same target population or have the same audiences (e.g., Ministry of Health and the Medical Association of Jamaica). This coordination is intended to include, for example, the related ministries' advising the NCDA of all proposed projects and activities related to drug abuse, and NCDA review and comment on all public awareness education material and training being proposed or considered by the public sector.

### 3.2 Drug Abuse Prevention Programs in Jamaica

The GOJ has, for the most part, focused on public awareness campaigns during the past five years. Recently, however, the NCDA has begun to plan for prevention programs that are targeted to high risk populations and geographic areas. Importantly, the NCDA is taking into account the fact that most prevention strategies currently being designed and implemented elsewhere recognize co-dependencies (i.e., the relationship between abuse of multiple drugs) and at the same time take into account the different use patterns by socio-economic group and other factors.

Various public sector entities have been involved in drug abuse prevention as well over the past five years, including the following:

- \* Ministry of Education, which, with UN funding, developed and implemented a school based drug abuse education project in 1985 which has been evaluated and which is planned for revision by the end of 1989; the MOE has also produced 30-minute programs that are broadcast over the Educational Broadcasting Service weekly;
- \* the Jamaica Broadcasting Corporation, which has developed and broadcast a number of drug prevention programs;
- \* the Jamaican Information Service, which has produced and broadcast drug prevention spots for its daily and weekly programs, and which is currently planning an anti-drug trafficking campaign; and
- \* Ministry of Youth and Development, which has operated a Family Life Education project since 1982; this project includes a strong peer training and leadership component, and focuses on health issues, including drug abuse.

In addition, several public sector programs exist on which community-based activities could be built. These include the Ministry of Youth and Development's Youth Clubs and the Ministry of Education's SCOPE project. The latter has generated interest and capability on the part of local community advisory councils with regard to school vandalism.

Non-governmental organizations involved in drug prevention activities include the following:

- \* University of West Indies, which directed the public awareness component of the NCDA's U.N.-funded Narcotics Awareness Project, working directly with community councils at the parish level and with the Ministry of Education on parenting skills;
- \* Narcotics Anonymous, which was founded in 1984, and which, in conjunction with the Addiction Alert Organization, provides speakers (recovering drug abusers) on request for schools, health care facilities, churches, and other organizations;
- \* the Private Sector Organization of Jamaica (PSOJ), which has initiated plans for prevention (and rehabilitation) activities that could be supported in

a variety of ways by the organization as a whole, and by individual member companies through financial contributions (the PSOJ is a member of the NCDCA and is initiating collaboration with it on these activities); and

- \* The Scout Association of Jamaica, which in collaboration with Guides, Rangers, Red Cross, 4-H, Girls' and Boys' Brigades, Cubs, Brownies and Cadets has recently initiated a prevention campaign (Amplified Drug Abuse Prevention for Scouts - ADAPTS), which will include rallies, video messages, and training of youth for peer counseling and other activities.

In addition, organizations which have expressed an interest in drug prevention activities include Jamaica/Western New York Partners of the Americas, the Anglican Diocese of Jamaica, the Salvation Army, and Southern University, which was contracted to provide technical assistance to the Ministry of Education for the USAID-funded Primary Education Assistance project. Importantly, the NCDCA includes more than 20 private sector organizations in its general assembly.

While there is increasing interest on the part of private sector employers in establishing Employee Assistance Programs patterned on those in the U.S., they are keenly aware that to do so without the availability of rehabilitation services would be fruitless and unfair for those who would self-identify as drug abusers seeking treatment. There are no known employers who have attempted to set up counseling programs in their organizations.

The only known evaluations of drug abuse prevention activities in Jamaica have been 1) that conducted by the Ministry of Education on the primary education materials (the report should be available prior to the implementation of this USAID funded project), and 2) the recently-issued evaluation of the NCDCA Narcotics Awareness Project.<sup>20</sup> The latter evaluation indicates that, of the community-based projects initiated through the project, 8 of the 13 parish-level committees are active. An internal review of the various training and workshop activities showed that constraints to successful implementation included lack of continuity among groups and individuals involved, and need for increased support from a coordinated national agency. There has been no external evaluation of drug abuse prevention projects in Jamaica.

### 3.3 Drug Abuse Rehabilitation in Jamaica

Drug abuse rehabilitation services are scarce in Jamaica. In fact, there is only one free-standing program for the residential treatment of drug abuse -- a small private practice

facility operated by a physician in Montego Bay. This facility provides a six-week treatment regimen at a cost of J\$10,000; shorter term treatment is also available. For short-term detoxification, alcoholics and other drug abusers may seek treatment in a public or private hospital (e.g., the University of the West Indies hospital's 15-bed psychiatric unit), which have no health care providers specifically trained in treatment of drug dependencies. Most private hospitals are reportedly reluctant to admit drug abusers, maintaining, as do the public facilities, that their staff are not trained to care for the special problems of drug abusers. However, St. Joseph's Hospital does have beds allocated for psychiatric care, including drug dependence. Upper and upper-middle class Jamaicans who seek treatment do so in the United States; they may also seek treatment in Jamaica, with a private psychiatrist or other physician. However, it is reported that few such physicians are willing to provide such care.

Both Alcoholics Anonymous and Narcotics Anonymous (and their affiliate organizations such as Alateen and Alano.) have groups which meet weekly throughout the island; it has been estimated that approximately 200 Jamaicans are regular members of one or both of these self-help organizations. Volunteer members of these organizations will provide individual counselling to all those who seek it on an as-needed basis. Some abusers reportedly attempt to self-treat, with no medical assistance. Several churches in Kingston, Mandeville, and the north coast operate community based counseling services provided voluntarily by church members who are health care providers, teachers or other professionals, some of whom have received some training in counseling methods. Reportedly, drug abusers have received counseling through these sources.

Mental health services have in other countries served as the basis for drug abuse rehabilitation, but in Jamaica the availability of such services is minimal. The MOH operates no specialized outpatient mental health facilities; however, the Ministry has 20 positions for mental health counselors at community health centers (these are nurses trained in mental health counseling). The MOH has one public psychiatric hospital, which also provides some outpatient care.<sup>21</sup> The UWI hospital has a psychiatric ward, and St. Joseph's Hospital has beds allocated for psychiatric care, as mentioned above. Reportedly, 15 psychiatrists and 10 psychologists practice in Jamaica. Four of the psychologists have PhDs (two from U.S. universities and one from a British university), and the remainder have masters degrees.

The Addiction Alert Organization has developed a proposal for a 30-bed in-patient treatment facility. AAO has been actively seeking private sector funding and has suggested that the GOJ underwrite 10 of the 30 beds. The treatment modality would follow the 28-day model developed in the U.S. and used in rehabilitation facilities throughout the world. The Richmond

Foundation (based in England, with a Jamaican affiliate) also has a proposal for an in-patient rehabilitation facility. The NCDA is planning to incorporate both proposals, and plans from the MOH, as part of a comprehensive package of public and private sector plans for rehabilitation services in Jamaica for which they will seek funding from the EEC and other donors.

#### **4. CURRENT AND POTENTIAL DONOR SUPPORT FOR DRUG ABUSE PROGRAMS IN JAMAICA**

##### **4.1 U.S. Government**

Since 1985, USAID/Jamaica has funded drug abuse prevention and research activities in Jamaica, including the national household and school surveys of drug abuse and a public information component to further public awareness of the problem of drug abuse. These activities were undertaken by the NCDA, with the Pan American Health Organization (PAHO) serving as the implementing agency. The USAID Population and Family Planning Project has a Family Life Education component covering a number of health and family planning issues, including drug education. The AIDS/STD Project also has a small drug abuse education component designed to address the linkage between AIDS and drug use. In addition, in 1988 USAID provided funds to JAMPROC for preparation and production of 5,000 brochures describing methods to secure packaging of exports as a means of narcotics control.

The Narcotics Awareness Unit of the American Embassy and the United States Information Service in Jamaica have provided funds for long-term training in the U.S., public awareness campaigns, workshops and other activities related to drug abuse prevention. The Drug Enforcement Agency also participates in drug abuse awareness activities, including providing speakers for schools, service clubs, and other organizations. All of these activities, as well as those related to the supply of drugs, and drug prevention activities of USAID, are undertaken with the guidance of the U.S. Mission Narcotics Coordinator, the Deputy Chief of Mission.

##### **4.2 Current and Potential Support from Other Donors**

There has been increasing interest in supporting drug abuse prevention and rehabilitation projects in Jamaica on the part of donors other than AID. For example, in addition to serving as the implementing agency for the two AID-funded surveys of drug abuse in Jamaica, PAHO has provided technical assistance and training to the GOJ for both public awareness and research programs. United Nations agencies (UNFDAC and UNDP) have funded various activities of the NCDA. Donors which have expressed an interest in funding drug abuse prevention or rehabilitation efforts in Jamaica include:

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the European Economic Commission (EEC) (which may provide US\$500,000 for public awareness and for development and implementation of rehabilitation services), and

the Organization of American States (OAS) (which may provide an unspecified amount of funding for educational activities).

The NCDA and private sector organizations are in the process of preparing proposals for submission to funding sources, and in some cases have initiated negotiations with them. The NCDA is endeavouring to ensure that some level of funding is available for all three strategic areas of its policy agenda: control (supply), prevention (including general public awareness and targeted projects), and rehabilitation, as well as for institutional strengthening (including training and information systems development, for example). Other than the USAID project, however, no formal grant agreement is near completion.

While a number of donors are interested in funding prevention programs, there are relatively fewer sources of support for rehabilitation services. There is a related technical issue in this regard. Unless or until there are at least minimal rehabilitation services available, it would be unreasonable (and unethical) to implement public awareness campaigns that create a demand for such services. Even in the case of a telephone hotline unless the operators were trained to provide emergency counselling and it were made clear that rehabilitation services are not currently available, ethical issues arise.

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