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90605

**DRUG ABUSE
PREVENTION PROJECT
MID-TERM EVALUATION
(JAMAICA)**

The Narcotics Awareness and Education (NAE) Project is designed to strengthen the capabilities of Lesser Developed Country (LDC) institutions to design, implement and evaluate effective drug awareness and prevention programs. The project focuses on drug demand reduction through public awareness and education. Key to the overall project strategy are activities that: generate an understanding of the nature and extent of drug abuse in a given country; develop public awareness of the problem among government policy makers, opinion leaders and the general public and of the importance of implementing comprehensive prevention programs before the drug problem gets out of hand; and assist in obtaining the support of key national leaders and institutions to develop and effectively implement national prevention strategies. Among the technical support services involved in the project strategy are technical assistance, training, research, information dissemination, and policy dialogue.

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FINAL REPORT

**DRUG ABUSE PREVENTION PROJECT MID-TERM EVALUATION
(Project No. 532-0161)**

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USAID/JAMAICA DRUG ABUSE PREVENTION PROJECT (532-0161)

MID-TERM EVALUATION

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EXECUTIVE SUMMARY

Introduction

In September 1989, USAID/Jamaica provided the Government of Jamaica with a bilateral grant agreement in the amount of US\$500,000. This grant funded a "Drug Abuse Prevention Project," (Project No. 532-0161) over a five year period. The project is currently in its third year. The project has three major components: 1) development of human resources for drug abuse prevention; 2) community based secondary and tertiary prevention activities; and 3) improvement in drug abuse prevention information.

The National Council on Drug Abuse (NCDA) serves as the primary implementing agency for this project. Under the terms of the project a three year sub-grant was made to Jamaica/Western New York Partners (JNYWP), a non-governmental organization, to manage the community based prevention component of the project. A sub-grant agreement was also signed by the NCDA and the Kingston Restoration Company (KRC). That agreement covers the operating costs over a three year period of a Teen Center for youth in the inner Kingston area.

The purpose of the present mid-term evaluation is to assess project accomplishments in the areas of training, community development and research and to identify what future training, service delivery and research needs under the project in the next 18 months are the most likely to have an impact on reducing demand for narcotics.

The Narcotics Awareness and Education Project deployed a four-person team to conduct the mid-term evaluation during the period from September 10-October 2, 1992. In addition, AID/W designated a technical advisor to the RD/ED NAE Project to assist the evaluation team.

Major Findings, Conclusions and Recommendations

Implementation of the Drug Abuse Prevention Project has made limited progress. From the outset, the NCDA had difficulty meeting some of the basic requirements outlined in the Project Agreement; e.g., timely delivery of a coherent strategy, with annual implementation workplans identifying clear priorities, specific activities, timeframes and resources required for achieving them.

The current organizational structure of the NCDA seems insufficient to ensure effective and efficient operation of the Drug Abuse Prevention Project along with the numerous other responsibilities of the NCDA. The management structure of the NCDA is highly centralized and lines of

responsibility and communication within NCDCA do not appear to be clearly defined.

From the outset of grant award the NCDCA has experienced management and administrative constraints. The NCDCA simply has not had the basic infrastructure to effectively cope with the infusion of approximately 25 new staff nor the demands of creating a new project organization within a short period of time. It may be concluded that this has been a case of organizational overload.

With regard to the training component of the project, NCDCA records are incomplete and evaluation mechanisms employed to date do not provide information on the impact of local training. It is impossible to determine from existing records how many trainees have participated in local training workshops or the impact of the training on participant knowledge and attitudes or on subsequent community drug prevention activities. To date, training has not addressed a number of the human resource development needs outlined in the agreement.

The grant agreement calls for four training and evaluation manuals to be developed over the life of the project (LOP). To date, only a Peer Counselors Manual has been developed. USAID/Jamaica reviewed the manual and provided comments. A final document incorporating those comments, or addressing the issues raised was never sent back to USAID for final approval.

With regard to the community based component, only four of a projected 16 LOP community based activities are actually in place. The evaluation team found that the monitoring mechanisms required were not implemented and that project meetings were not held as required by the agreement. Lines of communication between the NCDCA and the umbrella agency were not clearly delineated and collaboration was poor.

The small numbers of people being reached by JWNYP activities call into question the cost-effectiveness of the JWNYP approach. In addition, the JWNYP lacks the management capability to meet management and oversight responsibilities with respect to existing projects and to fully undertake contractual obligations. The team, therefore, recommends an orderly wrap-up of this component of the project.

The KRC Teen Center represents a comprehensive, community-wide approach to drug abuse prevention based on a risk-focused strategy that has been shown to produce effective results in a variety of social and cultural contexts.

With regard to improvements in drug abuse information, the project continues to operate without a data base. Efforts to integrate existing medical and social service data into a drug abuse prevention information system have not progressed beyond the initial planning stage. Only one study has been conducted to date. The principal conclusions of that study were not accompanied by supporting documentation, and the study has been disallowed by USAID/Jamaica.

At least some of the more notable problems in the implementation of the USAID/NCDA Project may be attributable to the lack of fit between the goals of the project and the NCDA's principal priorities, as expressed in its Integrated Demand Reduction Strategy (IDER). The IDER approach is based on the social and economic development of communities. The NCDA sees the latter approach, in and of itself, to be a deterrent to drug abuse. However, very limited resources are available for demand reduction programs. These limited resources cannot address all the social and economic problems that contribute to drug abuse. The NCDA approach does not provide the infrastructure needed for the development of targeted programs addressing high risk populations. The intent of the USAID project is to assist in the development of these targeted programs.

Instead of focusing on high risk populations as identified in the grant agreement, the NCDA has elected a national program organized by parish, without particular reference to high risk populations. There is no indication that these individuals were located in high risk communities or associated in any way with high risk populations. Consequently, it is difficult to see how many of the activities funded under the present USAID project are ultimately translated into the desired, targeted secondary and tertiary prevention programs.

The team has been advised of the findings of the recent draft audit report on the NCDA. These results are likely to require that an alternate mechanism for project implementation be utilized to meet project goals during the remainder of the project. Utilizing such a mechanism, the team recommends that remaining project funds be directed to the implementation of specific activities which will respond to the project purpose and to its current needs.

Future program development

The evaluation team has been asked to make recommendations for project components likely to reduce the demand for

illicit substances with emphasis on crack/cocaine. A new, more comprehensive project is required to address the growing need for information, education and early treatment interventions by the Jamaican public.

The team recommends a new comprehensive project which will have as its goal: "To inform and educate the Jamaican public about the specific effects of drug abuse, and to prevent an increase in the incidence and prevalence of crack use through the establishment of a viable public and private sector information, education, prevention counseling, and early treatment program."

The project as envisioned would have five components:

- A) Communication and information;
- B) Early treatment;
- C) Program support, technical assistance and training for PVOs and NGOs conducting drug abuse prevention activities;
- D) Research and evaluation; and
- E) Project management.

I. INTRODUCTION

In September 1989, USAID/Jamaica provided the Government of Jamaica with a bilateral grant agreement in the amount of US\$500,000. This grant funded a "Drug Abuse Prevention Project," (Project No. 532-0161) over a five year period. The project is currently in its third year. The goal of the project is to prevent further significant increases in the abuse of drugs of all types among high risk groups in Jamaica during the life of the project. The project purpose is to improve the capability of the Jamaican public and private sectors to develop and implement drug abuse prevention programs aimed at high risk target groups, primarily youth between 12 and 25 years of age.

The project has three major components, each of which is designed to meet the project purpose and contribute to the Project goal in the most cost efficient manner possible. These components are:

- development of human resources for drug abuse prevention;
- community based secondary and tertiary prevention activities; and
- improvement in drug abuse prevention information.

The National Council on Drug Abuse (NCDA) serves as the primary implementing agency for this project. The NCDA, which existed as a sub-unit of the Office of the Prime Minister (OPM) at the outset of the project is now a statutory organization reporting to the OPM. The NCDA is the GOJ agency with primary responsibility for developing and coordinating public policy and programs regarding the supply of and demand for drugs.

Under the terms of the project a sub-grant was to be made to a non-governmental organization to manage the community based prevention component of the project. This component constitutes small grants to grassroots organizations to undertake secondary and tertiary prevention activities directed toward high risk populations. In October 1990, the Office of the Prime Minister, on behalf of the National Council on Drug Abuse, provided a sub-grant to Jamaica/Western New York Partners (JWNYP) for this purpose. The agreement provided for funding of J\$175,000 for the

first year (approximately US\$25,000) with incremental funding over a three year period.

In October 1991, a sub-grant agreement for J\$431,500 (approximately US\$23,000) was signed by the NCDCA, through the Office of the Prime Minister, and the Kingston Restoration Company (KRC). The agreement covers the operating costs over a three year period of a Teen Center designed to carry out a wide variety of activities including drug education, career counseling and recreational events for 90 youth in the inner Kingston area.

A. Scope of the Evaluation

The purpose of the present mid-term evaluation was to assess project accomplishments in the areas of training, community development and research and to identify what future training, service delivery and research needs are the most likely to have an impact on reducing demand for narcotics. In order to carry out the evaluation, AID initiated a buy-in to the Worldwide RD/ED Narcotics Awareness and Education Project (NAE) implemented by Development Associates.

The specific objectives of the evaluation were to highlight the lessons learned from the project with respect to what is working in demand reduction. The evaluation was also designed to review the project's impact in changing the attitudes and practices of drug users toward the use of illegal drugs. In carrying out its tasks, the evaluation team was requested to assess the relative merits of the various approaches to demand reduction currently being implemented including training of providers, youth programs, skills training for high risk groups, and peer counseling.

The mid-term evaluation was designed to determine indicators of current levels of performance under the project and problems and constraints in the implementation of the project with corresponding recommendations for mid-course corrections in the project activities, products and inputs.

B. Methodology

The Narcotics Awareness and Education Project deployed a four-person team to conduct the mid-term evaluation during the period from September 10-October 2, 1992. Development Associates provided the following specialists: a senior substance abuse program design and evaluation specialist

(team leader, with extensive experience in the design, implementation and evaluation of drug abuse prevention programs for over 20 countries), a clinical substance abuse specialist (with over 23 years experience researching substance abuse problems in Jamaica), and a training/education specialist (with seven years residence and professional experience in Jamaica). Porter/Novelli, subcontractor to Development Associates under the NAE contract provided a senior communication specialist with extensive field work experience in Jamaica. In addition, AID/W designated a technical advisor to the RD/ED NAE Project to assist the evaluation team.

The evaluation team employed a wide range of information gathering methods to assess the performance of the Drug Abuse Prevention Project. Data gathering included site visits to the offices of the NCDA, JWNYP, KRC, and project activity sites in Kingston, Portland, and Westmoreland. Documents reviewed included project files, correspondence, reports and surveys. These documents were obtained from USAID, the NCDA, JWNYP, the KRC and other governmental and non-governmental organizations working in the area of drug abuse prevention. Videos of NCDA workshops were examined. Interviews were held with USAID project staff, NCDA, JWNYP, and KRC management, staff and participants trained through the project. The evaluation team also met with the management and staff of a number of organizations in drug abuse prevention, treatment and rehabilitation in Jamaica. A list of persons interviewed can be found in Appendix C.

II. PROJECT MANAGEMENT IMPLEMENTATION AND STRUCTURE

A. Project Management and Oversight Responsibilities

USAID/Jamaica entered into a bilateral grant agreement with the National Council on Drug Abuse as the implementing agency to undertake a number of activities designed to improve the capability of the Jamaican public and private sectors to design and implement drug abuse prevention programs for high risk target groups. Both the project paper and the grant agreement outlined the core components of the project:

- Development of human resources in the design and implementation of secondary and tertiary prevention projects, drug abuse information systems and related areas of drug abuse prevention. Included in this component is the preparation of training manuals and handbooks for use by secondary and tertiary prevention. These manuals are to be used by community groups involved in such programs for training and evaluation purposes and by the GOJ for planning and management purposes.
- Establishment of community based secondary and tertiary drug abuse prevention activities in geographic areas identified as high risk and/or serving high risk population groups.
- Improvement in drug abuse preventive information through community-level epidemiologic studies; review of hospital medical records and emergency room observation; and development of a national drug abuse information system to provide decision makers in the NCDA and the umbrella NGO with an ongoing flow of information useful to: 1) determine the extent and type of drug abuse in Jamaica; and 2) determine change in the need and demand for secondary and tertiary prevention policy and programs.

The NCDA has responsibility for the development of human resources component and the improvement in drug abuse information component. At the time of the mid-term evaluation, the community-based prevention activities program was structured as follows: The major element was

managed through the sub-grant issued by NCDA in October 1990, to JWNYP. The second element consisted of the funds allocated to the NCDA to enable it to directly fund small, community based projects. By September 1992, the only activity which the NCDA had funded through this mechanism was the sub-grant awarded in October 1991, to the Kingston Restoration Company.

B. Organizational Structure and Lines of Responsibility

The current organizational structure of the NCDA seems insufficient to ensure effective and efficient operation of the Drug Abuse Prevention Project along with numerous other responsibilities of the NCDA.

At the time of the USAID/NCDA Project start-up, the NCDA had minimal staff. In a relatively short time, NCDA staffing has grown from five to 30. However, it has still not reached its full staffing complement and key management positions remain vacant. For example, the post of Deputy Director (identified in the NCDA Five Year Implementation Plan) has not been filled. The present Executive Director was appointed in July, 1990. She does not have administrative support other than one secretary. Critical field officer positions are not presently staffed. Because of the current freeze on hiring imposed by the GOJ, it is unlikely that this situation will improve in the near future.

Illustrative of this management constraint is the very limited implementation of the community-based prevention component of the project. As discussed in the chapter on the community-based prevention activities program, implementation is far behind schedule and, with the exception of the Teen Center of the Kingston Restoration Company, what is in place suffers from serious deficiencies.

NCDA issued a sub-grant to JWYNP to serve as the umbrella agency for the community based programs in drug abuse prevention. In the sub-grant agreement between the Office of the Prime Minister on behalf of the NCDA and JWNYP, among the express responsibilities of the NCDA as Grantor are to:

- monitor the progress of the Project to ensure its compliance with the terms and conditions set out in the Agreement. Meetings among representatives of the Grantor and the Grantee will be held quarterly to review progress towards meeting

Project objectives and resolving problems and to provide guidance and assistance to the Grantee as appropriate; and

- quarterly Project Director Meetings will be convened at which the Grantee, Grantor and USAID will review the progress of the Project activities.

The evaluation team found that the monitoring mechanisms required to be put into place by the NCDA have not been implemented and that project meetings were not held as required by the agreement. Lines of communication between the NCDA and the umbrella agency have not been clearly delineated and collaboration has been poor.

The NCDA has recently been established as a statutory body and the organization is still evolving as an independent agency. It should be noted that the process of institutional development is typically a long-term one, on occasion can require over five years.

Given the management and administrative limitations of the NCDA at the time the award was made, the goals of the project appear to have been overly ambitious. The NCDA simply did not have the basic infrastructure to effectively cope with the infusion of approximately 25 new staff nor the demands of creating a new project organization within a short period of time.

It may be concluded that this has been a case of organizational overload. From the outset, the NCDA had difficulty meeting some of the basic covenants of the project; e.g., timely delivery of a coherent strategy, with annual implementation workplans identifying clear priorities, specific activities, timeframes and resources required for achieving them.

In addition, lines of responsibility and communication within NCDA do not appear to be clearly defined. Of NCDA's 30-person staff, the evaluation team was informed that the NCDA counterpart to the USAID project was composed only of the Executive Director and an accountant. USAID funds are used to fund the training officer. The NCDA Director of Research, indicated to the team that she was no longer responsible for research activities under the USAID project.

The management structure of the NCDA is highly centralized. In discussing the project policy and overall management of

the project, the Executive Director expressed that these mechanisms have to be reviewed and changes made. For example, the Executive Director, who serves as the GOJ counterpart to the project, indicated that she did not participate in the July, 1990 meetings with consultant Dr. Jillson-Boostrom that resulted in basic amendments to the USAID project. She informed the evaluation team that the Chairman dealt directly with the consultant.

C. Early Project Implementation Problems

The project experienced early implementation problems including a delay between the signing of the grant agreement, initial disbursement of funds and commencement of activities. The grant agreement was signed on September 29, 1989. However, in its progress report of April 1991, NCDA reported to USAID that activities did not commence until August, 1990.

Implementation delays were caused, in part, by the time required by the GOJ to meet the Conditions Precedent to Disbursement in Article 4 of the grant agreement. Prior to the first disbursement under the grant, the GOJ was to furnish to AID:

"(a) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms; and

(b) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2., and of any additional representatives, together with a specimen signature of each person specified in such statement."

Both the Legal Opinion and the Certificate of Authorized Representatives were received by USAID on January 17, 1990, over three and a half months after signing of the grant agreement.

Another significant aspect of the early project implementation problems was the fact that a set of "building blocks" expected to be in place by the end of the second quarter (March 31, 1990) were not achieved. As identified in the Grant Agreement Implementation Schedule, these included: (1) NCDA's becoming a statutory body; (2) an

umbrella PVO/NGO being selected to implement the community-based component of the project; and (3) the development by NCDA of a training needs assessment and plan, and selection of training priorities for the first year of the project. None of these activities had been concluded by July, 1990.

Administrative arrangements within USAID/Jamaica changed during the initial phase of the project. Technical assistance was provided by Dr. Irene Jillson-Boostrom, the consultant who assisted in the project design and the preparation of the project paper. During her July 1990, technical assistance, Dr. Jillson-Boostrom addressed the issue of the assignment of management of the Drug Abuse Prevention Project within USAID.

The directors of the USAID/Kingston offices most relevant to the project (i.e., the Office of Health, Nutrition and Population (OHNP) and the Office of Education and Human Resources (OEHR) had been on home leave during the period of project design (July/August 1989). As a result, the decision regarding location of the office was held in abeyance until the end of the development of the project paper. The decision to locate the project in OEHR was made by the Project Development Committee in the absence of the director of that office and without the benefit of his (or the eventual Project Officer's) involvement in the design of the project.

Between October 1989, and August 1990, the Drug Abuse Prevention Project was assigned to the OEHR. In August 1990, based on recommendations made by Dr. Jillson-Boostrom, USAID transferred responsibility for the project from OEHR to OHNP. This decision was made for the following reasons:

- The Director of the OHNP had been appointed the USAID Narcotics Coordinator. In this position she represented USAID at the US Mission-wide Narcotics Coordinating Committee meetings. This placed her, and the OEHR Project Officer, in a difficult position with respect to exchange of information and effective coordination of project activities. As Project Officer for the Drug Abuse Prevention Project, the OHNP Director would be in a better position to conceptually and practically integrate mission-wide drug abuse policies and programs with the USAID project.
- The most effective use possible of USAID funds would include establishing strong linkages with

projects which have clear relationships with drug abuse prevention in the broadest sense. OHNP had several related projects (including AIDS/STD Prevention, which included a small drug abuse education component).

The shift in administrative responsibility for the project resulted in the lack of continuity in project management within USAID/Jamaica and contributed to some of the early implementation delays experienced by the project.

III. DEVELOPMENT OF HUMAN RESOURCES FOR DRUG ABUSE PREVENTION

The NCDA, in its 1989 Five Year Plan for Prevention and Control of Drug Abuse, identified training of human resources as a critical part of its strategy to strengthen the capability of Jamaican institutions to respond to the drug problem. The Drug Abuse Prevention Project is mandated to address these training needs through provision of training to the following groups:

- NCDA Council members and Secretariat staff in drug abuse policy and program issues, selecting, adapting, designing and evaluating secondary and tertiary prevention strategies;
- Professionals and non-professionals working at the community level in public and private sector organizations in: crisis intervention, referral approaches and means of developing secondary and tertiary prevention activities appropriate for specific high risk groups;
- Physicians, nurses and social workers involved with programs in early detection and screening, referral approaches and basic counseling;
- Personnel managers and occupational health staff of private industry in identification and referral of individuals with drug problems.
- Participants from community grants projects in: the design and implementation of prevention strategies targeted to high risk populations, organizing communities for drug abuse prevention activities, management and evaluation systems and referral networks; and
- Individuals responsible for developing and maintaining the NCDA information system and those responsible for drug abuse research.

Training under this component of the project has been provided through local training workshops and through short-term overseas training.

A. NCDCA Local Training Workshops

Fourteen workshops have been held to date, eight in 1991 and six in 1992. The NCDCA failed to supply information on numbers of participants in several of these workshops so it is impossible to report on the total number of participants trained to date. The NCDCA does not maintain information on occupation of participants and maintains incomplete records on agency affiliation of participants. As a result, this information is not included in the present report. Available information on workshops conducted to date is provided in Table 1.

It should be noted that, except in one case, the information reported in Table 1 was obtained from workshop evaluation reports prepared by the local consultant contracted to evaluate workshops. Enrollment figures reported in evaluation reports are not always consistent with registration lists supplied by the NCDCA.

1. Content of NCDCA Training Workshops

A two-phase training program was designed to address training needs for youth and community workers. Community workers includes NCDCA field staff, teachers, police officers, health educators, nurses, and other individuals active in the community. Although mandated in the grant agreement, no established selection criterion has been developed by the NCDCA for selection of workshop participants.

Designated the "Target Hope Program," NCDCA workshops include the following modules:

YEAR 1: Assessing attitudes/values, counselling skills, effective communication, improving interpersonal encounters, family relations, drug prevention information, community mobilization strategies and creative approaches/alternatives to substance abuse.

YEAR 2: Responsible sexual behaviors, preventive health behaviors, family life/family health/family planning; drug abuse and AIDS, effective communication strategies; drug information update, planning and development of drug prevention action plans.

The focus of workshops is essentially the same for all target groups with the addition of peer counseling techniques for youth groups. Local training workshops have

TABLE 1
NCDA LOCAL TRAINING WORKSHOPS

TARGET AUDIENCE	NUMBER OF PARTICIPANTS		
	MALE	FEMALE	TOTAL
<u>1991</u>			
COMMUNITY LEADERS/MIDDLESEX	9	23	32
COMMUNITY LEADERS/CORNWALL	12	19	31
COMMUNITY LEADERS/SURREY	13	18	31
PEER LEADERS/MIDDLESEX	18	17	35
PEER LEADERS/CORNWALL	10	22	32
PEER LEADERS/SURREY	15	18	33
CHURCH LEADERS	8	14	22
JWNYP PARTICIPANTS	NO INFORMATION		
<u>1992</u>			
COMMUNITY LEADERS/MIDDLESEX	15	13	28
COMMUNITY LEADERS/CORNWALL	NO INFORMATION		
COMMUNITY LEADERS/SURREY	14	10	24
PEER LEADERS/MIDDLESEX	16	14	30
PEER LEADERS/CORNWALL	--	--	16
PEER LEADERS/SURREY	NO INFORMATION		

Source: NCDA Secretariat

included all topics identified in the grant agreement for community, youth and frontline personnel, except for training in management and evaluation systems for participants from community small grants. This training was to include training in the maintenance of records on service provision. No training in this area has been provided.

The team agreed that the messages presented by the NCDCA regarding the effects of drug use on the body are not always credible. For example, during a presentation reviewed by the team on the physiological effects of drug use, it was stated that all drugs that are smoked cause lung cancer, bronchitis, and asthma. This has not been supported by scientific evidence. In response to a question from a participant regarding the amount of alcohol sufficient to induce alcoholism, the presenter responded that in some cases a single sip was enough. The presenter also confused the effects of chronic alcoholism, tobacco use, and other drugs stating that the use of these substances leads to lung and stomach cancer. These and similar statements are not based on established evidence and provide inaccurate messages to participants.

2. Training Manuals and Training Materials

The grant agreement calls for four training and evaluation manuals to be developed over the life of the project. To date, only a Peer Counselors Manual has been developed. USAID reviewed the manual and provided comments. A final document incorporating those comments or addressing the issues raised was never sent back to USAID for final approval. The NCDCA reports that it does not know how to incorporate the comments made by USAID/Jamaica and has not, therefore, revised the document. There are no plans for development of other training manuals and the NCDCA Executive Director told the evaluation team that she was unaware that project documents called for other training manuals to be developed.

The grant agreement identifies informational and educational materials, including print and audiovisual materials; e.g., books, pamphlets, training guides, and videotapes, as allowable commodities to be purchased with grant funds. Limited funds appear to have been used for the purchase of such materials. It appears that workshops could have benefitted from them. Some trainers do not appear to be sufficiently well grounded in drug prevention information and in drug counselling techniques, especially peer

counselling techniques. In addition, materials utilized in workshops do not present information in a clear and accessible fashion.

3. Assessment of the Impact of NCDA Workshops

Anecdotal evidence exists regarding the impact of local training. Several participants interviewed during the course of the mid-term evaluation indicated that participation in the workshops has had a positive impact on their community drug prevention activities.

Information supplied by NCDA Regional Managers indicated that the majority of participants in the 1991 Youth and Community workshops are still active in drug prevention activities in their communities.

The grant agreement specifies that technical assistance will be provided to enable the NCDA to evaluate the effectiveness of local training. Local technical assistance has been provided and all workshops (except the 1991 JNYWP workshop) have been evaluated. Evaluation methodology includes administration of pre- and post-tests to participants.

Despite efforts by the NCDA to evaluate its workshops, it is impossible to assess the impact of NCDA workshops. The assessment instrument utilized is an opinion/satisfaction survey and is not sufficiently sensitive to provide valid and reliable measures of participant attitudes, knowledge, or practices. In addition, administration of the pre-tests does not always occur at the outset of the workshop. Failure to administer the pre-test at the beginning of workshops contaminates evaluation findings. Finally, evaluations have not attempted to assess the impact of training on subsequent drug prevention activities of participants.

The present mid-term evaluation is limited to the use of secondary data sources, including existing reports, surveys, site visits and project documents to assess the impact of NCDA workshops. It is impossible to assess the impact of these workshops from these data sources or to determine which category of community leaders, health providers or educators are making the best use of training or whether training has been a catalyst for further demand reduction or prevention measures in the parishes.

B. Overseas Training

To date, 13 individuals have participated in overseas training. All overseas training has taken place at the Caribbean Institute for Alcohol and Other Drugs (CARIAD). The number of overseas trainees by gender and agency affiliation is provided in Table 2. All overseas trainees have been enrolled in either counselling or community drug prevention programs at CARIAD.

TABLE 2

OVERSEAS TRAINEES BY GENDER AND AGENCY

Agency	Male	Female	Total
NCDA FIELD STAFF	4	2	6
UWI - DETOX	1	1	2
UWI - PSYCH WARD	1	0	1
RICHMOND FELLOWSHIP	1	0	1
ADDICTION ALERT	0	1	1
SALVATION ARMY	1	0	1
CORNWALL HOSPITAL	0	1	1
TOTAL	8	5	13

Source: NCDA Secretariat

C. Strategic Planning for Human Resource Development

Technical assistance was provided for the preparation of a training plan. This training plan was not finalized. The grant agreement requires that the Training Plan be revised annually. The NCDA submitted training plans in 1991 and 1992 and USAID approved them. These plans provide information on the proposed training for the year, including number and types of workshops planned, number of participants, parishes represented and costs of each workshop.

These documents do not represent strategic planning documents that indicate training needs, training gaps, proposed training for each area of need, implementation schedule or projected number of trainees and outputs over the life of the project. As a result, the project has operated in the absence of an effective plan for the design and implementation of training program.

D. Conclusions

As indicated above, NCDAs records are incomplete and evaluation mechanisms employed to date do not provide information on the impact of local training. It is impossible to determine from existing records how many trainees have participated in local training workshops or the impact of the training on participant knowledge and attitudes or on subsequent community drug prevention activities.

Training has not addressed the needs of NCDAs staff with respect to enhanced management, planning or evaluation; the needs of community projects with respect to evaluation or management systems or the needs of the drug prevention, treatment and rehabilitation system with respect to training in the development and maintenance of a drug prevention information system or in drug abuse research. Training in these areas is mandated in the project agreement. Although grant funds have been disbursed for training under the information component, these funds have been used to train community, drug treatment, and rehabilitation works in counseling and community prevention strategies.

The project has operated without a strategic planning document. In addition, the NCDAs executive staff appear to be unfamiliar with the requirements of the project with respect to production of training materials.

E. Recommendations

The team has been advised of the findings of the recent draft audit report on the NCDAs. These results are likely to require that an alternate mechanism for project implementation be utilized to meet project goals during the remainder of the project. Utilizing such an alternative mechanism, through funds remaining from the current project (see Appendix D, Project Expenditure Report), the team recommends that project funds be directed to the following

activities under the Development of Human Resources component of the project:

- Provision of technical assistance to assess the impact of NCDAs training workshops financed by the project to date. The remainder of planned workshops, except for the second Church Leaders Workshop should be postponed. Pending the outcome of this assessment funding of further workshops may be considered.
- Provision of technical assistance and training to community organizations supported under the project in appropriate evaluation procedures.
- Provision of technical assistance to conduct a training needs assessment of the drug prevention, treatment and rehabilitation system that reflects training to date and planned training under the present project and the UN Integrated Demand Reduction Project.

IV. COMMUNITY BASED SECONDARY AND TERTIARY PREVENTION ACTIVITIES PROGRAM

A. Overview: Program Intent and Requirements

As part of the project design, it was planned that a sub-grant would be made to a Jamaican non-governmental or private voluntary organization to serve as an umbrella organization to manage a small grants program for community based drug prevention projects. The grant agreement included this component in order to: 1) use the opportunity to expand rapidly secondary and tertiary prevention efforts; and 2) build on an existing base of private sector initiatives. The intent was to ensure the closest possible links with and among grassroots organizations which have direct contact with high risk populations. The types of projects to be supported through these small grants were:

- peer leadership programs operated through community centers or youth clubs;
- development of drug awareness materials (including, for example, plays, music, posters and videos) by high risk group members;
- cultural and sports activities for high risk youth and young adults, coupled with drug prevention and healthy lifestyle education (including voluntary involvement of Jamaican cultural and sports figures);
- peer tutoring of high risk youth to enhance basic skills and encourage completion of formal schooling; and
- referral linkages between community centers and other support systems such as training and employment programs, and with rehabilitation services.

Jamaica Western New York Partners (JWNYP) was selected to serve as the umbrella agency for community based programs. The NCDA entered into a sub-grant agreement with the JWNYP in October 1990.

By mid-1990, the NCDA indicated to USAID that there was no opportunity in the original grant to directly fund small,

community based projects that the NCDA perceived as in critical need and relevant to their implementation plan. Consequently, in September, 1990 USAID amended the Grant Agreement to reallocate US\$50,000 for use directly by the NCDA to fund such small community based projects. The Kingston Restoration Company subsequently received a sub-grant from the NCDA for operation of its Teen Center.

B. NCDA's Understanding of the Community Based Component of the Project

In interviews with the evaluation team, Dr. Winston Davidson, Chairman of the NCDA, stated that: "this is basically a training project." When the issue of NCDA's role in community based programs was raised, he indicated that he was not aware of NCDA's ability to issue grants directly. Mrs. Maureen Haynes, Executive Director of the NCDA confirmed her own understanding of the project stating that "We have responsibility for training, not community based programs under the USAID program."

However, in July 1990, USAID/Jamaica requested Dr. Irene Jillson-Boostrom to provide technical assistance to NCDA to review project design and implementation for the purpose of making appropriate recommendations. At that time, Dr. Davidson and Mrs. Haynes indicated that there was no capability within the project to fund small, community based projects that may be identified by the NCDA as in critical need and relevant to their five year implementation plan. In recognition of the importance of "quick response" funds to support community based prevention projects, the consultant, working with the Chairman, Executive Director, and Chairman of the Project Advisory Committee recommended to USAID that the Human Resource Development component be reduced by US\$100,000 with these funds being allocated as follows:

\$75,000 to the Community Based Intervention Strategies and Special Projects component, with \$50,000 for use directly by the NCDA for "for special projects" in order to provide the NCDA with rapid response capability to undertake community based intervention projects and epidemiologic research as deemed appropriate and immediately necessary and \$25,000 available through the umbrella PVO to allow for increased funding of community based intervention strategies.

The remaining \$25,000 was to be allocated for Improving Drug Abuse Prevention Information. These recommendations were implemented in PIL # 8 dated September 20, 1990.

On several occasions in 1991 and 1992 the NCDA Regional Manager for the County of Middlesex sent requests for funding of community based programs to the Narcotics Assistance Section of the US Embassy or the United States Information Service. These requests were passed on to USAID. USAID responded to the first request of October 1991, and indicated that the NCDA regional manager could submit the request to his own agency for approval under the USAID/NCDA project. Copies of this reply were sent both to the Chairman and the Executive Director of the NCDA. Another funding request from SISTREN was under consideration by the NCDA in 1991.

In October 1991, the NCDA approved a sub-grant agreement for J\$431,5000 to the Kingston Restoration Company to operate a community based Teen Center over a three year period in inner Kingston. In August 1992, the Addiction Alert Organization (AAO) sent a proposal to the NCDA to fund an Adolescent Drug Abuse Prevention Program. At that time the Executive Director of the AAO informed the AID/W official who was the technical advisor designated to assist this evaluation team that she had received a phone call from the NCDA Executive Director who indicated that the project would be funded.

As a result of the increased funding for community based activities, 16 community based projects were projected as project outputs by early 1992.¹ Of these only four are in place. In June 1992, USAID indicated to the Executive Director its concern that no expenditures had been made for this project component for the last two vouchers received and that there was quite a bit of money left in that line item. USAID further indicated that it needed to know why activities were not being funded as planned.

On June 11, 1992, USAID met with NCDA and Jamaica Western Partners to discuss this and other concerns. NCDA responded that they had proposals which they would submit to USAID for approval for additional community project activities.

¹ USAID/Jamaica, Drug Abuse Prevention (Project No. 532-0161)
"Project Status Report: October 1, 1991-March 31, 1992.

The conclusion is that, at the present, NCDAs management states that it does not understand its role with regard to this important aspect of the project.

C. Jamaica Western New York Partners

Jamaica Western New York Partners (JWNYP) is a private voluntary organization. It provides technical assistance for community development through a program of professional exchanges between Jamaica and Western New York. The voluntary contribution of professionals who are registered in a Skills Bank, is the foundation of the partners' voluntary technical assistance service. JWNYP is administered by a 16 member Board of Directors, with an elected chairperson.

The approach to drug prevention adopted by JNYWP is intended to be an holistic strategy to assist young people to handle social, emotional and economic challenges. The JWNYP was contracted to provide two types of local training: vocational skills training programs and training workshops on varied topics including drug information and drug prevention, family relations, sexually transmitted diseases, parenting skills and small business. A total of 12 projects were to be selected for inclusion in the project: three during the first year, four during the second year and five during the third year.

To date, only three community projects have been funded through the JWNYP. Eleven months into the second year of the sub-grant agreement, the JWNYP has not identified projects for inclusion in Year Two.

Projects currently funded under the project include: the Fairy Hill Community Project in Portland, the Harp United Youth Club in West Kingston and the Sheffield All-Age School Youth Club in Westmorland. These communities were identified on the basis of their existing relationship with JWNYP. The JNYWP indicated that previously "successful" projects with existing infrastructure were selected. Projects were selected on the basis of geographical location, rather than on the basis of being in areas where communities were at high risk for drug abuse.

1. JWNYP Training Workshops

The JWNYP provided four 1-day workshops for participants in the three community programs funded under the project. Topics included: Drug Abuse, Starting a Small Business, The Adolescent Physical Development, STDs, Financing a Small Business, Parenting, and Personal Development.

Records indicate that approximately 25 individuals attended each of the four workshops. Exact figures were not documented in records provided to the evaluation team. Evaluations of the workshops were undertaken by JWNYP. However, these evaluations are primarily opinion/satisfaction surveys and do not provide information on participant knowledge and attitudes or the impact of training on participant behavior. The JWNYP is no longer offering training workshops to project participants.

2. JWNYP Skills Training Programs

The JWNYP is responsible for provision of skills training in the community projects funded under the project. Training in paper making and needle work is offered at Fairy Hill. Training in leather craft is provided at Harp United Youth Club and at the Sheffield All Age School Youth Club. Site visits by teams members were made to all project sites. These site visits indicated significant problems.

Supervision of projects by JWNYP is inadequate. The JWNYP proposal, which forms an annex to the sub-grant agreement, stipulates that JWNYP will visit project sites four times per year. The JWNYP has not made a site visit to Sheffield since January 1992, or to the Fairy Hill Papermaking Project in calendar year 1992.

The team was unable to document the number of participants in skills training programs, although site visits indicate that participation in skills training programs is low. There are presently no individuals in training in paper making at Fairy Hill. The number of participants in the needle work program at that project could not be determined. The Sheffield and Harp United have more active programs. However, the numbers in skills training appear to be small. Indications are that less than 15 individuals are in training at two of the three sites and 35 at Sheffield. There is no procedure in place for the assessment of the impact of participation on subsequent drug prevention

activities or on the employment status of participants in skills training programs.

An underlying assumption of the JWNYP approach to drug abuse prevention is that vocational training in combination with training in coping mechanisms, drug abuse prevention and small business management will increase the social and economic well-being of participants and thus reduce their risk of abusing drugs. This approach requires that participants be taught an economically viable skill. Discussions with project participants and with the JWNYP indicates that areas for skills training were selected with insufficient attention to market conditions and that there is insufficient attention to training in product marketing. The economic viability of projects is questionable. In addition, there is no evidence of established curriculum for skills training programs with specified training goals and objectives for skills training programs.

Interviews with two community and one youth representative from the Fairy Hill project indicate that there are no identifiable drug prevention activities in the community. There are more active programs at Harp United and Sheffield. Insufficient linkages exist between JWNYP and NCDA project activities.

D. KINGSTON RESTORATION COMPANY

In October 1991, a sub-grant agreement for J\$431,500 (approximately US\$23,000) was signed with the NCDA through the Office of the Prime Minister and the Kingston Restoration Company (KRC). The objective of the sub-grant is to provide a drug free recreational and educational environment for high risk youth who reside in a marginal area of inner Kingston. The agreement covers the operating costs over a three year period of a Teen Center. In addition to support for the operating costs of the center received through the USAID/NCDA Project, the Bureau for International Narcotics Matters provided funds to restore and equip a building to house the Teen Center.

The KRC is a private non-profit organization established in 1983 for the purpose of restoring a marginal area of downtown Kingston. As a result of its presence in the neighborhood, the KRC has developed a strong rapport with the residents in the area. Drug abuse problems were highly visible and ranged from alcoholism to crack addiction. However, the KRC was particularly alarmed by the sharp

increase in the use of crack over the last few years. Its staff reported that five years ago, crack was only available at a few locations in the community. By 1991, it was readily available on any block in the neighborhood.

The Teen Center is designed to carry out a wide variety of activities including drug education, career counseling and recreational events for 90 youth in the inner Kingston area. To achieve its objective, the KRC has established a youth leader program called the Youth Educational Support System (YESS) which targets high school youth between the ages 12 - 19. This program started with 60 members. It now has 120 young persons and, given the popularity of the program in the area, KRC believes that it could reach as high as 200 teenagers. Many of the participant youth come from families in which drugs are used.

Quarterly reports on the KRC Teen Center indicate that implementation of the program is on schedule. During its site visit to KRC, the evaluation team found the staff to be motivated, dynamic people, dedicated to achieving the objectives of the project and all having experience of direct relevance to the project.

Although it is too early to assess the impact of the Teen Center, its activities appear to have the potential for a positive outcome in terms of drug abuse prevention among the youth involved in its program and in the community at large through the outreach efforts of the program. KRC staff have reported that drugs are no longer dealt openly on the street corners as before the initiation of the program.

It is clear that the KRC program addresses a wide range of risk and protective factors involved in drug abuse. It works to reduce the risk factors that make youth more likely to use drugs and to reinforce the protective factors such as bonding to school and community. In addition to providing a drug free recreational and educational environment for youth, KRC staff monitor academic achievement through a review of each student's report card. As required, this is followed up with meetings with parents and teachers. A program in computer literacy is operating within the Teen Center. Time is also reserved for two hours each day at the Teen Center for a "homework center" during which time the students do their school assignments. Music lessons are provided one afternoon per week. Shortly, teachers will be hired to increase the math and English skills of the students. Youth in this program are also involved in community outreach such as a clean up of Kingston Harbor,

carolling and providing meals for the elderly during Christmas. Mass anti-drug marches have been held by the YESS participants.

E. Conclusions

The small numbers of people being reached by JWNYP activities call into question the cost-effectiveness of the JWNYP approach. In addition, the JWNYP lacks the management capability to meet management and oversight responsibilities with respect to existing projects and to fully undertake contractual obligations. The team, therefore, recommends an orderly wrap-up of this component of the project.

KRC Teen Center represents a comprehensive, community-wide approach to drug abuse prevention based on a risk-focused strategy that has been shown to produce effective results in a variety of social and cultural contexts. The evaluation team does feel, however, that although good process evaluation is being undertaken, a more systematic approach to evaluating the impact of the project is required.

F. Recommendations

The team recommends the following to strengthen the Community Small Grants component:

- Begin an orderly wrap-up of the JWNYP sub-grant. As part of that wrap-up, the team recommends that the requests for training equipment already received by JWNYP from Sheffield and Harp United projects be honored.

The team has been advised of the findings of the recent draft audit report. These results are likely to require that an alternate mechanism for project implementation be

utilized to meet the goals of the project. Utilizing such a mechanism, through remaining project funds (see Appendix D, Project Expenditure Report), the team recommends the following:

- Provide funding for community based secondary and tertiary programs; and
- Provide technical assistance and training to community organizations supported under the project in appropriate evaluation procedures.

V. Improvements in Drug Abuse Prevention Information

A. Current Status

The grant agreement mandated that technical assistance, training, and limited commodity support be provided to NCDA and the NGO or PVO managing the community grants program described above for the ongoing collection and analysis of information useful for decision makers to determine the following:

- 1) the extent and type of drug abuse in Jamaica and
- 2) changes in the need and demand for secondary and tertiary prevention services.

Specifically, technical assistance was to be provided to the NCDA for the design and implementation of small scale epidemiologic studies, including community based studies of cocaine and crack use, review of hospital medical records and emergency room observation. Studies were to provide data which would become part of a Drug Abuse Prevention Information System to be developed and maintained by NCDA. Training for individuals responsible for developing and maintaining the NCDA information system and those responsible for drug abuse research was to be provided.

Despite technical assistance provided in June, 1991, the research component has not achieved any of the above goals. Computers have been received and installed at NCDA and JNYWP. However, use of these computers appears limited to word processing and the project continues to operate without a data base. Efforts to integrate existing medical and social service data, including drug related hospital and emergency room admissions, community mental health worker admissions, etc., into a working drug prevention information system have been limited to the UWI Hospital and have not progressed beyond the initial planning stage. As a result, there continues to be a lack of information to inform decision making for drug prevention, treatment and rehabilitation.

In a debriefing meeting with the evaluation team, the Chairman of the NCDA questioned the team's finding that no significant progress has been made on establishing a drug abuse information data base. After subsequent reassessment, the evaluation team still concludes that the NCDA's efforts to develop an information system are still in the preliminary planning phase. At UWI work has begun to organize the intake data. No other significant progress has been made on development of information systems.

Training in the development and management of a drug prevention information system has not been provided. Individuals funded for overseas study under this component of the project have received training in either community drug prevention services or in counselling. Training in drug abuse research has not been funded.

One study has been conducted to date. The principal conclusions of that study were not accompanied by supporting documentation and the methodological weaknesses of the study compromise its usefulness in providing direction to the project. At meetings of January 10 and April 3, 1992 and in correspondence dated March 13, USAID/Jamaica indicated to the NCDA its willingness to meet with the local contractor who performed the study in order to make recommendations for improvements in the study. In correspondence dated April 3, 1992 the NCDA indicated that it would take responsibility for scheduling this meeting. To date, no meeting has been scheduled.

It was difficult to identify the components of the NCDA infrastructure that could be held accountable for meeting the requirements of this component of the project. The grant agreement stipulates that all project funded studies be coordinated with the Research and Development Committee of the NCDA, however, this committee has been made a subcommittee of the Health and Medical Measures Committee and appears to be dormant.

According to the NCDA Director of Research, her responsibilities with NCDA no longer include the USAID project. Discussions with the NCDA administration, suggested a lack of confidence in the Director of Research. As a result, she appears to have been effectively removed from input into the present project.

B. Conclusions

In our view the project currently functions without a data base. A technical assistance report of June 1991, recommended that the project undertake, as soon as possible, studies to generate the information needed for rational planning.² This recommendation has not been implemented and is still valid.

Given the lack of accurate prevalence data, geographically targeted epidemiological surveys of drug knowledge, attitudes and practices are required. Analysis of secondary data on drug related emergency room, hospital, community health worker admissions, etc., is necessary to enhance planning for secondary and tertiary drug prevention and treatment programs.

Highly focussed, community based, ethnographic studies should be conducted to identify the cultural meanings and the socioeconomic costs and benefits associated with drug abuse. Given the apparent rapid growth of use of crack/cocaine in urban areas consistently reported by those interviewed during the course of this evaluation and since there has already been ethnographic research on ganja use, it is recommended that future studies focus on crack/cocaine. Specifically, an ethnographic study of male crack users will be a useful complement the recent ethnographic study of female crack users that was financed by the INM.³

C. Recommendations

The team recommends the following to strengthen the Drug Prevention Information Component:

- Provide technical assistance for the compilation and analysis of data from medical facilities;
- Provide technical assistance for the conduct of an ethnographic study on male crack uses; and

²Harry Day and William Milsap, "Technical Assistance Report to USAID/Jamaica," June 28, 1991.

³Melanie Dreher and Rebekah Hudgins, "Crack Use and Women in Jamaica," INM, 1992.

- Provide technical assistance for targeted community surveys of drug knowledge, attitudes and practices.
- Provide technical assistance to identify appropriate agency/institution to be responsible for development and maintenance of a Drug Abuse Prevention Information System.
- Provide technical assistance to establish Drug Abuse Prevention Information System.

VI. CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

At least some of the more notable problems in the implementation of the USAID/NCDA Project may be attributable to the lack of fit between the goals of the project and the NCDA's principal priorities, expressed in its Integrated Demand Reduction Strategy (IDER). The IDER approach is based on the social and economic development of communities. The NCDA sees the latter approach, in and of itself, to be a deterrent to drug abuse. While there is much to recommend this position, it does not provide the infrastructure needed for the development of targeted programs addressing high risk populations. The intent of the USAID Project is to assist in the development of these targeted programs.

Economic development is important to overall demand reduction strategies and a comprehensive approach which embraces both direct and indirect strategies is a key issue for success. However, very limited resources are available for demand reduction programs. These limited resources cannot address all the social and economic problems that contribute to drug abuse.

Instead of focusing on high risk populations as identified in the grant agreement, the NCDA has elected a national program organized by parish, without particular reference to high risk populations. Accordingly, many of the participants in the training programs were selected from parish committees in the Integrated Demand Reduction Program. There is no indication that these individuals were located in high risk communities or associated in any way with high risk populations. Consequently, it is difficult to see many of the activities funded under the present USAID project are ultimately translated into the desired, targeted secondary and tertiary prevention programs.

Given the fundamental differences between the project goals and the strategies of the NCDA, it is not surprising that in the final debriefing, the Chairman of the NCDA indicated to the evaluation team and the Director of USAID/Jamaica that the goals of the project are no longer valid. Given these conceptual differences, the lack of progress towards project goals, i.e., to improve the capability of the Jamaican public and private sectors to develop and implement drug abuse prevention programs aimed at high risk target groups,

primarily youth between 12 and 25 years of age, is also not surprising.

The current organizational structure of the NCDA seems insufficient to ensure effective and efficient operation of the Drug Abuse Prevention Project along with numerous other responsibilities of the NCDA. In light of this finding, the goals of the grant agreement appear to have been overly ambitious. This is especially true given the management and administrative limitations of the NCDA at the time the award was made. The NCDA simply did not have the basic infrastructure to effectively cope with the infusion of approximately 25 new staff nor the demands of creating a new project organization within a short period of time. It may be concluded that this has been a case of organizational overload.

As indicated above, NCDA records are incomplete and evaluation mechanisms employed to date do not provide information on the impact of local training. It is impossible to determine from existing records how many trainees have participated in local training workshops or the impact of the training on participant knowledge and attitudes or on subsequent community drug prevention activities.

To date, training has not addressed the needs of NCDA staff with respect to enhanced management, planning or evaluation; the needs of community projects with respect to evaluation or management systems or the needs of the drug prevention, treatment and rehabilitation system with respect to training in the development and maintenance of a drug prevention information system or in drug abuse research. Training in these areas is mandated in the project agreement. Although grant funds have been disbursed for training under the information component these funds have been used to train community, drug treatment, and rehabilitation works in counseling and community prevention strategies.

The project has operated without a strategic planning document. In addition, the NCDA executive staff appear to be unfamiliar with the requirements of the project with respect to production of training materials.

The small numbers of people being reached by JWNYP activities call into question the cost-effectiveness of the JWNYP approach. In addition, the JWNYP lacks the management capability to meet management and oversight responsibilities with respect to existing projects and to

fully undertake contractual obligations. The team, therefore, recommends an orderly wrap-up of this component of the project.

KRC Teen Center represents a comprehensive, community-wide approach to drug abuse prevention based on a risk-focused strategy that has been shown to produce effective results in a variety of social and cultural contexts. The evaluation team does feel, however, that although good process evaluation is being undertaken, a more systematic approach to evaluating the impact of the project is required.

The project currently functions without a data base. A technical assistance report of June 1991, recommended that the project undertake, as soon as possible, studies to generate the information needed for rational planning. This recommendation has not been implemented and is still valid.

Given the lack of accurate prevalence data, geographically targeted epidemiological surveys of drug knowledge, attitudes and practices are required. Analysis of secondary data on drug related emergency room, hospital, community health worker admissions, etc., is necessary to enhance planning for secondary and tertiary drug prevention and treatment programs.

Highly focused, community-based, ethnographic studies should be conducted to identify the cultural meanings and the socioeconomic costs and benefits associated with drug abuse. Given the apparent rapid growth of use of crack/cocaine in urban areas consistently reported by those interviewed during the course of this evaluation and since there has already been ethnographic research on ganja use, it is recommended that future studies focus on crack/cocaine. Specifically, an ethnographic study of male crack users will be a useful complement the recent ethnographic study of female crack users that was financed by the INM.

B. Recommendations

Begin an orderly wrap-up of the JWNYP sub-grant. As part of that wrap-up, the team recommends that the requests for training equipment already received by JWNYP from Sheffield and Harp United projects be honored.

The team has been advised of the findings of the recent draft audit report on the NCDA. These results are likely to require that an alternate mechanism for project

implementation be utilized to meet project goals during the remainder of the project. Utilizing such a mechanism, the team recommends that remaining project funds be directed to the following activities under the current project:

- Provide technical assistance to assess the impact of NCDA training workshops financed by the project to date. The remainder of planned workshops, except for the second Church Leaders Workshop should be postponed. Pending the outcome of this assessment funding of further workshops may be considered;
- Provide technical assistance and training to community organizations supported under the project in appropriate evaluation procedures;
- Provision of technical assistance to conduct a training needs assessment of the drug prevention, treatment and rehabilitation system that reflects training to date and planned training under the present project and the UN Integrated Demand Reduction Project;
- Provide funding for community based secondary and tertiary programs;
- Provide technical assistance for the compilation and analysis of data from medical facilities;
- Provide technical assistance for the conduct of an ethnographic study on male crack uses; and
- Provide technical assistance for targeted community surveys of drug knowledge, attitudes and practices;
- Provide technical assistance to identify appropriate agency/institution to be responsible for development and maintenance of a Drug Abuse Prevention Information System; and
- Provide technical assistance to establish Drug Abuse Information System.

VII. LESSONS LEARNED

Implementation of the Drug Abuse Prevention Project has made limited progress. Significant problems have appeared which bring the project to a critical crossroads. Several operational lessons may be drawn from the experience with this project:

- It is imperative that conceptual issues be clarified during the project design phase to ensure that all parties are working under the same assumptions regarding project purpose, content and structure.
- Project design must adequately reflect the institutional capabilities of the implementing agencies.
- If the institutional capabilities of the implementing agencies are inadequate, appropriate technical assistance should be provided.
- If the project design includes locally provided training in subject areas for which local expertise has not been developed, provide training in the necessary skills required to teach these subject areas; e.g., peer counseling techniques, to a cadre of trainers prior to the implementation of local training.

VIII. FUTURE PROGRAM DEVELOPMENT

The evaluation team has been asked to make recommendations for project components likely to reduce the demand for illicit substances with emphasis on crack/cocaine. A new, more comprehensive project is required to address the growing need for information, education and early treatment interventions by the Jamaican public.

In the following pages of this report the team makes recommendations for components of a new comprehensive project which will have as its goal: "To inform and educate the Jamaican public about the specific effects of drug abuse, and to prevent an increase in the incidence and prevalence of crack use through the establishment of a viable public and private sector information, education, prevention counseling, and early treatment program."

The project as envisioned would have five components:

- 1) Communication and information;
- 2) Early treatment;
- 3) Program support, technical assistance and training for PVOs and NGOs conducting drug abuse prevention activities;
- 4) Research and evaluation; and
- 5) Project management.

A. Communication and Information

The communication and information strategy which follows takes into account the need for multiple interventions to address varied target audiences. The strategy addresses behavioral norms and situational factors which influence the initiation, continued use and cessation of drug use. This strategy will be implemented through the development and dissemination of targeted messages to reach key segments of the Jamaican Public.

1. Mass Media

Mass media will set the stage, create a supportive environment for abstinence from drugs, influence social

norms surrounding drug use, and reinforce positive social and cultural contexts for non-use. A single message should be developed and reinforced through the use of multiple media and continuous exposure. This message should allow for adaptation according to the medium selected. Early indications are that the message should focus on the use of crack/cocaine and the negative influences of the drug on Jamaican society, culture, industry, and families. This will allow the majority, non-using public, to have an achievable, desirable, common goal: to reduce the incidence of crack/cocaine use in Jamaica.

Use of the following media are recommended:

- 1) Television and radio, for commercial announcements to reach the broadest possible audience with repeated exposures.
- 2) Television and radio programming, including news/talk show format as well as popular entertainment vehicles, to reach specific targeted segments of the population.
- 3) Popular music and dance halls, which can effectively reach a key target audience in an alternative and credible manner.
- 4) Theater performances, such as plays and musicals.
- 5) A national, toll-free drug hotline, to provide information, education, and referrals.
- 6) A national drug information clearinghouse, to gather, analyze, and disseminate information including literature on substance abuse prevention and treatment.

B. Early Treatment

The majority of USAID resources should be placed into activities directed towards preventing the onset of drug use. However, there is a need for crisis intervention systems for individuals who are in the early stages of experimentation with drugs and for individuals trying to get off drugs.

It is especially important to incorporate gender specific strategies to address the unique needs of women as well as male drug users. It has been long noted that women using

drugs have special needs that differ from the needs of male drug users. It is also widely known in the addiction treatment community that female drug users present themselves for services in the later stages of addiction and often with more complications than their male counterparts. Preliminary evidence from Jamaica indicates that the drug (crack) careers of women are not necessarily unidirectional trajectories toward increasing addictions. Rather, women may try crack on a number of separate occasions, sometimes months apart, before initiating regular crack use. Furthermore, women often discontinue crack use for months at a time - sometimes at their own volition and sometimes because they have been incarcerated or travelled out of Jamaica. A number of women attribute their initiation to crack use or their resumption of crack use to some personal or family crisis. These periods of pre-regular use and abstinence may represent windows of opportunity for early intervention that could persuade women from pursuing crack use. Evaluation team interviews with a number of providers revealed few existing programs which attend to the special problems of Jamaican women.

These interventions would be designed to provide gender appropriate information and referrals to furnish support to individuals who might otherwise turn or return to crack/cocaine use to deal with the difficult conditions in their lives. The exact nature of these interventions may vary according to the context (community, resources, family structure, etc.) and the socio-demographic characteristics of the individuals themselves. The strategy should, however, include opportunities for immediate attention with possibly a place of temporary refuge for intensive counseling. Whether such "crisis centers" are located within the community or in another accessible location is probably not as significant as having well-prepared staff who can counsel clients effectively. Nevertheless, it would be useful to try various models for delivery of such services and evaluate them accordingly. Possible sites for early treatment interventions are listed below:

- 1) Workplace programs, including, but not limited to employee assistance programs.
- 2) Hotlines.
- 3) Health clinics (e.g., MOH clinics), with trained health care providers able to address issues relating to crack/cocaine use.

- 4) Half-way houses to provide an environment for users attempting to stop who must wait for entrance to one of Jamaica's in-patient rehabilitation facilities, and for those who have finished in-patient treatment and who must now be re-integrated into their respective communities.
- 5) High risk community and school-based support groups which provide a safe environment for children and teenagers to ask questions and discuss family and social circumstances which involve issues of the use of illicit substances.

Any of the above interventions would provide front line service to those most in need. As such, this component will be critical to the success of any project undertaken.

C. Program Support, Technical Assistance and Training for PVOs and NGOs Conducting Drug Abuse Prevention Activities

Activities funded under this component should draw heavily from the private sector. The evaluation team has interviewed individuals from several PVOs and NGOs conducting seemingly effective substance abuse prevention programs which have not been supported through the current Drug Abuse Prevention Project. The team has been impressed with the capabilities of several organizations and feel that added support for these groups would increase the likelihood of their services reaching high risk groups. Examples of such groups include the Addiction Alert Organization, SISTREN, Breakthrough, and the community center in Waterhouse lead by Monsignor Richard Albert (with community outreach activities presently covering over one-third of Kingston's total population). The future project will need to incorporate appropriate program development and support, technical assistance and training for such PVOs and NGOs conducting drug abuse prevention activities to strengthen their capabilities in programmatic and service delivery design, implementation and evaluation.

D. Evaluation and Research

Each of the activities supported under the new project should include mechanisms to evaluate their impact on drug use and knowledge, attitudes and behaviors surrounding the use of drugs. Efforts must be initiated from the outset to

be able to assess program effectiveness during the course of support by the new project.

If the activities mentioned above are not completed under the current Drug Abuse Prevention Project (532-0161) as previously recommended, these activities should be included in the future project with appropriate technical assistance for capacity building for Jamaican professionals. Highly focused, community based surveys and ethnographic studies should be conducted to identify the socioeconomic dimensions and the cultural meanings associated with drug abuse. These could be initiated in a variety of selected communities fairly quickly using small pilots, existing data, focus groups and other rapid assessment techniques. The results of these preliminary studies could be used directly in program formulation and indirectly in the selection of communities for more in-depth, larger scale studies. Given the apparent rapid growth of use of crack/cocaine in urban areas consistently reported by those interviewed during the course of this evaluation, it is recommended that proposed studies focus on crack/cocaine in urban surroundings.

Building on the already existing ethnographic study of female crack use funded by INM, differences noted in the nature and extent of male crack use call for a correlative study of the use of this drug by males. In addition, the differences among communities in the extent and patterns of crack use lend themselves to comparative studies which could reveal the social, cultural, and economic factors which either inhibit or promote drug abuse at the community level. These data would be particularly helpful in establishing the relative cost-effectiveness of different prevention and intervention models within the Jamaican context.

E. Project Management

Project management and oversight will be critical to the success of a future project. Consideration should be given to the contracting of a local/international agency or individual(s) to manage the administration of project funds, oversee the technical aspects of the sub-projects, and be responsible to USAID/Jamaica for the successful and timely implementation of the project.

The project should have at least three operational components: project oversight, project implementation, and project evaluation. While USAID/Jamaica will be the entity ultimately responsible for the project, a project director or mechanism for direction is recommended. Project implementation will be undertaken by Jamaican public and private sector institutions, with domestic and international technical assistance as required.

While each of the five components recommended in the future project represent discrete areas of undertaking, their actual configuration in the final project design and implementation remains to be determined.

Appendix A
LOGICAL FRAMEWORK
DRUG ABUSE PREVENTION PROJECT

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

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APPENDIX A

Project Inputs

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

APPENDIX B

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- Amendment No. 4, September 30, 1991

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JWNYP. Drug Abuse Prevention Project Documents including progress reports, workshop evaluator's reports, and training workshop files.

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Addiction Alert Organization (AAO). "Phase I, Freeman Project Proposal". Kingston, June, 1990.

Stone, Carl. "Ethnographic Study of Drug Use and Drug Trafficking at Seven Locations". (unpublished manuscript) December, 1991.

Stone, Carl. "Update of Drug Use Survey". (unpublished manuscript). December, 1991.

Stone, Carl. National Survey on the Use of Drugs in Jamaica. USAID sponsored survey, 1990.

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Appendix C

LIST OF PERSONS INTERVIEWED

ACOSTRAD

Alfred Braithwaite, Chairman

ADDICTION ALERT

Sonita Abrahams, Executive Director

Jan Lopez

CATHOLIC OPINION

Richard Albert

FAIRY HILL COMMUNITY PROJECT

Paulette Wallace
Paper Producer

Gloria Dorma
Paper Producer

Ann Marie Allison
Participant in NCDA and JNYWP Workshops

HARP UNITED YOUTH CLUB

Frank Bowen
Member

Devon Gordon
Sports Coordinator

Roy Powell
Leader

Raymond Sterling
President and Treasurer

JAMAICA ADVERTISERS ASSOCIATION

Gregory McClure

JAMAICA/WESTERN NEW YORK PARTNERS

Vivien Crawford
Treasurer

Eleanor Jones
Chairperson

Enid Lawrence
Executive Director

John McFarlane
Chairperson Elect

KINGSTON RESTORATION COMPANY

Elizabeth Phillips
Director, Community Development

Donovan Dumetz
Youth Coordinator

Joan Heath
Community Development Officer

Keith Evans
Table Tennis Instructor

Other YESS Program Participants

NATIONAL COUNCIL ON DRUG ABUSE

Delroy Allyn
Consultant for Workshop Evaluation

Hugh Blackwood
Middlesex Regional Manager

Ena Campbell
Director of Research

Winston Davidson
Chairman

NATIONAL COUNCIL ON DRUG ABUSE
(continued)

Maureen Haynes
Executive Director

Egeton Newman
Surrey Regional Manager

Carol Samuels
Director of Training

Violet Smyth-Stevenson
Cornwall Regional Manager

MINISTRY OF HEALTH/AIDS PROGRAM

Althea Adams

Althea Bailey
ACOSTRAD

Phyllis Clarke
AIDS Hotline

Howard Daley
UWI-Detox Unit

Kathy Little

Ian McKnight
Family Centre

Kenny Sammon
Jamaica Aids Supports

Peter Weller
Family Health International/AIDS CAP

Audrey Wilson
National AIDS Control Program

SALVATION ARMY

Federico Craig, Director of Welfare Services

Colonel Edwards

SISTRIN

Laura Finnikin

SCHEFFIELD ALL-AGE SCHOOL

Mr. Spragg
Principal

Sarah Willis
Leather Craft Instructor

SOCIAL DEVELOPMENT COMMISSION

Claudette Roberts
Portland Parish Manager

LITTLE PEOPLE

Cathy Levy

Joe Robinson

USAID/JAMAICA

Betsy Brown
Director
Office of Health, Nutrition and Population

Robert Queener
Mission Director

Marjorie Lewis
Controller

Kathleen MacKay
Project Officer

Heather Royes

Marilyn Zak
Mission Deputy Director

US EMBASSY

Lynn Allison
Political Section

Walter Davenport
INM

Virginia Ferris
USIS

Jerome Harris
DEA

Glen Holden
Ambassador

Lacy Wright
DCM

Steven Widener
DEA

U.S. PEACE CORPS

Ann Conway

Elizabeth Ramesar

DRUG ABUSE PREVENTION & CONTROL - 532-0161
EXPENDITURE REPORT

EL	NAME	COLUMN A TOTAL LOP AMOUNG	COLUMN B OBLIGATED/EARMARKED	COLUMN C DISBURSED	COLUMN D (B-C)=D BALANCE OF FUNDS REMAINING IN FY 92	COLUMN E OUTSTANDING ADVANCES REMAINING	COLUMN F (A-B)=F OUTSTANDING LOP AMOUNT
01	Development of Human Resources	182,000.00	166,552.00	110,847.00	55,705.00	22,904.00	15,448.00
	PIL #19 - 3-day workshops					5,000.00	
	PIL #11 - Workshops & Ethnographic Studies					994.00	
	PIL #21 - Trng for 1992					16,910.00	
02	Community Based - Small Grants	215,000.00	150,896.00	14,655.00	136,241.00	21,506.00	64,104.00
	PIL #14 - KRC					21,506.00	
03	Improvement in Drug Abuse Information	61,000.00	61,000.00	31,518.00	29,482.00	0.00	0.00
04	Administration	0.00	0.00	0.00	0.00	0.00	0.00
05	Audits & Evaluation	25,000.00	10,000.00	0.00	10,000.00	0.00	15,000.00
06	Contingency & Inflation	17,000.00	12,000.00	0.00	12,000.00	0.00	5,000.00
	TOTALS	500,000.00	400,448.00	157,020.00	243,428.00	44,410.00	99,552.00

date - 09/25/92

APPENDIX D

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DRUG ABUSE PREVENTION AND CONTROL
SCOPE OF WORK
FOR EVALUATION

I. BACKGROUND

The Drug Abuse Prevention and Control Project is a five year Grant with the National Council on Drug Abuse (NCDA). The NCDA is a sub-unit of the Office of the Prime Minister. Two other sub-receptients, Jamaica Western Partners (JWP) and Kingston Restoration Corporation (KRC) all implement elements of the project. The Project was authorized in September 21, 1984 for US\$500,000 and is now in its third year of operation. This evaluation will be the first evaluation of the project since its authorization.

1. Public Policy with Regard to Drug Abuse

In the late 1980s, the GOJ targeted drug abuse as a priority area of concern. The National Council on Drug Abuse (NCDA), established in 1984, is the administrative vehicle for coordination of the government's response to drug abuse. The NCDA, a quasi-governmental body, reports to the Office of the Prime Minister. The NCDA has a 15 member Advisory Board comprised of the Ministries of Health and Education, as well as representatives of the private sector. The NCDA's five-year plan (promulgated in 1989) includes several key areas of emphasis: research and development, community-wide institutional strengthening, dissemination of information, legal reform, security (i.e. supply and distribution of drugs), rehabilitation, alternative occupations, and international cooperation. The NCDA has a staff of 24 individuals and focuses its activities on regional (parish) - level activities.

Since 1989, the NCDA's demand reduction policy has centered on community-based activities within the framework of an "Integrated Demand Reduction Strategy". This strategy, which has been implemented throughout the island has included a wide variety of educational and prevention activities involving broadly representative organizations at the community and national levels. This approach seeks to address the underlying causes of drug abuse (e.g., unemployment or under-employment and illiteracy) at the same time as it implements drug education and prevention activities. The NCDA has also worked with the private sector in its activities to raise issues of policies with respect to prevention of drug use in the private sector (e.g., coverage of treatment of drug abuse or work place personnel policies).

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2. Drug Abuse Prevention Programs

Over the past few years both the public and private sectors in Jamaica have developed and implemented a wide range of prevention activities throughout the island.

Overall, the types of drug abuse prevention activities which have been carried out in Jamaica since 1989, and the public and private sector organizations which have been involved, include:

- * conduct of community-wide training and planning workshops throughout the island and production and distribution of printed drug education materials by the NCDA, related to their Integrated Demand Reduction Project;
- * school-based drug abuse education, carried out by the Ministry of Education (MOE) with funding from the United Nations (UN) and other sources;
- * mass media public service announcements and other drug prevention programs, sponsored by public and private sector organizations;
- * youth peer training and counseling through community-wide projects operated or supported by the Ministry of Youth and Community Development (MOYCD), the NCDA, and JWP;
- * comprehensive and varied prevention activities targeting youth in Jamaica, carried out by local non-Government Organizations (NGOs) such as the Scout Association of Jamaica, Red Cross, and Boys' Brigades;
- * outreach and secondary/tertiary counseling of adolescent drug users, by Addiction Alert; and
- * family counseling by Addition Alert, Richmond Fellowship and the Salvation Army.

To date no systematic evaluation has been carried out which could identify which prevention projects have been relatively more successful or which could serve as models for future programs in Jamaica. However, it may be useful to list a few variety of prevention activities implemented in Jamaica.

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- * In inner Kingston, the Kingston Restoration Project (started in the mid-1980s) has operated a Teen Centre since October, 1991. The Centre carries out a wide variety of activities (including, for example, drug education, career counseling and recreational events) for 90 youth in the inner Kingston area. In January the Centre received approval for a total of J\$207,698 from INM and J\$431,500 from U.S.A.I.D. through the NCDA. The INM funds have been used to restore and equip a building which had been used as a community center and office. The U.S.A.I.D./NCDA funds are to be used for operating costs over a three year period.
- * The Freeman Project, operated by the Addition Alert Organization, includes educational sessions provided for target groups, including adolescents and family intervention counseling. It is largely (through not exclusively) funded through public and private sector donations from the U.K.
- * National Drug Awareness Week is organized annually by the NCDA and sponsored by multiple donors (including the United States Government (USG)). This series of events is planned and carried out at the parish and national level and has involved participants (and donors) from the U.S., Caribbean and European countries.
- * SISTREN is an internationally renowned, independent women's cultural organization founded in Kingston in 1977. The multi-media work of SISTREN often includes discussions regarding drug abuse as part of its self-esteem educational and training activities targeting working class women in Jamaica.
- * The Joint Trade Union Research Development Centre (JTURDC) has included as part of its training of union shop stewards early detection and referral for drug abuse. JTURDC also provides on-going education and information for members.

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II. PURPOSE

To assess project accomplishments in the areas of training research and community development and to identify what future training, service delivery, and research needs are the most likely to have an impact on reducing demand for narcotics.

III. EVALUATION OBJECTIVES

The specific objectives of this external evaluation are to highlight the lessons learned from the project in terms of what is working in demand reduction. The evaluation should also serve to review the project's impact in changing the attitudes and practices of consumers toward the use of illegal drugs.

The evaluation will assess the relative merits of the various approaches to demand reduction currently being implemented including training of providers, youth programs, vocational training for high-risk groups and peer counseling. Based on this review the evaluation should highlight the most successful mix of program strategies and areas for future program development.

IV. SCOPE OF WORK

The contractor will provide a four person team consisting of a clinically trained substance abuse specialist, a local training evaluation specialist, a substance abuse research specialist and a narcotics communications specialist. Additionally, AID/W will finance the participation of a demand reduction officer to assess the project's management structure.

1. Training:

The training assessment should include a review of project-funded provider training, peer counseling, training for out of school youth and school education.

a) Evaluate the impact of these training programs. How many participants are actively involved in demand reduction programs? How has the training been linked to drug abuse prevention services?

b) Is it possible at this juncture to determine which category of community leaders, health providers or educators are making the best use of training.

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c) Has training been a catalyst for further demand reduction or prevention measures in the parishes?

2. Youth Programs:

The multi purpose teen centers have been financed to create drug free recreational environments for high risk urban youths.

a) Have substance abuse messages been adequately incorporated into these programs?

b) How have young adults been mobilized to combat drug abuse? What lessons can we learn from these experiences?

c) NCDA has trained a network of youth counselors. What is the role of these counselors? How can this network be mobilized to raise awareness and change behaviour?

d) Based on a review of the Jamaica Western Partners experience, what has been the impact in terms of drug abuse prevention in communities where JWP vocational skills training is available?

3. Communications/Promotion:

The Project currently does not have a discreet communications component, yet has employed mass media to promote peer counselling, and specific events. Based on a review as to what the Project has done and a review of the U.N. funded communications component, what other face-to-face or mass media communications strategies should the project finance?

4. Research:

What types of evaluative and behavioral research are needed to assess the program and monitor behavior change. How can the project make better use of existing data from rehab facilities on client profiles and recovery rates to enhance demand reduction programs.

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5. Early Treatment Programs:

Although the Project has currently focused its prevention messages on high-risk youth, if funds were made available through A.I.D. on an experimental basis for early treatment programs what would be the most cost effective use of these resources?

6. Project Management's Structure:

Assess the organizational structures. Are the lines of activity and communications between the NCDA and sub-receptients clearly delineated? Do community groups working in demand reduction have relatively easy access to Project funds? How can the Project be structured to assure that community interventions are adequately financed?

V. METHOD AND PROCEDURES

The Evaluation team will draw upon existing reports, surveys and site visits to assess the performance of the Drug Abuse Prevention Project. The evaluation team will utilize project documents available from USAID and the NCDA to assess project outputs, as well as interviews with project and sub-project personnel.

The final evaluation report will incorporate the following format:

- Executive Summary
- Table of Contents
- Body of the Report organized into findings, conclusions and recommendations
- Appendices

VI. REPORTS

The draft report should be submitted to USAID and NCDA one week after completion of the evaluation. The final report will be submitted within two weeks of receipt of the draft report incorporating comments from USAID, the NCDA and other sub-receptients. In addition, the evaluation team will complete the abstract and narrative sections of the USAID evaluation summary form. The team will be expected to prepare a debriefing for USAID, NCDA and sub-receptient staff during the course of the evaluation.

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VII. TEAM QUALIFICATIONS

A four person technical team consisting of a locally hired training/education specialist; a clinical substance abuse specialist (team leader); a communications specialist and a substance abuse evaluation specialist should be identified. All candidates should have graduate level training in their respective areas and substantial demonstrated experience in substance abuse and demand reduction programs.

VIII. TERM OF PERFORMANCE

September 7 - 30, 1992

IX LEVEL OF EFFORT

Assumption is the team leader would be allocated 24 days which includes report writing while the other team members would work for 18 days each.

Consultant Time:	18 days x 3	= 54 days
	24 days x 1	= <u>24</u> days
Total Consultant Time		= 78 days

(A six day work week is authorized).

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APPENDIX F

Drug Abuse Prevention Concepts

Among drug abuse professionals, primary prevention is generally understood to refer to those programs which aim at providing information, education and resistance skills to those who are vulnerable to drug abuse before the appearance of signs and symptoms of the problem. Primary prevention focuses on reducing the incidence of drug use by new users. It also includes providing activities and services to strengthen individual capabilities to reject drugs. Offering teenagers alternative drug-free environments, social events, and promoting healthy approaches to choosing not to use (for example, building self-efficacy or resisting peer pressure) are primary prevention efforts.

Secondary prevention aims at identifying in the early stages of experimentation with drugs and providing them with educational and counseling services to persuade them to cease experimentation and engage in alternative healthier behaviors.

Tertiary prevention aims at ending compulsive use of drugs through treatment and rehabilitation (including medically-based pharmaceutical therapy and in-patient treatment) and providing them with adequate after-care services, in order to sustain drug-free behaviors and to prevent relapse.

In real life situations, differentiating between primary prevention, secondary prevention and treatment (tertiary prevention) can sometimes be confusing. The distinctions depend on when the individuals are identified as at risk and how soon preventive actions are taken. For example, actions taken long before problems arise for children of alcoholics (generally considered a high-risk group) would be considered primary prevention. However, if preventive action occurs shortly before a suspected problem arises or is first identified (e.g. school absenteeism) then it can be debated whether this activity is prevention or early treatment. Many prevention experts consider the concept of prevention, in its purest sense to be synonymous with primary prevention.

It should be noted that the Drug Abuse Prevention Project discounts primary prevention and has elected to focus on targeted, community-based program efforts of secondary and tertiary prevention (but excluding medically-based in-patient treatment programs).