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**MID-TERM EVALUATION
USAID/Jamaica
HIV/AIDS and STD
Prevention and Control Project
(Project No. 532-0153)**

Health Technical Services Project

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November 1995

*The Mid-term Evaluation of the
USAID/Jamaica HIV/AIDS and STD Prevention
and Control Project (Project No. 532-0153)*

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Acronyms

ACOSTRAD	Association for the Control of Sexually Transmitted Diseases
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention
ASHE	Caribbean Performing Arts Ensemble
ATSP	AIDS Technical Support Project
BCC	Behavioral Change and Communication
CATC	Caribbean Applied Technology Center
CCSS	Care, Counseling and Social Support
CDC	Center for Disease Control and Prevention, Atlanta (US Public Health Service)
CHC	Comprehensive Health Center
CI	Contact Investigator
CSW	Commercial Sex Workers
EOP	End of Project
EPI	Epidemiology
GTZ	German Technical Cooperation (GTZ in German)
HATS	HIV/AIDS Tracking System
JAS	Jamaica Aids Support
JRC	Jamaica Red Cross
JSS	Jamaica Sentinel Surveillance
KAP	Knowledge, Attitude, Practice
KAPB	Knowledge, Attitude, Practice, Behavior
KSA	Kingston, St. Catherine Area
LAC	Latin America and the Caribbean
LAN	Local Area Network
LOP	Life of Project
MAJ	Medical Association of Jamaica
MCH	Maternal and Child Health
MOH	Ministry of Health
MTE	Mid Term Evaluation
MWM	Men with Men
NAC	National AIDS Committee
NACP	National AIDS Control Program
NGO	Non Governmental Organization
PASA	Participating Agency Service Agreement
PM	Project Manager
PMO	Principal Medical Officer
PSA	Public Service Announcements
PVO	Private Voluntary Organization

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PWAIDS	People with AIDS
PWHIV	People with HIV
RA	Resident Advisor
RPC	Regional Program Coordinator
RRF	Rapid Response Fund
SS	Sentinel Surveillance
STD	Sexually Transmitted Disease
STDCA	STD Clinic Attender
TCI	Targeted Community Interventions
USAID	United States Agency for International Development
UWI	University of the West Indies

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1. Executive Summary

- 1.1. Jamaica is the largest of the Caribbean islands (4,422 square miles). Jamaica's multi-racial population of 2.4 million people, is primarily of African, European, East Indian and Chinese origin.
- 1.2. The first case of AIDS was diagnosed in 1982. In June 1995 the HIV seroprevalence was estimated at three per 1,000 (mainly heterosexual transmission), with a total **1,202** AIDS cases, of whom **680** had died. All Parishes are affected. The St. James Parish has the highest AIDS case rate (**112.9/100,000** [189 cases/1982-June 1995]), followed by Kingston (**81.2/100,000**, [570 cases/1982-June 1995]), Trelawny (**40.4/100,000**, [30 cases/1982-June 1995]), St. Catherine (**36.0/100,000**, [30 cases/1982-June 1995]). The Clarendon Parish has the lowest case rate (**9.4/100,000**). Ninety-one (**91**) cases of pediatric AIDS were reported (8% of all cases).
- 1.3. This epidemic is spreading the most rapidly in St. James. In Kingston and Montego Bay HIV prevalence among STD clinic attenders rose from .3% in 1986 to 4% in 1994. The prevalence increased from 1.4% in 1989 to 5.8% in 1992 in Ante-Natal Clinic (ANC) attenders. It is estimated that between **10,000** and **15,000** persons were infected with HIV in 1995.
- 1.4. In addition to HIV/AIDS, STDs are a serious problem with high rates of reported cases of syphilis, gonorrhea, and chlamydia in the public sectors (to date, no figures on the private sector). Numbers of reported congenital syphilis are still high despite the control measures.
- 1.5. To respond to this AIDS epidemic and the rise of STD cases, USAID/Jamaica has been supporting the AIDS and STD Prevention and Control Program. It is conducted and coordinated by the Ministry of Health National AIDS Control Program (MOH/NACP). A first project was initiated in 1988, then amended in September 1992. It is projected to last through August 1996. This Evaluation Team mainly focused on the current project, based on the USAID Strategic and Implementation Plan (from September 1993 to August 1996).
- 1.6. The main objectives of the MOH and AIDSCAP/USAID are to decrease STDs, increase condom use, and reduce the number of sexual partners in selected target groups to reduce the rate of sexually transmitted HIV. In that respect, this project identified the following target groups: STD Clinic attenders, commercial sex workers (CSWs), adolescents, adults with multiple sex partners, men who have sex with men (MWM), and persons who are HIV+. This project also targets people who could influence the course of the epidemic such as: the medical health community, policy makers and opinion leaders, and members of the business sector.

- 1.7. **This USAID/Jamaica HIV/AIDS and STD Prevention and Control Project** consists of **21 AIDSCAP sub-agreements**, a **PASA** with the Centers for Disease Control and Prevention (CDC) of Atlanta, and **USAID/Jamaica support**. As of August 1995, USAID/Jamaica had received **US \$4,134,252** with a remaining balance of **US \$1,087,455** through August 1996. This project focuses on the following areas: (1) behavior change and communication (BCC); (2) STD prevention and control: the Contact Investigator (CI) program and sentinel surveillance of HIV/AIDS; (3) evaluation of project activities; and (4) capacity building and sustainability. This project also promotes activities conducted by both the **private and public sectors**.
- 1.8. With less than ten months to go, this project has reached and in some cases exceeded the established indicators. While there have been some problems, which are addressed by this Team, overall this is a **good project** which deserves **continued support** to further establish the foundations of prevention and control measures for HIV/AIDS and STDs in Jamaica.
- 1.9. While BCC has made important progress using existing methods, this Team felt that these efforts must be sustained while developing new strategies and approaches concerted to move beyond the current **PLATEAU stage**. Target groups have received **sufficient information**. The next phase requires translating that **informational base** in lasting behavioral change. This can be achieved through dialogue with target groups and integrating other social programs. The multiplicity of BCC sub-agreements has led to a **fragmented approach** that can easily be corrected. This may also be based on the multitude of indicators and the need to achieve the predetermined objectives by target dates, thus conveying a **sense of inflexibility** in the strategic approach. It should be noted that the National BCC strategy, as well as AIDSCAP sub-agreements, promotes three messages: (1) increase condom use; (2) abstinence, and delay the onset of sexual relationships; and (3) one faithful uninfected partner. However, the BCC should have gone beyond the current target groups and selected them on the basis of **socio-cultural and economic** boundaries rather than along purely demographic variables. This strategic project approach has also seemed to leave out **young males** and little has been done to better understand their role as the main sexual decision maker.
- 1.10. The STD, CI and sentinel surveillance activities have been well conducted. While the STD project in the public sector has reached the predetermined objectives, further studies and surveys are needed to quantify these achievements. In view of our findings, it will be necessary to consolidate the current level of accomplishments and refine some activities during the **next project cycle**. The next project cycle could then achieve full **institutional integration** and **capacity building** of all STD-related activities and **surveillance** of STD HIV/AIDS. When the **system** is fully **operational**, it could be gradually **decentralized** (to some extent a pilot approach has begun in the Northwestern Region).

- 1.11. Since 1988, HOPE Enterprises, Ltd. has conducted numerous **social research projects** with various international organizations such as the Futures Group/SOMARC, John Snow, CDC, etc. HOPE Enterprises has provided some **invaluable and timely support** to USAID-funded STD HIV/AIDS prevention and control activities. This support has been in the form of surveys, impact studies, evaluations of project activities, etc. In view of HOPE's current achievements, **support** to HOPE should **continue**, but at the same time HOPE should also develop the **in-house capacity** of the EPI Unit to conduct similar work. However, HOPE Enterprises should always maintain an **advisory capacity** to the EPI Unit and the NACP.
- 1.12. One of the weak points of this project is the overall level of **institutional integration and capacity building** of the various project activities, in large part due to the design of the various sub-agreements. Some of the project management problems could also be easily corrected as suggested in this report. Both the private and public sectors did equally well managing the various sub-agreements of this project. This diversification should be continued, provided the level of activity output can be sustained.
- 1.13. Finally, we would like to **congratulate** those who contributed to the success of the various project activities. We conclude by recommending that this **project** continue in its present form while consolidating the activities as proposed in various sections throughout this report.
- 1.14. **FOUR MAJOR RECOMMENDATIONS**
 - 1.14.1. **Continue the project** with cohesive, non-fragmented approach strategies.
 - 1.14.2. **Target groups** based on socio-cultural and economic boundaries, especially young males, and promote dialogue with all target groups.
 - 1.14.3. **Consolidate STD and surveillance activities**, and the **CI program**.
 - 1.14.4. Establish **new management tools** at AIDSCAP Jamaica and **promote capacity building** over the life of the next project cycle.

2. Evaluation Methodology

- 2.1. The intent of this mid-term evaluation of the **USAID-funded HIV/AIDS and STD Prevention and Control Project** is to review its performance to date and recommend any future changes.
- 2.2. This Evaluation Team met in Washington, D.C. on October 16, 1995 for briefings by USAID/Latin America/Caribbean Bureau and the Latin America/Caribbean Division of AIDSCAP. In Jamaica (October 17-19) the Team reviewed the scope of work and developed an approach for the assignment and tentative table of contents under the leadership of a team planning facilitator from the Health Technical Services Project in Washington. The field work began on October 18th with a meeting at USAID/Jamaica. Another orientation meeting with USAID Senior staff took place on the 18th. Also on the 18th the EPI Unit Principal Medical Officer (PMO) and the NACP Director made a presentation. The PMO gave an overview of the National AIDS Control Program, the EPI Unit and its working relationship with USAID-funded HIV/AIDS and STD Prevention and Control activities. The PMO also shared his overall expectations of this evaluation. In addition, the AIDSCAP Resident Advisor held several meetings with the Team. During the first meeting with the Resident Advisor, the Team was presented with AIDSCAP's program strategies in Jamaica. It was then agreed between the Team and the Resident Advisor to use the Project Status Report as of **August 31, 1995** as the cut-off date for evaluating the respective components of the project.
- 2.3. The next four weeks were spent interviewing staff of the Project (all project managers and a number of project staff), the EPI Unit, the National AIDS Control Program, and National AIDS Committee (NAC). A number of field visits were made in Kingston, Ocho Rios, and Montego Bay (see Annex 2 for the individuals met and interviewed during the evaluation). The draft report was submitted to USAID/Jamaica November 13, 1995.

3. Initial Project Design

- 3.1. A budget of US \$3,082,414 was authorized in 1988 (under the Cooperative Agreement) for a **six-year HIV/AIDS and STD Prevention and Control Project** (No. 532-0153). The purpose of this project was twofold: (1) to reduce HIV/AIDS transmission; and (2) to reduce the incidence and prevalence of STDs in Jamaica.

- 3.2. This project was to focus on three key areas: (1) HIV/AIDS and STD surveillance program of the Ministry of Health; (2) targeting specific risk groups for interventions; and (3) public education programs. The following assistance was to be provided with this project: (1) long- and short-term technical assistance; (2) in-service and overseas training for health providers; (3) computer hardware and software; (4) STD pharmaceutical and medical supplies; (5) support to the staff of the Epidemiology Unit (EPI) of the MOH; and (6) training materials.

4. Design of the Current of USAID/Jamaica HIV/AIDS and STD Prevention and Control Project

- 4.1. In 1992, USAID/Washington selected Jamaica as one of the 15 countries to receive technical assistance under the AIDS Control and Prevention (AIDSCAP) Project. The intent was to develop a comprehensive service delivery and communication program to achieve a tangible impact. This led to the amendment of the project. An additional obligation of **US\$1,051,838** (under the Contract) was awarded. The focus remained the same, but strategies were to be more focused in **three key areas**: (1) improving both the **diagnosis and treatment** of STDs; (2) **promoting** the use and distribution of **condoms**; and (3) promoting the **reduction of sexual partners**. The new Strategic and Implementation Plan was only operational in 1993, and had been designed in collaboration with the EPI Unit of the MOH, NACP, and the LAC Bureau within the framework of USAID's AIDS Technical Support Project (ATSP).
- 4.2. As of August 1995, USAID/Jamaica had received **US \$4,134,252** with a remaining **US \$1,087,455** balance through August 1996. Since 1993, the AIDSCAP program has developed **21 sub-agreements**, three of which were passed to strengthen financial and administrative support. In addition **USAID/Jamaica** made an **important financial contribution** to the project through the purchase of pharmaceutical and medical supplies, 15 vehicles for CIs, and training in the States. Through a PASA (**US \$108,220**) with the Centers for Disease Control and Prevention (**CDC**), short-term **technical assistance** was provided to the EPI Unit of the MOH. The focus was to improve epidemiologic surveillance, develop the training materials and data collection tools for CIs, and to provide support to the additional ten recruits of the CI program unit.

5. Behavioral Change and Communication Activities

5.1. ASSOCIATION FOR THE CONTROL OF SEXUALLY TRANSMITTED DISEASE/ACOSTRAD (PVO)

5.1.1. Objectives

Through a sub-agreement with AIDSCAP, ACOSTRAD II (US \$311,014 from December 1993 to July 31, 1995) aimed at **reducing or stabilizing** STD prevalence in the following high-risk target groups: (1) sexually active adults in the marginalized community of inner Kingston; (2) CSWs; (3) adolescents (both in and out of school); and (4) STD clinic attenders. Through peer education and counseling, ACOSTRAD promoted **condom use** and **safer sexual practices**. ACOSTRAD also initiated institutional linkages with other organizations to promote its mandate.

5.1.2. Specific Findings

- 5.1.2.1. ACOSTRAD trained 64 peer counselors (50 planned): 32 for the marginalized areas of Kingston (10 planned); ten for the CSWs of Montego Bay (16 planned); five CSWs in Kingston (7 planned) and 17 for the STD clinic attenders throughout Jamaica. This team was able to assess the work of the peer counselors who are supported by CIs in Montego Bay.
- 5.1.2.2. ACOSTRAD conducted **the five training programs** planned in Kingston and in Montego Bay.
- 5.1.2.3. ACOSTRAD conducted the three refresher training sessions planned for STD clinic attender counselors.
- 5.1.2.4-5 ACOSTRAD has reached **154,822** people (91,458 female and 63,364 male), and distributed **192,508** educational materials on STD and HIV/AIDS (the target was 53,530 people and 113,500 pieces of educational materials).
- 5.1.2.6. By the end of 1994, a total of **9,376,919** condoms were distributed in Jamaica. By August 1995, ACOSTRAD had distributed **490,446** free condoms (planned **300,000**). In the sampling of **1,000** commercial outlets in 1994, **55%** outlets had condoms. Stigmas and problems related to condom usage remain however: (1) women still find it uncomfortable to openly purchase a condom or impose its use on her partner; (2) despite the sharp increase of persons trying a condom for the first time, there is no indication of consistent condom usage; and (3) the number of sexual partners is on the rise.
- 5.1.2.7. Peer counselors succeeded in establishing a basic level of awareness and some limited knowledge of STDs and HIV/AIDS among clinic attenders. One study (August 1995) reports that **96%** of STD clinic attenders identified at least **two** correct preventive strategies including **an accessible condom distribution outlet**. This is ahead of the 50% target of this indicator. However, the same study revealed that only **9%** of STD clinic attenders **assessed their risk appropriately** and **39%** (in Kingston) feel that

they are not personally at risk of getting AIDS. No data was provided for marginalized areas of Kingston, CSWs peer counselors or adolescents.

- 5.1.2.8. ACOSTRAD has **collaborated and cooperated** with other institutions and organizations, and attended a total of **96 meetings**.

5.1.3. General Findings

- 5.1.3.1. Peer counselors fared better with STD attenders than with the inner city communities. Whereas the dissemination of information may be sufficient in STD clinics, community workers have to establish long-term intimate networks of influence within communities. This latter process takes time and is not quantifiable within a year or two.

- 5.1.3.2. This team questions the impact of Peer Counselors on the behavior change of STD clinic attenders. An evaluation of Peer Counselors conducted at the CHC in Kingston states *"The current approach using peer educators is still to communicate basic knowledge which many in the group have already heard and misinterpreted by filling in the many information gaps to their own satisfaction. Repeating the same basic information to such a group only results in them dismissing you because "you nuh understand how it go"... Observing the Peer Educator straining to be heard, and the various dismissive reactions of the audience, it was clear that she was having very little meaningful effect."*

- 5.1.3.3. In Montego Bay, the population of rural origin has deeply-seated beliefs, along with a built-in system of denial regarding sexual practices. Even though most Jamaicans view themselves as "at risk", they do not believe to be in any real direct danger. This suggests that all Jamaicans admit facing a random risk, but believe that only a few (homosexuals and bisexuals) face a direct "real" risk.

- 5.1.3.4. This team questions the use of open public lectures to a large audience of men to effectively communicate information. In these large forums any counselors turned "messenger" must have gained the credibility of the targeted audience in order to achieve any measurable behavioral change. Being a peer is not necessarily the solution. Jamaican culture would predicate an adult (credibility based on age and gender) to take on this role, since peers may just say *"what does a person of my own age know that I don't?"* Consequently, older male Peer Counselors would have a greater impact on male STD clinic attenders.

- 5.1.3.5. Clinic attenders often complain about being poorly treated by the medical personnel at STD clinics, sometimes waiting more than two hours to be examined.

5.1.4. Conclusions

- 5.1.4.1. Though ACOSTRAD achieved most of its goals, the strategies promoting condom use and safer sexual practices have failed to incorporate a two-way dialogue on a

specific topic in a small group-setting. This form of dialogue promotes a forum where views are exchanged and challenged, at the same time fostering a climate of trust. Trust is the essential ingredient for participants to recognize and accept other's viewpoints and advice, as well as their willingness to be influenced.

5.1.5. Recommendations

- 5.1.5.1. At the community level, educators should be redirected to build networks of influence and not just to disseminate information in order to establish authority with the audience. Peer Counselors have to be chosen based on socio-cultural criteria of age, sex and social class.
- 5.1.5.2. Peer Counselors have to operate in small group settings.
- 5.1.5.3. Dialogue with target populations should be promoted in a climate of mutual respect and empathy in order to dispel any incorrectly held biomedical views.
- 5.1.5.4. The BCC Team must mix with the STD clinic attenders. The team should take the "pulse" of the people and be aware of their thinking and feelings.

5.2. JAMAICA AIDS SUPPORT/JAS (PVO)

This is the second sub-agreement between JAS and AIDSCAP. This sub-agreement focuses on men with men (MWM) in Kingston, Montego Bay and Ocho Rios. In these communities, JAS has established support groups and is promoting behavior change among MWM.

5.2.1. Objectives

Jamaica AIDS Support (JAS) II, is an AIDSCAP-funded project (US \$215,816 from May 1994 to June 1996) with a clear mandate to reduce STD/HIV transmission among target groups in Jamaica.

5.2.2. Specific Findings

With a year to go at the time of this evaluation, JAS has met the specific proposed project indicators and exceeded all planned projections.

- 5.2.2.1. JAS has set up a counseling network in Kingston, Montego Bay and Ocho Rios and has trained 38 peer counselors (25 planned by 1996) who have made 6,615 contacts (1,000 planned by 1996). In addition, the three centers have organized support groups, which meet biweekly in Kingston, and once a week in Ocho Rios and Montego Bay. So far 4,643 MWM were reached (1,000 planned by 1996). JAS has

also organized a workshop on religion and sexuality attended by **664** people (35 planned). In addition **368** (24 planned) special events were organized reaching **17,002** MWM (6,000 planned). At present JAS cooperates with five other organizations.

- 5.2.2.2. JAS has, to date, organized **64** weekly (30 planned) support groups for 529 persons (350 male and 179 female) with AIDS (PWA/100 planned) in the three towns targeted, of which **112** PWA work as peer counselors (10 planned).
- 5.2.2.3. JAS has distributed **6,171** materials to date.
- 5.2.2.4. Three hundred and seventy three (373) blood samples were drawn from MWM (the results were not in at the time of this evaluation). Twenty four (**24**) other towns are participating in seroprevalence and Knowledge, Attitude, Practice and Behavior (KAPB) surveys.
- 5.2.2.5. JAS is run by a team of highly motivated and dedicated people who have put into place the management organization prescribed by the project. JAS has put together a *Board of Directors* and they have met **eight** times. The fund-raising operation is gaining more support from various organizations throughout the country, especially in Kingston. The Senior Management has gone through six training management workshops and has established the management system of JAS. In addition, **33** staff members have participated in a team building workshop.

5.2.3. Conclusions

- 5.2.3.1. JAS succeeded in establishing bridges outside the realm of the gay and bisexual community. This support was instrumental in providing care to PWA and in setting up the support groups.
- 5.2.3.2. Given the high rate of AIDS cases (94 cases between 1982 and March 1995) in the gay and bisexual community, JAS should take on a more selective and structured approach to prevention and control measures.

5.2.4. Recommendations

- 5.2.4.1. We recommend that JAS take an active role in the *National AIDS Committee*. Particularly within the Counseling and Social Support Sub-Committees, but also in the Legal and Education Sub-Committees. JAS is the only organization to care for PWA but also to have well-organized support groups.
- 5.2.4.2. **Support to JAS should be maintained and strengthened. JAS and its home-based care of PWAs should become a prototype which can be duplicated throughout Jamaica.**

5.3. AMERICAN NATIONAL RED CROSS AND THE JAMAICA RED CROSS SOCIETY (NGO AND PVO)

This program benefits from a well-organized and structured organization (Jamaica Red Cross) with satellite branches throughout Jamaica. To promote a sustainable prevention program for the youth, the program draws its peer educators from target groups who will participate in three levels of training: (1) instructor/trainer workshops for adult leaders who will be training peer educators; (2) peer educator workshops; and (3) peer-to-peer sessions. Topics will be presented to adolescents on HIV/AIDS, and risky sexual behaviors. The program encourages abstinence for those who accept it, and encourages those who are sexually active to consistently use condoms and have only one faithful partner.

5.3.1. Objectives

Through an AIDSCAP sub-agreement (US \$390,967 from May 1993 to May 1996) the Jamaican Red Cross (JRC) in collaboration with the American National Red Cross (they contribute \$140,831 to JRC in matching funds to this program) is developing an **island-wide risk reduction program** targeting adolescents (14-19) to prevent the spread of HIV and STDs.

5.3.2. Specific Findings

- 5.3.2.1. JRC has completed the **Curriculum for Peer Counselors**. During this evaluation the **Instructor Trainers** manual was tested. The training manuals are effective tools in presenting accurate information to relevant groups. So far, 35 instructors have been trained (30 planned). In addition JRC has developed a number of games, posters and brochures on STD/HIV and two excellent handbooks for workshop participants. The activity kit *Together We Can* (1995) is particularly well-designed and benefited from the inputs of numerous sources.
- 5.3.2.2. To date JRC has trained 137 peer counselors (450 planned over the life of the project with less than a year to go), and contacted 2,605 adolescents (4,500 planned). With the peer education handbook pre-tested and ten months to go, the Red Cross should be in the position to reach the established program indicators.
- 5.3.2.3. The radio program on 106 FM is successful and caters to adolescents. So far 71 **radio dramas** have been aired.

5.3.3. General Findings

- 5.3.3.1. This sub-agreement has been carried out in a structured and systematic manner which strengthens the possibility of its sustainability within an established reputable organization.

5.3.3.2. Based on the design of this program fewer people were trained. However, the strength of this approach lies in the selection process of peers and trainers. The training manuals are professionally designed. In due course, this could become a semi-autonomous network of adolescent health clubs/groups who can themselves address a vast array of HIV/AIDS issues.

5.3.4. Conclusions

5.3.4.1. The training approach should have a lasting impact as opposed to the radio program.

5.3.4.2. **The Red Cross, Face to Face, ACOSTRAD and the Targeted Community Intervention target adolescents in their respective programs. Therefore, these four groups should pool their experiences and materials to develop common strategies focusing on adolescents.**

5.3.4.3. While the Red Cross has succeeded in disseminating information, building awareness, and developing an adolescent network to propagate behavior change, it still remains to be seen how the Red Cross will permanently establish this network. Over time, this network should not only disseminate information, but contribute to the development of new behavior-changing strategies through its interaction with adolescents. This issue should have been raised in the sub-agreement.

5.3.4.4. The Red Cross has not achieved an equal gender balance except in one of their workshops. The Red Cross is aware of this problem, but as with other sub-agreements, the gender discrepancy in workshop attendance and leadership is not yet addressed. Note that males are sexually active two years before females, and are still culturally recognized as the sexual decision makers.

5.3.5. Recommendations

5.3.5.1. A study of the cost effectiveness of the Red Cross program along with other sub-agreements sharing similar target groups should be conducted.

5.3.5.2. All sub-agreements with similar target groups (adolescents) should share experiences and materials, and develop their strategies together.

5.3.5.3. The Red Cross should place a special emphasis on incorporating males as participants and in leadership positions.

5.3.5.4. The Red Cross should develop a strategy for setting-up semi-autonomous and self sustained networks.

5.4. FACE TO FACE (PUBLIC SECTOR)

Face to Face has trained “outreach workers” and peer educators to disseminate information to the target groups (awareness of STDs and HIV, condom usage,

encouraging abstinence and delaying sexual activity, and also encouragement of partner reduction). *Face to Face* has developed a number of approaches by going to schools, work places, and various clubs to **identify and train community and peer leaders**. *Face to Face* is also working through various youth organizations: Boy Scouts and Girl Guides to identify and train peer educators (Facts of Life Peer Education Program). In the rural areas, *Face to Face* is recruiting teachers for Did You Know Sexuality Program. *Face to Face* has also organized a number of special events (Reggae Sunfest, road fairs, farm displays, house-to-house education), as well as a range of other risk assessment techniques such as the Risk Wheel. The Targeted Community Interventions in marginalized communities is quite remarkable. Throughout the above activities, *Face to Face* always demonstrates the importance of correctly placing a condom on a dildo.

5.4.1. Objectives

Through an AIDSCAP sub-agreement (US \$259,750 from July 1994 to August 1996), *Face to Face* proposes to reduce HIV infection among adolescents (13-18 years) and young adults (19-30 years) by educating them about sexuality, convincing them to adopt safer sexual behaviors, and by delaying the onset of sexual activity.

5.4.2. Specific Findings

All of the sub-agreement indicators have been surpassed, though the program has a year to go.

- 5.4.2.1. *Face to Face* has set up an island-wide network of **94** active *Face to Face* team members and coordinators (80 planned). Ninety-two (92) new team members have been recruited, but that number may be decreased to the established 80 indicated in the program implementation document. For these recruits, *Face to Face* has organized **67** training and support sessions.
- 5.4.2.2. *Face to Face* has organized **12,571** rap sessions thus reaching **84,652** people (3,000 sessions for 50,000 were planned). Through the "People Wave," *Face to Face* has conducted **nine** training sessions in **nine Parishes** and trained **183 peer educators**. The aim was to reach adolescents both in school and out-of-school. In addition, the program has trained **259 teachers** in innovative strategies on sexuality, STDs and HIV/AIDS. At present **143 primary schools** are participating in sexuality programs (40 planned).
- 5.4.2.3. *Face to Face* has trained **20** community youth leaders (Boy and Girl Scouts) to implement the HIV/STD education program "People Wave." A total of 96 special events were organized (World AIDS Day, fairs) to promote HIV/AIDS awareness. The group ASHE performed "VIBES in a World of Sexuality" in seven different sites.

5.4.2.4 The program has developed a series of HIV/STD prevention materials used by the trainers for the various target groups. The program has distributed **120,580** educational materials.

5.4.3. General Findings

5.4.3.1. The following findings are based on work done by HOPE Enterprises. As a result of this program, 70% of adolescents had (prompted) knowledge of at least two prevention practices, and 66% of adolescents shared an appropriate perception of risk. However, unprompted knowledge is low (7% for males, 9% overall). Both prompted and unprompted knowledge is lower than for adults. Only 14% of adolescents mention abstinence as a preventive measure (versus 27% of adults), while 65% of adolescents will not use a condom. Based on the Lifestyle Survey (1993), there is high condom usage 15 to 19 year old age group (70% for males and 35% for females), but this usage pattern declines steadily with age. Twenty-one per cent had initiated sex before age 12.

5.4.4 Conclusions

5.4.4.1. *Face to Face* succeeded in raising awareness in rural areas and places not reached by the other AIDSCAP sub-agreements. Contact Investigators working for *Face to Face* in Montego Bay were the first to indicate that HIV was spreading into deep rural populations of that Parish. Both the Risk Wheel and the condom demonstrations have helped women initiate condom use, while promoting a greater sense of personal risk.

5.4.4.2. While the level of awareness in adolescents has markedly improved, it is not entirely clear if this translates into sustainable behavior change.

5.4.5. Recommendations

5.4.5.1. Again, we recommend that the various sub-agreements targeting adolescents develop a common comprehensive approach. This approach should take into the account socio-cultural backgrounds, gender, and age. It should also be decided whether *Face to Face* takes the lead and coordinates activities targeting adolescents, or whether each of the sub-agreements be assigned a specific adolescent group (i.e. *Face to Face* and rural youth). In addition, some of the techniques developed by *Face to Face* (i.e. Risk Wheel) could be used through other sub-agreements.

5.4.5.2. *Face to Face* should focus on building and initially supporting the creation of semi-autonomous networks developing activities of their own. *Face to Face* should establish a less didactic and more interactive communications approach between adolescents and young adults of the program. This is crucial to understanding rural populations on key behavior change issues.

5.5. COUNSELING AND SOCIAL WELFARE (PUBLIC SECTOR)

This program was established to develop services for people with HIV/AIDS. Its first step was to establish a national AIDS/STD HelpLine in 1989 and a national system of identification and referral for people testing positive for HIV. In addition the program focuses on improving the quality of counseling to persons referred to by the national referral system.

5.5.1. Objectives

Through this AIDSCAP sub-agreement (US \$120,381 from August 1994 to August 1996), Counseling and Social Welfare (1) works on a National support and referral system for PWHIV; (2) conducts educational activities using the referral network; and (3) provides a regular confidential HelpLine for counseling and referral services.

5.5.2. Specific Findings

- 5.5.2.1. Counseling and Social Welfare has established formal links with JAS, the family center, the Poor Relief Agency and community mental health officers. A total of 22 agencies actively participate in the referral network. It is not clear whether this network is monitored or consolidated so as to become fully operational. Of all 14 parishes 134 counselors are currently in training (60 planned). To date, 171 persons of social services are involved in the referral network and these have been included in the Care, Counseling, and Support sub-committee of the NAC. The program is currently working on a resource and referral manual which will list related services and agencies. The program has also trained over 539 persons in counseling techniques: public health nurses; HelpLine volunteers; blood bank staff; community volunteers; pastoral counselors; volunteer groups; physicians; and community mental health officers.
- 5.5.2.2. The program has trained and hired five counselors to provide confidential information and counseling to callers. HelpLine has referred 11,251 calls to support groups. A Care, Counseling and Social Support (CCSS) team established in 1993 developed the national system of referral to train health care personnel. In 1994, this helped channel 1,472 referrals through HelpLine and brought together agencies and organizations. These calls enabled the program to provide 40 organizational referrals. A referral directory was developed.
- 5.5.2.3. The HelpLine counsels callers and refers them to the health care system. Information gathered by the HelpLine is analyzed and fed back into the BCC program so as to improve the educational materials. For two years a volunteer counselor operated three hours a day on the HelpLine. In 1991 a full-time and a part-time counselor were hired to work ten hours a day. As a result there was a marked improvement in the

quality of the counseling. All the information (confidential) is recorded for analytical and referral purposes. Between May and September 1991 Helpline launched a promotional campaign which resulted in a ten-fold increase in the number of calls: 500 in 1990 to 5,041 calls in 1991. Without publicity the number of calls dropped to 4,225 in 1994, and about 4,100 in 1995 at the time of this evaluation.

5.5.3. General Findings

- 5.5.3.1. While this sub-agreement attempts to improve the quality of care and services of HIV+ persons, there is no evidence supporting a decrease in initial hysteria of HIV+ persons or suggesting that HIV+ persons are getting better treatment based on this program. JAS continues to report problems with the quality and type of treatment and it is important that this work be sustained.
- 5.5.3.2. The unstated expectation that the clinical psychologist would give expert guidance to the entire BCC effort has not materialized and various reasons are provided on missing this important opportunity. The clinical psychologist claims that there was no clear written mandate thus increased the risk of invading other BCC team members' "turfs." Some claim that the clinical psychologist was not assertive enough and failed to be immersed in BCC's daily activities.

5.5.4. Conclusions

- 5.5.4.1. The HelpLine provides an effective tool and needs to be sustained. The national system of identification and referral should be consolidated, and its operational capacity tested and monitored. The training of caregivers and related personnel must be sustained. The clinical psychologist must be given explicit responsibilities not only to provide expert guidance in developing BCC strategies as a whole, but also to ensure that the BCC incorporates findings and suggestions from the various sub-agreements that reflect the evolving field realities.

5.5.5. Recommendations

- 5.5.5.1. By August 1996 this sub-agreement should develop a promotional plan to raise and sustain the number of calls to the HelpLine. This can be done through the media, public service announcements (PSAs), churches, theaters, dance halls, or other mediums of communication.
- 5.5.5.2. This sub-agreement should consider consolidating and strengthening the national referral system for the remaining LOP. This organizational task does not require the skills of a clinical psychologist. The work with counselors needs to be continued.
- 5.5.5.3. The clinical psychologist should advise the BCC team and set up a system for converting research results and field work into new program activities.

5.6. COMMUNICATION TEAM (PUBLIC SECTOR)

The BCC team coordinates communications issues for all of the sub-agreements (*Face to Face*, HelpLine, ACOSTRAD, Red Cross, JAS, Targeted Community Interventions [TCI] teams, AIDS in the Workplace) to ensure consistency and validity. The BCC team supervises all media campaigns. In addition, the BCC works in conjunction with the NAC to ensure consistency of their mutual activities. The BCC team also develops posters, brochures, comic books and flyers targeted at adolescents, young adults, and other key target groups. Throughout the country BCC has organized talks on STD/HIV/AIDS and behavior change.

5.6.1. Objectives

Through a sub-agreement with AIDSCAP (US \$155,219 from July 1994 to August 1996), the Communication Team of the EPI Unit of the MOH is to provide appropriate behavior change communication materials for the NACP programs.

5.6.2. Findings

- 5.6.2.1. Despite the enormous challenge, the BCC team has succeeded in keeping most of the proposed activities on schedule. **Forty-five** of the NAC organizations use messages developed by the BCC team. By the end of August 1995, **191,293 pieces** of educational material were distributed. BCC has conducted workshops with: the Police, Face to Face parish coordinators, ACOSTRAD, the Red Cross peer educators, drama teachers, and a group of pastors. The **Terry-Ann video** (the first person with AIDS to go public on television in Jamaica) was aired on World AIDS Day. The team contributed to the improved and sustained level of awareness of HIV/AIDS over the years. The BCC succeeded in establishing excellent working ties with all the sub-agreements.
- 5.6.2.2. Despite the high level of awareness there has been little proven change in behavior during the recent years. Condom sales were at four million in the mid-80s and have leveled off at about 9.4 million in 1994-1995. Between 1992 and 1994 unprompted knowledge of two methods of HIV protection fell from 51% to 39%.
- 5.6.2.3. Multiple partnership has risen between 1992 and 1994. The number of people who reported having two or more partners in the last 12 months increased from 49% to 53% for men, and 6% to 14% for women. This, along with inconsistent use of condoms, should become a cause of concern.

5.6.3. Conclusions

5.6.3.1. Most of the BCC activities lack **gender-specific strategies**, especially when targeting males. Based on studies conducted in Jamaica, adolescent and adult males are the **key sexual decision makers**. This cultural bias must be taken into account when selecting appropriate male messengers to target the male population. **Empowerment of women** to reach the male population may be more difficult to achieve in this cultural context. Furthermore, **behavioral change** may have reached a **PLATEAU** that could be correlated to the short time span of the program. It should be noted that the model for behavioral change is adequate, but that unfortunately the BCC Team needs **guidance** to reshape the current strategies required to take it from this **PLATEAU** to the **next strategic level**. While target groups have been bombarded with messages, there appears to be little **two-way communication** and dialogue. When research is conducted, there is no systematic mechanism to incorporate the findings into program activities. It would appear that the **multitude of indicators** (a full two pages) in this sub-agreement may have led to BCC's fragmented approach, thus losing sight of the **ultimate goal**.

5.6.4. Recommendations

- 5.6.4.1. The BCC Team and all sub-agreement leaders collaborating with the BCC Team should meet during a retreat to reshape the BCC strategies. Specific training on the following issues should be offered to the BCC Team: (1) Jamaican family structure and community culture; (2) in depth and practical courses on behavioral psychology, specifically sexual behavior change patterns. BCC could develop a new approach to promote culturally-appropriate behavior change. Most importantly, this multi-level approach has to address the specificity of target groups.
- 5.6.4.2. The BCC Team should share the grass roots operations of the Comprehensive Health Center (CHC), the Targeted Community Interventions (TCI) and other programs. The BCC team must take into account the following variables in developing communication materials with other program leaders to promote behavioral change: (1) specific approaches for males by age group, distinct of those for females; (2) the social-cultural-economic background of the target population (rural, urban, rich, poor, educated, non-educated, blue collar, framer, laborer, etc.). Cultural credibility should be the single most important factor in selecting and training peer educators.
- 5.6.4.3. Instead of cataloging and trying to dispel the flourishing new myths (i.e., Stone and AIDS) the BCC Team should instead try to understand them and see how to adapt messages and strategies accordingly.
- 5.6.4.4. In collaboration with Hope Enterprises, the BCC Team should setup an in-house research group. BCC should systematically review ongoing research and feedback it

receives on the various programs, and then be in the position to suggest new activities and strategies. This may require more staff for the BCC Team.

5.7. PUBLIC RELATIONS HIV/STD RISK REDUCTION (PRIVATE SECTOR)

Berl Francis and Company Ltd (BF&C) is a well-established and reputable public relations firm in Kingston. BF&C developed communications messages for the national media. Through BF&C's extensive informal social networking, it successfully gained support from media leaders and other national figures.

5.7.1. Objectives

BF&C managed an AIDSCAP sub-agreement (US \$151,431 from July 1994 to May 1996) to create and maintain a supportive national social climate for behavior change in **adolescents and adults** with multiple partners, and **opinion leaders** in Jamaica.

5.7.2. Findings

- 5.7.2.1. In targeting opinion leaders, BF&C is on target. It has sent 85 letters to inform opinion leaders about the program and request their support. Numerous meetings were setup with religious leaders (84), community leaders (12), policy makers (8), PR representatives and the media (17). BF&C organized one NACP press conference and held nine meetings with the press. As a result **16** opinion leaders have officially **endorsed** the campaign. The **Jamaican Council of Churches** has endorsed the program and provided logistical support and has adopted one of their projects in 1995.
- 5.7.2.2. In targeting adolescents, BF&C: developed and published **29** comic strips; organized a five-part comic strip competition; prepared **31 columns** for a Safer Sex Column in response to the Helpline questions; organized a live debate broadcasted on Radio Jamaica and shown on JBC TV; coordinated a musical roadshow for **800** students from four schools in Montego Bay, and **2,500** students from five schools of Savannah La Mar; and coordinated a radio program entitled "Young Power" with peak audiences of 38,000 in the 15 to 24-year-old age group. BF&C has successfully pushed the publication of articles (**197**) containing references to STD and HIV/AIDS (during this evaluation, several papers appeared on the front pages of leading papers, e.g., Gleaner, Herald).
- 5.7.2.3. In targeting young adults, BF&C has developed sexual health articles that have appeared in 11 issues of one of the largest mass circulation papers in the country (about 200,000 copies). BF&C has also organized 45 radio and TV talk shows. Four comic strips and cartoons for STAR have been prepared. So far 18 church leaders are

involved in the program and support people with AIDS. One of them wrote an article on AIDS.

5.7.3. Conclusions

BF&C succeeded in targeting the established media, editors, and leaders. As a result, HIV/AIDS issues are more frequently addressed by the written press, radio and television stations. The audience can now translate this energy and good will in deeds, particularly regarding care and compassion for people with AIDS. As a result, BF&C must continue, on behalf of the program, to regularly inform the media leaders and seek their support.

5.7.4. Recommendations

5.7.4.1. While BF&C has established a remarkable track record with the established media, popular mass cultural media should also be tapped, including DJ and Dance Hall culture. These latter two exercise a great influence on all social strata, from males to Rastafari, popular churches, informal religious figures, and movements. BF&C should have no problem moving from the established media to the above listed cultural media.

5.7.4.2. The success of this sub-agreement is inherent to BF&C networks. But how can it be sustained and transferred to the EPI Unit? How can one access and develop the mass cultural channels to the people? Both issues should be carefully reviewed so that the EPI Unit can conduct the same activities.

5.8. AIDS IN THE WORKPLACE (PRIVATE SECTOR)

AIDS in the Workplace targets large companies (500 and more employees). Any collaboration is done with the support of the company CEO. Subsequently various AIDS-related meetings are scheduled in either a branch office or in one of the company's departments. Similar meetings are also organized with national trade union centers. As a result, these companies hold workshops on AIDS, while others are developing company policies on AIDS-related issues. This is the only sub-agreement to reach the working class (from lower middle to upper classes), the backbone of the Jamaican institutional society.

5.8.1. Objectives

Through this AIDSCAP sub-agreement (US \$13,400 from October 1994 to August 1996), AIDS in the Workplace is to establish a policy dialogue with CEO's and

Company Directors. The adoption of AIDS policies for the workplace using behavior change activities is the goal.

5.8.2. Findings

The results are impressive considering that this sub-agreement has operated with such a small budget. This is due to the personal involvement of the Project Manager.

- 5.8.2.1. With a year to go, the project has met and in many cases exceeded the proposed indicators. Twenty-five CEOs (20 planned, targeting banks, financial services, farming, tourism, and insurance services) have participated in Bosses Care. Thirteen CEOs were met individually, and **eight** quarterly meetings were held. While **25** may seem small, convincing and attracting 25 CEOs is an intensive and time-consuming process.
- 5.8.2.2. The project is slowly moving ahead with the training sessions and the distribution of workplace kits. **Forty two** (20 planned) sessions to train in-house (company) coordinators have been conducted and another **11** in-service training sessions have taken place. As a result only 23 workplace kits have been distributed (2,000 planned) and **2,902** employees (10,000 planned) have participated in **43** in-house (a minimum of 100 planned) education sessions.
- 5.8.2.3. At the time of the evaluation some of the most prestigious companies in Jamaica that were participating in the program had developed various company AIDS policies on for example, discrimination, care, employment, screening. Other companies were working on their policies. Some of the companies had started developing AIDS-related policies prior to this project. For the most part it appears that employees in these companies want to gain accurate information on the mode of transmission of AIDS. Their chief concern is the right to confidentiality in the event one contracts AIDS. So far **12** AIDS policies have been developed and put into place. NCB is in the process of developing a **self-sustained** program and has made substantial financial contributions to JAS.

5.8.3. Conclusions

A lot of ground still needs to be covered, particularly in the tourist industry, life insurance companies, and most areas of the public sector. The success of proposed activities depends on the commitment of the CEOs and line managers who can support middle- and lower-level staff's work on AIDS-related issues.

5.8.4. Recommendations

- 5.8.4.1. The project (additional funds required) should conduct an **assessment** to establish a realistic prioritization of needs in the workplace. This new phase would be funded by the public sector.
- 5.8.4.2. Check the *Private Sector Organization and the Joint Trade Union Research and Development Center* and see if they can either support the project or share some of the activities' costs.
- 5.8.4.3. Develop a program for the tourist industry [in conjunction with the Jamaica Tourist Board, the Jamaica Hotel, and Tourism Association, etc.] and for life insurance companies.

5.9. TARGETED COMMUNITY INTERVENTIONS/TCI (PUBLIC SECTOR)

To conduct the proposed activities, the TCI used a multidisciplinary approach and a team consisting of social workers, health workers, and a drama specialist. At first, the team focused on a small group in target communities immersing itself in the culture and social life of the community, and then identifying persons in the target community who could carry on the work in their communities.

5.9.1. Objectives

This AIDSCAP sub-agreement (US \$52,253 from September 1994 to August 1996) is to reduce STD/HIV transmission through behavior change among residents of selected marginalized communities in Kingston.

5.9.2. Findings

- 5.9.2.1. A team of two social workers, two nurses and one drama specialist have developed a community mobilization model to ensure support for the community's future activities. The team has worked in five communities: Majestic Gardens, Bowerbank, Riverton Meadows, Calaloo Mews, and McIntyre Villas ("Donkirk"). Two hundred (300 planned) interpersonal community-based sessions were conducted. A total of **4,882** females and **3,133** males (20,000 planned) attended these sessions. Five-thousand, five hundred and thirty-eight (**5,538**) pieces of educational materials were distributed. With guidance from the team, the community developed **two** video skits, and another script is completed. Both the community that developed the script and other communities were very receptive to the final product.
- 5.9.2.2. Twenty four (**24**) condom access points have been established in six communities, and **55** meetings have been held with community leaders and organizations. On their

own initiative, this group has pre-test-counseled and tested 177 persons for HIV and Syphilis in four communities. The TCI team has also regularly met Face to Face, ACOSTRAD, and the BCC team (23 meetings).

- 5.9.2.3. A baseline survey prior to this sub-agreement revealed that these communities have a high level of AIDS awareness, and knowledge of transmission and prevention methods against STDs and AIDS. However, while multiple partnership is high and the average age of initiation into sex for males is 11.5 years, most of them do not consider to be at risk. They feel that there is no risk as long as they select one of their multiple partners from the same community.

5.9.3. Conclusions

- 5.9.3.1. TCI's innovative approach has the greatest chance to bring about behavioral change. This approach is based on the following steps: getting close to the people; treating them with respect; using their cultural forms; and inviting both community personalities and talented people to conduct the program activities. This way the relevant biomedical issues pertaining to the epidemic are conveyed while at the same time building a partnership with the population to address the issue. This subtle approach enables people to safely continue living up to their culturally-accepted behavior. This is achieved by gaining people's confidence. Together they establish ways to establish behavior change. Finally, this project has attracted a large number of men, and has acquired considerable grass roots experiences and knowledge vital to the BCC program.
- 5.9.3.2. The flip side of this approach, is that communities may perceive the TCI Team as the AIDS Team in search of HIV+ people so as to remove them from the community (i.e., incident in McIntyre Lands).

5.9.4. Recommendations

- 5.9.4.1. This project should consolidate its work in each of the target communities before expanding to others (such as the move to three other communities).
- 5.9.4.2. The TCI Team should step back and carefully assess their approach and the lessons learned. The emphasis should be placed on community organization and not just its mobilization while working with respected community leaders.
- 5.9.4.3. The TCI Project Manager should also be a core member of the BCC team. There is a wealth of knowledge acquired on techniques and approaches to effectively communicate with targeted young males.

6. STD Case Management and HIV/AIDS Surveillance Activities

6.1. STRENGTHENING STD SERVICES AND CASE MANAGEMENT (PUBLIC SECTOR)

The Strengthening STD Services and Case Management activities portion of this sub-agreement is part of a comprehensive plan conducted by the National STD Program and is supported by multiple donors. However this project is only one of the contributing factors to the overall achievement of the STD Program.

6.1.1. Objectives

Strengthening STD Services and Case Management activities were supported by an AIDSCAP sub-agreement (US \$155,394 from July 1994 to August 1996) and through a PASA with the CDC for technical assistance (US \$108,220 from March 1994 to August 1996) to develop and strengthen STD services. Technical assistance to develop and strengthen STD services and train Contact Investigators was previously provided by CDC through an earlier PASA. Strengthening STD Services and Case Management activities consists of four objectives: (1) to strengthen STD case management and education of public STD Clinic Attenders (STDCAs); (2) to strengthen laboratory capacity in STD clinics to ensure quicker and more effective patient diagnosis; (3) to strengthen CI services; and (4) to conduct STD-related operational research.

6.1.2. Findings

Before this AIDSCAP sub-agreement was signed, the STD Program was funded through an interim budget. For the purpose of this evaluation we based our findings on the AIDSCAP sub-agreement, the PASA with CDC, and USAID/Kingston support.

- 6.1.2.1. The CDC reviewed the STD morbidity reporting systems, corrected the aggregate STD morbidity reporting, modified the data entry process, corrected and standardized the STD morbidity reports, and in collaboration with the EPI Unit created new forms (STD Interview Record, STD Field Record). The new STD **reporting forms** (see Annex 5) have been disseminated to all STD clinics and health personnel have received adequate training on using the new reporting forms.
- 6.1.2.2. The STD program developed the **STD software database** in collaboration with CDC, which is now operational. The software captures the summary STD clinic data submitted each month by each of the parishes, which is then published in a summary report. Since summary reports are available from a menu screen, the STD Program

can at anytime provide **accurate morbidity** distribution (over time and location) in Jamaica.

- 6.1.2.3. Dr. Alfred Brathwaite of the STD program wrote an excellent manual entitled: **Practical Case Management of Common STD Syndromes, specially adapted for use in Primary Health Care Centers**. This reference manual is now used by all health care providers in public STD clinics. So far **1,445** manuals have been distributed (2,000 planned for LOP) and it is used by **26** public clinics (13 planned by LOP) [The extent to which private sectors physicians were targeted in this distribution of manuals is not clear]. This manual provides a systematic approach to the case management of STDs: diagnostic tools, prescription of the correct treatment, and counseling of the patient and his/her partner.
- 6.1.2.4. The drop in STD cases in the public sector is certainly attributable to the systematic case management of STDs and improved contacts with clinic attenders (**syphilis** cases decreased by 61.5% for females and 64.2% for males; 1987 is the base line year; see Annex 4) thus decreasing the risk of **spreading** STDs and further STD-related **complications**. The following figures (1991 study by the EPI Unit, WHO and the CDC) are indicative of STD services in public clinics: **91%** of the STD clinic attenders were seen by clinic staff who had received some training (emphasis should be on **same: STD case management training** for all), and who correctly diagnosed **82%** of **gonorrhoea** cases and **70%** of **syphilis** cases. In addition, **48%** of these patients were invited to refer their partners, **59%** were informed that condom use was a risk reduction measure, but only **23%** were offered **condoms** during their visit (**61%** of the clinics had condoms). Correct diagnosis is based on the correct prescription or administration of the appropriate drug. The staff will **not prescribe drugs** if drugs are not available. While services were improving (to our knowledge there is no baseline evaluation) three years after the USAID project started, there is a need to again quantify **five years** (against the 1991 results) later the progress made by this **strong program**. This could be done by conducting another **evaluation** of the STD program in the public sector to **assess** the **STD services**. Here are some of the issues that could be covered: (1) diagnosis; (2) availability of prescribed drugs; (3) laboratory services; (4) notification and tracing of partners through the CIs; (5) accessibility; (6) quality of services; (7) need for further training; and (8) overall management and staffing of the clinic. While the achievements and the energies invested are remarkable, we would caution against making any hasty conclusions until figures can be collected from **representative samples** of the **population at risk** and the **availability** of standardized STD services (both public and private sectors) in relation to the STD National Program.
- 6.1.2.5. **STD repeaters** remain an important issue that has to be addressed both in case management of STD clinic attenders and by the BCC strategies. Some STD clinics feel that they are missing potential STD cases such as the Type 5 STD clinic in Montego Bay and that they could not screen the employees (over 10,000) in the free

- zone. Furthermore, this project reaches mostly young adults and low socio-economic groups.
- 6.1.2.6. Medical and lab supplies, pharmaceuticals for STD research, and support to the Comprehensive Health Center (CHC) in Kingston (Annex 6) are provided to the STD program. **This support should continue** and focus on operational STD research. Since there are sometimes **shortages of prescribed drugs** (i.e., for chancroid) at STD clinics, part of the donated supplies could be used to establish strategic stocks, while another part could support a revolving STD drug fund.
- 6.1.2.7. The STD program conducted some broad-based training sessions for **533 primary health care workers** (500 planned for LOP) over **15 sessions**, an STD-related practical course for **21 medical doctors (MDs)**, family nurse practitioners and registered nurses (RNs), as well as four regional Case Management Regional workshops. The STD Program should offer regional workshops on Case Management of STDs and Reporting every year as a means of sharing applicable findings on operational STD research while providing recurrent training to participants (MDs, RNs, Contact Investigators, and Laboratory Technical Assistants) who can also share field experiences. Such valuable field experiences and suggestions could further contribute to revised editions of the Case Management Manual and improve field case management of STDs. While the STD Program further consolidates and fine tunes its activities in the public sector, the current level of expertise must be shared with the private sector and the program must **train** health personnel who provide STD services (once the activities of 6.1.2.9. are completed, the Program could focus on this important issue).
- 6.1.2.8. In reference to **laboratory work** (this Team could unfortunately not assess private labs due to the emphasis placed on the public sector): 71 public labs, ANC labs, and centers can now conduct RPR testing (13 public STD clinic labs and major ANC labs were planned for LOP) when they have reagents and qualified personnel in place. STD clinics diagnose, test and treat **60%** of their patients in **one day** while **85%** of the patients are diagnosed and treated in less than one week. RPR testing can be done in all STD clinics. Twelve (**12**) Laboratory Technical Assistants have been trained through this sub-agreement. Subsequently they were permanently employed by the government. However, keeping these LTA in the public sector is a major feat (the LTA of Type 5 in Montego Bay left after 20 years of loyal service): the private sector pays much better. These and future LTAs should receive continuing training courses. Such a course (three day week-end) on Case Management of STDs and basic related lab work could lead to a Certificate.
- 6.1.2.9. A **survey** of physicians from the private sector was conducted. The objective of the survey was to enlist **private physicians** to be part of the sentinel surveillance system, and to evaluate their STD/HIV/AIDS activities. Some **127** physicians responded to the questionnaire. However, there are a few problems with the survey. The STD-related work load cannot be estimated based on an incomplete total number of non-

STD patients. Since a **representative sampling** from the private sector was not achieved over a period of time it is not possible to compare both sectors. Given the importance of enlisting the private sector in STD related activities (**48% of the STD patients reported to the MOH seek treatment in the private sector**), this survey should be reprogrammed.

6.1.3. Conclusions

6.1.3.1. Overall, we feel that this is a **strong program** with solid foundations in the public sector. The program improved the **reporting** system from the Comprehensive Health Center (CHC) and the 13 STD clinics, and trained large numbers of health personnel in **STD Case Management**. Consequently, clinics are **providing better services** to STD clinic attenders (needs to be quantitatively demonstrated). However, it is imperative that the STD Program bring on board the **private sector** during this next phase of the project. This could be done in collaboration with the Medical Association of Jamaica (MAJ).

6.1.4. Recommendations

6.1.4.1. The STD program should consider incorporating its database into the HIV/AIDS Tracking System (HATS) program.

6.1.4.2. At this stage the STD program should **document** (through the proposed studies) the current level of achievements and quality of services provided, and **further improve** island-wide program activities. Since the STD program was able to develop and test the tools to ensure proper case management of STD cases, we recommend that the STD program promote both public and private sectors to use the **same national standards** and case management **guidelines**.

6.1.4.3. The STD program should continue conducting operational research on the four STDs and a special emphasis should be placed on **STD repeaters**. The new data base should help to track these people.

6.1.4.4. The STD program should seriously look into gaining support from companies of the Free Zone and the Tourist Industry of Montego Bay to set-up a **mobile STD clinic** to reach their employees (this is probably not **cost-effective**, but we did agree with field practitioners that it may be the best way of reaching out to the 10,000 employees in the Free Zone alone). These companies (whether they have access or not to their employee medical records) would have to agree to a non-discrimination policy for anyone testing positive for HIV.

6.1.4.5. The **survey** on STD-related activities in the **private sector** should be reprogrammed.

6.1.4.6. The STD program should strengthen at all levels its **interaction** with the **private sector**.

6.2. THE CONTACT INVESTIGATOR (CI) PROGRAM (PUBLIC SECTOR)

A number of current CI activities are supported by the AIDSCAP sub-agreement that supports the Strengthening of STD Services and Case Management (US \$155,394 from July 1994 to August 1996) and through a PASA with the CDC for technical assistance (US \$108,220 from March 1994 to August 1996).

6.2.1. Findings

- 6.2.1.1. The concept of Contact Investigators is not new to Jamaica. It started in 1937 to help control the spread of syphilis. Therefore, the MOH felt that this simple concept of contact tracing could be extrapolated to effectively stop the spread of STDs and HIV/AIDS.
- 6.2.1.2. The legacy of the initial CI syphilis era is still strong. Current CIs are able to reach **60%** of two named contacts for each case of diagnosed syphilis (personal communication). A study conducted by Jamaican Sentinel Surveillance (JSS) on confirmed HIV cases (the number of index cases is not available), came up with 118 contact names of which 75 persons were located and 45 tested (13 were HIV+). This cohort study was conducted by a number of persons over a period of time. According to JSS the average cost to contact people with locating information amounted to US \$24 per partner. It is unfortunate that a number of variables are missing from this study. In Jamaica, of **467 HIV+** cases, **268 cases** were reported by CIs (**58%**). CIs are for the most part the health focal point in their communities, and sometimes the communities health leaders. CIs are often invited to give presentations on health-related issues.
- 6.2.1.3. One Regional Senior Medical Officer was quick to point out how deceptive numbers on CIs are on paper. This Officer felt that a 50% contact-rate based on index rates was a great success. CI's have to go through the EPI Unit or one of the STD clinics to identify contact cases. Some of the compounding factors in the search of contact cases are: having part of a name or no name at all; having a sketchy description of the person; having an incomplete street address or a description of a place; and most important having to rely on public transportation. It should be noted that CIs conduct most of their investigation beyond working hours at STD clinics and on week-ends. The new lease program of 15 USAID-donated vehicles should improve CIs field work.
- 6.2.1.4. Most of the 25 CIs have a health background (e.g., Public Health Inspector, Midwife, Social Worker, Nurse). However, physicians in the private sector do not seem to connect with CIs (they fail to understand the role of CIs). Some efforts should be made to link the two groups to facilitate reporting, counseling, and further tracing of partners of STD and HIV/AIDS diagnosed cases.

- 6.2.1.5. **CI Data Base:** In collaboration with the CDC, two new reporting forms have been developed and are in the process of being implemented, the Interview Record (IR) and the Field Record (FR). Two new forms were also created for supervisors to track IRs and FRs; in addition there is a new monthly reporting form for supervisors that contains an important element: a section on supervisor critiques over one month, based on field visits (the forms are in Annex 5). CIs we met were all pleased with the changes and indicated that this was a marked improvement from the cumbersome and tedious reporting system that required extracting data from a number of sources in order to write a monthly activity report. The current monthly CI reports are based on entering the contents of the above CI forms on the CI database in Kingston; the instructions for filling out the new forms were developed with CDC in-country; however there is no procedure manual to conduct this new task with new forms.
- 6.2.1.6. **Training:** In the past year, ten new CIs were trained. There are now 35 CIs. To ensure a smooth integration in the system, new recruits receive on-the-job training for six months. Both in 1992 and 1994, CDC participated in their training. PAHO and subsequently USAID, supported CDC's technical assistance (TA). A number of CIs voiced interest in receiving training in basic management and supervisory skills.
- 6.2.1.7. **CDC's collaboration:** This collaboration is valuable for the CI program. CDC has greatly contributed to the institutionalization of CI training as well as the establishment of a working framework including the monitoring and evaluation tools for CIs. At this point **four training modules** for CIs have been published and another two or three should be completed in the near future.
- 6.2.1.8. **Support from the USAID Mission in Kingston:** Within a month, 15 of the CIs or Field Officers working on STD/AIDS control will be purchasing vehicles (donated by USAID) through a lease and sale agreement; however one issue was given lip-service: Can CI's afford the maintenance and related expenses of these vehicles? Lease payments will go to a revolving account. The MOH will manage the account under the Supervision of the Accountant General. Over the next four to five years, this escrow account should accumulate sufficient funds to purchase a new batch of cars for CIs. It is hoped that this operation would contribute to the sustainability of the CI program. Since 1988, only 2 CIs left their job. This is a highly motivated group of professionals.

6.2.2. Conclusions

- 6.2.2.1. The word CI seems to conjure up extreme reactions: some rightfully argue that it is not a cost-efficient concept; others attribute the low prevalence of AIDS to CIs longstanding tradition of work and commitment. However, based on the few documented achievements we reviewed and our field visits, we **highly recommend maintaining full support to CI program**. In view of this highly polarized climate, we recommend that any restructuring and/or streamlining of the CI program be implemented based on recommendations made by the proposed study. Since the issue

of CIs in the private sector was never addressed during this evaluation, it can unfortunately not be assessed in this report.

6.2.3. Recommendations

- 6.2.3.1. CDC can design with the STD Program the remaining two or three modules with no further travel. To expedite the process we recommend creating a new budget line for this activity (not planned in the PASA). To date, the CDC conducted this activity *pro bono*. To facilitate this process, the CI program should have direct access to CDC through INTERNET.
- 6.2.3.2. CDC should travel to Jamaica and develop the field investigation manual in-country (management, supervision and performance) for CIs in collaboration with the STD Program (not planned in the PASA).
- 6.2.3.3. CDC should, along with the STD program plan (programmed in the PASA), create a cost benefit study of the CI program (preferably when all the training modules and manuals are completed).
- 6.2.3.4. Introduce the CI program to Medical Association of Jamaica (MAJ) workshops' on STDs and HIV/AIDS Treatment, Control and Prevention.
- 6.2.3.5. Plan training sessions in field management: (1) for the Senior CIs of each of the Regions along with their "Shadow Deputy"; and (2) for all other CIs.
- 6.2.3.6. Each STD clinic should have two CIs, one working with STD clinic attenders and the other one on field mission. They would regularly alternate roles.
- 6.2.3.7. Develop a stress management/counseling workshop for CIs in collaboration with a clinical psychologist.
- 6.2.3.8. Whether or not there are CIs in the private sector should be strongly promoted.

6.3. MEDICAL ASSOCIATION OF JAMAICA/MAJ (PRIVATE SECTOR)

MAJ has a membership of 600 (1,104 active physicians reported by JSS), and it is the umbrella organization for 14 associations in Jamaica. MAJ organized a series of five workshops on STD training for private practitioners. According to rough estimates, though 50% to 60% of the STD patient load sees private practitioners, all STD training has focused so far on the public sector; this sub-agreement was expected to complement the MOH's training in the private sector.

6.3.1. Objectives

Through a sub-agreement with AIDSCAP (US \$162,408 from March 1994 to November 1995) a number of workshops were to be organized to train private

physicians in STD prevention, diagnosis and treatment, and to expand its management capacity.

6.3.2. Findings

- 6.3.2.1. **1,038 health care providers** (698 doctors, 177 nurses, 59 medical students, and 99 others) attended five workshops held in Montego Bay, Mandeville and Kingston. Seventy-one certificates were awarded to those who came to all five workshops. The various workshops focused on **Urethritis** (Workshop 1), **Genital Ulcer Diseases** (Workshop 2), **HIV Infection** (Workshop 3), **Syndrome of Vaginal Discharge** (Workshop 4), and **STDs in Children and Adolescents: The Child At Risk** (Workshop 5). In collaboration with the University of North Carolina (UNC) and the EPI Unit of the MOH, MAJ developed training manuals on diagnosis and treatment of STDs, taking a medical history, and information on condom usage. The evaluation of these seminars is currently being planned.
- 6.2.3.2. MAJ has yet to evaluate the number of private practitioners who diagnose and treat STDs according to the National Standards.
- 6.3.2.3. MAJ put its management system in place during the summer of 1994 and HOPE has contributed to setting-up a monitoring and evaluation system.
- 6.3.2.4. MAJ has also developed some educational materials and book markers on **AIDS Diagnostic Scoring System**, **Algorithm for Management of Lower Abdominal Pain (PID)**, **Case Definition of AIDS/HIV for Surveillance**, **Algorithm for Management of Genital Ulcer Disease (GUD)**, **Management for Vaginal Discharge**, and **Differential HIV/AIDS Diagnosis**.
- 6.3.2.5. MAJ, the EPI Unit of MOH and UNC have contributed a number of articles on STDs to the MAJ Journal, the General Practitioners Journal, the Journal of Pediatric Association, and the Journal of Caribbean College of Family Practitioners.

6.3.3. Conclusions

- 6.3.3.1. Based on the overall patient load of the private sector, **MAJ's contribution** to the control and prevention of HIV/AIDS and STD is **essential**. The activities developed in this sub-agreement, established the foundations of an **ongoing training process** on HIV/AIDS- and STD-related issues, that could ultimately lead to some kind of annual continuing education courses for practicing physicians.

6.3.4 Recommendations

- 6.3.4.1. Based on the existing track record for the five workshops, MAJ should **target practitioners** who did not attend the first round of workshops.
- 6.3.4.2. In collaboration with University of the West Indies (UWI) Medical School, the Medical Council of Jamaica, MAJ should consider establishing an island-wide **Continuing Education Course program** for practicing physicians.
- 6.3.4.3. MAJ should **contribute** to the formulation of any HIV/AIDS– and STD's–related **policies**.
- 6.3.4.4. MAJ should **export** the five **workshops** to the English–speaking islands of the Sub-Region.
- 6.3.4.5. MAJ and the STD Program should target private practitioners with a series of workshops on STD Case management and counseling of People with HIV (PWHIV) and People with AIDS (PWAIDS).
- 6.3.4.6. Further **financial support** is required to ensure the sustainability of the organization and to support a nation-wide membership drive to reach the **largest number** of practicing physicians.

6.4. THE JAMAICA SENTINEL SURVEILLANCE/JSS (PUBLIC SECTOR)

The Jamaica Sentinel Surveillance plays a pivotal function by collecting, analyzing and reporting figures in order to evaluate the effectiveness and impact of HIV/AIDS activities. At present, surveillance of HIV/AIDS is achieved through case notification, hospital, laboratory and sentinel surveillance.

6.4.1. Objectives

Jamaica Sentinel Surveillance (JSS) activities were supported by an AIDSCAP sub-agreement (US \$114,953 from July 1994 to August 1996) and through a PASA with the CDC for technical assistance (US \$108,220 from March 1994 to September 1996). JSS objectives were: (1) improvement of the notification system of reportable cases of HIV/AIDS; (2) active surveillance of HIV/AIDS; (3) laboratory surveillance of HIV/AIDS; and, (4) sentinel surveillance in 44 surveillance sites.

6.4.2. Findings

- 6.4.2.1. With **CDC's technical support** (three separate TDYs to Jamaica to work with JSS), an HIV/AIDS Tracking System (HATS) has been developed using Microsoft Access; the system is now operational. In addition to reported HIV and AIDS cases, the HATS software includes information on syphilis and HIV/AIDS interviews, and field

investigations data, collected by CIs. However, the system requires specific professional expertise (system analyst and a programmer to maintain, support and eventually upgrade the system). While this system is not commonly used as a surveillance tool, **EPI Info** (jointly developed by the World Health Organization and the CDC) would have been the appropriate tool for data collection, reporting and overall surveillance, with a built-in simple means of reprogramming (with minimal training). EPI Info is a simple software, well-suited for future expansion of the decentralized surveillance system, not only for STDs, HIV/AIDS, CIs (including their field work), but surveillance of all reportable diseases. An EPI Info data base is used to enter information on AIDS-related calls on the HelpLine, but we haven't seen any reports based on this system. CDC did train the staff (66) to use this software. Ultimately, the selection of a software has to be made by the JSS technical staff.

- 6.4.2.2. All the reporting forms have been simplified (Annex 5 and 9). Every year, JSS sends a status report to all Parishes (slides and overheads) on the HIV/AIDS epidemic.
- 6.4.2.3. JSS put together a **folder** that included: HIV/AIDS Field Guides, HIV reporting forms, a class 1 notification booklet, and a physician notification guideline. A total of **1,190** folders has been distributed (3,000 planned for LOP). An additional **6,000** HIV/STD report forms were distributed (100,000 planned for LOP was totally unrealistic). **Thirty-six** HIV/AIDS cases have been reported to public hospitals (17 females and 19 males). HIV/AIDS field guides were distributed to **1,104** doctors (70% of physicians for LOP). **One hundred-seventy** private practitioners are submitting annual reports, **up 35%**. However, a 1993 survey of physicians (in part supported by USAID), clearly states that only **54%** of physicians in private practice reported all their AIDS cases (**66%** had never diagnosed an AIDS case), while **8% reported some and 38% did not report**. Of physicians seeing AIDS patients, **16% preferred not to report**, 21% would eventually report and 63% had reported. In view of the recommended STD survey in collaboration with CDC, the reporting of HIV/AIDS should be further assessed looking at a representative sampling of private and public sectors.
- 6.4.2.4. Upon graduating, physicians are required to register only once with the Jamaican Medical Registration Board. Therefore targeting **70%** of these physicians is **unrealistic**. Thereafter there is no system in place tracking practicing physicians (some may have retired, left the country, or died). According to JSS, out of **1,104** practicing physicians in 1994, **738** were in Kingston and St. Andrew, while **366** were in rural areas. There was no information on the type of practice for **647** physicians. Numbers seem to vary between MAJ and JSS.
- 6.4.2.5. In 1994-1995, JSS collected, tested, and analyzed blood samples from: **2,689** STD clinic attenders; **2,055** antennal clinic attenders; **1,635** food handlers; **262** beach boys; **175** MWM; **50** mental patients; **200** hospitalized patients; **410** members of TCI groups; and **360** hotel workers. Two hotel workers in St. Ann's (n=360) and six community members (n=413) tested HIV+. While this sentinel surveillance is on

track and provides valuable information on the spread of the epidemic, financial constraints may become a limiting factor in the future: kits cost US \$1.89 while collection and processing fees amount to US \$ 3.50. Despite the above results, the sentinel surveillance is not a representative sample of the population at risk. While consolidating these 44 surveillance sites, JSS should consider targeting other group: blood donors, UWI students, selected schools, white collar workers (banking and insurance systems, i.e., AIDS in the Workplace), factory workers in the Montego Bay Free Zone, workers in coffee plantations, etc.. Within the Sentinel surveillance framework, JSS also trained 984 health professionals including 607 physicians on HIV/AIDS reporting and pre- and post-test counseling. Blood collection for both Informal Commercial Importers and sailors did not take place while there are ongoing negotiations to work with prisoners.

- 6.4.2.6. The sentinel surveillance conducts blood test confirmatory and supplementary testing of HIV+ samples, VDRL, and MHATP. Each October JSS provides testing at four different sites for 1,600 consecutive STD-attending patients. Each April and October, 1,200 food handlers (all consecutive blood samples) are tested for VDRL. Between 1994 and 1996 300 Commercial Sex Workers (CSW) and beach boys were tested for HIV, in all parishes, with particular emphasis in KSA, St. Catherine, St. James, Hanover, and Westmoreland.
- 6.4.2.7. Between January and September 1995, out of 467 HIV+ reported cases, 268 were reported by CIs, 105 by physicians, 76 by KPH, Family Centers, Nurses and other health care workers.
- 6.4.2.8. Based on a study conducted by JSS, 75 out of 118 named partners of HIV infected patients were located and 45 tested. Of the 45, 13 were HIV+ and 32 HIV-. This study funded by PAHO (US \$12,000) is an interesting lead into the USAID-funded activities both for surveillance, and costing of identification of potentially infected partners of index cases by the CIs. The cost of tracing partners with an address amounted to US\$24. There were some problems in the study design. JSS agreed that given the relevance of this effort, this type of investigative work and the publication of the findings could further the cause of CIs.
- 6.4.2.9. The National Reference Laboratory and the four Private Labs in Kingston report and provide results on confirmed/supplementary for HIV testing on a quarterly basis. The public labs have distributed 514 HIV/AIDS forms to government physicians and have received to date 247 confirmed HIV results. Private labs have received 277 confirmed HIV results. In addition to these results, based on 1994 statistics: 4 private labs in Kingston conducted 22,595 tests and less than 1% were HIV+, while government labs conducted 10,857 tests of which 8.5% were HIV+. Since there was no satisfactory answer, it may be worthwhile looking into this issue (socio-economic status? confidentiality? availability of reagents? no waiting lines? lower socio-economic groups want to be tested?). A visitation surveillance program to these laboratories, especially the private ones, could be conducted by CIs. Among other

things it could ensure that positive tests are reported, while maintaining a link with both the patient and the practitioner requesting a lab test.

- 6.4.2.10. All labs in Kingston can do both confirmatory and supplementary testing for HIV positive samples (Elisa and Western blot). The Cornwall Lab in Montego Bay cannot do a second Elisa. It has no reader for the ABOTT kit, thus a delay of one month to six weeks is necessary to get a confirmation from the National Reference Lab in Kingston. The lab at the Cornwall Hospital could confirm, if equipped, the results within a week for 90% of the positive cases.
- 6.4.2.11. Public and private labs mentioned above have successfully passed the quality control test (blind tests) conducted by CAREC, the CDC, and PAHO. Between 1982 and 1995 there were only four AIDS cases from blood transfusion.
- 6.4.2.12. For the most part, the private practitioners do not mind having their names disclosed for positive lab tests, hence the need to report back to them first prior to reporting to the HIV/AIDS Sentinel Surveillance.

6.4.3. Conclusions

- 6.4.3.1. Now that the HIV/AIDS database is operational, JSS should be able to monitor the HIV/AIDS epidemic trends and provide timely reports on its evolution. However, further consolidation of the system is required to insure adequate reporting from all health professionals including physicians from both the private and public sectors, and the various laboratories.

6.4.4. Recommendations

- 6.4.4.1. JSS must actively focus on **consolidating all current activities** with a special emphasis on the reporting system, and the providers of reports.
- 6.4.4.2. JSS should gradually integrate the other databases (STD and CIs) into HATS. To facilitate this process JSS should also be linked by INTERNET to the CDC.
- 6.4.4.3. In consolidating sentinel surveillance, JSS should consider setting up new Sentinel Surveillance (SS) sites. We encourage JSS to complete the SS testing of bus drivers, security guards, and prisoners.

6.5. THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) OF ATLANTA

6.5.1. Findings

- 6.5.1.1. CDC helped redesign new forms for CI prevention/intervention activities (see Annex 5).

- 6.5.1.2. CDC provided at no cost 13 computers (with associated hardware) to the EPI Unit. In June 1995 computers were installed, and a local area network (LAN) was setup.
- 6.5.1.3. Three data bases (software support was requested by the EPI Unit) for STDs, HIV/AIDS, and CI using a database are in place. One limitation of this system is that it requires entering all previous program data (eight years) on STD and HIV/AIDS on the new system. EPI Info on the other hand may have better served the EPI Unit and STD program's long-term surveillance needs. EPI Info would have been a flexible user-friendly tool well suited for future expansions of the decentralized surveillance system.
- 6.5.1.4. CDC provided all supporting documents to design and adapt the training modules for CIs. This task was not part of the initial PASA and was performed *pro bono* by the CDC. Of the projected six modules, four are done. The one on HIV/AIDS was the most extensively revised. Both the CDC and the STD Program have been discussing drafting a field investigation manual for CIs.
- 6.5.1.5. A cost-benefit study on CIs needs to be conducted before the end of this PASA.

6.5.2. Conclusions

- 6.5.2.1. Through PASA, CDC (March 1994 - August 1996) will have brought invaluable, timely, and very generous technical assistance to the EPI Unit of the MOH. CDC's input may still be required beyond the existing PASA.

6.5.3. Recommendations

- 6.5.3.1. With the STD Program, the CDC can design the remaining two or three modules with no further TDYs. To expedite the process we recommend creating a budget line for this activity (not planned in the PASA) conducted to this day *pro bono* by the CDC.
- 6.5.3.2. CDC should develop in-country, the **field investigation manual** (management, supervision and performance) for CIs in collaboration with the STD Program (not planned in the PASA).
- 6.5.3.3. Along with the STD program (programmed in the PASA) the CDC should plan a **cost-benefit study** of the CI program (preferably when all the training modules and manuals are done).

7. Internal Evaluation Process and Rapid Response Projects

7.1. HOPE ENTERPRISES LIMITED (HOPE) I AND II (PRIVATE SECTOR)

7.1.1. Objectives

To (1) conduct baseline, process and follow-up assessments of behavioral correlates of risks related to HIV infection; (2) conduct assessment on condom use and condom purchaser; (3) pre-test and post-test media materials and campaigns; (4) conduct ethnographic study of Jamaican sexual behavior, formative research including identification, procurement, interpretation, and analysis of relevant materials; and (5) develop a system to ensure capacity building and sustainability.

To conduct, analyze, and report by August 1996 the results of: (1) post-study for target groups having a baseline study regarding knowledge of preventative practices, condom availability, reported multiple sex partners and reported condom use in the most recent sexual intercourse of risk, (2) a pre- and a post-study for those target groups not already having a baseline study for these same issues, (3) maintain evaluation-focused communication with NACP and Implementing Agencies (IA), and (4) build the capacity of HOPE.

7.1.2. Findings

7.1.2.1. **Studies** are **designed** using the **AIDSCAP/WHO Global Program on AIDS (GPA) model** with modifications where necessary to accommodate local language and mores. Input from AIDSCAP Headquarter Evaluation Specialists is also solicited. **Recommendations** are solicited from AIDSCAP/Jamaica and EPI Project Managers as well as review on JSS for ease of data entry. After refinements are made, the final survey document is again reviewed by the PMs, the Principal Medical Officer (PMO), the consultant methodologist/statistician, STD specialist and/or other staff as appropriate.

7.1.2.2. The HOPE Project Manager (PM) determines the **parameters** of the **sample** and secures technical input for drawing the sample from the Statistical Institute of Jamaica Census Information Office.

7.1.2.3. Interviewers are thoroughly trained and provided with a written introductory format to ensure consistency in conducting quantitative and qualitative interviews and focus groups. Interviewer staff include from four to six men and six to eight women. Effort is made to pair interviewer and interviewee by sex.

7.1.2.4. Individual project time from inception to report depends on the design staff's familiarity with the material and the degree of complexity of the study. **Minimum turn-around time is about 3 months.**

- 7.1.2.5. **Draft reports** are reviewed by project staff before final edition. Reports are distributed to AIDSCAP (five copies) and to the PMO-EPI (ten copies).
- 7.1.2.6. **Survey results** are used to direct management decisions regarding deployment of resources. Example: The 1994 study of STD clinic attenders revealed that in Kingston 4.5% were HIV+. In Montego Bay, 8% were HIV+, and in Ocho Rios 6-8% were HIV+. In addition, studies of commercial sex workers (CSWs) in Kingston in 1995 revealed an HIV+ rate of 14%, whereas the rate in Montego Bay was 25%. This indicated the need for allocation of resources into the Western Region.
- 7.1.2.7. Activities are frequently designed or refocused taking into consideration the survey findings in the planning. Example: When designing a project related to adolescent sexuality, the Jamaican Red Cross Society (JRCS) utilized information in the HOPE study which revealed that 21% of adolescents initiated sexual activity by age 12, and 35% by age 14. Since the JRCS felt they were beginning their project late in the overall HIV/AIDS activity process, the JRCS expanded their target group from an original focus of ages 13 to 16 years to ages 13 to 20 years to reach those who would have been in the target group in the 4 years before the activity commenced (see **Annex 10 for a complete listing of studies conducted by HOPE**).
- 7.1.2.8. HOPE **responds to requests** from the PMs to pre-test the content of radio and video messages, small media (pamphlets, comics, posters, decals, etc.) to determine whether the message is reaching the target audience and how effectively it is being conveyed. Refinements are made accordingly. Example: The Communications Unit designed information posters for use in STD clinics. HOPE pre-tested the posters and discovered that in order to reach the target group, the message needed to be transmitted in simpler terms featuring street names for diseases as well as medical names.
- 7.1.2.9. HOPE is sensitive to, and perceptive of, relevant issues as they are identified during the course of their other activities in the community. HOPE communicates information thus derived as quickly as possible by phone or letter to relevant staff. Example: In preparing to conduct a focus group among male STD clinic attenders, the HOPE PM noticed signs of disinterest on the part of the attenders in the large waiting room presentation given by the peer counselor. Raising the issue in the focus group, it became evident that an older male, preferably with credibility in the community, could relate more effectively as counselor with the target group and that the youthful age of a counselor was less important to the young men than was his status. It was also learned that the counseling sessions should be one-on-one or in small groups in the waiting room. (Letter HOPE to current RA 9/26/95)
- 7.1.2.10. **Considerable professional interface** exists between the HOPE PM and AIDSCAP PMs. The HOPE PM participates and makes presentations at semi-annual evaluation and planning meetings, monthly senior staff meetings, has weekly communications with the RA, and provides technical assistance as needed to the PMs and the BCC Team.

- 7.1.2.11. HOPE is scheduled to **complete post-tests** identified in 7.1.1.1. above, analyze and write reports by August 1996 when the AIDSCAP contract is scheduled to end.
- 7.1.2.12. HOPE charges to its AIDSCAP budget any services rendered to other AIDSCAP sub-agreements.
- 7.1.2.13. **Capacity building** in the form of computer analysis, statistical, and data presentation training will be provided to the Project Manager and three staff persons by AIDSCAP-HQ. No date has yet been set.

7.1.3. Conclusions

- 7.1.3.1. Hope Enterprises Limited (HOPE) is a **highly professional organization** which provides an **invaluable data-gathering resource** for the AIDSCAP program. HOPE follows acceptable professional procedures for design, conduct and reporting of their surveys.
- 7.1.3.2. HOPE takes an **assertive position** in supplying statistics and interpretations of findings to AIDSCAP project staff. HOPE makes them readily available in written reports, presentations at staff meetings, in individual consultation and communications between HOPE staff and PMs.
- 7.1.3.3. HOPE not only provides the results of **quantitative and qualitative data-gathering** but also communicates verbally, or in writing, to project staff useful information and relevant insights gained during the course of other work activities.
- 7.1.3.4. Several AIDSCAP project staff **report frequent and specific use of statistics supplied by HOPE** in determining their focus and designing their messages. However, there is considerably **less opportunity** for information input and exchange at the regional and parish levels where it could have considerable impact on implementing STD clinic and community programs.

7.1.4. Recommendations

- 7.1.4.1. **Funding for HOPE should continue** in order to support its outstanding service to project management and design. The awareness and attitudes towards HIV/AIDS are in the process of change. An example is the series on the subject in *The Gleaner* and the growing positive response to HIV/AIDS in fund-raising and community and training activities. Behavior change may follow based on the development of a critical mass. These factors should be measured to identify areas of success and those in need of support.
- 7.1.4.2. **Future studies** should include focus on motivation for safe sex and health-seeking behaviors.
- 7.1.4.3. Qualitative and quantitative **studies** should be continued. These should acknowledge the strength/reality of the country's mores.

- 7.1.4.4. HOPE routinely presents its latest findings at AIDSCAP staff meetings. These should be **offered at the beginning of the meetings** to contribute a reference point for relevant decision making in subsequent discussions.
- 7.1.4.5. A **system of feedback** of quantitative and qualitative information from HOPE to AIDSCAP project staff should be formalized at all levels. If time and budget preclude personal visits by HOPE staff to share information with regional and parish staff meetings, **periodic distribution of a video** which presents the latest survey findings and their possible impact on messages and program implementation should be considered. Local associations of private doctors should be considered in such distribution efforts.
- 7.1.4.6. An **information hot-line** perhaps housed in the HelpLine office is suggested. Receipt and transmission of communications regarding new **trends and myths** surfacing at the community/consumer level, in parishes, at STD clinics, etc. could be a benefit. A forum of the HOPE and other PMs should be convened as frequently as needed to address these issues as quickly as possible and communicate the response information back to persons in the field.
- 7.1.4.7. A **bi-monthly or quarterly newsletter** to the field including the latest news in the EPI Unit, interpretations of new statistical information, project progress, etc. should be considered. Documents prepared by HOPE should become part of an **HIV/AIDS Resource Center**.
- 7.1.4.8. As time and budget allow, HOPE should provide training to sub-agreement Project Managers and staff in survey design, data collection and analysis so that they can initiate or participate in the activity, fully understand the value, and use such information most efficiently.
- 7.1.4.9. Post-test reports identified in 7.1.1.1. should be completed and available no later than June 30, 1996 so information is available for planning purposes in the event the AIDSCAP program either ends or is extended.

7.2. RAPID RESPONSE PROJECTS (AIDSCAP)

The main objective of the Rapid Response (RR) Projects is to provide small grants (<US \$5,000) to indigenous, otherwise unsupported NGO's. Through local AIDSCAP administration, these grants are designed to fund short-term, single focus development activities. These activities include providing innovative and cost-efficient methods of enhancing the focus of the country program. Usually private sector and governmental agencies are not eligible to receive RR funds.

7.2.1. Caribbean Performing Arts Ensemble (ASHE)

7.2.1.1. Objective

To use the performance arts to communicate and emphasize the use of "Super Safer Sexual Skills".

7.2.1.2. Findings

- 7.2.1.2.1. Over 2,000 guests viewed the performance at World AIDS Day 1994. The program was carried by one TV station, two radio stations, and four local newspapers. It reached an estimated 569,800 Jamaicans country-wide. Following this event, JAS reported a 100% increase in private sector financial and in-kind contributions, including salary for one full-time nurse plus private sector assistance to the Family Center at UWI. In addition, the APEX Company produced three *pro bono* commercials for JAS which are aired on JBC as a public service.

7.2.2. Berl Francis and Company Ltd.

7.2.2.1. Objectives

To (1) attract political and business leaders to attend the Candlelight Ceremony of World AIDS Day 1993, (2) publicize the event; and (3) gain public support for HIV/AIDS prevention activities.

7.2.2.2. Findings

- 7.2.2.2.1. The grantee is a private company which currently receives an AIDSCAP grant of US \$189,531. Three hundred invitations were delivered to political and business leaders. A representative from each political party attended and participated in the ceremony. Representatives from ten companies pledged financial support; three companies pledged to send medical and food supplies to the Family Center at UWI. Five persons volunteered to work at the Family Center. The funds were also used to pay for radio and photographic coverage and videotaping of the event.

7.2.3. Health Education Learning Program (HELP)

7.2.3.1. Objectives

To (1) stimulate awareness of the celebration of World AIDS Day 1993 (WAD); and (2) provide HIV/AIDS information to in-school and out-of-school youth in the KSA Area.

7.2.3.2. Findings

7.2.3.2.1. HELP is a youth volunteer group sponsored by the educational arm of the Ministry of Health. Three schools participated in a banner competition for WAD, 50 out-of-school youths attended an HIV/AIDS seminar and 120 marchers from six schools participated in the parade wearing donated caps and T-shirts provided by the private sector. Media coverage included three radio stations, one TV station and two newspapers. An undefined number of materials were distributed. Ten churches were contacted with HIV/AIDS lesson plans to be included in Sunday School classes. Later, the HELP committee conducted a logframe workshop to enable them to apply for larger grants in the future.

7.2.4. Jamaican Amateur Athletic Association (JAAA)

7.2.4.1. Objective

To sponsor a six-day relay road race to raise the level of awareness and participation in ongoing HIV/AIDS-related activities.

7.2.4.2. Findings

7.2.4.2.1. The JAAA is an NGO which coordinates athletic activities reaching approximately 400,000 young people, primarily men. Runners stopped at 13 parish capitals en route where local representatives of the MOH provided informational materials regarding STD/HIV/AIDS prevention to the assembled crowds. The race ended at the 1994 World AIDS Day celebration. An estimated total of 30,000 persons were directly reached with AIDS messages in the parish capitals and an additional 250,000 were informed via media coverage.

7.2.5. Kingston Restoration Co. Limited (YESS)

7.2.5.1. Objective

To conduct a four-day HIV/AIDS and Drug Abuse workshop-camp to train 70 youths (12-16 years old) to act as peer counselors in the inner cities of Kingston and Montego Bay.

7.2.5.2. Findings

- 7.2.5.2.1. Kingston Restoration Co. (KRC), which sponsors a leadership development program called Youth Educational Support Systems (YESS), is an NGO funded by USAID and several large Jamaican companies. A total of 52 young women and 30 young men from Kingston and Montego Bay attended the workshop to become peer counselors. Formal presentations on STDs, HIV/AIDS and condom use were given by experts and then by the young people. There has been no supervision or periodic refresher training provided the peer counselors since the workshop.

7.2.6. National AIDS Committee (NAC)

7.2.6.1. Objective

To videotape and broadcast the Candlelight Ceremony of World AIDS Day 1994.

7.2.6.2. Findings

- 7.2.6.2.1. The National AIDS Committee (NAC) is a registered PVO which acts in an advisory capacity to the MOH. RR funds granted were not used for the purpose stated in the proposal. Instead, they were used to buy red ribbon, pay persons at the Family Center to make bows for distribution at the Candlelight Ceremony, and purchase candles for the ceremony. A reported 282,000 persons viewed the ceremony on JBC News and 287,000 on JBC News and JBC Entertainment Report.
- 7.2.6.2.2. As a result of the publicity, JAS, another USAID-funded sub-agreement, received a reported 25 pledges of support plus the salary for a full-time nurse. Fifty persons volunteered to work in AIDS programs, and there was a 100% increase in calls to the HelpLine.

7.2.7. National AIDS Committee (NAC)

7.2.7.1. Objective

To (1) raise money to support AIDS-related training programs; and (2) sensitize the legal profession and business executives to the needs of persons with HIV/AIDS in the workplace.

7.2.7.2. Findings

7.2.7.2.1. NAC presented the film "Philadelphia" to a selected group of patrons including the Governor-General, members of the Diplomatic Corps, donor agencies, attorneys, business leaders, and members of the media. Three hundred and seventy of a possible 393 tickets were sold at J\$ 1,000 each so that income totaled J\$ 370,000. The event has led to the development of supportive health policies related to treatment of persons with HIV/AIDS in the workplace within several Jamaican companies.

7.2.8. Conclusions on Rapid Response Projects

7.2.8.1. Three of the grants are out of compliance with the RR funds guidelines. One was awarded to a private sector company already receiving an AIDSCAP grant of US \$189,531. Another went to an arm of the MOH although governmental agencies are not eligible to receive RR funds. The third was used for an activity completely different from that which was proposed.

7.2.8.2. All RR funds were awarded to established groups having very close personal or professional contact with the MOH or affiliated personnel.

7.2.8.3. Project participants in most cases reported little direction from AIDSCAP in methods of conveying informational messages that would optimize impact.

7.2.8.4. Good media coverage was achieved in all cases.

7.2.8.5. Two of the projects attracted a sizable proportion of male participants.

7.2.9. Recommendations on Rapid Response Projects

7.2.9.1. The current RA should set priorities for optimum use of the year's RR funds. The amount of time spent providing technical assistance to these projects should be considered. The current RA should conduct an outreach campaign to identify indigenous, grass-roots NGO candidates. A training session to inform the NGOs of program guidelines, responsibilities, methods of proposal writing and gathering of

criteria for project selection is also suggested. The formation of an advisory board or group would ensure objectivity and help avoid favoritism.

- 7.2.9.2. In providing guidance to the RR project, the country program plan and integration with other AIDSCAP projects should be stressed and facilitated. Since the RR funds are small single issue activities, the importance of linkages or referrals to existing projects such as HelpLine, STD clinics, etc., for follow-up activities should be encouraged. This will increase cost efficiency and maximize impact.
- 7.2.9.3. All proposed and/or recommended studies by the Evaluation Team could be conducted using RR funds.

8. Decentralization of AIDSCAP Activities in the NorthWestern Region

8.1. BACKGROUND ON THE DECENTRALIZATION PROCESS

- 8.1.1. Since 1978, through primary health care (PHC), some form of decentralization has taken place in the NorthWestern Region, the testing ground to many initiatives including the successful EPI. While decentralizing STD and HIV/AIDS activities, it should be an integral part of health care such as MCH, EPI, Environmental health, communicable diseases.
- 8.1.2. On March 1, 1995 a Regional Program Coordinator (RPC) for the Western Region was hired by AIDSCAP. That position had been advertised in the Summer of 1994, but no suitable candidates were identified. April 1, 1995, the newly hired Program Coordinator moved to Montego Bay.
- 8.1.3. GTZ (conducting HIV/AIDS prevention and control activities only in the St. James Parish) and AIDSCAP had to agree on the RPC's role, who would also serve as Project Manager for GTZ in St. James. Until recently, the resourceful RPC was able to conduct her activities using her uncle's car. Now she has to rely on the GTZ vehicle, public transportation, and/or coordinate her field trips with the Regional office that has only one car and one driver. Overall this transportation situation has slowed down the RPC's work in Trelawny, Hanover, and Westmoreland.
- 8.1.4. At the time of this evaluation the RPC had developed a work plan for GTZ (from April to September 1995). She was in the process of conducting a performance evaluation and organizing the AIDS Day, and was developing a project proposal for AIDSCAP to be reviewed by the Regional Senior Medical Officer for the Western Region, the EPI Unit PMO, and the AIDSCAP-J RA. This Team was to receive on November 24, 1995 a copy of the proposal. For unexplainable reasons the RPC could not fax the requested document to Atlanta.

8.2. OBJECTIVES FOR THE AIDSCAP PROGRAM IN THE NORTHWESTERN REGION

The following are the AIDSCAP program objectives in the NorthWestern Region :

1. Coordinating and monitoring current HIV/STD activities.
2. Targeting the following groups: out-of-school youth, people with HIV/STDs and related families, CSW, and migrant workers.
3. Promoting family life education for in and out-of-school youth.
4. Mobilizing influential people to support STD and HIV/AIDS programs.
5. Assisting NGOs and communities in developing project proposals for the control and prevention of STD and HIV/AIDS activities.
6. Supporting communities and NGOs on their action plans.

8.3. FINDINGS

- 8.3.1. The AIDSCAP Program Coordinator established an activity table for St. James. Lines of demarcation between the GTZ bilateral support for HIV/STD control and AIDSCAP activities are not clearly defined. The Program Coordinator reports to the Regional Senior Medical Officer who in turn reports back on STD and HIV/AIDS to the EPI Unit PMO.
- 8.3.2. To date the AIDSCAP RPC (despite the financial and transportation problems) has visited all four Parishes once a month since assuming her new responsibilities.
- 8.3.3. The NorthWest Region is well suited to set up sustainable STD and HIV/AIDS activities. A number of funding sources would consider supporting STD- and AIDS-related activities, such as the Hanover Trust, Industries and factories in the Free Zone, and some philanthropists.

8.4. CONCLUSION AND RECOMMENDATIONS

- 8.4.1 This initiative could become a pilot approach for future expansion into the three other Regions. While Kingston provides the overall framework and guidance, the regional program activities are developed by the Regional Senior Medical Officer, the four Parish Medical Officers, a cross-section of health care providers, and the AIDSCAP Regional Program Coordinator.
- 8.4.2. The above proposed activities should also take into account their integration into the existing health systems for MCH, health promotion, health education, surveillance, and environmental health.

9. Project Management

9.1. EPI UNIT OF THE MINISTRY OF HEALTH (MOH)

- 9.1.1. The EPI Unit of the MOH is headed by the Principal Medical Officer (PMO).
- 9.1.2. The PMO is also the Managing Director of the National AIDS Committee (NAC) established in 1988. (NAC serves in an advisory capacity to the Ministry of Health and provides intersectorial coordination for AIDS activities.) The NACP is presently working on implementation of HIV/AIDS related policy issues. The Legal and Ethical, Care Counseling and Support, and AIDS in the Workplace sub-committees are exploring specific policy issues and development in their areas of interest.
- 9.1.3. Every year the EPI Unit organizes a planning and evaluation workshop. At the December 1994 workshop, funded by PAHO and under the leadership of the PMO, program activities were reviewed and a number of pertinent recommendations were made. It is not clear how these can be incorporated in the various AIDSCAP sub-agreements.
- 9.1.4. The PMO is fully involved in the management of the AIDSCAP program. Reports from staff reveal he has always been readily available to the current Resident Advisor (RA) as well as individual project staff to provide technical assistance and well-considered recommendations regarding operation of their activities. He offers full support to the program, and AIDSCAP in turn supports 95% of the funding for the HIV/AIDS-related personnel and activities of the EPI Unit, which essentially cover the entire country.
- 9.1.5. In addition to funding five AIDSCAP staff persons directly, AIDSCAP also funds approximately 34 additional personnel and the cost of their activities as defined in the individual sub-agreements. These latter persons are managed financially under an additional sub-agreement with the Caribbean Applied Technology Center. By sub-agreement with MOH, AIDSCAP provides operating equipment for the EPI Unit which in turn provides furniture, fixtures and clerical support at the telephones. AIDSCAP pays for 6% of the EPI Unit space although its rightful share of rent would be 14% when its percentage use of the common areas is factored.
- 9.1.6. The EPI Unit, in its effort toward decentralization, has opened a Western Regional office in Montego Bay headed by an extremely focused, competent, well organized Regional Director. The AIDSCAP Western Regional Coordinator position has recently been filled and formalized in the hands of another extremely articulate, competent and experienced employee. Issues related to the Western Region will be discussed below. As a result of the statistics derived from studies that indicate the rates of STDs and HIV are proportionally higher in the Western region, more resources are being moved in that direction. However, despite speculation to the contrary, there appears to be no intention of shifting the base of STD/HIV/AIDS operations out of Kingston.

- 9.1.7. Given the number of agencies and organizations supporting the NACP, an organizational chart should be established which reflects reporting responsibilities within the EPI Unit, including those funded by USAID (AIDSCAP sub-agreements, PASA with CDC, etc.).
- 9.1.8. Though sustainability was a recurrent issue, the MOH/EPI Unit and NACP had not, to date, developed a sustainability strategy including short-, medium- and long-term plans to ensure that the EPI Unit can absorb the current USAID-funded activities.

9.2. USAID/JAMAICA

- 9.2.1. USAID/Jamaica has oversight responsibility for the AIDSCAP project, monitoring AIDSCAP performance in relation to its overall objectives and logframe indicators, and as documented in its monthly reports. Mission staffs offer guidance and counsel, and recommendations as needs or problems are identified. Mission concurrence is required for all sub-agreements and grants, and relevant personnel should be included in the information-sharing loop. The former RA had monthly briefing meetings with the then USAID-HPN, but only two meeting's minutes were circulated.
- 9.2.2. The current RA intends to maintain a schedule of monthly meetings with the Director of the General Development Office who assumed this position in July 1995.
- 9.2.3. This Evaluation Team felt that after it had gained a global appreciation of the various USAID funded STD and HIV/AIDS prevention and control activities, it would then meet with the concerned USAID staff to review USAID's relevant files. Much to the team's regret, this did not take place.

9.3. USAID/WASHINGTON

- 9.3.1. USAID/W offers technical assistance and monitors the AIDSCAP program in Arlington, Virginia directly. An essentially supportive and collegial relationship exists between the two agencies which share common goals (i.e., the control and prevention of HIV/AIDS). Toward that end, joint planning meetings are held as well as joint site visits. A report of the last joint visit in June 1994 included extensive recommendations to strengthen and enhance program implementation including addressing the need for key policy issues, technical assistance for AIDSCAP-J and the EPI Unit, cost recovery, improvement in issues related to working with the private medical sector, case management of STDS/HIV/AIDS, sustainability and dissemination of lessons learned. Responsibility for addressing each issue and a time frame were also included.

9.4. AIDSCAP IN ARLINGTON

- 9.4.1. AIDSCAP-HQ provides considerable technical support to AIDSCAP-J. The Director of the AIDSCAP/LAC Regional Office made 2 site visits as part of a team effort. He supported travel of the current RA to HQ for the purpose of familiarizing her with procedures. He also assigned the Financial Officer (FO) to assist the current Resident Advisor (CRA) in resolving financial problems prior to her appointment. AIDSCAP-HQ also sponsored a visit by the FO to assist the CRA on site. The AIDSCAP-J project has received ongoing technical assistance from the LAC Evaluation Specialist and the HQ Evaluation Unit, as well as from the HQ STD, Policy, Communication, and Technical Support Units. Ongoing support is provided on an on-call basis from a very responsive HQ country program assistant (CPA).

9.5. AIDSCAP JAMAICA

- 9.5.1. This Team was not able to meet with the former RA. As a result our evaluation has been limited. However it may appear that the former RA encountered some difficulties with the staff and the EPI Unit for unidentified reasons. She took office in Jamaica, after the 18 sub-agreements were launched. Regrettably USAID/Jamaica and AIDSCAP-LAC did not remedy the situation. We may suggest that communications be improved by more frequent meetings and on-site visits by USAID-LAC and AIDSCAP-LAC.
- 9.5.2. Given the number of AIDSCAP sub-agreements and activities, the current RA should serve as a Project Director and the various project managers would serve in an advisory position to the NACP and the EPI Unit. The Project Director, with proven leadership qualities, insures the smooth management of the various sub-agreements and reporting to both USAID/Jamaica and Washington, while facilitating access to the various experts at AIDSCAP-LAC.
- 9.5.3. The CRA started her new job (September 15, 1995) one month prior to this evaluation. The CRA will focus on program monitoring to ensure recording of accomplishments, in-depth financial monitoring, coordination, updating USAID/Jamaica in monthly meetings and gaining their concurrence as appropriate.
- 9.5.4. Aside from the project papers, there is no established scope of work for the various activities. The CRA would greatly benefit from working with the respective project managers so as to organize and consolidate the various project activities.
- 9.5.5. Now and then, the project should provide **project and human resources management training** to all senior project staff. The staff felt that their specialty and expertise was not a validation of managerial acumen, and support in that direction would be important. A recurrent leitmotif was, how to delegate responsibilities? These issues have not been addressed to date.

- 9.5.6. When staff is hired, irrespective of the position or rank, the country office should establish an **orientation procedure** to ensure that new staff has full knowledge and understanding of the **organizational structure** (to be clearly displayed) of AIDSCAP and its working relationship with the EPI Unit and the NACP. This is an essential ingredient: that everyone in the program follows the same channels of communication, and works within an accountable, established system. To this end, there should be a job description for all positions with the project and a **procedures manual** for the staff. Some of the issues covered in a **procedures manual** should include: communication procedures; reporting systems; personnel policies; evaluation and promotion of personnel; recruitment; motivation of staff; time management; meetings; conflict management; conflict resolution; and work quality.
- 9.5.7. To enhance the management of various sub-agreements, project managers should be fully aware of AIDSCAP **administrative and managerial procedures** as well as the existing **financial systems**. To this end, in collaboration with AIDSCAP-LAC, the country office should at least organize a yearly workshop to review these procedures and review related problems. Since no one on this Team had the **required financial expertise**, we could not assess the **contribution** of the new (refer to SOW, Annex 1) budgeting-financing methods that combine the MOH, USAID/Jamaica, Global Field Support and the USAID LAC bureau.
- 9.5.8. Although having **multiple CAs**, as opposed to one contractor, is the **appropriate approach** to strengthen institutional capacity, it is **not realistic**. The PMs should have been provided with a **procedural framework** and tools to gradually establish this institutional capacity over the life of the project. If **institutional capacity indicators** had been included in the sub-agreements, this **might** have been achieved.
- 9.5.9. **Sub-agreements' indicators** and the monthly reports can be overwhelming at times and both issues are not a true job performance indicator. Interviews reveal there is some informal coordination between AIDSCAP sub-agreement projects which takes place frequently on the basis of personality, common interests, and proximity in the working environment. In view of the above points, there is a general sense to review the appropriateness of indicators and targets while ensuring that no targets are missed. This review process should lead to a refinement of targets and indicators while taking into account data and findings to ensure that **objectives and targets are appropriate**.
- 9.5.10. Over time project managers and other project staff have made suggestions, some writing proposed changes and improvements to the existing activities. One of them, drafted (June 1, 1993) by the accounting officer recommending a Financial Management System for the AIDSCAP Country Office was particularly constructive. The former RA never provided any feedback on this draft recommendation. Had this draft been given closer attention, some of the present problems with the Caribbean Applied Technology Center (CATC) could have been avoided.
- 9.5.11. Given the budget constraints, the level of staffing will probably not be increased. At best, it will remain the same. Therefore it will be necessary to explore optimum

- utilization of the talents and potential of each staff person. At present, there is no official Program Officer. The designated candidate is the current Program Assistant.
- 9.5.12. All reports from USAID/W and AIDSCAP-LAC urge that emphasis be placed on capacity building and sustainability for what may be the remainder of the AIDSCAP contract. However, only two of the AIDSCAP sub-agreement project managers refer in any way to capacity building among the staff.
- 9.5.13. AIDSCAP/Jamaica placement within the EPI Unit has many advantages: immediate on-site contact with some of sub-agreement Project Managers and a direct link to the EPI Unit PMO and staff. We consider this more advantageous than proximity to USAID. In addition, the office rent is cheaper than would be elsewhere. The only disadvantage is the lack of telephone lines for the AIDSCAP staff. However, AIDSCAP Jamaica just got a separate fax line, a satellite phone to contact AIDSCAP/LAC, and a cellular phone for Kingston.
- 9.5.14. The current RA and PMs attend monthly senior staff meetings and annual Evaluation and Planning meetings sponsored by the EPI Unit.

9.6. CARIBBEAN APPLIED TECHNOLOGY CENTER (CATC) I, II AND III (PRIVATE SECTOR)

9.6.1. Objectives

CATC through an AIDSCAP sub-agreement (US \$1,074,217 for the LOP from October 1992 to August 1996) is to: (1) provide financial and administrative support for six sub-agreements including the AIDSCAP-J Country Office, AIDS in the Workplace, Communications Team, Community Counseling, Epidemiology Unit, Face-to-Face Communication, STD Program and the Targeted Community Intervention Program; (2) provide personnel administration including compliance with local employment regulations, health, life insurance, pension, leave, etc., benefits for approximately 34 persons; (3) conduct human resource development activities including personnel recruitment, job descriptions, contracts, and performance appraisals; and (4) maintain necessary bank accounts.

9.6.2. Findings and Recommendations

- 9.6.2.1. Financial matters were not clearly stated within the SOW of this evaluation, but nonetheless are important here. It appears advisable to ask Ernst & Young for directions in order to evaluate and identify the needs of CATC in this area.

9.7. CONCLUSIONS ON PROJECT MANAGEMENT

- 9.7.1. In our view, this project received **adequate management** support from the various supporting agencies. Despite some of the identified management limitations of the project, the achievements reached by the various sub-agreements are a reflection of the degree of staff **commitment** to this project. However, under the leadership of the current RA, AIDSCAP-J will have to be **restructured** and new **management tools** be implemented as suggested. These new practices should **foster** skilled, experienced and competent project managers in organizing, leading, **facilitating** and **supporting** the work force reporting to them.
- 9.7.2. Having **multiple CAs**, as opposed to one contractor, was the **appropriate approach** to strengthen institutional capacity but no framework was in place to accomplish the goals. There appears to still be little if any emphasis or movement in that direction.

9.8. RECOMMENDATIONS ON PROJECT MANAGEMENT

- 9.8.1. While this Team has identified a number of **managerial limitations**, we recommend a **two step resolution** (preferably before designing the next phase of this project): (Phase 1) in collaboration with AIDSCAP-LAC prepare a **survey on managerial issues** (including those this Team has raised) pertaining to this project and submit the survey to all project staff; (Phase 2) based on the responses, AIDSCAP-J in collaboration with AIDSCAP-LAC should organize a **workshop** addressing the management issues raised and come up with definitive recommendations and a enforceable workplan.
- 9.8.2. A **task force** should be identified to develop strategies and prepare for **levels of sustainability**.

10. Future Directions

10.1. BCC ACTIVITIES

- 10.1.1. The multiplicity of sub-agreements has inevitably led to a **fragmented approach**. This must be overcome. In addition, the multitude of indicators and the need to achieve the predetermined objectives by target dates, often takes away from the overall mission of this prevention and control program. This conveys a **sense of inflexibility** in the strategic approach.
- 10.1.2. BCC should select target groups on the basis of **socio-cultural and economic** boundaries rather than along purely demographic variables.
- 10.1.3. BCC should develop a strategic approach targeting **young males**.
- 10.1.4. To achieve significant behavior change, BCC should engage in an in-depth community-based and grass-root approach based on **dialogue** with the target groups
- 10.1.5. BCC should **integrate** community involvement with other social programs (i.e., the Family Life Education Program, the Social Development Commission, etc.).
- 10.1.6. BCC should actively conduct **research** on two important issues: (1) Males as the sole sexual decision maker; and (2) Multiple partnership and its impact on the family and kinship.
- 10.1.7. While BCC has made important progress using existing methods, these efforts must be sustained while developing concerted new strategies and approaches to move beyond the **PLATEAU stage**.

10.2. STD CASE MANAGEMENT AND HIV/AIDS SURVEILLANCE ACTIVITIES

To insure within the **next project cycle** full **institutional integration** and **capacity building** of all STD-related activities and **surveillance** of STD HIV/AIDS, it requires consolidating the current level of accomplishments and fine-tuning some activities when necessary. Once the **system** is **consolidated** and/or **strengthened** and fully **operational**, we **recommend** a gradual **decentralization** of these activities [to some extent a pilot approach has begun in the NorthWestern Region]. In summary, for the next phase we would recommend:

- 10.2.1. Establish the **national full standardization** of case management of STD clinic attenders by the **private** and **public** sectors and all participating institutions (labs, MAJ, hospitals, etc.), and conduct the proposed studies and evaluations.
- 10.2.3. Complete the **institutionalization** of the **CI Program** along with the STD Program
- 10.2.4. Achieve **full integration** of all databases into the HATS program.
- 10.2.5. Maintain and expand the **contribution** of the Medical Association of Jamaica.
- 10.2.6. **Maintain** close institutional ties with the Centers for Disease Control and Prevention (CDC).

10.3. EVALUATION

- 10.3.1. Funding for HOPE should continue while developing the in-house capacity of the EPI Unit to conduct similar work. HOPE should always maintain an advisory capacity to the EPI Unit and the NACP.

10.4. SUSTAINABILITY AND CAPACITY BUILDING

- 10.4.1. Sustainability and capacity building should become the focus of one sub-agreement in the next project cycle.

10.5. POLICY

- 10.5.1. When applicable, any of the sub-agreements should promote new HIV/AIDS-related policies. The next project cycle should promote: (1) NACP's role in developing legal and ethical policies; (2) policies on family life education; and (3) the integration of STD and HIV/AIDS policies into unified social policies.

Annex I

Issues Raised in the SOW Addressed by This Mid-Term Evaluation Report

**Issues Raised in the SOW
Addressed by
This Mid-Term Evaluation Report**

- Q1. Assess the performance of the project to date by determining the degree to which it is progressing toward achieving the goals and objectives of the project by the PACD.
- Q2. What has been the impact of the HIV/AIDS/STD prevention and control program since the project started in 1988 on controlling the rates of spread of these diseases in Jamaica, especially among both the highest risk populations and the general population?
- Q3. How effective is the project strategy of promoting the provision of services by private practitioners?
- Q4. How effective is the role of cost recovery in sustaining project funding?
- Q5. Has the project staff been able to adequately collect, analyze, and use various types of behavioral, epidemiologic, management and other data for programmatic, technical, and policy decisions?
- Q6. Are the project outputs being achieved? If not, why not? Evaluate the effectiveness and the efficiency of achieving outputs in reaching the project purpose.
- Q7. Which interventions seem to have the most impact on controlling STD/HIV/AIDS—IEC, social marketing of condoms, others?
- Q8. Have the project efforts helped the target populations understand that they are at risk for STDs and HIV/AIDS? Have they responded with behavioral change? Examine the role of media campaigns and the “hot line” in this regard.
- Q9. How has the formation of a local advisory group ACOSTRAD helped?
- Q10. There has been an increase in condom use since the inception of the project. How has the project's promotion program contributed to that output? Is it possible to determine how much can be attributed to this project as compared to family planning efforts to promote condom use? How effective is the increase in condom use in controlling the spread of STDs/ HIV-AIDS in Jamaica?
- Q11. How effective is the expanded role of NGOs in AIDS prevention? How adequate is the coordination with the National HIV/AIDS Prevention Program?
- Q12. How do the roles of the National AIDS Committee and ACOSTRAD differ? Are there duplication of efforts? What type of institutional strengthening do both organizations need?

- Q13. How effective is the implementation strategy of using multiple CAs (rather than one contractor) to help strengthen the institutional capacity of the EPI Unit of the MOH to control the sexually-transmitted disease epidemic? Please comment on the role and performance briefly on each CA.
- Q14. What activities under the project are working well and should be continued or replicated outside of the Kingston metro area? What would be the most effective manner of implementing expansion to other sites in Jamaica?
- Q15. What level of staff is required to implement the activities under the project? How are the MOH's institutional capabilities being strengthened?
- Q16. How effective are the several sub-projects in helping to control STD/HIV/AIDS and in sustaining project activities?
- Q17. How effective are AIDS Prevention Activities at the parish level? How effective is the model to have a Western Regional Coordinator based in Montego Bay?
- Q18. Assess management by MOH, AIDSCAP/Jamaica, AIDSCAP/LAC, USAID/Kingston, USAID/Washington, in terms of support for project activities.
- Q19. How well have the offices of USAID/Jamaica, USAID/W, the MOH, and AIDSCAP supported management of the project?
- Q20. What is the effectiveness of the "AIDSCAP Resident Advisor" in managing the project working in Jamaica? Is this a good model?
- Q21. What is the contribution of the new budgeting-financing methods combining Mission, MOH, Global Field Support (FS) and LAC Bureau sources as a contributing factor to success or failure of the project in terms of improving management effectiveness?
- Q22. Make recommendations for future bilateral efforts.
- Q23. Are the outputs described in the log frame still relevant to obtaining the impact and results expected at the outset?
- Q24. What is the likelihood that project activities will be sustained when funding ceases in terms of the following: 1) perceived effectiveness of interventions; 2) ability to train needed human resources within Jamaica; 3) continuous sources of financing; 4) strength of administrative seat (EPI/MOH) of the project; 5) existence of a constituency for STD/HIV/AIDS prevention and control activities?
- Q25. Is the use of contract investigators (active case detection) a cost-effective method in finding new cases and tracking the epidemic compared to a passive approach?
- Q26. How effective is the role of cost recovery in sustaining project financing?

Annex 2

Schedule of Visits for the Evaluation Team

**Schedule of Visits for the Evaluation Team
October 17 - November 14**

Wednesday 18

9:30 a.m. o

Briefing at EPI Unit

- Director of the National Program
- AIDSCAP Resident Advisor
- Review of KAPB Findings and Implications
- Maxine Wedderburn, Hope Enterprises Ltd.

2:00 p.m. o

Planning Meeting at USAID

Thursday 19

9:30 a.m. o

Meeting with STD Team - Comprehensive Health Center Conference Room

**Tour of Comprehensive Health Clinic
Visit to the lab**

- Dr. Alfred Brathwaite, STD Technical Advisor
- Dr. Tina Hylton Kong, Senior STD Clinician
- Mr. Paul Gordon, Acting Chief Contact Investigator

4:00 p.m. o

Meeting with Jamaica AIDS Support (JAS)

- Mr. Ian McKnight, Program Manager, JAS
- Mrs. Christine English, Director, Support Services, JAS
- Mr. Fabian Thomas, Director, Education and Funding Raising JAS

5:30 p.m. o

**Observation of JAS Facilitator Training Session
at St. Hugh's High School**

Friday 20

9:15 a.m. o

Meeting with Dr. Margaret Green, Project Manager STD Training of the MAJ

11:00 a.m. o

Meeting with Face to Face Team

- Mrs. Cathy Lyttle, Project Manager, Face-to-Face
- Mrs. Susan Ewerse, KSA Face to Face Coordinator

2:00 p.m. o

Meeting with Dr. Peter Weller, Project Manager, Counseling and Social Welfare

- o **Meeting with Mrs. Phylis Hall Clarke, HelpLine Administrator, and tour of HelpLine**

- Saturday 21**
- 9:00 a.m. o **Meeting with Monseigneur Richard Albert at St. Patrick's Roman Catholic Church**

- Sunday 22**
- 10:00 a.m. o **Visit to Marginalized TCI community (Riverton City)**
 - Ms. Audrey Wilson, TCI Project Manager

- Monday 23**
- 9:00 a.m. o **Meeting with Communications Team**
 - Ms. Lovette Byfield, Project Manager
 - Mr. Norman Hall, Communication Specialist

- 3:15 p.m. o **Meeting with Mrs. Berl Francis, Project Manager, Public Relations HIV/AIDS Risk Reduction**

- Tuesday 24**
- 2:00 p.m. o **Meeting with Ms. Audrey Wilson, Project Manager, Targeted Community Intervention (TCI)**
 - Tour of community

- 4:00 p.m. o **Meeting with the ACOSTRAD Team**
 - Mrs. Vivienne Patterson, Project Manager
 - Dr. Alfred Brathwaite, Chairman ACOSTRAD

- 6:30 p.m. o **Visit to ACOSTRAD CSW drop-in center**

- 7 :30 p.m. o **Visit to JAS Gay and Bisexual Support Group**

- Wednesday 25**
- 10:00 a.m. o **National AIDS Committee (NAC) Meeting (Pegasus Hotel)**

- 1:00 p.m. o **Meeting with NAC Executive Committee**

- 4:00 p.m. o **Meeting with Mrs. Lois Hue, Project Manager
Island-wide Risk Reduction Program at Red Cross Office**

- o **Visit to Adolescent Peer Counseling Session**

Thursday 26

- o **Western Region Programme**

- 9:00 a.m o **STD Clinic Type 5 Clinic**
Coordinator, Nurse I. Wilson

- Nurse I. Wilson, Family Nurse Practitioner
- Nurse B. Fray, STD Clinician
- Ms. D. Samuels, Contact Investigator
- Ms. O. Burnett, Contact Investigator
- Ms. P. Myers, Lab. Technician
- Ms. M. Jarrett, Lab. Technician
- Ms. S. Clarke, Clinic Educator
- Ms. J. Myrie, Clinic Educator

- 10:00 a.m o **Jamaica AIDS, Type 5 Clinic**
Coordinator: Mr. I. McKnight

Support Luke: 38, Type 5 Clinic

Coordinator: Ms. G. Meredith

- Mr. I. McKnight, Director, JAS
- Mr. D. Cammock, Western Region Coordinator, JAS
- Ms. G. Meredith, Coordinator Luke 6 :38

- 11:00 a.m o **National Programme, Peer Educators, GTZ supported Type 5 Clinic**

Coordinator: Ms. J. Harrison

- Ms. J. Harrison, Communications Officer
- Ms. J. Gilling, Peer Educator
- Ms. S. Holder, Peer Educator
- Mr. C. Barnett, Peer Educator
- Mr. D. Brown, Peer Educator
- Ms. F. Wellington, Program Coordinator

- 2:00 p.m o **ACOSTRAD Westmoreland Savanna-la-mar Health Center**
Coordinator: Ms. P. Beckford

- Mrs. P. Beckford, Chairman
- Mr. W. White, Vice-Chairman
- Ms. B. Blake, Secretary
- Mr. N. Neyler, PRO

- 2:30 p.m o **Members of the Association**

- 5:00 p.m o **Face-to-Face
Market Walk, Montego Bay, Shoe Market**
Coordinator: Nurse Fray
- Nurse B. Fray, Parish Coordinator, P/T
 - Ms. J. Myrie, Team Member
 - Ms. T. Gayle, Team Member
 - Ms. D. McNeill, Team Member
 - Ms. K. Thompson, Team Member
 - Ms. R. Johnson, Team Member
 - Nurse J. Mcghie, Team Member
 - Cecile, Team Member
- 9:00 p.m o **ACOSTRAD, CSWs
Bottom Road**
Coordinator: Mrs. I. Harding
- Mr. L. Hamilton, Contact Investigator
 - Ms. B. Samuels, Contact Investigator
 - CSWs
- Friday 27**
- 9:00 a.m o **ACOSTRAD Project, Type 5**
Coordinator: Mrs. I. Harding
- Mrs. I. Harding, Intervention Coordinator
 - Nurse I. Wilson, FNP
 - Ms. B. Samuels, Contact Investigator
 - Mr. L. Hamilton, Contact Investigator
- 9:30 a.m o **MO (H) St. James, Type 5**
Coordinator: Ms. F. Wellington
- Dr. L. Jackson-Myers
- 10:00 a.m o **Regional Contact Investigator's Meeting, Type 5**
Coordinator: Mrs. P. Beckford
- Mr. S. Miller, Hanover
 - Mr. W. Miller, Westmoreland
 - Mrs. P. Beckford, Westmoreland
 - Mrs. C. Stupart, Trelawney
 - Ms. D. Samuels, St. James
 - Ms. O. Burnett, St. James
- 11:00 a.m o **Meeting SMO (H) Western Region, CRH Conference Room**
Coordinator: Ms. F. Wellington
- Shelia Campbell-Forrester, Senior Medical Officer, Health

- 11:45 a.m o **Regional Team Meeting . . (canceled)**
 Coordinator: Ms. F. Wellington
- Dr. S. Campbell-Forrester, SMO (H)
 - Mrs. P. Beckford, Parish Coordinator, Westmoreland
 - Mrs. I. Wilson, Parish Coordinator, St. James
 - Mrs. C. Stupart, Parish Coordinator, Trelawney
 - Mr. S. Miller, Parish Coordinator, Hanover
 - Mrs. I. Harding, Intervention Coordinator ACOSTRAD
 - Ms. F. Wellington, Regional Coordinator HIV/STD
- 2:00 p.m o **Debriefing Meeting, 2nd floor Conference Room**
 Coordinator: Ms. F. Wellington
- USAID Team
 - SMO (H)
 - Regional Coordinator
 - Resident Advisor, AIDSCAP
- Saturday 28**
- 11:00 a.m. o **Red Cross Peer Educators Workshop - Marine Park Ocho Rios**
- o **Visit to JAS Ocho Rios**
 Andrew Green at Catholic Church, Ocho Rios
- Monday 30**
- 8:30 a.m. o **Meeting with Mrs. Marcia Erskine, Project Manager, AIDS in the Workplace**
- 9:30 a.m. o **Presentation of check to Workplace programme-
 Marjorie McLean, NCB New Kingston Branch,
 Knutsford Boulevard**
- 10:30 a.m. o **Introduction/presentation of NCB Group HIV/AIDS
 Programme by Michael Johnson, Training Manager
 NCB Group, NCB Training Center, 70B King Street**
- 12:00 o **Meeting with Flo Wellington (Western Regional Coordinator at the Pegasus)**
- 2:00 p.m. o **Berl Francis & Co Ltd.**
 - Mrs. Berl Francis & Mrs. Karlene Morgan

Tuesday 31

- 10:30 a.m. o **Meeting with Sentinel Surveillance Team**
 - Dr. Elizabeth Ward, Project Manager Sentinel Surveillance
- o **Demonstration of HATS - Mr. Sheldon Whorms, Systems Administrator**

Wednesday 1

- 9:00 a.m. o **HIV/STD HelpLine**
Mrs. Phyllis Hall-Clarke, Administrator
- 3:00 p.m. o **Meeting at USAID, briefing on progress**

Thursday 2

- 10:00 a.m. o **Meeting with Mrs. Maxine Wedderburn, Project Manager, Evaluation of AIDSCAP II at Hope Enterprises**
- 2:00 p.m. o **Meeting with Dr. Henley Morgan Project Manager, Support to the EPI Unit: Financial and Administrative and Support for AIDSCAP/Jamaica Country Office Personnel**

Friday 3

- 9:30 a.m. o **Meeting with Dr. Yasmin Williams, Project Manager, Strengthening STD Services and Case Management in the Public Sector at EPI Unit**
- 11:00 a.m. o **Market Walk at Spanish Town Market with Mrs. Susan Ewerse-Brown**

Monday 6

- 9:00 a.m. o **Meeting with Mrs. Gale Hall AIDSCAP/Jamaica Resident Advisor**
- 2:00 p.m. o **NAC Meeting at EPI Unit**

Tuesday 7

- 10:00 a.m. o **Meeting with Dr. E. Ward**

Monday 13

- 4:00 p.m. o **Presentation by the evaluation team of findings to some of the USAID staff**

Tuesday 14

- 2:30 pm o **Open-ended discussion between evaluation team and some USAID staff**

SCHEDULE OF VISITS FOR DR. DONALD ROBOTHAM

Wednesday 1

- 2:30 - 3:30 p.m.** o Meeting with Norman Hall, Communications Team at the EPI Unit

- 3:30 - 4:30 p.m.** o Meeting with Dr. Peter Weller, (Counseling and Social Welfare) at the EPI Unit

Thursday 2

- 10 a.m. - 11 a.m.** o Meeting with Mrs Cathy Lyttle and Mrs. Susie Ewerse (Face to Face) at the EPI Unit

- 11 a.m - 12 noon** o Meeting with Dr. Alfred Brathwaite, Mr. Ken Douglas and Mr. Paul Gordon at the EPI Unit

Friday 3

- 8:00 - 900 a.m.** o Meeting with Ms. Audrey Wilson, Project Manager Targeted Community Intervention at EPI Unit

- 9:00 - 10:00 a.m** o Meeting with Ian McKnight, Project Manager, Jamaica AIDS Support at JAS

- 11:30 - 12:30 a.m.** o Meeting with Mrs. Berl Francis, Project Manager, Public Relations HIV/AIDS Risk Reduction at her office (see listing of contacts)

- 2:00 p.m.** o Meeting with Mrs. Lois Hue, Project Manager, Island wide Risk Reduction Program at Red Cross Headquarters (see listing of contacts)

Annex 3

An Overview of Reported AIDS Cases in Jamaica

**An Overview of Reported AIDS Cases in Jamaica
December 1992 to June 1995**

Summary of cases of AIDS reported in JAMAICA from December 1982 to June 1995

Year reported	Male	Female	Total	Cumulative Total
1982	1	0	1	1
1983	0	0	0	1
1984	1	0	1	2
1985	3	0	3	5
1986	6	0	6	11
1987	19	13	32	43
1988	22	8	30	73
1989	44	20	64	137
1990	41	21	62	199
1991	74	60	134	333
1992	68	32	100	433
1993	156	80	236	669
1994	200	159	359	1028
Jan-Mar 1995	58	51	109	1137
Apr-Jun 1995	43	22	65	1202
Total	736	466	1202	1202
Total Cases =				1202
SEX:	Males	736	61.2%	
	Females	466	38.8%	

Source: Dr. Peter Figueroa, MOH/EPI Unit, 1995

Distribution of reported deaths of AIDS Cases by sex and year: 1982 - June 1995

Year reported	Male	Female	Total	Cumulative Total
1982	0	0	0	0
1983	1	0	1	1
1984	1	0	1	2
1985	1	0	1	3
1986	5	1	6	9
1987	13	7	20	29
1988	17	7	24	53
1989*	31	11	42	95
1990	26	22	48	143
1991	52	37	89	333
1992**	40	31	71	303
1993	110	49	159	462
1994***	82	62	144	606
Jan-Mar 1995	31	15	46	652
Apr-Jun 1995	16	12	28	680
Total	426	254	680	680

Source: Dr. Peter Figueroa, MOH/EPI Unit, 1995

Total Deaths 680 :
 * 1 death (female) by suicide
 ** 1 death (male) by suicide
 *** 2 deaths (male & female) by drug overdose

DEAD

Males **426** 57.9% all male cases of AIDS
 Females **254** 54.5% all female cases of AIDS

ALIVE

Males 310
 Females 212

Overall Mortality Rate: 56.6%

Distribution of reported AIDS Cases by Parish: 1982-June 1995

Parish	Number of Cases	Rate/100,000 population (1994 mean population)
Kingston & St. Andrew	570	81.2
St. Thomas	21	23.5
Portland	18	22.9
St. Mary	23	20.1
St. Ann	51	32.9
Trelawney	30	40.4
St. James	189	112.9
Hanover	22	32.9
Westmoreland	23	17.5
St. Elizabeth	27	18.4
Manchester	30	17.2
Clarendon	21	9.4
St. Catherine	134	36.0
Parish not known	43	
Total	1202	48.2

Source: Dr. Peter Figueroa, MOH/EPI Unit, 1995

Distribution of reported AIDS cases by age and sex: 1982-June 1995

Age (yrs)	Male	Female	Total
<1 year	22	23	45
1 - 4	21	22	43
5 - 9	1	1	2
10 - 19	8	17	25
20 - 29	163	138	301
30 - 39	247	158	405
40 - 49	151	57	208
50 - 59	61	25	86
>=60 years	25	8	33
Not known	37	17	54
Total	736	466	1202

Source: Dr. Peter Figueroa, MOH/EPI Unit, 1995

Reported AIDS cases in Jamaica by transmission Category: 1982-March 1995

Risk Category	Male	Female	Total
Heterosexual	340	401	741
Homo./Bisexual	94	0	94
IV drug used *	4	3	7
Hemophiliac	4	0	4
Blood Transfusion	3	1	4
Mother to Child	43	48	91
Not Determined	217	44	261
Total	705	497	1202

Source: Dr. Peter Figueroa, MOH/EPI Unit, 1995

Annex 4

Incidence of Primary and Secondary Syphilis, 1987-1994

Incidence of Primary and Secondary Syphilis, 1987-1994

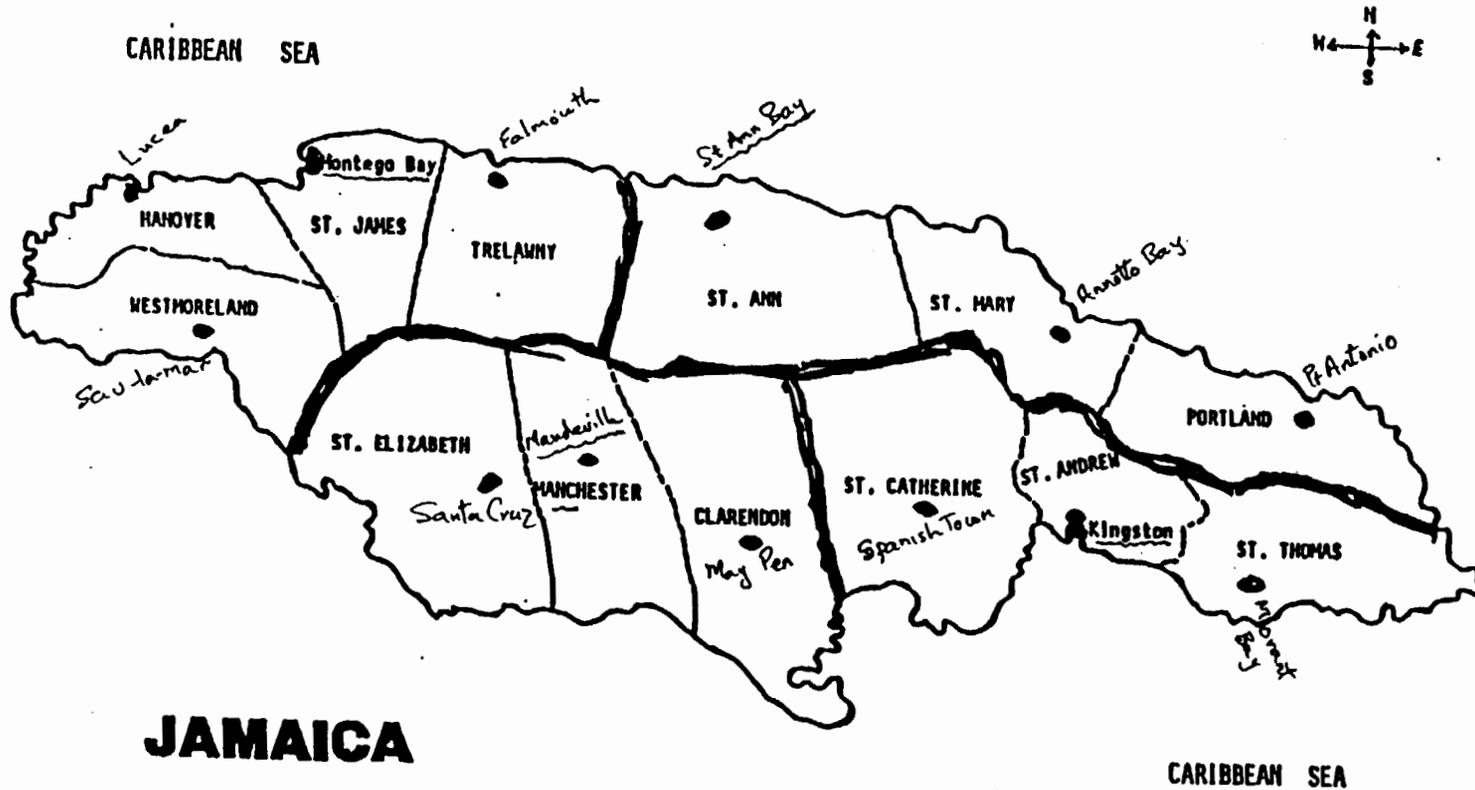
<i>YEAR</i>	<i>SEX</i>	<i>NO. CASES</i>	<i>RATE PER 100,000</i>	<i>% DECREASE OVER 1987*</i>
1987	M	1110	94.7	-
	F	1007	85.1	-
1988	M	904	77.1	18.6
	F	735	62.1	27.0
1989	M	947	79.5	16.1
	F	840	69.9	17.9
1990	M	755	62.6	33.9
	F	771	63.8	25.0
1991	M	678	55.7	41.2
	F	557	45.7	46.3
1992	M	479	38.9	58.9
	F	480	39.0	54.2
1993	M	415	33.5	64.6
	F	416	33.5	60.6
1994	M	424	33.9	64.2
	F	411	32.8	61.5

Source: Dr. A. Brathwaite, MOH/EPI Unit, 1995.

* Percentage based on rate per 100,000.

Annex 5

STD Program



JAMAICA

- Parish Boundaries
- Region "
- STD CENTRES
- ~ Regional Centre

Location of all STD Public Clinics

STD Program

Annex 5

Reporting Forms for the STD Program and Cls

STD MEDICAL CASE RECORD — STD CENTRE

Doctor # _____ Date: ____/____/____
DO MM YY

Name: _____ Sex: M / F Age: _____ D.O.B: ____/____/____
DO MM YY

Address: _____ Parish: _____

New patient/first visit
 Follow-up visit
 Old patient/new episode

REASON FOR VISIT		HISTORY	
No	Yes	Last Sexual Intercourse ____/____/____ <small>DO MM YY</small>	
<input type="checkbox"/>	<input type="checkbox"/>	No. of Partners: Last month _____	
<input type="checkbox"/>	<input type="checkbox"/>	Last three months _____	
<input type="checkbox"/>	<input type="checkbox"/>	Male _____ Female _____	
<input type="checkbox"/>	<input type="checkbox"/>	No	Yes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Partner Problem _____	
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotic (last 2 weeks) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Site of Exposure	
<input type="checkbox"/>	<input type="checkbox"/>	Genital <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Other <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Contraception	
<input type="checkbox"/>	<input type="checkbox"/>	Pill <input type="checkbox"/> Inj <input type="checkbox"/> Condom <input type="checkbox"/> TL <input type="checkbox"/> Other <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	LMP ____/____/____ <small>DO MM YY</small>	
<input type="checkbox"/>	<input type="checkbox"/>	Pap Smear ____/____/____ Result _____ <small>DO MM YY</small>	
<input type="checkbox"/>	<input type="checkbox"/>	Allergy (esp. penicillin) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Past STD _____	
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	

LAB TESTS ORDERED (specify type)

Blood TRUST/VDRL MHA/TP FTA Other _____

Smear _____

Darkfield _____

Wet Prep _____

Culture _____

Chlamydia _____

Other _____

PHYSICAL FINDINGS

No Yes Sites/Description (tick or circle as appropriate)

Vaginal/Urethral Discharge Normal - clear, mucoid/white Abnormal (yellow/green, mod./profuse, curdy, frothy, odour)

G. Ulcer _____

Rash _____

L.A.P. _____

Nodes _____

Warts _____

Cervix _____ | CET _____

Cervical Discharge Normal-clear, mucoid/white Abnormal-mucopurulent, bloody

_____ No. hrs LPU _____

Other abnormal findings _____ | Amine pH _____

No Yes STD. Provisional Dx. A ____ B ____ C ____ D ____ Final Dx. A ____ B ____ C ____ D ____ (Fill in numeric code)

TIHERAPY: Given on site _____ | Prescription _____

Amoxicillin 3.0 gm + 250 mg Clavulanic Acid PO + 1 gm PU | Metronidazole ____ mg PO x ____ days

Benzathine Penicillin G 2.4 MU: IM weekly x ____ | Doxycycline 100 mg PO BID x ____ days

Ceftriaxone 250 mg IM | Erythromycin 500 mg PO QID x ____ days

Other _____

Health Education: Drug Compliance Partner: Treatment Reduction Condom: Usage; No. Issued _____
 Disease Awareness

Recommendation: _____

Clinician: _____ Contact Investigator: _____

Referral to: Social Worker Hosp Clinic Name: _____ Return date: ____/____/____
DO MM YY

Reporting Forms for the STD Program and Cls

STD MEDICAL CASE RECORD — STD CENTRE

Docket # _____ Date: ____/____/____
 Name: _____ Sex: M / F Age: _____ D.O.B: ____/____/____
 Address: _____ Parish: _____
 New patient/first visit
 Follow-up visit
 Old patient/new episode

REASON FOR VISIT No Yes Duration <input type="checkbox"/> <input type="checkbox"/> Dysuria _____ <input type="checkbox"/> <input type="checkbox"/> Genital Discharge _____ <input type="checkbox"/> <input type="checkbox"/> Genital Ulcer Disease (GUD) _____ <input type="checkbox"/> <input type="checkbox"/> Rash _____ <input type="checkbox"/> <input type="checkbox"/> Itching _____ <input type="checkbox"/> <input type="checkbox"/> Lower Abdominal Pain (LAP) _____ <input type="checkbox"/> <input type="checkbox"/> Contact to _____ <input type="checkbox"/> <input type="checkbox"/> Partner Referral _____ <input type="checkbox"/> <input type="checkbox"/> Other _____		HISTORY Last Sexual Intercourse ____/____/____ No. of Partners: Last month _____ Last three months _____ Male _____ Female _____ No Yes <input type="checkbox"/> <input type="checkbox"/> Partner Problem _____ <input type="checkbox"/> <input type="checkbox"/> Antibiotic (last 2 weeks) _____ <input type="checkbox"/> <input type="checkbox"/> Site of Exposure Genital <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contraception Pill <input type="checkbox"/> Inj <input type="checkbox"/> Condom <input type="checkbox"/> TL <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LMP ____/____/____ DO MM YY <input type="checkbox"/> <input type="checkbox"/> Pap Smear ____/____/____ Result _____ DO MM YY <input type="checkbox"/> <input type="checkbox"/> Allergy (esp. penicillin) _____ <input type="checkbox"/> <input type="checkbox"/> Past STD _____ <input type="checkbox"/> <input type="checkbox"/> Other _____	
LAB TESTS ORDERED (specify type) Blood <input type="checkbox"/> TRUST/VDRL <input type="checkbox"/> MIIATP <input type="checkbox"/> FTA <input type="checkbox"/> Other _____ <input type="checkbox"/> Smear _____ <input type="checkbox"/> Darkfield _____ <input type="checkbox"/> Wet Prep _____ <input type="checkbox"/> Culture _____ <input type="checkbox"/> Chlamydia _____ <input type="checkbox"/> Other _____			

PHYSICAL FINDINGS No Yes Sites/Description (tick or circle as appropriate)		
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal/Urethral Discharge <input type="checkbox"/> Normal - clear, mucoid/white <input type="checkbox"/> Abnormal (yellow/green, mod./profuse, curdy, frothy, odour)
<input type="checkbox"/>	<input type="checkbox"/>	G. Ulcer _____
<input type="checkbox"/>	<input type="checkbox"/>	Rash _____
<input type="checkbox"/>	<input type="checkbox"/>	L.A.P. _____
<input type="checkbox"/>	<input type="checkbox"/>	Nodes _____
<input type="checkbox"/>	<input type="checkbox"/>	Warts _____
<input type="checkbox"/>	<input type="checkbox"/>	Cervix _____ CET _____
<input type="checkbox"/>	<input type="checkbox"/>	Cervical Discharge <input type="checkbox"/> Normal-clear, mucoid/white <input type="checkbox"/> Abnormal-mucopurulent, bloody
<input type="checkbox"/>	<input type="checkbox"/>	Other abnormal findings _____ No. hrs LPU _____
<input type="checkbox"/>	<input type="checkbox"/>	_____ Amine <input type="checkbox"/> pH _____

No Yes STD. Provisional Dx. A ___ B ___ C ___ D ___ Final Dx. A ___ B ___ C ___ D ___ (Fill in numeric code)

TIHERAPY: Given on site _____ | Prescription _____
 Amoxyicillin 3.0 gm + 250 mg Clavulanic Acid PO + 1 gm PU | Metronidazole ___ mg PO x ___ days
 Benzathine Penicillin G 2.4 MU: IM weekly x ___ | Doxycycline 100 mg PO BID x ___ days
 Ceftriaxone 250 mg IM | Erythromycin 500 mg PO QID x ___ days
 Other _____

Health Education: Drug Compliance Partner: Treatment Reduction Condom: Usage; No. Issued _____
 Discase Awareness

Recommendation: _____

Clinician: _____ Contact Investigator: _____

Referral to: Social Worker Hosp Clinic Name: _____ Return date: ____/____/____
 DO MM YY

STD CLINIC REPORT — STD CENTRE

PARISH _____

SEX _____

MONTH ENDING _____ 19__

NEW CASES

Age Groups	<1yr	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45+	TOTAL
SYPHILIS												
Total Syphilis												
Primary												
Secondary												
Early Latent												
Late Latent												
Tertiary												
Congenital												
OTHER SEROLOGICAL TESTS FOR SYPHILIS												
Total Equiv. Serol.												
P.S.H.Y. (*1)												
P.S.N.H. (*2)												

*1: Persons with a reactive serology, a history of yaws & no evidence of syphilis

*2: Persons with a reactive serology, no history of yaws or syphilis & no presumptive diagnosis made

OTHER STDs	<1yr	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45+	TOTAL
GONORRHOEA												
N.G.U./CERVICITIS												
HERPES GENITALIS												
CONDYLOMA ACUM.												

OTHER CONDITIONS			
CHANCROID		OPHTHALMIA NEONATORUM	
LYMPHOGRANULOMA VENEREUM		P.I.D.	
GRANULOMA INGUINALE		EPIDIDYMO-ORCHITIS	
TRICHOMONIASIS		EPI TREATMENT (GC)	
CANDIDIASIS		EPI TREATMENT (SYPHILIS)	
SCABIES		ALL OTHER STD	
PEDICULOSIS		ALL OTHER NON-STD	

PATIENT LOAD - New and Old Patients	
Total NEW patients seen (NEVER PREVIOUSLY registered in section)	
Total OLD patients seen (first admiss. THIS YEAR, previously reg. in section)	
Total REVISITS (patients already registered THIS YEAR, now reattending)	
TOTAL patient visits (EVERY VISIT to the section, both STD and non-STD)	
REINFECTION - GONORRHOEA CASES	
REINFECTION - SYPHILIS CASES	

Signed: _____

Name(BLOCK CAPITALS): _____

STD FIELD RECORD

Date Referral: ___/___/___ Original Patient Case #: _____

Disease Code: _____ Assign Date: ___/___/___ CI #: _____

Name: _____ Address: _____

DOB: ___/___/___ Age: ___ Sex: [M] [F] Parish: _____ Tel #: _____

Status: [1] Contact [2] Suspect Other Locating Info and Description:
 [3] Possible Case (Explain)

Exposure Dates: ___/___/___ To ___/___/___ Exposure Frequency: _____

Exam Date: ___/___/___ Disposition Date: ___/___/___

Disposition: _____ Diagnosis: _____

[] Not worked Reason: _____ [] Worked not located Reason: _____

Disposition Codes:

- STD:
- A - Brought for Rx
 - B - Previous Rx
 - C - Epidemiology Rx
 - D - Not Infected

- HIV:
- 1 - Previous Positive
 - 2 - Previous Neg/New Positive
 - 3 - Previous Neg/Still Negative
 - 4 - Previous Neg/No Test
 - 5 - No Previous Test/New Positive
 - 6 - No Previous Test/New Negative

- HIV/STD:
- E - Not Worked
 - F - Unable To Locate
 - G - Located, Refused Test
 - H - Located, Did Not Report
 - J - Out Of Parish

Supervisor Report Form

Month : _____ Year : _____

Supervisor : _____

Number of Visits Made to CI's : _____

Number of Interviews / Field
Investigations Critique : _____
(attach copies of Critiques)

Number of Meetings Held With CI Staff : _____

Supervisor Objectives :

- . Conduct at least 4 critiques per month
- . For each CI, conduct at least one critique per quarter
- . Conduct at least one group meeting of all staff per quarter

SYPHILIS INVESTIGATION REPORT

MONTH: _____ PARISH: _____ SEX: M / F
 C.I.#: _____ C.I. NAME: _____

P & S SYPHILIS INTERVIEWS

# PRIMARY & SECONDARY SYPHILIS CASES REPORTED	
# PRIMARY CASES REPORTED	
# SECONDARY CASES REPORTED	
# P&S CASES NAMING SAME-SEX PARTNER(S)	
# PRIMARY & SECONDARY CASES INTERVIEWED	
# CRITICAL PERIOD (CP) CONTACTS NAMED	
# CP CONTACTS INITIATED	
# ALL CONTACTS INITIATED	
# CRITICAL PERIOD (CP) CONTACTS TO P&S EXAMINED/TREATED	
# CP CONTACTS TREATED WITH P&S	
# CP CONTACTS TREATED WITH OTHER SYPHILIS	
# CP CONTACTS PREVIOUSLY TREATED	
# CP CONTACTS 'EPI TREATED'	
# CP CONTACTS NOT INFECTED	
# CP CONTACTS TO 'P&S' EXAMINED 0 - 7 DAYS	
# CP CONTACTS TO 'P&S' EXAMINED >7 DAYS	
# P&S CASES INTERVIEWED WITH DISEASE INTERVENTION	
# CP CONTACTS TO P&S NOT EXAMINED	
# CP CONTACTS TO P&S NOT WORKED	
# CP CONTACTS TO P&S WORKED, NOT LOCATED	
# CP CONTACTS TO P&S LOCATED, DID NOT REPORT	
# CONTACTS TO P&S RESIDING IN-PARISH	
# CONTACTS TO P&S RESIDING IN OTHER PARISH(S)	
# CONTACTS TO P&S REFERRED FROM OTHER PARISH(S)	

CLUSTER INTERVIEWS

# SUSPECTS TO P&S NAMED	
# SUSPECTS TO P&S EXAMINED	
# SUSPECTS TO P&S INFECTED	

SYPHILIS LAB TEST REACTORS

# SYPHILIS LAB TEST REACTORS EXAMINED	
# SYPHILIS LAB TEST REACTORS TREATED	
# SYPHILIS LAB TEST REACTORS PREVIOUSLY TREATED	
# SYPHILIS LAB TEST REACTORS NOT INFECTED	
# SYPHILIS LAB TEST REACTORS NOT EXAMINED	
# SYPHILIS LAB TEST REACTORS NOT WORKED	
# SYPHILIS LAB TEST REACTORS WORKED, NOT LOCATED	
# SYPHILIS LAB TEST REACTORS LOCATED, DID NOT REPORT	

HIV INVESTIGATION REPORT

MONTH: _____ PARISH: _____ SEX: M / F

C.I.#: _____ C.I. NAME: _____

HIV/AIDS INTERVIEWS

# NEW HIV POSITIVE CASES REPORTED	
# NEW HIV POSITIVE CASES INTERVIEWED	
# NEW AIDS CASES REPORTED	
# NEW AIDS CASES INTERVIEWED	
# CONTACTS TO HIV/AIDS NAMED	
# CONTACTS TO HIV/AIDS INITIATED	
# HIV/AIDS CONTACTS NOTIFIED	
# HIV/AIDS CONTACTS EXAMINED	
# HIV/AIDS CONTACTS NEWLY POSITIVE	
# HIV/AIDS CONTACTS PREVIOUSLY POSITIVE	
# HIV/AIDS CONTACTS NOT POSITIVE	
# HIV/AIDS CONTACTS NOT EXAMINED	
# HIV/AIDS CONTACTS NOT WORKED	
# HIV/AIDS CONTACTS WORKED, NOT LOCATED	
# HIV/AIDS CONTACTS LOCATED, DID NOT REPORT	
# CONTACTS TO HIV/AIDS RESIDING IN-PARISH	
# CONTACTS TO HIV/AIDS RESIDING IN OTHER PARISH(S)	
# CONTACTS TO HIV/AIDS REFERRED FROM OTHER PARISH(S)	
# HIV SURVEILLANCE INTERVIEWS CONDUCTED	
# AIDS SURVEILLANCE INTERVIEWS CONDUCTED	

HIV LAB TEST REACTORS

# HIV LAB TEST REACTORS EXAMINED	
# HIV LAB TEST REACTORS NEWLY IDENTIFIED	
# HIV LAB TEST REACTORS PREVIOUSLY KNOWN	
# HIV LAB TEST REACTORS NOT EXAMINED	
# HIV LAB TEST REACTORS NOT WORKED	
# HIV LAB TEST REACTORS WORKED, NOT LOCATED	
# HIV LAB TEST REACTORS LOCATED, DID NOT REPORT	

STD LABORATORY QUARTERLY REPORT FORM

PARISH _____

QUARTER ENDING / /

	TEST	MALE/MONTH			FEMALE/MONTH			TOTAL		
								MALE	FEMALE	TOTAL
1	VDRL/RPR (STS)									
	REACTIVE									
	NONREACTIVE									
	TOTAL									
2	REACTOR RATE**									
	STS REACTIVE <4									
	STS REACTIVE ≥4									
	STS NONREACTIVE									
	TOTAL									
3	MHA-TP									
	REACTIVE									
	NONREACTIVE									
	TOTAL									
4	DARKFIELD									
	POSITIVE									
	NEGATIVE									
	TOTAL									
5	GRAM STAIN SMEAR									
	GONORRHOEA (POS/TOT)									
	TRICHOMONAS (POS/TOT)									
	YEAST (POS/TOT)									
	GARDNERELLA (POS/TOT)									
	TOTAL (POS/TOT)									
6	CULTURE									
	GONORRHOEA (POS/TOT)									

TEST	MALE/MONTH			FEMALE/MONTH			TOTAL		
							MALE	FEMALE	TOTAL
7	GONOCOCCAL RESISTANCE***								
	PENICILLIN (POS/TOT) PPNG (POS/TOT)								
	TOTAL (POS/TOT)								
8	WET PREPARATION								
	TRICHOMONAS (POS/TOT) YEAST (POS/TOT) GARDNERELLA (POS/TOT)								
	TOTAL (POS/TOT)								
9	MISCELLANEOUS								
	FTA-ABS (POS/TOT) LCVCCFT (POS/TOT) CHLAMYDIA (POS/TOT) DONOVAN BODIES (POS/TOT) HIV/ELISA (POS/TOT) HSV CULTURE (POS/TOT)								
10	OTHER (SPECIFY)								
	TOTAL (POS/TOT)								

KEY: *This report should be completed monthly but submitted quarterly.

**Record only the result of the first STS each year.

***Record GC strain as either resistant to Penicillin or PPNG positive depending on results to these tests.

COMMENTS: _____

STD SYNDROME-BASED REPORT FORM FOR NON-STD HEALTH CENTRE — TYPE III*

Health Provider _____

Location _____ Month _____ Year _____

SYNDROME	AGE/SEX	NO. OF PATIENTS TREATED/ INITIAL VISIT	NO. OF PATIENTS RETREATED/ FOLLOW-UP VISITS	TOTAL NO. PATIENT VISITS
Vaginal discharge	<15			
	15-19			
	≥20			
Pelvic inflammatory disease	15-19			
	≥20			
Urethral discharge	15-19			
	≥20			
Genital Ulcer	Men			
	Women			
Ophthalmia neonatorum	≤1 mth			
Other STD	Men			
	Women			
TOTAL				

*Without a Contact Investigator. Diagnosis will normally be made by a Physician or Family Nurse Practitioner.

Annex 6

USAID Funded Pharmaceuticals and Supplies for STD Research

USAID Funded Pharmaceuticals and Supplies for STD Research

MEDICAL/LAB SUPPLIES - STD Research	J\$	US\$
300 MHA - TP	13,184	412
20 microtiter plates	1,472	46
1200 chlamydia EIA (Syva) tests	164,736	5,148
10 chlamydia buffer & universal reagent kits	14,144	442
1050 chlamydia collection kits	21,824	682
500 caps for tubes syva cat nr 2900294	1,280	40
500 polypropylene tubes Syva cat nr 2600179	2,400	75
100 disposable reagent reservoir Syva 41100395	2,560	80
2 lab timers min 1 hr	960	30
4 heating blocks for MULTI-BLOCK Heater, Lab line	1,920	60
2000 petri dishes	9,856	308
50 oxydase dropper reagent	960	30
20 exam table paper	672	21
1050 blood collection tubes and 21 g needles	13,184	412
2000 latex gloves	7,680	240
2000 alcohol swabs	1,024	32
2 needle containers	4,864	152
1800 procto swabs	5,120	160
300 cotton swabs	7,840	245
1000 plastic specula	3,200	100
2000 slides	5,184	162
1050 cover slips	3,328	104
6 lab notebooks	2,912	91
10 lab markers	544	17
2 gal bleach	960	30

20 pH paper	5,920	185
10 test tube racks (min 60 tubes)	4,768	149
50 soap	2,080	65
500 syringes 3cc	3,520	110
500 syringes 10cc	4,160	130
500 cryo vials	5,696	178
12 freezer boxes & separators	125,248	3,914
1 multichannel pipette Syva cat nr 4100386	7,648	239
2000 pipette tips 100 µl	3,328	104
2000 pipette tips 100 µl	1,984	62
immersion oil	320	10
4 gram stain kits	1,280	40
SUBTOTAL	457,760	14,305
PHARMACEUTICALS - STD Research		
drugs to treat 2,000 patients (for GC, CT, TV, CA)	885,760	27,680
SUPPORT TO COMPREHENSIVE HEALTH CENTER:		
repairs to lab & pharmacy/air condition unit	132,576	4,143
telephone system upgrade	48,000	1,500
SUBTOTAL	180,576	5,643
TOTAL	1,524,096	47,628

The addressed topics were: Genital ulcer disease, congenital syphilis (*since the number of cases have gone up*), ophthalmia Neonatorum (*to reduce the number of cases*), vaginal discharge (*validation of the algorithms*).

Annex 7

Sentinel Surveillance and Testing

Sentinel Surveillance and Testing

Sentinel Surveillance

HOTEL WORKERS	HIV POSITIVE		
	POS	TOTAL	%
St. Ann's (Ocho Rios & St. Ann's Bay)	2	360	0.5
Community Members	6	410	1.4

Number Positive private Laboratories

Number HIV positive confirmed: 173

Number Sentinel Surveillance Packages/Fields finds distributed: 1,500

Informed Commercial Importer: 2/374

JSS testing of 413 community members

COMMUNITY	HIV			VDRL			MHATP		
	POS	TOT	%	POS	TOT	%	POS	TOT	%
1993 Majestic Gardens	4	169	2.3	19	169	11.2	47	169	27.8
1994 Majestic Gardens	0	64	0	4	67	5.9	13	61	21.3
1995 Majestic Gardens	1	67	1.4	3	67	4.4	19	67	28.3
1995 Bower Bank	1	37	2.7	5	37	13.5	5	37	13.5
1995 Riverton City	0	73	0	5	73	6.8	17	73	23.2
TOTAL	6	410	1.4	36	413	8.7	101	407	24.8

Source: Dr. E. Ward, MOH/EPI Unit, 1995

413 Community members tested

1.4% HIV positive

24.8% past & current history of Syphilis

Number of Doctors by Practice Type - Jamaica 1994

Private	193
Public	75
Both	175
Not Stated	647
Other	14
Total	1104

Number of Doctors by Location - Jamaica 1994

Kingston & St. Andrew	738
Rural	366
Total	1104

Annex 8

HIV/AIDS Reporting and CIs

HIV/AIDS Reporting and CIs

Reported new cases of AIDS and Contact Investigations

VARIABLE	YEAR			
	1991	1992	1993	1994
TOTAL NEW AIDS CASES REPORTED (JAMAICA)	134	105	236	359
Total new HIV cases reported	278	471	590	1035
New HIV cases interviewed (%)	217 (78)	142 (30)	190 (32)	317 (31)
Number contacts named to HIV (ratio)	355 (1.6)	505 (3.6)	420 (2.2)	778 (2.5)
No. located HIV contacts (%)	N/A	N/A	255 (61)	508 (65)
No. located contacts examined (%)	185 (52)	182 (36)	192 (75)	304 (60)
HIV contacts newly positive (%)	69 (37)	47 (26)	57 (30)	75 (25)
New AIDS cases interviewed (%)	N/A	N/A	162 (28)	105 (23)

Source: Dr. E. Ward, MOH/EPI Unit, 1995

Breakdown by Parish of HIV/AIDS tracking and follow up by Contact Investigators, July-December 1993

Parish	Number of worker	# assigned	# known dispos	# located	# examined	hours worked
K.S.A.	2	241		132	69	241
ST. CATH	2	139		60	52	155
ST. JAMES	2	130		45	34	248
MANCHESTER	1	39		28	19	128
ST. ANN	1	9		1	1	19
CLARENDON	1	33		23	5	75
Total		591	360 (70%)	289 (40%)	180 (62%)	866
Syphilis for Period		50		28	17	

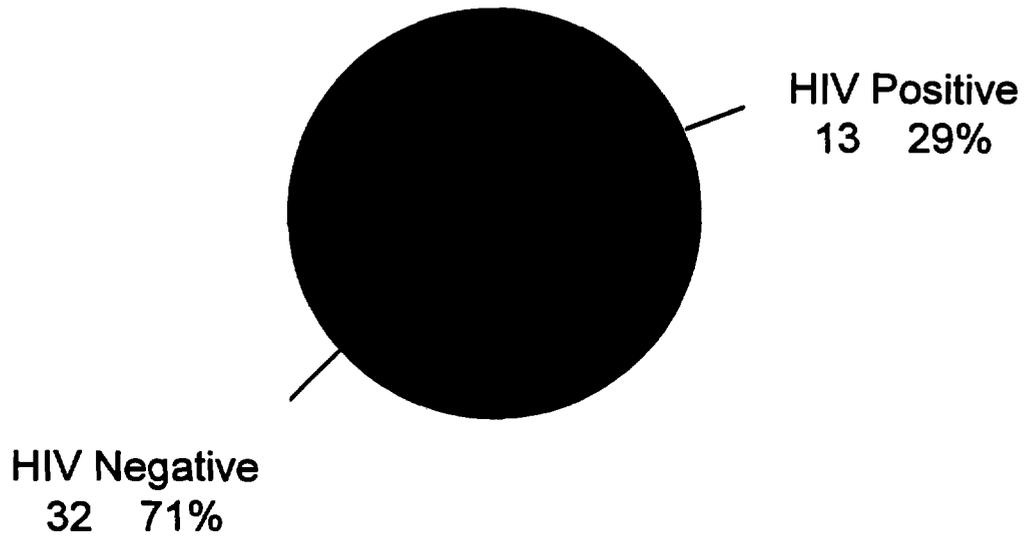
Source: Dr. E. Ward, MOH/EPI Unit, 1995

The Opportunity for CIs to Break the Chain of HIV Infection

118 - Named partners of HIV infected patients

75 - Locating information

45 - Examined and tested



Summary of findings:

60% of patients with locating information
 38% of all patients identified and alerted of risk of HIV infection

Number of HIV* Cases by Person Reporting: January - September 1995

Category	Number
Contact Investigators	268
Other **	76
Not Stated	18
Doctors	105
Total	467

Source: Dr. E. Ward, MOH/EPI Unit, 1995

* Does not include AIDS cases

** Includes KPH, Family Center, Nurses etc

Annex 9

HIV/AIDS Confidential Reporting Form

HIV/AIDS CONFIDENTIAL REPORTING FORM

Send all reports to P.M.O. Epidemiology Unit,
 MINISTRY OF HEALTH, 30-34 Half Way Tree Road,
 Kingston 8, Jamaica W.I.
 Telephone 92-83411 or 92-86430.
 Fax # 928-5674

FOR THE EPI-UNIT ONLY	
EPI ID#	
CASE ID#	

Surname: _____ First Name: _____ Mid. Name: _____

Pet Name: _____ Sex: M / F Occupation: _____

D.O.B.: ____/____/____ Age: ____ (____) weeks if infant Marital Status: _____
DD MM YY

Address: _____ Parish: _____ Tel: _____

Next of kin: _____ Address: _____
(Name) (Parish)

CONTACTS

S.	Surname	First Name	Relationship	Address	Parish
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Sexual practice of patient: Heterosexual / Homosexual / Bisexual / Not Known

RISK BEHAVIOUR	CLINICAL STATUS	Date: ____/____/____ DOCKET # _____ <small style="margin-left: 100px;">DD MM YY</small>
Blood Transfusion..... Y / N	Weight Loss (>10%)..... Y / N	Candidiasis..... Y / N
Crack/Cocaine use..... Y / N	Fever (>1mth)..... Y / N	Lymphadenopathy..... Y / N
Intravenous drug use..... Y / N	Cough (>1mth)..... Y / N	Diarrhoea..... Y / N
Genital Ulcers/Sores..... Y / N	Shortness of Breath..... Y / N	Gen. dermatitis..... Y / N
Sex with prostitute..... Y / N	Pulm. Tuberculosis..... Y / N	Shingles..... Y / N
History of STD..... Y / N	Kaposi's Sarcoma..... Y / N	Cruled scabies..... Y / N
Current STD. Y / N _____	CNS involvement..... Y / N	Specify _____
Other: _____	Other _____	

Current Status of patient: HIV (no symptoms) / HIV (Some symptoms) / AIDS / AIDS DEATH

Date of onset/of Symptoms ____/____/____ Diagnosed as AIDS ____/____/____ Date of Death ____/____/____

HIV Test date: ____/____/____ Lab: _____ Result: pos / neg
(Type)

HIV Test date: ____/____/____ Lab: _____ Result: pos / neg
(Type)

Patient's Doctor: _____ Address: _____

Source of Information: _____

Reported by: _____ Position _____ Date: ____/____/____
(Print)

Please feel free to write any additional information on the back of this form and send under confidential cover to the P.M.O. above.

Annex 10

Studies Conducted by Hope Enterprises Limited

Studies Conducted by Hope Enterprises Limited

1. Findings of the 1994 Knowledge, Attitude, Behavior and Practice Study on AIDS and STDs in Jamaica (Adult Population, 15 - 49 years) - February 1995.
2. "Using Evaluation Results to Inform Programme Implementation" - February 1995
3. Brief Overview of the Evaluation Component of the USAID/AIDSCAP/Jamaica Project - November 8, 1994
4. Elasticity of Demand for Condoms (Conducted as part of the Condom Environmental Assessment)
 - a. Condom Distribution Report for the period April 1994 - DRAFT
 - b. Demand Elasticity for Condoms in Jamaica
5. KAP Report of Study Carried out Among Female Commercial Sex Workers in Jamaica - October 1994
6. Report of KAPB survey on HIV/AIDS Carried out among Adolescents in Jamaica - October 1994
7. Findings of Pre Test for fourth STD Seminar (19/94)
8. Background Briefing Book for HIV/STD Control Program in Jamaica (Based on a Review of Secondary Research - July 1994
9. Findings of Pre Test for third STD Seminar (7/94)
10. Findings of Post test for third STD Seminar (7/94)
11. Sexual Decision Making and Barriers to Initiate Condom use in Main Relationships - A Female Perspective - July 1994
12. Evaluation of 2nd STD Seminar hosted by MAJ/UNC/AIDSCAP conducted May 1994 - June 1994
13. Tabular findings of Pretest of 2nd STD Seminar hosted by MAJ/UNC/AIDSCAP among Medical Doctors (5/94) - June 1994
14. Tabular findings of Post Test of STD Seminar hosted by MAJ/UNC/AIDSCAP among Medical Doctors (12/94) - May 1994
15. Tabular findings of Pretest of STD Seminar hosted by MAJ/UNC/AIDSCAP among Medical Doctors (12/94) - April 1994

16. Findings of Post Test for 2nd STD Seminar (4/94)
17. Commercial Condom Distribution Report Period: 1993 - February 1994
18. Findings of an In-depth Study carried out among Male STD Clinic Attenders - January 1994
19. A Strategic Analysis of all available a Jamaican AIDS Research Reports - November 1993
20. Findings of the 1992 Knowledge Attitude and Practice Study on AIDS and STDs in a Marginal Community in Kingston, Jamaica - September 1993.
21. Findings of the 1992 Knowledge, Attitude, Behavior and Practice Study on AIDS and STDs in Jamaica - May 1993.
22. Report on the Condoms Environment in Jamaica - April 1995
23. Findings of Pretest of Radio Serial on AIDS - September 1994
24. Report on a Pretest for a Comic Strip Series - April 1995
25. Report on a Pretest of STD Poster - March 1995
26. Reanalysis of Extant Data to Establish Baseline Indicators for Men Who Have Sex With Men - May 1995
27. Report of Baseline Indicators Study Among Male STD Clinic Attenders - April 1995 (DRAFT)
28. AIDSCAP/Jamaica Sub-project Narrative Report for the Period of June 15, 1993 - March 31, 1995
29. Findings of Pre Test for 4th STD Seminar (10/94)
30. Findings of Pre Test for fifth STD Seminar (3/95)
31. Findings of Post test for fifth STD Seminar (3/95)
32. Report of a KAPB Survey Among Male STD Clinic Attenders in Jamaica - August 1995
33. Condom Distribution Report Period: Third Quarter 1995 - September 1995
34. Reanalysis of Extant Data to establish Baseline Indicators for Men Who Have Sex With Men - March 1995

Annex 11

Budget Summary of USAID Funded Activities

Annex 11

Jamaica Mission Budget & Expenditures
August 31, 1995

	LOP Budget	Expend 8/95	Balance Remaining
Program Management:			
40445 Program Mgt	630,620	621,510	9,110
STD Projects:			
41447 AIDS STD Risk Reduction	548,317	341,061	207,256
41448 STD Activities	18,115	18,115	0
51446 Medical Association of Jamaica/Training	181,415	152,002	29,413
51448 National STD Program (CATC)	145,073	89,305	55,768
43460 AIDS/STD Risk Reduction (ACOSTRAD)	41,066	41,066	0
46454 EPI Unit Support	210,152	210,152	0
56445 LOA Nurse Practitioner Assoc.	14,734	14,734	0
56446 LOA MAJ	31,496	31,496	0
<u>4 Operations Research LOAs Cancelled</u>	0	0	0
	1,190,368	897,931	292,437
Condom Projects:			
42446 SOMARC CSM	91,642	91,642	0
<u>SOMARC CSM 2 Cancelled</u>	0	0	0
Targeted Intervention Projects:			
43458 Little People/Teen Players	53,710	53,710	0
53451 Face to Face (CATC)	263,173	144,453	118,720
53454 Counselling/Community Outreach (MOH)	120,381	45,632	74,749
53457 Targeted Community Intervention (MOH)	54,131	35,579	18,552
43459 Jamaica AIDS Support (JAS)	303,229	215,892	87,337
53459 HIV/STD Workplace Pgm (CATC)	24,140	24,140	0
	818,764	519,406	299,358
EPI Surveillance Projects:			
51449 Sentinel Surveillance (CATC)	103,508	70,835	32,673
<u>Sentinel Surveillance 2 Cancelled</u>			
Communications Projects:			
53450 LOA for Bert Francis	145,029	71,902	73,127
53453 Materials Development/BCC (MOH)	155,423	97,886	57,537
<u>Mass Media Subagmt Cancelled</u>	0	0	0
	300,452	169,788	130,664
Institutional Strengthening Projects:			
46445 CATC Capacity Building	988,163	664,950	323,213
Training Projects:			
56450 Training Course	10,735	10,735	0
Policy Projects:			
<u>Policy Cancelled</u>			
TOTAL	4,134,252	3,046,797	1,087,455

Note: Pgm Mgt figure includes net reduction from expendts transferred to core

Projected Jamaica Budget for Remaining Funds

I. Balance of Funds - August 31, 1995		1,087,455
II. Expenditures Remaining - Subagreement Budgets		
51449 Sentinel Surveillance	32,673	
43459 JAS	87,337	
46445 CATC Capacity Bldg	323,213	
53457 Targeted Comty Intervent	18,552	
53453 Mat Dev/BCC Strategy	57,537	
51448 Natl STD Programme	55,768	
53454 Counseling/Cmty Outreach	35,892	
53450 LOA for Berl Francis	73,127	
53451 Face to Face	118,720	
51446 MAJ Training	29,413	
41447 AIDS/STD Risk Reduction	207,256	
<i>Subtotal Subagreement</i>	<i>1,039,488</i>	
Expenditures Remaining - Other		
Program Management:	7,000	
Audits on Subagreements	24,793	
G&A	10,174	
STD TA	6,000	
<i>Subtotal Other</i>	<i>47,967</i>	
Total Expenditures		1,087,455
III. Balance of Funds Remaining - End of Project		<u>0</u>

Annex 12

Project Status Report

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Summary of USAID Strategic and Implementation Plan

Overview of Target Groups, Technical Strategies and Implementing Agencies

Overview of Target Groups: Reach, BCC Material and Evaluation

PROJECT STATUS REPORT

BEHAVIOR CHANGE COMMUNICATION

Subagreements:

Association for the Control of Sexually Transmitted Diseases II

Association for the Control of Sexually Transmitted Diseases III

Jamaica AIDS Support I

Jamaica AIDS Support II

American National Red Cross in collaboration with the

Jamaica Red Cross Society

Face-to-Face

Little People & Teen Players Club

Counseling & Social Welfare

Communication Team

Public Relations HIV/STD Risk Reduction

AIDS in the Workplace

Targeted Community Interventions

Mass Media Campaign for Young Adults

Health Information Unit

Rapid Responses: ASHE Caribbean Performing Arts Ensemble

Berl Francis

Bellevue Hospital

Health Education Learning Program

National AIDS Committee

STD MANAGEMENT

National STD Program - Clinic Attenders
Medical Association of Jamaica (LOA)
Medical Association of Jamaica (Sub)
Nurse Practitioner Association
Comprehensive Health Center
Sentinel Surveillance

CONDOMS

The Futures Group (SOMARC I)
The Futures Group (SOMARC II)
Condom Promotion Workshops

EVALUATION

Hope Enterprises Limited I
Hope Enterprises Limited II

PROGRAM MANAGEMENT

Caribbean Applied Technology Center

SUMMARY OF USAID STRATEGIC AND IMPLEMENTATION PLAN FOR HIV/AIDS PREVENTION AND CONTROL IN JAMAICA

COUNTRY PROFILE

Jamaica is a country of 2.5 million people. The country is approximately half urban and half rural with fifty percent of the total population living in the capital of Kingston.

The first case of AIDS was diagnosed in 1982. The epidemiological pattern is primarily heterosexual. HIV seroprevalence is estimated at 3 per 1,000. The number of reported AIDS cases in Jamaica as of June 1995 was 1,202 of whom 680 have died. All Parishes are affected. The AIDS case rate is highest in St. James 189/100,000 population and KSA - 570/100,000; 134/100,000 in St. Catherine, 51/100,000 in St. Ann, 30/100,000 in Trelawny and Manchester, and lowest in Portland - 18/100,000. Ninety-one (91) cases of AIDS in children have been reported representing 8% of all cases. The pattern remains one of predominantly heterosexual transmission.

HIV sentinel surveillance indicates that the HIV/AIDS epidemic appears to be spreading most rapidly in St. James. Serosurveys of STD attenders in Kingston and Montego Bay found HIV prevalence of 0.3% in 1986. In Kingston, HIV prevalence among STD attenders is 4% in 1994. In St. James HIV prevalence among STD attenders was 4.3% in 1991 and 7% in 1993. Among Ante-natal clinic (ANC) attenders HIV prevalence increased from 0.14% in 1989 to 0.44% in 1992. It is estimated that there are between 10,000 - 15,000 persons with HIV infection in Jamaica. This number is increasing every day despite current control efforts.

The high incidence of STD in Jamaica continues to be a major concern. Reported cases of syphilis, gonorrhea and NGU remain high and it is not known what the incidence of STD are in the private sector. Moreover, the very high levels of gonococcal resistance to penicillin and tetracycline mean that significantly more expensive drugs must be used for treatment. The continued high number of reported cases of congenital syphilis - 64 in 1993, indicates that infective syphilis remains a major problem and that control measures, including Ante-natal Care, remain seriously inadequate. Pregnant women are urged to ensure that they attend ANC, are tested for syphilis, return for the test results and receive appropriate treatment where indicated.

Syphilis rates are approximately three times the US rates (20% of patients seen at the Comprehensive Health Clinic in 1991 had a positive VDRL). Congenital syphilis is a national health concern. The national STD program is extensive and receives funds from multiple donors.

AIDS PREVENTION AND CONTROL

The AIDS and STD Prevention and Control program is conducted and coordinated by the MOH/NACP supported by USAID/Kingston. Funding for the program began under a Project initiated in 1988. An amendment to the Project Paper was drafted in September 1992 and through August 1996. Plans for the program are reflected in the USAID Project Paper, the Jamaica Implementation Plan for September 1992 - September 1993 and the draft Strategic and Implementation Plan for September 1993 - August 1996.

The goal of the Jamaica program is to reduce the rate of sexually transmitted HIV. The primary program objectives are to decrease STDs, increase condom use and reduce the number of sexual partners in selected target groups.

Target groups identified by USAID, AIDSCAP and the Jamaica HIV/AIDS/STD Control and Prevention Project are the following:

- STD Clinic attenders
- Commercial sex workers (CSWs)
- Adolescents
- Adults with multiple sex partners
- Men who have sex with men (MWM)
- Persons who are HIV +

A group of "intermediaries" are also identified as "targets" for the USAID program. Members of this group are not necessarily at higher risk of HIV infection or transmission but rather, because of their positions within the community/society, will influence the course of the epidemic. They are:

- Medical health community
- Policy makers and opinion leaders
- Retailers/commercial sector

The major components of the Jamaica program are:

- STD Prevention and Control
- Behavior Change Communication
- Condom Distribution and Promotion
- Private Sector Support
- Family Planning
- Capacity Building and Sustainability

OVERVIEW OF TARGET GROUPS, TECHNICAL STRATEGIES AND IMPLEMENTING AGENCIES

OVERVIEW OF TECHNICAL STRATEGIES AND TARGET GROUPS

TARGET GROUPS	STD	BCC	Condoms	Policy	BR	Evaluation
STD Clinic Attenders	XXX	XXX	X			X
CSWs	X	XXX	X			X
Adolescents	X	XXX	X			X
Adults with Multiple Partners	X	XXX	X			X
MWM	X	XXX	X			X
HIV+	X	XXX	X			X
Medical Health Community	XXX	X	X			X
Opinion Leaders		XXX		XXX		
Retailers			XXX			X

XXX = Emphasis Program Activity

X = Supporting Program Activity

OVERVIEW OF TECHNICAL STRATEGIES AND IMPLEMENTING AGENCIES

IMPLEMENTING AGENCY	STD	BCC	CONDOMS	POLICY	BR	EVALUATION
ACOSTRAD		xxx				
JAS		xxx				
Red Cross		xxx				
Face-to-Face		xxx				
Little People		xxx				
Counselling/Epi Unit		xxx				
Communication Team/Epi Unit		xxx				
Targeted Community Outreach/Epi Unit		xxx				
Berl Francis & Co. Ltd. I & II		xxx		xxx		
National STD Program	xxx					
Medical Association of Jamaica	xxx					
Nurse Practitioners Assoc.	xxx					
Comprehensive Health Center	xxx					xxx
Sentinel Surveillance						xxx
SOMARC			xxx			
Hope Enterprises						xxx

OVERVIEW OF TARGET GROUPS: REACH, BCC MATERIAL AND EVALUATION

TARGET GROUP: STD PATIENTS

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist	Research Planned	Research Conducted
ACOSTRAD II	20	Reach: 50,000 STD Patients	Reached 154,822 STD Patients	Amount not determined: comic books STD brochures	Approximately 192,508 pieces distributed	KAPB on STD clinic attenders	KAPB on STD clinic attenders completed
National STD Program/EPI Unit I	12		Trained - (Interim Budget) 14 Lab Assist. 10 Contact Investigators				
National STD Program/EPI Unit II	14	Train - 500 HCWs 26 Lab Assistants 10 Contact Investigators	Train - 533 HCWs 27 Lab Assistants 10 Contact Investigators 78 HCWs trained	2,000 manuals on guidelines	2,000 manuals printed 1,445 manuals distributed	Planned: Mass treatment GC resistance STD drugs efficacy Incidence /Prevalence STD Private Physicians Survey Vaginal Discharge Study	on-going on-going completed on-going
Nurse Practitioners Association	6	Train 80 nurses	Trained 72 nurses	0	0	Pre and post test	Pre and post test completed
Medical Association of Jamaica	18	Train 532 private practitioners	532 participants in 12 seminars	For each seminar: folders binders totebags pencils informational packets bookmarkers condom information periodic MAJ letters promotional material for visa bills	To date: 500 folders 500 binders 500 totebags 500 pencils 500 info. packets 300 bookmarkers 500 condom info. sheets	6 pre and post tests for continuing education seminars	4 pre tests 3 post test for continuing education seminars
Communication Team/EPI Unit I	12	0	0	Not determined	(Interim Budget) 20,000 condom brochures	0	0

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Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist	Research Planned	Research Conducted
Communication Team/EPI Unit II	14	0	0	People with STDs: 3,000 STD Awareness posters. 3,000 STD picture posters. 50,000 STD brochures. 50 copies of 'Roulette' 100 copies of video tape training manual. Reprint of: * 50,000 "RU Safe" brochures * 50,000 condom brochures * 20,000 comic books "Roommates" 50,000 STD stickers 20,000 "HIV Testing" brochures 10,000 brochures "Caring for HIV +" 1,000 STD Flip Charts 50,000 "STD/HIV Link" stickers 4 PSAs for radio 20,000 "Roommate" comic books 50,000 "RU Safe" brochure 50,000 condom brochure 50 "Roulette" videos 50,000 STD/HIV link stickers 100 video taped training manual 10,000 "Caring for HIV" brochure 20,000 "HIV Testing" brochure 50,000 STD stickers 3,000 STD Awareness posters 50,000 STD brochures 1 display board	980 distributed 40 copies distributed 7,799 distributed 4,496 distributed 2580 distributed	Pre-test materials	
Hope Enterprises I	21	N/A	N/A	N/A	N/A		See list of studies attached.
Hope Enterprises II	4	N/A	N/A	N/A	N/A	STD Clinic Attenders Post Test	Completed
Comprehensive Health Center	1	Reach: 1,000 female STD patients	Reached: 723 female patients	0	0	Research Study on Vaginal Discharge	Completed
Sentinel Surveillance	9	Reach: 4,000 STD Patients	1,715	0	0	Seroprevalence study	In process

TARGET GROUP: COMMERCIAL SEX WORKERS

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed	Research Planned	Research Conducted
ACOSTRAD II	20	Reach: 500 CSWs	Reached: 410 CSWs	Approximately: 1,000 STD brochures 1,000 comics 1,000 low literacy material 1,000 pamphlets/posters	Approximately: 4,000 pieces of materials distributed	Baseline Survey for Cornwall Region	Completed
Hope Enterprises I	21	0	0	0	0		See list of studies attached.
Hope Enterprises II	4	N/A	N/A	N/A	N/A	Extant data on CSWs Baseline FGD and KABP	Completed Completed
EPI Unit Surveillance Team	0	Test: 200 CSWs	0	0	0	Seroprevalence Study	In process

TARGET GROUP: ADOLESCENTS

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research Conducted
Little People & Teen Players	9	4,500 adol.	12,965 adol	55 performances of "Vibes" 500 teachers guides 40,000 stickers 25,000 posters 25,000 programs	45 perfor. 11,000 stickers 800 posters 5,000 brochures 500 buttons	N/A	See list of studies attached.
American & Jamaican Red Cross	29	4,500 adol.	2,604 adol.	1 curricula weekly radio series	1 curricula		See list of studies attached.
Face to Face I	19	Not determined	approx. 38,919	Not determined	approx. 44,600 pieces of material distributed	0	0
Face to Face II	14	50,000 adol.	84,652	To be determined	0		
Health Education Learning Programme	1	6 youth org.	6 youths org.	pamphlets caps buttons	pamphlets caps buttons	0	0
ASHE	3	5,000 adol.	2,400 adol.	2,000 pamphlets/brochures	2,000 pamphlets/ brochures		
Communication Team/EPI Unit I	12	0	0	Not determined	Interim Budget: 25,000 Abstinence stickers 5,000 picture books 30,000 comic books 20,000 "Am I Ready" brochures	0	0

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research Conducted
Communication Team/EPI Unit II	14	0	0	<p>200,000 abstinence stickers. 60,000 flyers. "Did You Know: Sexuality" 20,000 STD Brochure</p> <p>20,000 STD Stickers</p> <p>100 video training manuals 3000 school kits for guidance counselors and teachers, speakers bureau. Reprint of games and activity from Red Cross school peer education project.</p> <ul style="list-style-type: none"> • 20,000 "RU Safe" brochures • 10,000 condom brochures • 20,000 comic books "Who Will Play With Tommy" • 10,000 comic books "Roommates" • 50,000 "Am I Ready" brochure • 70 Local Video Production 	<p>At artwork stage</p> <p>Draft in circulation for review. In the process of being printed.</p> <p>Preliminary draft in review</p> <p>18,580 RU Safe brochures distributed. 6,990 condom brochures distributed 22,641 "Who Will Play With Tommy" comic books distributed. 3,550 "Roommates" comic books distributed 99,376 "Am I Ready" brochures distributed. 130 videos produced.</p>		
Berl Francis & Co.	14	0	0	<p>Audio and video tapes of 16 TV and talk shows.</p> <p>16 sets of deejay blurbs.</p> <p>16 copies of tapes with songs by popular singers.</p> <p>30 newspaper articles.</p> <p>30 comic strips published.</p> <p>Videotapes or publications showing the 2 challenge quiz and debate competition in schools.</p> <p>Copies of Drama scripts or videos showing activities of drama competition.</p> <p>5 endorsements of leading artists, tape and 4 PSAs on radio by EOP.</p>	<p>In process - trying to work with JBC to air "Living Life" which looks at healthy lifestyles once every two weeks.</p> <p>In process. Focusing on World AIDS Day to distribute tapes</p> <p>Developed 197 newspaper articles</p> <p>25 comic strips published</p> <p>3 video tapes developed</p> <p>Received 2 endorsements from leading artists</p>		
Hope Enterprises I	21	N/A	N/A	N/A	N/A		See list of studies attached.
Hope Enterprises II	4	N/A	N/A	N/A	N/A		

TARGET GROUP: ADULTS WITH MULTIPLE PARTNERS

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research/Evaluation Conducted
ACOSTRAD II	20	Reach: 3,000 adults	Reached: 154,822 adults	Amount not determined: STD Brochure Comic Books Low literacy material pamphlets posters	Approximately: 195,508 pieces of material distributed	0	0
Face to Face I	19	Not determined	Approx: 116,756 adults	Not determined	Approximately: 133,802 pieces of material distributed	0	0
Face to Face II	14	Train: 80 Reach: 50,000	Trained: 94 Reached: 89,419	Handbook Others to be determined	Final stage of development	0	0
Bellevue Hospital	3	25 patients	120 patients	Amount not determined: Condom brochures calendars posters "RU Safe" brochures	Approximately: 300 pieces of material distributed	Test HIV patients	50 patients tested for HIV
Targeted Community Outreach/EPI Unit I	5	Not determined	Approx. 2000	Condom brochures calendars posters "RU Safe" brochures	Approximately: 2,000 pieces of material distributed.	HIV tests for community residents	170 people tested for HIV
Targeted Community Outreach/EPI Unit II	12	20,000 adults	8,015 adults	20,000 educational materials video	Approximately 5,538 pieces of material distributed.	0	0

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research/Evaluation Conducted
Communication Team/EPI Unit II	14	Train: 30 NAC Member Organizations 2 Speaker Bureau Workshops	5 NAC member organizations 1 Speakers Bureau Workshop	2,000 STD Picture posters 30,000 STD Brochure 50 copies of Roulette Reprint of: * 50,000 "RU Safe" brochures * 50,000 condom brochures * 20,000 "Roommates" comic books * 2,000 STD Awareness posters * 150 Local Video Production * 52 ads for HelpLine 100 copies tape training videos 40,000 Condom stickers Monthly meetings with PR firm (Berl Francis Ltd.) and advertising agency (to be selected). Quarterly meetings with agencies producing AIDS prevention materials. 10 onsite drama meetings conducted. Four public service announcements for persons with STDs. 12 "Vibes" performances conducted for youth.	40 copies distributed 15,950 "RU Safe" brochures distributed 5,430 condom brochures distributed 1,351 comic books distributed 674 STD awareness posters distributed 116 videos distributed 100 copies of video training manual distributed 4 formal meetings held. The communications team is in weekly contact with the PR firm. To be scheduled 3 performances scheduled.	0	0

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research/Evaluation Conducted
Berl Francis	14	0	0	<p>12 radio and TV talk shows and discussion programs conducted by EOP.</p> <p>30 sixty-second drama plays for radio prepared by EOP.</p> <p>10 information kits for talk show hosts prepared by EOP.</p> <p>100 safer sex columns prepared for Flair, The Gleaner, Pure Class - Herald, Star and other community newspapers by EOP.</p> <p>60 news and feature articles prepared by EOP.</p> <p>30 comic strips and cartoons for Star prepared by EOP.</p> <p>500 speakers kits prepared for community volunteers by EOP.</p> <p>8 tapes of healthy lifestyle songs distributed to selected sound system operations by EOP.</p> <p>4 program for World AIDS Day and Safer Sex Week conducted by EOP</p> <p>500 press kit folders prepared over LOP.</p>	<p>40 programs have been aired.</p> <p>20 information kits distributed</p> <p>174 safer sex columns prepared</p> <p>118 articles prepared</p> <p>5 programs conducted</p> <p>205 press kits folders prepared</p>	0	0
Hope Enterprises I	21	N/A	N/A	N/A	N/A		See list of studies attached.
Hope Enterprises II	4	0	0	0	0	<p>Baseline KABP for 5 worksites</p> <p>Baseline for 3 marginalized communities</p> <p>National KABP</p>	<p>completed</p> <p>Analyzing data</p>

TARGET GROUP: MEN WHO HAVE SEX WITH MEN

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research/Evaluation Planned	Research/Evaluation Conducted
JAS I	17	300 contacts by peer counselors 500 attend weekly support group 3,000 thru special events	400 contacts 400 in weekly support group 3,500 thru special events	5,000 pamphlets 1,000 posters 2,000 stickers	Postponed to JAS II	Baseline KAPB for MWM	Baseline KAPB for MWM completed.
JAS II	16	1,000 contacts by peer counselors 1,000 attend weekly support group 6,000 thru special events	17,002	6,000 pamphlets 2,000 posters 3,000 stickers	6171 BCC material distributed	KABP and seroprevalence study	on-going
Hope Enterprises I	21	N/A	N/A	N/A	N/A		See list of studies attached.
Hope Enterprises II	4	N/A	N/A	N/A	N/A	KABP for MWM Post-test	Completed

TARGET GROUP: HIV POSITIVE PEOPLE

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed	Research Planned	Research Conducted
JAS II	16	100 PWHIV/AIDS	529	3 books	0	0	0
Counseling Team/EPI Unit I	10	4 Helpline Counselors	4 Helpline Counselors	0	0	Caller Survey	Ongoing
Counseling Team/EPI Unit II	13	60 Counselor in 14 parishes 6 Helpline Counselors	134 Counselors trained 6 Helpline Counselors	Resource manual	Resource manual drafted	0	0
Communication Team/EPI Unit II	14	0	0	20,000 HIV testing brochures 10,000 "Caring for HIV +" brochures 1,000 STD flip charts 50,000 "STD/HIV Link" stickers 4 PSAs	0	0	0
Hope Enterprises I	21	N/A	N/A	N/A	N/A	Key informant with HIV exposed individuals	In development stage
Hope Enterprises II	4	N/A	N/A	N/A	N/A	Revise instrument	

TARGET GROUP: MEDICAL/HEALTH COMMUNITY

Implementing Agency	Months in Operation	Target/Train	Reached/ Trained	BCC Material Planned	BCC Material Developed/Dist.	Research Planned	Research Conducted
National STD Program/EPI Unit I	12		Trained - (Interim Budget) 14 Lab Assist. 10 Contact Investigators				
National STD Program/EPI Unit II	14	Train: 500 HCWs 26 Lab Assistants 10 Contact Investigators	553 HCWs 27 Lab Assistants 10 Contact Investigators	2,000 manuals on guidelines	2,000 materials printed 1,445 manuals distributed	Mass treatment GC resistance STD drugs efficacy Incidence /Prevalence STD Private Physicians Survey Vaginal Discharge Study	on-going on-going completed on-going completed
MAJ	18	Train: 500 practitioners	532 participants in 12 seminars	for each seminar: 500 folders 500 binders 500 totebags 500 pencils 500 info. packets 300 bookmarkers 500 condom info. sheet periodic MAJ letters promotional material for visa bills	500 folders 500 binders 500 totebags 500 pencils 500 info. packets 300 bookmarkers 500 condom info. sheet		See list of studies attached.

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed/Dist.	Research Planned	Research Conducted
Nurse Practitioners Association	6	Train: 80 nurses	Trained: 72 nurses	0	0		See list of studies attached.
Counseling Team/EPI Unit I	5	Train: Not determined	Approximately 75	0	0	0	0
Counseling Team/EPI Unit II	13	Train: 60 Counselors in 14 Parishes 6 Helpline Counselors	134 Counselors trained 6 Helpline Counselors	Resource and referral manual 15,000 pamphlets on living with HIV/AIDS	225 pamphlets distributed	0	0
Hope Enterprises I	21	N/A	N/A	N/A	N/A		See list of studies attached.

TARGET GROUP: POLICY MAKERS AND OPINION LEADERS

Implementing Agency	Months in Operation	Target/Train	Reached/Trained	BCC Material Planned	BCC Material Developed	Research Planned	Research Conducted
NAC	1	not determined	356	0	0	0	0
Berl Francis & Co. Ltd.	14	not determined	350	Captioned photographs and press stories	Captioned photographs and press stories	0	0

TARGET GROUP: CONDOM RETAILERS/COMMERCIAL SECTOR

Implementing Agency	Months in Operation	Target	Reached	BCC Material Planned	BCC Material Developed	Research Planned	Research Conducted
SOMARC	26	5,000 retail outlets	660 outlets	500 Radio Spots 300 T-shirts 25,000 "RU Safe" brochures 10,000 posters 10,000 decals 50,000 drip mats	1,114 radio spots 454,600 printed promotional material	Condom audit User profile survey Message cognition and impact distribution penetration Briefing book on AIDS database	Completed Contracted out to Hope Enterprises
Hope Enterprises I	21	N/A	N/A	N/A	N/A	Demand elasticity	Completed
Hope Enterprises II	4	N/A	N/A	N/A	N/A		

BEHAVIOR CHANGE COMMUNICATION

HIV/AIDS Risk Reduction II

Implementing Agency: Association for the Control of Sexually Transmitted Diseases (ACOSTRAD)
FCO No: 21447
Project Manager: Mrs. Althea Bailey
Mechanism of Funding: Sub-agreement
Start: December 1, 1993
End: April 30, 1995 Amended to: July 31, 1995
% of Time Utilized: 100%
LOP Funding (US\$): 285,614 " 311,014
Amount Disbursed (US\$): 288,814
Expenditure to Date (US\$): 290,234
% Expended of Budget: 93%
Status: Completed

Goal: To stabilize or reduce STD prevalence in the following target groups: sexually active adults in the marginalized community of inner Kingston, CSWs, adolescents (both in and out of school), and STD clinic attenders.

Outputs:

1. Expanded peer education/outreach program among target populations.
2. Established condom distribution system.
3. Established linkages with other organizations for support of elements not provided in the sub-project.

Indicators	Accomplishments:
<p>1.1 50 people from target population selected and trained as peer counselors through LOP: 10 from marginalized areas of Kingston, 16 CSWs working part-time in Montego Bay, 7 CSWs working full-time in Kingston, 17 STD clinic attenders counselors.</p>	<p>1.1 32 peer counselors trained from marginalized Kingston. Peer counselors were selected with the assistance of Kingston Restoration Company, a development organization in the area. 10 new CSW peer counselors from Montego Bay have been identified with the assistance of the CIs and training is on-going. 5 CSWs peer counselors work full time in Kingston. 17 STD clinic attenders counselors work throughout Jamaica.</p>
<p>1.2 3 training programs conducted by EOP.</p>	<p>1.2 5 training programs conducted: 1 for marginalized community, and 1 for Montego Bay peer counselors.</p>
<p>1.3 2 refresher/in-service sessions conducted through LOP</p>	<p>1.3 3 refresher training sessions conducted for STD clinic attender counselors.</p>
<p>1.4 Approximately 53,530 people reached/contracts made (by gender) through LOP. (includes: 3000 residents of marginalized Kingston, 500 CSWs, and 30 bar/club owners and managers and 50,000 STD clinic attenders.</p>	<p>1.4 Approximately 154,822 people have been reached. (91,458 F and 63,364 M).</p>
<p>1.5 113,500 information, education and communication (IEC) materials developed and distributed.</p>	<p>1.5 Approximately 192,508 pieces of educational materials distributed</p>
<p>2.1 300,000 condoms distributed for free in STD clinics.</p>	<p>2.1 490,446 condoms distributed for free.</p>
<p>2.2 At least 50% of target populations can identify accessible condom distribution outlets by EOP.</p>	<p>2.2 At least 70% of target populations can identify accessible condom distribution outlets.</p>
<p>3.1 ACOSTRAD is involved in collaborative relationships with other NGOs. Regular meetings currently include: monthly NAC education subcommittee meeting, a quarterly NAC meeting, and Care and Counseling Support meeting.</p>	<p>3.1 ACOSTRAD is involved in regular meetings with other NGOs. 96 meetings held.</p>

Other Accomplishments:

1. The data collection baseline for the marginalized community was completed. Significant findings are: 62% of population claim they changed their behavior since they heard about AIDS (this is similar to the general public). Behavior change consists of condom use: 68% of residents and 71% of visitors. This is significantly higher than the general public which reported 24% change in using condoms (1993). Reducing number of partners is favored by females more than males.
2. The marginalized community intervention team conducted a march to promote prevention of the spread of AIDS. The march was well attended and got some media coverage although more would have been desirable.
3. ACOSTRAD has identified 11 CSWs interested in skill development including sewing, cashier capabilities and hair dressing, priority will be given to HIV+ CSWs. Exploratory discussions are being held with vocational training centers.

HIV/AIDS Risk Reduction III

Implementing Agency: Association for the Control of Sexually Transmitted Diseases (ACOSTRAD)
FCO No: 41447
Project Manager: Mrs. Vivienne Patterson
Mechanism of Funding: Subagreement
Start: August 1, 1995
End: August 26, 1996
% of Time Utilized: 8%
LOP Funding (US\$): 147,972
Amount Disbursed (US\$): 22,765
Expenditure to Date (US\$): 7,557
% Expended of Budget: 5%

Goal: To reduce STD/HIV/AIDS transmission in selected target groups in Jamaica.

Outputs:

1. Expand peer education/outreach program for CSWs.
2. Continue sustainable BCC community intervention targeting people with multiple sex partners.
3. Continue educational sessions for STD Clinic Attenders.
4. Adequate supply of free and retail condoms for target population

Indicators	Accomplishments:
1.1 Conduct 1 refresher training program for 21 CSW peer counselors in Kingston and Montego Bay by EOP.	1.1 1 refresher training program for CSWs in Montego Bay planned for September.
1.2 300 CSWs participate in educational sessions by EOP.	1.2 77 female CSW participated in educational sessions
1.3 Peer counselors refer 200 CSWs to STD clinics in Kingston and Montego Bay by EOP.	1.3 10 female CSWs referred to STD clinics in Kingston and Montego Bay by peer counselors.
1.4 20 Bar/clubs owners and managers reached/sensitized by EOP.	1.4 3 bar/club owners/managers reached/sentized.
1.5 5,000 pieces of low literate BCC material developed and distributed by EOP.	1.5 To be developed.
1.6 60,000 pieces of BCC material reprinted and distributed by EOP.	1.6 3,335 BCC material distributed to date.
2.1 Marginal community intervention expanded in Kingston by EOP.	2.1 Program expanded the boundary to Rae Town. OTARR will be completed in December.
2.2 5 ACOSTRAD peer counselors conduct community outreach through EOP.	2.2 5 ACOSTRAD peer counselors conducted community outreach.
2.3 A minimum of 20,000 community members reached through interpersonal community bases sessions by EOP.	2.3 203 and 100 female and male community members reached through interpersonal community sessions respectively.
2.4 5 community volunteers trained by EOP.	2.4 To be selected.
2.5 10,000 pieces of BCC material distributed to members of marginal communities by EOP.	2.5 533 BCC materials distributed to members of marginal communities.
2.6 Peer counselors refer 200 people with multiple sex partners to STD clinics by EOP	2.6 4 females referred by peer counselors to STD clinics.

Indicators		Accomplishments:	
3.1	17 STD peer educators provide peer education/outreach sessions to 50,000 STDCAs through EOP.	3.1	17 STD peer educators provided peer education/outreach sessions to STD clinic attenders. 6,234 and 3,663 female and male STD clinic attenders respectively attended peer education outreach sessions.
3.2	40,000 pieces of BCC material reprinted and distributed to STD clinic attenders by EOP.	3.2	
4.1	At least 15 condom outlets established by bar/club operators by EOP.	4.1	1 condom sales outlet established in bar/club by bar/club owner.
4.2	600,00 condoms distributed by EOP.	4.2	43,918 condoms distributed to date.

Jamaica AIDS Support (JAS) 1

Implementation Agency:	Jamaica AIDS Support
FCO No:	43459
Project Manager:	Mr. Ian McKnight
Mechanism of Funding:	Subagreement
Start:	December 1, 1992
End:	April 30, 1994
% of Time Utilized:	100%
LOP Funding (US\$):	91,178
Amount Disbursed to Date (US\$):	85,946
Expenditure to Date (US\$):	71,895
% Expended of Budget:	79%

Goal: To reduce risky behavior among MWM in Kingston and two other towns in Jamaica

Outputs:

1. Peer counseling network providing services to MWM and their families expanded.
2. Expanded group support and intensive education program for MWM and their families implemented.
3. Outreach system to reach MWM expanded.
4. Innovative appropriate and target educational materials for MWM developed and distributed.
5. Reliable linkages with condom distribution system established.

Indicators:		Accomplishments:	
1.1	25 peer counselors trained and 300 contacts made by November 1993	1.1	35 peer counselors trained and 400 contacts made.
1.2	Counseling network functioning in Kingston and 2 other towns by Nov. 1993.	1.2	Counseling network functioning in Kingston and Ocho Rios, efforts were made to expand to Montego Bay.
1.3	100% of contact investigators at STD clinics aware of JAS activities and linked with peer counselors by end of project.	1.3	No record, activity continues in JAS 11.
2.1	Weekly support group functioning for MWM reaching 500 attenders in total (350 in Kingston and 75 in each other town).	2.1	Weekly support group functioning: 400 people reached.
2.2	Weekly support group functioning for PWAs and their families.	2.2	Continued under JAS II.
2.3	30 people attend intensive workshop on religion and sexuality.	2.3	Postponed to JAS II.
3.1	12 special events (one per month) carried in LOP.	3.1	30 special events carried out
3.2	3000 MWM reached through special events.	3.2	3,500 MWM reached through special events.
3.3	JAS acts as liaison with 5 other organizations.	3.3	Accomplished
4.1	5000 pamphlets, 1000 posters and 2000 stickers developed and distributed.	4.1	3,000 pamphlets, 1000 posters,
5.1	200,000 condoms distributed.	5.1	20,000 condoms distributed
5.2	Kingston and two other JAS base towns participate in activities	5.2	Kingston, Montego Bay and Ocho Rios participated in activities

Comments:

The Jamaica AIDS Support project has successfully reached young men who have sex with men. Despite, the intolerance and violence targeted towards homosexuals, JAS has successfully created a safe atmosphere for these men to congregate and learn about safe sex practices. The project initiated activities in Kingston in 1992 and has now expanded to Montego Bay and Ocho Rios.

Jamaica AIDS Support (JAS) II

Implementation Agency:	Jamaica AIDS Support	
FCO No:	43459	
Project Manager:	Mr. Ian McKnight	
Mechanism of Funding:	Subagreement	
Start:	May 1, 1994	
End:	August 26, 1996	Amended to: June 30, 1996
% of Time Utilized:	57%	
LOP Funding US\$:	236,400	Proposed Amendment: 211,138
Amount Disbursed to Date (US\$):	122,701	
Expenditure to Date US\$:	122,546	
% Expended of Budget:	52%	

Goal: Reduce STD/HIV transmission among target groups in Jamaica

Output:

1. Enhance communication interventions to promote behavior change among MWM.
2. Long term counseling and support services for people who are HIV positive or who have AIDS.
3. Innovative, appropriate and targeted educational materials for MWM developed and distributed.
4. Seroprevalence survey among MWM in Jamaica.
5. Reliable links established with the NFPB and Grace Kennedy, to distribute and sell condoms.
6. Expanded capacity of organization to design, implement and manage HIV/AIDS prevention programs.

Indicators:	Accomplishments
1.1 25 peer counselors trained and 1,000 contacts made by EOP.	1.1 38 new peer counselors trained and 6,615 contacts made.
1.2 Counseling network functioning in Kingston and 2 other towns by EOP.	1.2 Counseling network functioning in Kingston, Ocho Rios and Montego Bay.
1.4 Weekly support group functioning for MWM reaching 1,000 attenders in total (600 in Kingston and 200 in each of two other towns).	1.4 Weekly support groups functioning in Kingston, Ocho Rios and Montego Bay. The Kingston group meets biweekly as a large group and, on alternate weeks, meets in smaller "cell" groups. Each "cell" group addresses safer sex, education, public awareness activities, and fund raising activities. The group in Ocho Rios meets weekly and the Montego Bay group. 4,643 MWM reached.
1.5 35 people attend intensive workshop on religion and sexuality by EOP.	1.5 664 persons attended workshop.
1.6 28 special events (one per month) carried out in LOP.	1.6 Calendar of events for special events is in place. 36 special events
1.7 6,000 MWM reached through special events by EOP.	1.7 17,002 MWM reached.
1.8 JAS acts as liaison with 5 other organizations by EOP.	1.8 Liaise with 5 organizations regularly.
2.1 Thirty weekly support groups functioning for PWA (15 in Kingston, 5 in each other town) by EOP.	2.1 64 support groups functioning in Kingston.
2.2 100 PWA attend counseling sessions by EOP.	2.2 529 PWA attend counseling sessions. (350M and 179F).
2.3 10 PWA work as peer counselors by EOP.	2.3 112 PWA work as peer counselors. (73M and 39F)
3.1 6,000 pamphlets, 2,000 posters and 3,000 stickers developed and distributed by EOP.	3.1 6,171 BCC materials distributed.
4.1 Blood drawn from 300 MWM by EOP.	4.1 373 samples drawn. Testing in process.
4.2 Kingston and four other JAS base towns participate in survey by EOP.	4.2 Kingston and 24 other towns are participating in seroprevalence and KABP survey.
6.1 Board of Directors assembled and meeting quarterly year 1 and semi-annually year 2.	6.1 Completed. 8 meetings held.
6.2 Fund raising plan developed by month 4.	6.2 In place
6.3 Management Training Workshop attended by Senior Management by month 6.	6.3 Completed. 6 senior management attended workshop.
6.4 Management system established by month 1.	6.4 Established
6.5 Budget/financial system by month 1.	6.5 In place
6.6 35 JAS staff participate in Training/Team Building Workshop by month 8.	6.6 33 staff participated

Island Wide Risk Reduction Program

Implementing Agency:	American National Red Cross in collaboration with the Jamaica Red Cross Society
FCO No:	46045
Project Manager:	Mrs. Lois Hue
Mechanism of Funding:	Subagreement through PVO/NGO competitive process
Start:	May 1, 1993
End:	May 1, 1996
% of Time Utilized:	78%
LOP Funding:	390,967
Amount Disbursed to Date (US\$):	117,838
Expenditure to Date:	190,511
% Expended of Budget:	49%

Background:

The AIDSCAP subagreement is expanding a pilot project. The accomplishments of this pilot project include:

- o 23 peer educators trained
- o 700 students reached, the majority being girls
- o Television program aired and several high-level government officials participated in discussion on AIDS.
- o Newspaper article "HIV Education for Red Cross Youth" published.

Goal: Stabilize STD prevalence in Jamaica

Outputs:

1. Develop a training system for AIDS prevention outreach program for youth in Jamaica.
2. Establish an HIV/STD Peer Education Program in Jamaica.
3. Implement radio serial targeting youth, parents and adult leaders in Jamaica.

Indicators:	Accomplishments:
1.1 Curriculum developed by month 19 of project.	1.1 The curriculum for peer counselors completed. Curriculum for instructor trainers in process.
1.2 Curriculum tested and revised by month 24 of project.	1.2 Peer educators manual pre-tested. Instructor manual will be pre- tested.
1.3 Training materials developed by month 24 of project.	1.3 Some training material completed: games, posters, brochure on STD/HIV. Two additional handbooks completed.
1.4 30 instructor trainers trained by EOP. Peer education handbook and workshop plan finalized by EOP.	1.4 35 Instructors trained. Peer education handbook under pre-test should be completed by November. Workshop plans include design of workshop, selection of participants and resource people.
2.2 450 peer educators trained by month 36 of project.	2.2 137 peer counselors trained.
2.3 4,500 adolescent youth contacted by peer educators by EOP.	2.3 2,604 adolescents contacted.
3.1 Weekly radio serial drama and call-in implemented by month 20 of project.	3.1 71 radio drama aired to date.

Other Accomplishments:

- o Poster presentation held in Tokyo.
- o Final draft of pilot KAPB is being completed.
- o Educational material developed are being used in other AIDS prevention projects.

Jamaica Face-to-Face Education and Outreach Activities

Implementing Agency:	Face-to-Face/EPI Unit	
FCO No:	53451	
Project Manager:	Mrs. Cathy Lyttle	
Mechanism of Funding:	Subagreement	
Start:	July 1, 1994	
End:	August 26, 1996	Amended to: May 31, 1996
% of Time Utilized:	54%	
LOP Funding (US\$):	290,000	Proposed Amendment: 242,006
Amount Disbursed to Date (US\$):	158,873	
Expenditure to Date (US\$):	115,793	
% Expended of Budget:	45%	

Background:

The Face-to-Face program was initiated in September 1992 to conduct interpersonal activities in support of a mass media national condom promotion campaign. The mass media campaign was developed by the EPI Unit with technical assistance from AIDSCOM. Due to delays in initiating activities, AIDSCOM was not able to fund the Face-to-Face project as the mass media campaign was rescheduled to be launched after September 30, 1992 which was AIDSCOM's EOP. Hence, upon the request of the EPI Unit, USAID and AIDSCOM, AIDSCAP provided interim funding. A formal subagreement was subsequently developed which includes the following goal, outputs and activities:

Goal: To reduce HIV/STD transmission in adolescents and young adults in Jamaica.

Outputs:

1. Cadre of outreach workers identified, trained, and supported to provide STD/HIV/AIDS information, education, and training of peer educations to target groups through interpersonal techniques.
2. HIV/STD education programs developed and implemented for adolescents through schools and out-of-school forums.
3. HIV/STD education programs developed and implemented for sexually active young adults through workplaces, organizations, clinics and other settings.
4. Educational materials to support HIV/STD prevention widely distributed.

Indicators		Accomplishments	
1.1	80 Face-to-Face team members and coordinators active island-wide through LOP.	1.1	94 Face-to-Face team members and coordinators active
1.2	New team members recruited to maintain roster of 80.	1.2	92 new members recruited. Both new and old members will be allowed to stay on the project if they successfully pass an assessment. However, it is anticipated that this will reduce the number of participants to 80.
1.3	New and current team members given initial and follow-up training and support.	1.3	67 training and support sessions held.
2.1	3,000 informal, interpersonal rap sessions held with adolescents island-wide, directly reaching at least 50,000 by EOP.	2.1	12,571 rap sessions conducted reaching 84,652 people.
2.2	Different settings identified to reach adolescents (school and out-of-school) and corresponding peer educators trained - 3 training per parish through LOP: "People Wave".	2.2	9 training sessions conducted in 9 different Parishes. 183 peer educators trained.
2.3	80 teachers in selected areas trained in innovative strategies for sexuality programs, including HIV/STD component, by EOP: "People Wave"	2.3	259 teachers participate in sexuality programs.
2.4	Sexuality programs including HIV/STD component initiated in 40 primary and all-age schools focused in 5 target parishes by EOP.	2.4	143 schools participate in sexuality program

Indicators	Accomplishments
2.5 At least two community youth leaders in each parish (e.g. Boy Scout/Girl Scout Leaders) trained by sexuality teachers to implement HIV/STD education in their programs: "People Wave".	2.5 20 community youth leaders trained.
2.6 At least six special events (World AIDS Day, fairs, etc.) in each parish identified or organized to reach all target groups and HIV/AIDS awareness activities planned and implemented by EOP.	2.6 96 special events held.
2.7 At least one school and one out-of-school setting identified in each parish for performance by ASHE "VIBES in a World of Sexuality".	2.7 7 sites identified for performances by ASHE.
3.1 3,000 informal, interpersonal rap sessions held island-wide, reaching at least 50,000 young adults by EOP.	3.1 12,574 rap sessions reaching 85,419 people.
3.2 Different settings identified to reach sexually active young adults (work sites, clubs, community groups, etc.) and corresponding peer educators trained - 3 training per parish through LOP: "People Wave".	3.2 10 training sessions held. Reached 726 people.
4.1 HIV/STD prevention materials appropriate for trainers, outreach workers, and target groups identified or developed as needed.	4.1 Educational materials developed and is being distributed to the target audiences.
4.2 Trainer and outreach worker guidelines and reference manuals, and materials for target groups (e.g., posters, flyers, pamphlets, comic books, stickers, and fact sheets) utilized or distributed by the teams in training or sessions.	4.2 120,580 Face-to-Face Handbooks and promotional materials distributed.

Other Accomplishments:

The project has been on-going since 1992 with funding through the CATC subagreement. With this interim funding the project has been able to expand the program from a few parishes to all 14 now.

1. A separate subagreement has now been written which more clearly specifies the target groups and appropriate channels and which provides a management tool to plan and track activities.
2. 72 Face-to-Face Team members and coordinators participated in earlier project. Team members include public health workers, medical personnel, unemployed community persons and church leaders.
3. Conducted regional workshops for team members in new strategies and techniques for outreach, including follow-up training and support.
4. Conducted evaluation workshops for team members in AIDS education and strategies for outreach.
6. Trained community youth leaders from YWCA and the 4H club in peer counseling.
7. Involved in Pastors Training for all denominations in five parishes.
8. Conducted workshops to train teachers in innovative strategies for sexual programs in area schools.
9. Trained people in condom promotion conducted Condom Promotion Workshop.
10. Assisted in workshop addressing issues on being parents.
11. Face-to-Face involvement has been requested in training programs of other organizations including National Family Planning Board, Ministry of Youth and Ministry of Local Government.
12. Conducted community outreach AIDS education, including hairdressers, barbers, medical personnel in parishes.
13. Assisted in parish health fairs with displays on STDs/AIDS, condom demonstrations, distribution and counseling.
14. Participated in Reggae Sunfest by incorporating education on AIDS and STDs into ongoing activities.
15. Participated in special events island-wide including World Family Day and World AIDS Day, Safe Sex Week, AIDS Community Awareness Fair.
16. Assisted in several sessions of community drama.

Little People & Teen Players Club

Implementing Agency:	Little People & Teen Players Club
FCO No:	43458
Project Officer:	Mr. Joseph Robinson
Mechanism of Funding:	Subagreement
Start:	November 1, 1992
End:	July 15, 1993
% of Time Utilized	100%
LOP Funding US\$:	53,710
Amount Disbursed to Date (US\$):	53,710
Expenditure to Date (US\$):	53,710
% Expended of Budget:	100%
Status:	Completed

Goal: To reduce risky behaviors among youth.

Outputs:

1. HIV/STD education program (performance and peer education implemented).
2. Mechanism implemented to involve youth in HIV/STD education.
3. Development and distribution of materials.
4. Wider community (including parents and teachers) sensitized to the need to communicate with youth about HIV/STD.

Indicators		Accomplishments	
1.1	55 performances with peer education by October 1993	1.1	45 performances
1.2	4,500 persons reached by performances.	1.2	12,965 persons reached
2.1	Teachers from 15 schools meet for workshop on drama festival.	2.1	Canceled
2.2	Drama festival held in early 1994.	2.2	Participated in drama festival in late 1993
3.1	500 teachers' guides, 40,000 stickers, 25,000 posters, and 25,000 program produced.	3.1	800 posters, 5,000 brochures, 11,000 stickers, 500 buttons
4.1	5 performances for opinion leaders attended by 1000 persons.	4.1	10 performances for opinion leaders

Other Accomplishments:

1. In total VIBES has been performed over 100 times for 50,000 people in five countries. 600 evaluation forms were collected from these performances and audience members were asked to take a pre- and post-test to find out if they had change of knowledge and attitudes about sex and STDs before and after each performance. An analysis of sample indicated that there was a 20% increase in correct answers to these questions. In addition, each performance was followed by a question-and-answer period on safer sexual skills.
2. The play has been taped on video for distribution. The Communication Team is currently distributing it to organizations conducting AIDS prevention activities. In addition, numerous requests from other countries provide income generating opportunities from the tape.
3. The project was terminated at the request of the Project Manager as a result of internal disputes. The play is still being performed with AIDSCAP funding but through a different implementing agency.

Jamaica Counseling and Social Welfare

Implementation Agency:	Counseling & Social Welfare/EPI Unit		
FCO No:	53454		
Project Manager:	Dr. Peter Weller		
Mechanism of Funding:	Subagreement		
Start:	October 11, 1994		
End:	August 26, 1995	Amended to:	May 31, 1996
% Of Time Utilized:	52%		
LOP Funding (US\$):	120,381	"	85,273
Amount disbursed to Date (US\$):	36,703		
Expenditure to Date (US\$):	40,307		
% Expended of Budget:	47%		

Goal: To reduce the sexual transmission of HIV.

Outputs:

1. National support and referral system established for PLWHIV.
2. Communities with high prevalence of HIV/STD conduct educational activities and use referral network.
3. Confidential telephone counseling and referral service provided

Indicators:	Accomplishment:
<p>1.1 10 social services agree to become a part of referral network through LOP.</p> <p>Surveillance system will receive quarterly reports from 100% of service providers indicating assistance provided to PWHIV through LOP.</p> <p>AIDS/STD HelpLine reports a 50% increase in calls from people affected by HIV.</p>	<p>1.1 Developing formal links with JAS, the Family Center, the Poor Relief Agency and Community Mental Health Officers. 22 social agencies have agreed to become a part of the referral network.</p> <p>In discussion with Surveillance System.</p> <p>Deleted due to budget constraints.</p>
<p>1.2 60 counselors in all 14 parishes recruited and trained island-wide through LOP.</p>	<p>1.2 134 counselors in training</p>
<p>1.3 Care, Counseling and support sub-committee of the NAC will include members of social services involved in referral network through LOP.</p>	<p>1.3 171 on-going</p>
<p>1.4 Resource and referral manual will document scope of agencies and service through LOP.</p>	<p>1.4 on-going</p>
<p>1.5 15,000 pamphlets on living with HIV/AIDS developed and distributed by EOP.</p>	<p>1.5 Material collected to develop content of new pamphlet which will be drafted by the end of November. 225 pamphlets distributed.</p>
<p>1.6 Train 60 public health nurses, 15 helpline volunteers, 30 blood bank staff, 60 community volunteers, 60 pastoral counselors, 30 volunteers groups, 30 physicians, and 30 community mental health officers in counseling.</p>	<p>1.6 539 persons have been trained.</p>
<p>2.1 A cadre of 6 trained counselors provide confidential information and counseling to callers through LOP.</p>	<p>2.1 5 counselors trained and hired.</p>
<p>2.2 A minimum of 750 calls per month through LOP.</p>	<p>2.2 3,760 calls received to date.</p>
<p>2.3 85% referrals tracked with follow-up calls through LOP.</p>	<p>2.3 System for tracking referrals being developed. Attempts to track may impact on confidentiality and on the feasibility of the indicator. 40 referral organizations provided feedback.</p>
<p>2.4 25% of calls answered by volunteers by EOP.</p>	<p>2.4 222 calls answered by volunteers.</p>

Other Accomplishments:

With funding from the interim budget the CCO Team developed linkages of service provides and facilitated provision of services necessary for people affected by HIV. The initial groups linked together included mental health officers, contact investigators, poor relief workers and public assistance. Training sessions for the groups were conducted. CCO has also liaised with JAS, Family Center, Salvation Army, children's institutions and hospitals.

In addition, the following activities are being undertaken:

1. Training of the Blood Bank staff to deal with HIV/STD donors.
2. In association with JAS, coordination of HIV support groups.
3. Staff development workshops, for the National Program's staff and affiliated agencies, which deal with death, dying and bereavement.
4. Training of volunteers from Blessed Sacrament and other agencies in St. James to work with AID/HIV patients.
5. Three new Helpline staff have been trained and hired and are now on line.
6. A technical advisor has been hired to facilitate case conferences that address issues such as case management and staff burn-out.

Communication Team: Material Development and Support for BCC Activities

Implementation Agency:	Communication Team/EPI Unit	
FCO No:	53453	
Project Manager:	Ms. Lovette Byfield	
Mechanism of Funding:	Subagreement	
Start:	July 15, 1994	
End:	August 26, 1996	
% of Time Utilized:	54%	
LOP Funding (US\$):	220,219	Proposed Amendment: 155,219
Amount disbursed to Date (US\$):	90,849	
Expenditure to Date (US\$):	46,664	
% Expended of Budget:	30%	

Background: The Communication Team in the EPI Unit has the mandate to provide appropriate behavior change communication materials for the NACP programs. In this capacity, the Communication Team identifies needs, develops material or reprints existing material, distributes materials, and oversees the production of materials in other organizations.

Goal: To reduce risky behavior in target populations.

Outputs:

1. Organizations conducting communication activities strengthened through provision of appropriate resource materials.
2. Materials developed, reprinted, and distributed for adolescents, people with STD and young adults.
3. Coordination of public relation and mass media activities and production of small media.
4. Communication programs developed for specific target groups.

Indicators:	Accomplishments
1.1 30 NAC member organizations conducting HIV/AIDS/STD communication programs applying EPI Unit message strategy through LOP.	1.1 45 organizations participating.
1.2 500,000 HIV/AIDS/STD educational materials produced and distributed	1.2 191,293 educational materials produced and distributed. More are in the process of development
1.3 Five Integral Committee Meetings by EOP.	1.3 4 meetings held.
<u>Adolescents:</u>	
2.1.1 200,000 abstinence stickers.	2.1.1 In production
2.1.2 60,000 flyers. "Did You Know: Sexuality"	2.1.2 To be done
2.1.3 20,000 STD Brochure	2.1.3 Draft in circulation for review.
2.1.4 20,000 STD Stickers	2.1.4 In the process of being printed.
2.1.5 100 video training manuals	2.1.5 Not yet started.
2.1.6 3000 school kits for guidance counselors and teachers, speakers bureau.	2.1.6 Preliminary draft in review
2.1.7 Reprint of games and activity from Red Cross school peer education project.	2.1.7 Not yet ordered
* 20,000 "RU Safe" brochures	18,580 RU Safe brochures distributed.
* 10,000 condom brochures	6,990 Condom brochures distributed
* 20,000 comic books "Who Will Play With Tommy"	22,641 comic books distributed.
* 10,000 comic books "Roommates"	3,550 "Roommates" comic book distributed
* 50,000 "Am I Ready" brochure	99,376 'Am I Ready' brochures distributed.
* 70 Local Video Production	130 videos produced.
<u>People with STDs:</u>	
2.2.1 3,000 STD Awareness posters.	2.2.1 400 distributed
2.2.2 3,000 STD picture posters.	2.2.2 330 distributed
2.2.3 50,000 STD brochures.	2.2.3 In production
2.2.4 50 copies of 'Roulette'	2.2.4 40 copies distributed
2.2.5 100 copies of video tape training manual.	2.2.5 Not yet done
2.2.6 Reprint of:	2.2.6
* 50,000 "RU Safe" brochures	7,799 "RU Safe" brochures distributed.
* 50,000 condom brochures	4,496 Condom brochures in production
* 20,000 comic books "Roommates"	2,580 Comic book in production
2.2.7 50,000 STD stickers	2.2.7 To be done
2.2.8 20,000 "HIV Testing" brochures	2.2.8 To be done
2.2.9 10,000 brochures "Caring for HIV+"	2.2.9 To be done
2.2.10 1,000 STD Flip Charts	2.2.10 To be done
2.2.11 50,000 "STD/HIV Link" stickers	2.2.11 To be done
2.2.12 4 PSAs for radio	2.2.12 To be done

Indicators	Accomplishments
<p>Young Adults:</p> <p>2.3.1 2,000 STD Picture posters</p> <p>2.3.2 30,000 STD Brochure</p> <p>2.3.3 50 copies of Roulette</p> <p>2.3.4 Reprint of:</p> <ul style="list-style-type: none"> * 50,000 "RU Safe" brochures * 50,000 condom brochures * 20,000 "Roommates" comic books * 2,000 STD Awareness posters * 150 Local Video Production * 52 ads for Helpline <p>2.3.5 100 copies tape training videos</p> <p>2.3.6 40,000 Condom stickers</p> <p>3.1 Monthly meetings with PR firm (Berl Francis Ltd.) and advertising agency (to be selected).</p> <p>3.2 Quarterly meetings with agencies producing AIDS prevention materials by EOP.</p> <p>3.3 10 onsite drama meetings conducted by EOP.</p> <p>3.4 Four public service announcements for persons with STDs by EOPS.</p> <p>3.5 12 "Vibes" performances conducted for youth by EOP.</p> <p>* materials to be reprinted</p>	<p>2.3.1 120 distributed</p> <p>2.3.2 335 STD Brochures distributed</p> <p>2.3.3 40 copies distributed</p> <p>2.3.4:</p> <ul style="list-style-type: none"> 15,950 "RU Safe" brochures distributed 5,430 condom brochures distributed 1,351 Comic books distributed 674 STD awareness posters distributed 116 videos distributed <p>Quotation have been received from Ad. Agency. Type of media for Ads being selected</p> <p>2.3.5 To be done</p> <p>2.3.6 To be developed</p> <p>3.1 25 formal meetings held. The communications team is in weekly contact with the PR firm.</p> <p>3.2 11 meetings held.</p> <p>3.3 3 meetings held</p> <p>3.4 To be scheduled</p> <p>3.5 3 performances held</p>

Other Accomplishments:

The Communication team with technical assistance from PATH and OAR, developed a comprehensive communication strategy to guide the development of educational material. The communication strategy is based on well-conceptualized theoretical framework and based on findings from behavioral research data.

With funding from the interim budget the Communication Team has been able to conduct activities for World AIDS Day, Safe Sex Week and the Children's Expo. Funds were allocated in the interim budget to produce the following materials:

- 5,000 picture posters.
- 20,000 condom brochures reprinted.
- 30,000 comic books "Who will play with Tommy" reprinted.
- 200 condom promotion kits.
- 25,000 abstinence stickers.
- 20,000 "Am I ready" brochures reprinted.
- 300 videos of VIBES in the World of Sexuality.
- Tag lines on CDC videos for TV.

Since the signing of the subagreement the Communications Team has been involved in a number of activities. These include:

1. The production of an half an hour video on the Targeted Community Intervention Project.
2. A fifteen minutes television interview with an HIV + person.
3. A fifteen minutes television presentation on "Infections that affect Jamaican women".
4. A display booth at the Health Fair put on by Crown Eagle. During this fair the team was interviewed for one of the radio stations.
5. A display booth, which took second place, at the Population Week exhibition.
6. Production of the first two of a series of HIV/STD youth musical road shows which is targeting high and secondary schools in the western rural areas of Jamaica.

Public Relations HIV/AIDS Risk Reduction Project

Implementation Agency:	Berl Francis & Company Ltd.	
FCO No:	53450	
Project Manager:	Mrs. Berl Francis	
Mechanism of Funding:	Subagreement	
Start:	July 1, 1994	
End:	June 1, 1996	Amended to: May 31, 1996
% of Time Utilized:	78%	
LOP Funding (US\$):	189,531	Proposed Amendment: 151,431
Amount Disbursed to Date (US\$):	64,445	
Expenditure to Date (US\$):	78,980	
% Expended of Budget:	53%	

Goal: Reduce STD/HIV transmission in adolescents and adults with multiple partners and opinion leaders in Jamaica.

Outputs:

1. Communication messages for adolescents sustained through public relations efforts.
2. Communication messages for adults with multiple partners sustained through public relations efforts.
3. Communication messages for opinion leaders sustained through public relations efforts.

Indicators:	Accomplishments:
Opinion Leaders:	
1.1 500 letters written to opinion leaders explaining program by EOP. Number of letter have been reduced to 250 due to budget cuts.	1.1 85 Letters written and sent informing opinion leaders about program and asking for support.
1.2 20 meetings held between PR representatives and religious leaders by EOP.	1.2 Met with 71 religious leaders. Held 14 meetings.
1.3 20 meetings held between PR representatives and community leaders by EOP.	1.3 12 meetings held.
1.4 10 meetings held between PR representatives and policy makers by EOP.	1.4 8 meetings held.
1.5 20 meetings held between PR representatives and media by EOP.	1.5 3 ongoing media interaction. 17 meetings held.
1.6 5 press conferences made by PR representative by EOP.	1.6 Conducted one media briefing of NACP work. 9 meetings held.
1.7 50 opinion leaders formally endorse STD/HIV/AIDS prevention campaign by EOP.	1.7 16 Opinion Leaders formally endorse campaign.
Adolescents:	
2.1 Audio and video tapes of 16 TV and talk shows with STD/HIV/AIDS related contents prepared by EOP.	2.1 8 video tapes prepared.
2.2 Copies of 16 sets of deejay blurbs with STD/HIV/AIDS contents prepared and distributed for radio stations by EOP.	2.2 25 copies prepared and distributed. In process - trying to work with JBC to air "Living Life" which looks at healthy lifestyles once every two weeks.
2.3 16 copies of tapes with songs by popular singers with STD/HIV/AIDS messages recorded by EOP.	2.3 In process. Focusing on World AIDS Day to distribute tapes
2.4 Copies of 30 newspaper articles containing references to STD/HIV/AIDS published in Gleaner and Children's Own by EOP.	2.4 197 newspaper articles developed.
2.5 Copies of 30 comic strips published in Chill Magazine and Children's Own with contents about STD/HIV/AIDS by EOP.	2.5 25 comic strips developed and published.
2.6 Videotapes or publications showing the 2 challenge quiz and debate competition in schools with an STD/HIV/AIDS theme prepared by EOP.	2.6 3 video tapes developed.
2.7 Copies of Drama scripts or videos showing activities of drama competition prepared by EOP.	2.7 To be scheduled
2.8 5 endorsements of leading artists, tape and 4 PSAs on radio by EOP.	2.8 2 endorsements received from leading artists.

Indicators:	Accomplishments:
<p>Young Adults:</p> <p>3.1 12 radio and TV talk shows and discussion programs conducted by EOP.</p> <p>3.2 30 sixty-second drama plays for radio prepared by EOP.</p> <p>3.3 10 information kits for talk show hosts prepared by EOP.</p> <p>3.4 100 safer sex columns prepared for Flair, The Gleaner, Pure Class - Herald, Star and other community newspapers by EOP.</p> <p>3.5 60 news and feature articles prepared by EOP.</p> <p>3.6 30 comic strips and cartoons for Star prepared by EOP.</p> <p>3.7 500 speakers kits prepared for community volunteers by EOP.</p> <p>3.8 8 tapes of healthy lifestyle songs distributed to selected sound system operations by EOP.</p> <p>3.9 4 program for World AIDS Day and Safer Sex Week conducted by EOP</p> <p>3.10 500 press kit folders prepared over LOP.</p> <p>3.11 Arrange participation of AIDS prevention efforts in 2 Reggae Sunsplash and 2 Sumfest events over LOP.</p> <p>3.12 10 church leaders demonstrate their involvement in caring for/supporting persons with STD/HIV/AIDS over LOP.</p> <p>3.13 5 themes for sermons developed and used over LOP.</p> <p>3.14 5 church leaders to write articles on caring and supporting people with STD/HIV/AIDS over LOP.</p> <p>3.15 500 pamphlets on AIDS and business distributed by EOP.</p> <p>3.16 500 pamphlets with information on AIDS in the workplace policies distributed by EOP.</p>	<p>3.1 45 programs conducted.</p> <p>3.2 40 developed to be aired soon, some to be revised</p> <p>3.3 20 Information kits developed and distributed</p> <p>3.4 174 safer sex columns prepared</p> <p>3.5 118 articles prepared. In the process of influencing reporters to write more articles.</p> <p>3.6 4 comic strips and cartoons prepared.</p> <p>3.7 In the process of developing</p> <p>3.8</p> <p>3.9 5 programs conducted.</p> <p>3.10 205 press kits folders prepared.</p> <p>3.11 Participated in 2 events.</p> <p>3.12 18 church leaders demonstrate their involvement</p> <p>3.13 In the process of developing.</p> <p>3.14 1 church leader wrote an article.</p> <p>3.15 Liaising with Private Sector Officer</p> <p>3.16 70 pamphlets with information on AIDS distributed.</p>

AIDS In the Workplace

Implementation Agency:	EPI Unit
FCO No:	53459
Project Manager:	Mrs. Marcia Erskine
Mechanism of Funding:	Subagreement
Start:	November 1, 1994
End:	August 26, 1996
% of Time Utilized:	55%
LOP Funding (US\$):	31,400 Amended to: 13,400
Amount Disbursed to Date (US\$):	16,750
Expenditure to Date (US\$):	6,269
% Expended of Budget:	47%

Goal: To reduce STD/HIV transmission in selected target groups in Jamaica.

Outputs:

1. Policy dialogue with CEOs or Company Directors leads to the adoption of AIDS in the workplace policies.
2. Behavior change communication activities conducted for employees.

Indicators:		Accomplishments:	
1.1	20 CEOs participate in Bosses Care.	1.1	25 CEOs participated.
1.2	8 quarterly Bosses Care meetings	1.2	3 meetings have been held.
1.3	Terms of reference for Bosses Care Program established by EOP.	1.3	established
1.4	Quarterly coordination meeting with Berl Francis Ltd. and the Communication Team at the EPI Unit.	1.4	on-going
2.1	20 in-house coordinators trained and conducting AIDS prevention activities thru LOP.	2.1	42 in-house coordinators trained.
2.2	12 in-service training sessions conducted for in-house coordinators.	2.2	9 in-service training sessions conducted.
2.3	2,000 workplace kits developed and distributed by EOP.	2.3	23 workplace kits distributed.
2.4	10,000 employees participate in AIDS prevention education sessions.	2.4	2,711 employees participated
2.5	A minimum of 100 in-house education sessions.	2.5	43 in-house education sessions held
2.6	Video produced for education sessions.	2.6	Deleted due to budget cuts.

Targeted Community Interventions

Implementation Agency:	EPI Unit
FCO No:	53457
Project Manager:	Ms. Audrey Wilson
Mechanism of Funding:	Subagreement
Start:	August 1, 1994
End:	August 26, 1996
% of Time Utilized:	52%
LOP Funding (US\$):	52,253
Amount Disbursed to Date (US\$):	26,674
Expenditure to Date (US\$):	21,664
% Expended of Budget:	42%

Goal: To reduce STD/HIV transmission among those practicing high-risk behaviors in selected marginalized communities in Jamaica.

Outputs:

1. Expanded, tailored HIV/STD communication interventions developed and implemented for target groups in marginalized areas.
2. Condom retailing system established and people referred for free condoms.
3. Sustainable linkages established to other programs for peer education.
4. Appropriate educational materials widely distributed to target populations

Indicators:	Accomplishments:
1.1 Team of social workers, nurse counselor and actor/actress formed and trained in HIV/STD education, counseling and drams.	1.1 Team formed and conducting daily activities.
1.2 300 interpersonal community-based sessions held by EOP, reaching 20,000 people in six communities by EOP.	1.2 4,882 females and 3,133 males reached in 200 sessions.
1.3 Development of a community mobilization model for HIV prevention.	1.3 Model developed and replicated in other communities.
1.4 At least 20,000 HIV/STD prevention materials appropriate to target groups distributed to community members by EOP; materials for education and counseling team utilized in community sessions.	1.4 5,538 educational materials distributed.
1.5 A video production of HIV/STD developed, filmed, shown and distributed by EOP.	1.5 Video produced and 21 copies distributed.
2.1 At least 5 condom retail outlets set up and operational through LOP in each community.	2.1 5 outlets set in Bowerbank 7 in Majestic Gardens 1 White Wing 3 Calaloo Bed 5 Riverton Meadows 3 McIntyre Lands
2.2 At least 50% of target group can identify community retail outlets for condom and STD clinics for free condoms.	2.2 Not yet sourced
3.1 TCI team meets monthly with coordinators/staff of Face-to Face, ACOSTRAD, Helpline, and EPI Counseling Team; quarterly with staff of Sistren and other resource organizations relevant to the communities.	3.1 On-going
At least 50% of target groups can identify community resource and how to access them.	Community resources identified.
New print materials developed as necessary and distributed.	4.2 To be done.

Accomplishments with funding from interim budget:

In Bellevue Hospital and Majestic Gardens, five condom access points were established in each area. At least one person has been identified to monitor condom availability and usage, and one condom distributor has been contacted to target these areas for sale. Initial blood testing in Bellevue and Majestic Gardens has been completed. Community persons were identified and referred to Face-to-Face and have completed their initial training as peer educators. The resource persons will keep the issues and networks alive once the comprehensive intervention period is over. The philosophy of this intervention is to confront the community with its HIV/AIDS problem and challenge them to take control of the problem in a manner that will influence the sexual behavior of the community and

is in keeping with the ethics and philosophies of the NACP. In each community we found that knowledge of the presence of HIV infection in the community was a new concept. A commitment to behavior change was brought about by individual HIV/STD testing, condom accessibility, and education specific to the HIV/STD link.

Mass Media Campaign for Young Adults

Implementation Agency: Dunlop, Corbin, Compton
FCO No:
Project Manager: Mr. Gregory McClure
Mechanism of Funding: Subagreement
Start:
End: August 26, 1996
% of Time Utilized: 0
LOP Funding (US\$): 212,000
Amount Disbursed to Date (US\$): 0
Expenditure to Date (US\$): 0
% Expended of Budget: 0
Status: Not funded due to budget constraints

Goal: To stabilize or reduce STD/HIV prevalence among sexually active young adults in Jamaica.

Outputs:

1. Collaborate with EPI Unit and agencies involved in communications activities to develop messages and to ensure consistency.
2. Conduct mass media activities for adolescents

Indicators:	Accomplishments:
1.1 Meetings with EPI Unit and other agencies for development messages through LOP. 1.2 Messages in all radio and television spots are consistent with the EPI Unit messages through LOP.	

HEALTH INFORMATION UNIT

Implementing Agency: Health Information Unit (HIU)
Mechanism of Funding: Letter of Agreement
Start: October 1, 1993
End: September 30, 1994

Goal: To establish a Resource Center for the National HIV/STD Control Program of the MOH.

Objectives:

The center will serve as a national central repository for all HIV/AIDS information and thus will better organize resources of the MOH and expedite information retrieval and dissemination. Specifically, the center will facilitate referencing of materials for the public and support the outreach services of the Communication Unit. Also, as the HIV/STD Control Program is the only local agency dedicated to the dissemination of information on HIV/AIDS and other sexually transmitted diseases, its resource center will play an invaluable role in the National Information System as the national focal point for collection and dissemination of HIV/AIDS/STD materials and for information on the epidemic.

Accomplishments:

HIU has completed the renovations for the Resource Center and has started to gather materials.

Comment:

HIU activities have been incorporated into the subagreement entitled: Communication Team: Material Development and Support for BCC Activities.

RAPID RESPONSE

Name of Organization: ASHE Caribbean Performing Arts Ensemble
Mechanism of Funding: Rapid Response
Date of Application: November 12, 1993
End: December 31, 1993
LOP Funding US\$: 4,862
Expenditure US\$: 4,862

Objective of Activity: ASHE will reach young people with the musical production **VIBES** with an emphasis on the following messages: "It is cool to wait"; "If you must have sex, use a condom"; "Communicate with your parents"; and "Get the facts before engaging in sex".

Accomplishments:

1. VIBES was performed for a total of 2,400 people.
2. A candlelight service was conducted for 350 people, including government officials, AIDS workers, school children and the media. For the first time in Jamaican history a PWHIV spoke publicly. Government officials were very responsive and publicly embraced the speaker.
3. A total of 240 evaluation forms were completed after the performances. 90% of persons in attendance enjoyed and felt they learned from the production.
4. 3,000 condoms distributed
5. 2,000 pamphlets and brochures were distributed.
6. ASHE was invited to perform for 15 community events by teachers and social workers.

Name of Organization: Berl Francis
Mechanism of Funding: Rapid Response
Date of Application: November 19, 1993
End: December 31, 1993
LOP Funding US\$: 2,806
Expenditure US\$: 2,806

Objective of Activity:

To reach the national audience with the message "Time to Act" by inviting leaders in politics and business, as well as ordinary Jamaicans, to publicly pledge their support for HIV prevention, as the absence of public support by persons in leadership positions has been identified as one of the weaknesses of the prevention program.

Description of Activity:

The candlelight ceremony was 1 & 1/2 hours in duration and featured song, dance and dramatic presentations by the performing arts troupe ASHE. At intervals, community leaders, political leaders, a person with HIV, and a mother who has cared for her child with AIDS spoke of the actions they had taken in the prevention program and lighted candles to symbolize the need for others to become actively involved. Finally, everybody in the audience lit candles in memory of people who have already died, and as a pledge to help prevent further spread of AIDS.

Accomplishments:

1. 350 persons attended the program the candlelight ceremony.
2. Representatives of 10 companies pledged financial support to Family Center of Jamaica and Jamaica AIDS Support.
3. Captioned photographs and press stories were generated as a result of the ceremony.
4. The Family Center gained 3 new volunteers to assist with medical supplies.
5. 20 people volunteered to provide support services to JAS in the areas of moral support and counseling.

Name of Organization: **Bellevue Hospital**
Mechanism of Funding: **Rapid Response**
Date of Application: **September 22, 1993**
End: **August 1, 1994**
LOP Funding US: **2,465**
Expenditure US\$: **2,465**

Objective of Activity:

To conduct a workshop to reach 25 HIV + mentally ill patients and their caretakers.

Description of Activity:

Drama therapy and video were used to teach condom skills, negotiation skills and facts about HIV/STD. Drama therapy was conducted for small groups. Each group learned through role playing and watching skits.

Accomplishments:

1. 50 were tested for Syphilis and HIV. Of 25 males tested, 10 were VDRL reactive, 9 with titer below 4, one with a titer of 128. 10 were MHATP-reactive. 3 tested positive for HIV. Of the 25 females tested, 7 were VDRL reactive below 4, 8 were MHATP reactive.
2. 50 patients were reached and divided in three groups. Each group received drama education sessions for 6 weeks. Sessions were video taped and it was clear that the knowledge regarding STDs increased significantly.
3. 70% of 50 patients trained were able to demonstrate proper condom use.
4. 5 condom access points have been set up in the hospital.

Note: Activities in this Rapid Response were incorporated into the Targeted Community Intervention Program.

Name of Organization: Health Education Learning Program (HELP)
Mechanism of Funding: Rapid Response
Date of Application: November 19, 1993
End: November 30, 1993
LOP Funding US\$: 2,522
Expenditure US\$: 2,522

Objective of Activity:

To make youths more aware and knowledgeable about HIV/AIDS-related issues and how they affect youth in society today, and to foster discussion of preventative measures.

Description of Activity:

Outreach activities were targeted for 6 youth organizations. Activities included group discussions headed by a small team of health personnel, followed by video presentation on HIV/AIDS and distribution of materials including: "Help Stop AIDS Now" T-Shirts, buttons and caps. In addition, a march took place from Tom Redcam Library car park and ended at Mandela Park. A marching band and a banner led the parade, pamphlets were distributed, and an address by two guest speakers concluded the march.

Accomplishments:

1. 3 media houses provided publicity for the event.
2. The road march took place along the scheduled route, during which promotional items and pamphlets were distributed.
3. 6 youth organizations participated.
4. Two guest speakers addressed the public at the Mandela Park.

Name of Organization: National AIDS Committee
Mechanism of Funding: Rapid Response
Date of Application: February 15, 1994
End: March 31, 1994
LOP Funding US\$: 2,166
Expenditure US: 2,166

Objective of Activity:

The objective of the activity is to harness financial resources to assist the National HIV/AIDS Control Program. Specifically, the funds will be used for Prevention AIDS Education Programs.

Description of Activity:

A premier showing of the film "Philadelphia" in Kingston during the month of March 1994. The film features Denzil Washington, as the lawyer who represents a person who had contracted the HIV virus and is terminated from his job.

Accomplishments:

1. The Governor General of Jamaica was the patron for the evenings event.
2. Tickets were sold for \$1000 each.
3. 356 persons attended out of the 356 targeted.
4. A total of J\$380,000 was collected from this event.

STD MANAGEMENT

Strengthening STD Services and Case Management in the Public Sector

Implementing Agency:	National STD Program - Clinic Attenders	
FCO No:	51448	
Project Manager:	Dr. Yasmin Williams	
Mechanism of Funding:	Subagreement	
Start:	July 1, 1994	
End:	August 26, 1996	
% of Time Utilized:	54 %	
LOP Funding:	185,939	Amended to: 155,394
Amount Disbursed to Date (US\$):	74,159	
Expenditure to Date US\$:	99,072	
% Expended of Budget:	64 %	

Background:

The STD Team at the EPI Unit has the mandate to implement the National STD Program which is a comprehensive program with multiple donors providing support. AIDSCAP has supported activities through the interim budget and technical assistance. A subagreement has been developed and includes the following goal, outputs and activities:

Goal: Reduce the rate of sexually transmitted HIV in Jamaica.

Outputs:

1. Strengthened services for case management and education of public STDCAs.
2. Laboratories strengthened for quicker, more effective patient diagnosis.
3. Strengthened Contact Investigation service.
4. STD-related operational research conducted by EOP.

Indicators:	Accomplishments:
1.1 Improved report on clinic data developed by EOP.	1.1 Clinic reports have been developed.
1.2 New computer package developed and staff trained by EOP.	1.2 New computer package being developed with TA from CDC
1.3 At least 2,000 manuals of guidelines for management and counseling distributed during LOP.	1.3 1,445 manuals distributed
1.4 All 13 public STD clinics provided with program guidelines for management of STDCAs by EOPS.	1.4 26 public clinics use new guidelines for management of STDCAs
1.5 Orders for STD drugs submitted to MOH, as well as, for supplementary drugs, to USAID by EOP.	1.5 Orders of STD drugs are submitted to USAID (1/2 amount)
1.6 All 13 Parish STD clinics linked to CSM during LOP. (base 10% with condoms).	1.6 CSM project not funded due to budget constraints.
1.7 At least 500 PHC workers trained in 20 sessions by EOP.	1.7 533 PHC workers trained to date. 15 sessions held.
1.8 3-6 Doctors/Family Nurse Practitioners/Registered Nurse trained in practicum course by EOP.	1.8 21 Doctors/FNP/RN trained
2.1 All 13 public STD clinic labs and major ANC with RPR testing capabilities by EOP.	2.1 71 public lab/ANC labs/centers conducting RPR testing
2.2 One Medical Technologist employed for CHC during LOP.	2.2 Change requested to logistics coordinator who has now been employed
2.3 Skills of 10 Laboratory Technical Assistants (LTAs) upgraded for RPR testing by EOP.	2.3 Skills upgraded for 16 LTAs, UNC provides on-going TA.
2.4 8 LTAs trained and employed for 1 year during LOP.	2.4 27 Lab Assistants trained, 12 by AIDSCAP and 4 by GTZ
3.1 Three (3) review and update workshops and 1 seminar held p.a. during LOP.	3.1 5 Regional Workshops held.
3.5 CI assessment completed by 1995.	3.5 N/A

Other Accomplishments:

Prior to the signing of the subagreement the following activities were maintained with funding from the interim budget and other donors:

1. TA from CDC was provided to improve data management capabilities of the EPI Unit. CDC reviewed 4 data bases, initiated converting them into D-base, and revised reporting forms.
2. The case management guidelines manual was developed and printed.
3. The STD team has liaised with numerous organizations including:
MAJ to plan and implement STD seminars ACOSTRAD materials for STD clinic attenders Communication Team materials for STD clinic attenders National Family Planning Board for training in STDs for FP workers.
4. A training plan for the STD program was completed and submitted to the USAID's projects' officer.
5. A supplementary STD drug order was submitted to USAID.
6. The new CHC clinic manager, Dr. Yasmin Williams, came on board in January. She is currently involved in improving/resolving a number of the management issues at the CHC.
7. Four Lab Assistants were trained.
8. Steps were taken to ensure a steady supply of antigen for RPR testing.
9. UNC provided technical assistance in syphilis screening, Freida Behets visited in February and reviewed quality control for RPR testing. These were satisfactory.
10. The Central Lab has undertaken to do the MHATP control for the RPR test.
11. Staff upgrades, appointments and reclassifications were made by MOH/MPS.
12. The air conditioning at CHC has been repaired.
13. Discussions continue regarding vehicles for CIs; a meeting was held with USAID and their legal advisers.
14. 10 CIs were trained with TA from CDC. modules for sustainability of future training is scheduled for mid-May.
15. An Update and Review workshop was held in March. A review of the previous year's performance was attempted, but this was handicapped by the lack of sufficient data due to failure of the improvised Lotus program. A program in D-base is being written.

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STD TRAINING OF PRIVATE PRACTITIONERS

Implementing Agency:	Medical Association of Jamaica (MAJ)
FCO No:	51446
Mechanism of Funding:	Letter of Agreement
Start:	November 1, 1993
End:	February 28, 1994
% of Time Utilized:	100%
LOP Funding US\$:	21,945
Amount Disbursed to Date (US\$):	22,177
Expenditure to Date US\$:	19,452
% Expended of Budget:	91%

Goal: To heighten awareness about the importance of STD prevention and control, and to improve STD case management of 500 clinicians in the private sectors.

Outputs:

1. To improve the knowledge of STD prevention and control amongst private sector clinicians;
2. To improve the quality of STD case management in the private sector;
3. To heighten interest in effective, nationwide STD prevention and control among private sector clinicians, leading them to an increased involvement in the issue;
4. To improve the cooperation between the private and public sector in the endeavor to contain HIV through STD prevention and control;
5. To deliver a continuing education program for STD case management that can be used as a general model for continuing education in the private sector;
6. To evaluate the effectiveness of this model to improve STD case management and increase interest in STD prevention and control in the private sector; and
7. To identify sentinel physicians in the private sector who will assist the MOH in monitoring the HIV/STD epidemic.

Accomplishments:

First series of workshops were held December 3,4,5, 1993 in Montego Bay, Mandeville and Kingston. A total of 257 participants attended the lectures. The first workshop focussed on epidemiology of STDs and AIDS, cervicitis, urethritis and counselling. Presenters included: Dr. Peter Figueroa, Dr. Alfred Brathwaite, Dr. Peter Weller, Dr Myron Cohen and Dr. Fred Sparling. The event received media coverage and generated enthusiasm from the participants for continued education in this area.

STD Training of Private Practitioners

Implementing Agency:	Medical Association of Jamaica
FCO No:	51446
Project Manager:	Dr. Margaret Green
Mechanism of Funding:	Subagreement
Start:	March 1, 1994
End:	November 30, 1995
% of Time Utilized:	86 %
LOP Funding US\$:	178,505
Proposed Amendment:	135,008
Amount Disbursed to Date (US\$):	121,293
Expenditure to Date (US\$):	115,457
% Expended of Budget:	71 %

Goal: Stabilize the prevalence of STDs and transmission of HIV in Jamaica

Outputs:

1. Private physicians trained in STD prevention, diagnosis and treatment.
2. Expand management capacity of MAJ.

Indicators:	Accomplishments:
1.1 5 Seminars conducted for at least 500 practitioners by EOP.	1.1 5 seminars have been conducted on Urethritis, Genital Ulcer Diseases, HIV Infection, the Syndrome of Vaginal Discharge and STDs in Children and Adolescents: The Child at Risk. A total of 532 healthcare providers island-wide participated in the seminars.
1.2 300 private practitioners island-wide diagnose and treat STDs according to National Standards by EOP.	1.2 To be evaluated.
2.1 Management system in place by month 3	2.1 Management system in place.
2.2 Monitoring/evaluation system established by month 3	2.2 Monitoring and evaluation system is in place with Hope Enterprises.

Other Accomplishments:

1. Educational materials have been developed including a book marker placed in credit cards bills.
2. Panther condoms were endorsed by the MAJ in the newspaper.

Implementing Agency: Nurse Practitioner Association
Mechanism of Funding: Letter of Agreement
Start: November 1, 1993
End: April 30, 1994

Goal: To conduct a workshop for 80 nurse practitioners on HIV/AIDS/STDs which will include both prevention and treatment issues.

Outputs:

1. Identify high risk behavior for HIV/AIDS/STDs and recognize/understand/apply stated treatment and prevention strategies.
2. Counsel STD patients to reduce their risk of contracting HIV/STDs using personal risk assessments.
3. Effectively manage clients with STDs and HIV.
4. Assist the client and family in the development of appropriate strategies that will enhance their coping mechanisms with HIV/AIDS infection.
5. Provide guidelines that focus on fostering a caring attitude among health workers towards clients with HIV/AIDS/STDs.
6. Organize awareness programs that would meet the needs of clients and family members of HIV/AIDS infected individuals.

Accomplishments:

The Nurse Practitioners Association held a workshop for 72 participants December 2, 3, 1993 in Montego Bay. The Nurse Practitioners have a history of taking continued education seriously and participants value this workshop which focussed on diagnosing, treating and preventing STDs.

Vaginal Discharge Study

Implementing Agency: Comprehensive Health Center (CHC)
Mechanism of Funding: Interim Budget
Start: May 1, 1994
End:

Goal: The goal of the study is to evaluate algorithms for diagnosis and treatment of vaginal discharge among women presenting at CHC.

Outputs:

1. To determine the diagnostic validity (sensitivity and specificity of 2 flowcharts for diagnosis and treatment of women presenting with signs and symptoms of abnormal vaginal discharge.

2. To determine the prevalence of Neisseria gonorrhoea, Chlamydia trachomatis, Trichomonas vaginalis, yeast infection and bacterial .

Objectives:	Accomplishments:
1. To determine the diagnostic validity (sensitivity and specificity) of 2 flowcharts for diagnosis and treatment of women presenting at the CHC STD clinic with signs and or symptoms of abnormal vaginal discharge.	1. UNC has provided TA to design the study.
2. To determine the prevalence of Neisseria gonorrhoea, Chlamydia trachomatis, Trichomonas vaginalis, yeast infection and bacterial vaginosis among women presenting at the CHC STD clinic with signs and or symptoms of abnormal vaginal discharge.	2. The STD Technical Working Group approved the study protocol.
3. To identify possible additional local risk factors for cervical infection would increase the sensitivity and specificity of a vaginal discharge management algorithm for women presenting at the CHC STD clinic.	3. UNC provided TA to initiate the study, 723 women have participated in the study already.

Indicators:	Accomplishments:
4. To determine the cost per patient receiving case management and the cost per identified infection with <i>N. gonorrhoea</i> and/or <i>C. trachomatis</i> for each of the flowcharts.	4. Not yet sourced
5. To determine the feasibility and acceptability of using each of the flowcharts in the CHC setting.	5. Completed
6. To collect local <i>Neisseria gonorrhoea</i> strains for evaluation of antimicrobial minimum inhibitory concentrations.	6. Collected

Notes:

The Vaginal Discharge Study demonstrated the use of algorithms for diagnosing women. The study improved syndrome-based diagnosis of cervicitis.

Jamaica Sentinel Surveillance

Implementing Agency:	Surveillance Team/ERTU
FCO No:	51449
Project Manager:	Dr. Elizabeth Ward
Mechanism of Funding:	Subagreement
Start:	November 1, 1994
End:	August 26, 1996
% of Time Utilized:	55%
LOP Funding US\$:	114,953
Amount Disbursed to date (US\$):	51,024
Expenditure to Date US\$:	44,265
% Expended of Budget:	39%

Goal: Reduce the rate of sexually transmitted diseases in Jamaica

Output:

1. Sentinel survey in target groups implemented and data disseminated.
2. Increased number of government and non-governmental agencies accurately reporting HIV/AIDS reports recorded by Epidemiology Unit from to the EPI unit.
3. Improvement of the quality of laboratory testing for HIV/AIDS cases in both Governmental and Non Governmental sources.

Indicators:	Accomplishments:
<p>1.1 60% Blood samples (below) collected, tested and analyzed by March 1995 and 80% by EOP: 4,000 STD clinic attenders from a minimum of 4 STD clinics 2,400 Antenatal Clinic attenders 2,400 Food Handlers 300 CSWs/beach boys 400 Prisoners 300 MWM 600 Mental Patients 600 Hospitalized Patients 700 Marginalized community members 500 Hotel Workers</p>	<p>1.1 1,786 STD clinic attenders 2,055 Antenatal clinic attenders 1,635 Food handlers 262 Beach boys 175 MWM</p>
<p>2.1 3,000 Sentinel Surveillance Packages distributed through LOP.</p>	<p>2.1 1,190 packages have been produced including HIV/AIDS Field Guides, HIV Reporting Form, Class 1 notification booklet, Doctors Notification Guideline.</p>
<p>2.2 100,000 of HIV/STD Report forms distributed through LOP</p>	<p>2.2 6,000 forms distributed.</p>
<p>2.3 90% of HIV/AIDS cases admitted to public hospitals reported through LOP.</p>	<p>2.3 36 HIV/AIDS cases reported to the public hospitals. 17 females and 19 males.</p>
<p>2.4 70% of doctors receive AIDS/HIV field guide.</p>	<p>2.4 1,260 doctors received AIDS/HIV field guide.</p>
<p>2.5 20% increase in annual reports from private practitioners in year 1 and 35% increase in year 2.</p>	<p>2.5 170 private practitioners proved annual reports.</p>

Indicators:	Accomplishments:
3.1 A minimum of 4 laboratories reporting on a quarterly basis on the results and numbers of HIV tests performed during LOP.	3.1 54 laboratories reported on quarterly basis
3.2 A minimum of 3 non-government laboratories distribute HIV/AIDS report forms to private doctors through LOP.	3.2 On-going, all four private major labs participating. 87 report forms distributed.
3.3 Two branches of government laboratories service distribute HIV/AIDS forms to government doctors through LOP.	3.3 On-going, both major public labs participating. 514 report forms distributed.
3.4 Two branches of government laboratories providing confirmed/supplementary HIV results through LOP.	3.4 On-going, both major public labs participating. 277 results received.
3.5 A minimum of 3 non-government laboratories providing confirmed supplementary HIV results through LOP	3.5 On-going, all four private major labs participating. 17 results received.

CONDOMS

Condom Distribution in Jamaica

Implementing Agency:	The Futures Group (SOMARC) I
FCO No:	42446
Project Manager:	Mr. Kevin Kingsfield
Mechanism of Funding:	Subagreement
Start:	October 19, 1992
End:	August 31, 1994
LOP Funding (US\$)	98,324
% of Time Utilized:	99%
Amount Disbursed to Date (US\$)	82,249
Expenditure to Date (US\$):	96,324
% Expended of Budget:	86%

Goal: Increase condom sales

Outputs:

1. Media campaign implemented.
2. Retail promotion implemented.

Indicators:	Accomplishments:
1.1 85% of target group is reached over LOP with a message which motivates the purchase and proper use of the branded social marketing condom.	1.1 Not sourced.
1.2 1,000 radio spots aired over LOP.	1.2 1114 radio spots aired.
1.3 300 T-shirts with CSM message distributed at special event.	1.3 Not accomplished. Funds reprogrammed.
1.4 100,000 printed promotional materials produced over LOP.	1.4 454,600 printed promotional material produced and distributed.
2.1 5,000 new retail outlets carry CSM brand condom.	2.1 Not accomplished since local beverage and cigarette distributors who were identified to supply the condoms to their outlets backed out of the agreement. However, 25% of bars now carry condoms and the sale of condoms have increased significantly.

Other Accomplishments:

1. 10 print ads were produced and placed in two publications. They were not budgeted in the subagreement but were used to successfully support the radio messages.
2. Additional marketing support was provided to the media campaign through Grace Kennedy, the Panther distributor. In particular, two promotional campaigns, one for the trade and one for the consumer, were supported.
3. Needs assessment of counselling skills of outreach workers determined the training requirements for upgrading the skills of clinic employees to provide adequate counselling in condom use and promotion.
4. Assisted the NFPB in the divestment of the Panther brand to the private sector.

Condom Distribution in Jamaica

Implementing Agency: The Futures Group (SOMARC) II
FCO No: To be determined
Project Manager: Mr. Kevin Kingsfield
Mechanism of Funding: Subagreement
Start: October 15, 1994
End: August 26, 1994
LOP Funding: 88,000
% of Time Utilized:
Amount Disbursed to Date (US\$)
Expenditure to Date (US\$):
% Expended of Budget:
Status: Not funded due to budget constraints

Goal: To decrease the sexual transmission of HIV.

Outputs:

1. Distribution network expanded for condoms.

Indicators:	Accomplishments:
1.1 At least 3 condom distributors participate in program thru LOP. 1.2 5,000 new retail outlets carry CSM brand condom by EOP. 1.3 A minimum of 5 AIDSCAP implementing agencies participate in condom distribution thru LOP. 1.4 100,000 pieces of Point of Sales material developed and distributed. 1.5 Quarterly site visits to Parishes to conduct spot checks on accessibility to condoms thru LOP.	

Workshop: Condom Promotion Workshops
Mechanism of Funding: AIDSCAP Country Office Budget
Start: May 31, 1993
End: September 24, 1994

Goal: To provide information and skill to equip selected persons to function as condom promoters and counselors in specially identified communities and clinic.

Achievements:

1. A condom promotion manual was developed by PATH and pretested in Jamaica.
2. Condom promotion workshops have been held for the following participants:
 - 11 STD clinic attender counselors
 - 3 Face-to-Face project staff
 - 2 Regional Contact Investigators
 - 5 Contact Investigators
 - 6 Community Peer Counselors
3. Before the workshop the average score was 63% from the questionnaire on condom usage with the lowest score being 30%; after the workshop the average score was 78% with the lowest score being 61%. This is an indication that the participants knowledge had increased.

EVALUATION

Evaluation of AIDSCAP Jamaica I

Implementing Agency:	Hope Enterprises Ltd.
FCO No:	57445
Project Manager:	Mrs. Maxine Wedderburn
Mechanism of Funding:	Subagreement
Start:	June 1, 1993
End:	March 31, 1995
% of Time Utilized:	100%
LOP Funding US\$:	262,314
Amount Disbursed to Date (US\$):	250,664
Expenditure to Date:	263,179
% Expended of Budget:	100%

Goal: To incorporate evaluation results into ongoing and future programs in Jamaica.

Outputs:

1. Baseline, process and follow-up assessments of behavioral correlates of risk of HIV infection conducted.
2. Baseline assessment of condoms and condom purchasers conducted.
3. Media campaign pre- and post-tested.
4. Rapid ethnographic study of Jamaican sexual behavior conducted.
5. Formative research that includes identification, procurement, interpretation and analysis of all relevant materials conducted.
6. System to ensure capacity building and sustainability developed.

Indicators:	Accomplishments:
1.1 Consumer intercept survey of STD clinic attenders conducted and analyzed by month 15.	1.1
1.2 KAPB tracking studies of general population conducted and analyzed by month 4; focus groups and final report by month 7.	1.2 KAPB survey completed.
1.3 KAPB tracking studies of age-specific population (10-14) conducted by month 6; and analysis and final report by month 8.	1.3 Completed
1.4 KAPB survey of marginalized communities conducted by month 2; and analysis and final report by month 4.	1.4 Completed
1.5 Key informant interviews with HIV-exposed individuals conducted in months 7 and 13.	1.5
1.6 Re-analysis and interpretation of extant data on CSWs conducted by month 10.	1.6 Completed
1.7 Focus group discussion (FGD) to explore trust and condom issues by month 2.	1.7 Completed (Sexual Decision Making Among Women).
1.8 KAPB of MWM (Jamaica AIDS Support - JAS) conducted by month 14; and focus groups and analysis by month 16.	1.8 Completed
1.9 Process data collected monthly from all IAs.	1.9 Eliminated
2.1 Distribution check conducted in months 1, 7, and 13.	2.1 Completed two distribution check of condoms. Draft submitted in December 1994.
2.2 Demand elasticity analysis conducted by month 8.	2.2 Completed
2.3 Commercial environment study of 100 outlets conducted by month 6.	2.3 Completed
2.4 Results presented (to EPI Unit and AIDSCAP) by month 8.	2.4 Completed
3.1 Pre-testing conducted 2 months prior.	3.1 Completed
3.2 Post (interim impact assessment) - testing conducted midterm.	3.2 Mass Media Subagreement was not funded due to budget constraints.
4.1 Materials collected by end of month 1.	4.1 Completed and documented in briefing book.
4.2 Study conducted by end of month 2.	4.2 Completed.
4.3 Orally present results locally to all interested parties by month 3.	4.3 Completed.
5.1 Technical assistance (instrument development, interview techniques, data collection, interpretation and analysis) provided.	5.1 On-going.
5.2 Instruments co-developed.	5.2 On-going.
5.3 When relevant and appropriate, analyses jointly conducted.	5.3 On-going
5.4 Strategic planning jointly conducted.	5.4 To be scheduled

EVALUATION OF AIDSCAP Jamaica II

Implementing Agency:	Hope Enterprises Ltd.
FCO No:	47054
Mechanism of Funding:	Subagreement
Start:	April 1, 1995
End:	August, 26, 1996
% of Time Utilized:	29%
LOP Funding (US\$):	258,157
Amount Disbursed to Date (US\$):	50,717
Expenditure to Date (US\$):	65,237
% Expended of Budget:	25%

Goal: To incorporate evaluation results into ongoing and future programs in Jamaica.

Outputs:

1. Conduct the measurement of HIV/STD Prevention Indicators PI1, PI2, PI4, PI5, and additional subproject specific indicators and exposure measures.
2. Conduct the measurement of HIV/STD Prevention Indicator 2.
3. Maintain active evaluation focussed communication with the NACP and individual implementing agencies.
4. Build capacity of Hope Enterprises Limited.

Indicators:	Accomplishments:
1.1 Conduct a post study for all target groups already having a baseline study for PIs; conduct both a pre- and post-study for those target groups not having a baseline study for these PIs; and analyze and report on these PIs by August 1996.	1.1 on-going
2.1 Conduct condom audit every 6 months.	2.1 audit conducted in July 1995
3.1 Participate in annual HIV/AIDS Review.	3.1 on-going
3.2 Participate in EPI Unit Monthly Senior Staff meetings.	3.2 on-going
3.3 Conduct a minimum of one meeting per individual implementing agency or as frequently as needed.	3.3 11 meetings held.
4.1 Participate in computer analysis training.	4.1 To be scheduled
4.2 Participate in statistical training.	4.2 To be scheduled
4.3 Participate in data presentation training.	4.3 To be scheduled

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT

Implementing Agency:	Caribbean Applied Technology Center (CATC)
FCO Number:	50047
Mechanism of Funding:	Subagreement
Start:	October 1, 1994
End:	August 26, 1996
% of Time Utilized:	48%
LOP Funding (US\$):	205,913
Amount Disbursed to Date (US\$):	60,955
Expenditure to Date (US\$):	81,649
% Expended to Date:	40%

Goal: To provide support to the AIDSCAP Country Office.

Output:	Accomplishments:
1. Provide contracts to the following AIDSCAP staff positions. A) Program Officer b) Accounting Officer c) Program Assistant d) Secretary e) Driver	1. Contracts provided to listed AIDSCAP staff.
2. Receive and release funds to cover salaries, benefits and expenses.	2. On-going.
3. Account for and report to FHI all expenditure.	3. On-going.
4. Manage funds, reconcile bank account set up exclusively for the project.	4. On-going.
5. Provide hands-on assistance in the advertising of vacancies, personnel selections, performance appraisal and such other functions related directly to personnel performance which falls within the scope of work.	5. On-going.

Outputs:	Accomplishments:
6. Administer personnel entitlement (salary, leave, sick days etc.) through the provision and monitoring of policies.	6. On-going.
7. Address personnel administration and monitoring of policies.	7. On-going.
8. Be solely responsible for all matters relating to local taxation, labor and industrial laws.	8. On-going.
9. Account for all funds provided by USAID/AIDSCAP for salary support and other aspect of the program as needed.	9. On-going.
10. Adhere to personnel policy and procedural support to standardize the accessing of salary benefits, etc.	10. On-going.

Country Office

Implementing Agency: Country Office
Mechanism of Funding: Interim Budget
Start: September 1992
End: August 1996

Background: Capacity building is an important component of the AIDSCAP strategy, the transfer of technology has taken place in workshops.

Accomplishments:

1. 2 workshops on Logframes held for EPI Unit staff and Program Managers conducted by AIDSCAP Resident Advisor. As a result of these workshops, Program Managers were able to draft logframes and subagreements.
2. 1 Annual Review Workshop conducted in December 1993. AIDSCAP co-sponsored this workshop with USAID/Jamaica. Fred Nunes an AIDSCAP consultant facilitated the week long team building, review and planning workshop.
3. 1 capacity building workshop for small NGOs was held. CATC conducted workshop on fund raising techniques, proposal writing, managing financial resources, general office procedures and team building.

Annex I3

References

References

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