JAMAICA FINAL REPORT

October 1998 to September 2005

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT

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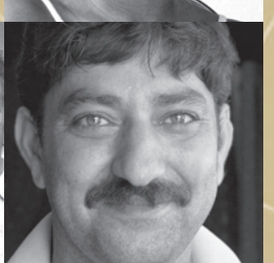
Family Health International

Impact Implementing AIDS Prevention and Care Project

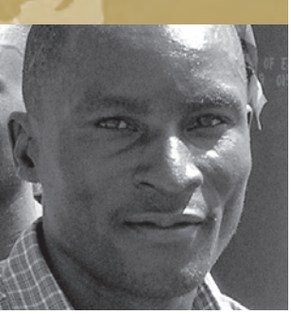












Final Report

for the

Implementing AIDS Prevention and Care (IMPACT) Project in

Jamaica

Impact Implementing AIDS Prevention and Care Project

October 1998 to September 2005

Jamaica Final Report

Submitted to USAID

By Family Health International

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GLOSSARY OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
ASHE	Ashe Caribbean Performing Arts Ensemble and Academy
BSS	Behavioral surveillance survey
CA	Cooperating agencies
ERTU	Epidemiology Research Training Unit
FHI	Family Health International
HIV	Human immunodeficiency virus
ICI	Informal Commercial Importer
IMPACT	Implementing AIDS Prevention and Care Project
M&E	Monitoring and evaluation
MOH	Ministry of Health
MRSL	Market Research Services Limited
MSH	Management Sciences for Health
MSM	Men who have sex with men
NACP	National AIDS Control Program
NGO	Nongovernmental organization
PLHA	People living with HIV/AIDS
SW	Sex worker
STI	Sexually transmitted infection
TA	Technical assistance
TOT	Training of Trainers
VCT	Voluntary counseling and testing
USAID	U.S. Agency for International Development
UWI	University of the West Indies

EXECUTIVE SUMMARY

From October 1998 to September 2005 the Implementing AIDS Prevention and Care (IMPACT) Project, managed by Family Health International (FHI), helped Jamaican partner organizations improve the reproductive health of youth. Activities included an evaluation of adolescent health interventions, a Behavioral Surveillance Survey (BSS) for vulnerable groups and an assessment of public health sector sexually transmitted infection (STI) clinics.

IMPACT/Jamaica helped design the evaluation process for a youth health intervention program sponsored by USAID called FOCUS on Young Adults (FOCUS). Implemented by the Addiction Alert Organization (AAO), FOCUS targeted adolescents in Kingston, Jamaica. Later, IMPACT/Jamaica selected a local market research group, Market Research Services Limited (MRSL), to conduct a BSS that included data on in-school and out-of-school youth, sex workers (SWs) and informal commercial importers (ICIs). Public health and HIV/AIDS programs in Jamaica received copies of the final reports for these two activities.

Partnering with the Epidemiology Research Training Unit (ERTU) of the Ministry of Health (MOH), IMPACT/Jamaica also helped conduct an assessment of the quality of STI case management. ERTU and IMPACT/Jamaica compared these findings with results of two earlier baseline assessments of STI facilities and quality of STI case management that had been conducted in the Jamaican public sector in 1991 and 1996, also with FHI's help. The comparison measured the impact of case management improvements made by the MOH over time and helped the U.S. Agency for International Development (USAID) and the MOH better plan future STI program interventions.

IMPACT/Jamaica allocated remaining funds to support the Ashe Caribbean Performing Arts Ensemble and Academy (ASHE), a nonprofit organization comprising performers, peer educators and teachers of the arts who specialize in using the performing arts to inform youth about social issues.

PROGRAM STRATEGIES, IMPLEMENTATION AND RESULTS

Introduction

From 1998 to 2005, IMPACT/Jamaica launched initiatives designed to further USAID's goal of improving the reproductive health of Jamaican youth. Using more than $350,000 of program funding provided by USAID, IMPACT/Jamaica invested most of its time and resources in building the technical and program management capacity of implementing partners by helping them plan, execute and document program activities. Local research groups, such as Hope Enterprises Ltd. and MRSL took part, as well as USAID and the ministries of health and education.

Country Context

Jamaica's History and Background
Jamaica is a small island nation in the Caribbean with an estimated population of about 2.7 million and a land area of nearly 11,000 square kilometers. The Spanish settled in Jamaica in the early 16th century and gradually exterminated the native Taino Indians, who had inhabited the island for centuries. They were soon replaced by African slaves. In 1655, England conquered the island and established a plantation economy based on sugar, cocoa and coffee. Over time, Jamaica obtained increasing independence from Britain, and in 1958 joined other British Caribbean colonies in forming the Federation of the West Indies. Jamaica gained full independence in 1962 when it withdrew from the federation.

Jamaica's political system is stable, although the country's economic problems include high unemployment, underemployment and growing debt. The Jamaican economy is heavily dependent on services, which account for approximately 60 percent of GDP. The country continues to derive most of its foreign exchange from remittances, tourism and bauxite/alumina.

HIV/AIDS in Jamaica

HIV seroprevalence in Jamaica increased greatly in the 1990s. An estimated 9,900 Jamaicans were living with HIV/AIDS at the end of 1999.

HIV/AIDS is transmitted primarily through sexual activity (61 percent of cases from 1982 to 2000 were transmitted via heterosexual contact), but mother-to-child transmission has also become a rising concern (8 percent of cases from 1982 to 2000). Homosexual/bisexual contact accounts for 6 percent of cases reported during this time frame. Data for pregnant women shows that HIV seroprevalence increased from 0.3 percent in 1991 to 2 percent in 1996. The highest seroprevalence rates are among SWs (approximately 20 percent), men who have sex with men (MSM) (approximately 25 percent) and STI clinic attendees (approximately 7 percent).

The National Response to HIV/AIDS in Jamaica

In response to the epidemic, USAID helped the MOH implement its HIV/AIDS/STI Prevention and Control Program from 1988 to 2001. The program's initial goal was to reduce HIV/STI transmission and the incidence and prevalence of STIs. Activities focused on strengthening three key areas: 1) the MOH HIV/AIDS/STI surveillance program; 2) public education programs; and 3) interventions for vulnerable groups.

Program Strategies and Activities

As stated previously, IMPACT/Jamaica's primary objective was to support local organizations implementing activities leading to improved reproductive health among youth. Primary activities and accomplishments during the course of the project are highlighted below.

Evaluation of Adolescent Health Interventions

In 1999, IMPACT/Jamaica worked with partners to evaluate AAO's adolescent drug prevention program.

A Jamaican NGO, AAO had been conducting a school-based drug prevention project among adolescents in Kingston in collaboration with local partners, including the Ministry of Education and the USAID-supported project FOCUS.

Designed to promote a healthy, drug-free lifestyle, the AAO project involved classroom interventions implemented throughout one semester to seventh- and eighth-grade students (ages 12-14) in pre-selected secondary schools in Kingston. It employed participatory methodologies such as song, dance, drama, and question and answer sessions conducted by trained adolescents.

A team from IMPACT/Jamaica, FOCUS on Young Adults, USAID and AAO convened in January 1999 to design a plan for evaluating the AAO program's impact. It would measure what changes, if any, in knowledge, attitude and risk behavior occurred in students exposed to the AAO intervention compared with those in control schools. The assessment methodology involved pre- and post-tests conducted at selected intervention and control schools.

Together with FOCUS, IMPACT/Jamaica developed and pre-tested the evaluation instrument. Hope Enterprises Ltd., a local research group, carried out the baseline impact assessment. They selected seven intervention schools and seven control schools, with more than 1,900 students participating. IMPACT/Jamaica maintained a close link with Hope Enterprises Ltd. and the

Ministry of Education throughout the data collection period and helped analyze data and write the final report. The report presenting the baseline findings was delivered in FY 2000. Below are highlights:

Family and Community

- The majority of students (approximately 70 percent) reported having a "very good" or "good" relationship with their parents.
- Approximately one-quarter of boys and girls reported having been badly beaten by a member of their household.

Drug Use

- Alcohol, marijuana and cigarettes were the three drugs reportedly used most often in neighborhoods and by friends.
- The substance used most often by students was alcohol (35 percent).

Sexual Experience

- A majority of boys (54 percent) and a minority of girls (12 percent) reported having had sex, with boys having sex earlier than girls.
- More than half of sexually active students did not use any form of contraceptive during their last intercourse. Among those who did, the method of choice was the condom.

Awareness of HIV/AIDS

- A majority of boys and girls (approximately 83 percent) was aware of HIV/AIDS.
- A majority of students displayed appropriate knowledge of HIV/AIDS and methods of prevention. Knowledge increased by grade.

Behavioral Surveillance Survey for Youth

In March 1999, IMPACT/Jamaica, in collaboration with the MOH and USAID/Jamaica, developed the draft protocol for a BSS and identified preliminary target groups for the study. The purpose of the survey was to provide previously unavailable data that would enable the MOH and its partners to begin tracking behavior, measure the impact of HIV/AIDS interventions and plan future programs.

IMPACT/Jamaica contracted a local research agency, MRSL, to conduct the BSS. In coordination with the partners, four target groups were selected, including male and female youth 15-17 years old (both in- and out-of-school), female SWs and ICIs.

IMPACT/Jamaica helped MRSL by documenting research methods and developing an analysis plan and review of report guidelines and format. IMPACT/Jamaica and the MOH identified the National Behavior Change Coordinator as the official counterpart from the MOH for the BSS. The coordinator was trained as a supervisor and took the lead in conducting the mapping exercises. The coordinator worked closely with MRSL in all stages of the BSS.

IMPACT/Jamaica also hired a consultant to work with MRSL to develop a plan to identify additional respondents in order to reach the target numbers. IMPACT/Jamaica also provided technical assistance (TA) in the development of the final report, which was completed at the end of FY 2001.

BSS Study Findings
The table below is taken from the BSS and provides an overview of the number of individuals from each target group involved in the study.

	In-school youth	Out-of-school youth	ICIs	CSWs
Total contacted	3,438	3,108	1,832	789
Total agreed (%)	2,802 (82%)	2,642 (85%)	1,175 (68%)	686 (87%)
Total completed (%)	2,719 (97%)	2,527 (96%)	1,109 (94%)	660 (96%)

Below are some highlights from the report:

HIV/AIDS and STI Awareness

- The findings showed that general awareness of HIV/AIDS was high among all four surveyed populations. However, knowledge about specific aspects of disease prevention and transmission was lacking, particularly regarding ways HIV *cannot* be transmitted.
- General STI awareness was high as well, but knowledge of specific STI symptoms among youth was limited.

Awareness of Condoms and Condom Use

- Awareness of condoms and knowledge of correct condom use was very high, but consistent condom use was low, even among high-risk individuals.
- The majority of SWs had paying and non-paying sexual partners, and almost one-quarter of SWs indicated inconsistent condom use.

Alcohol Use

- Alcohol use was common among youth, and was associated with higher levels of sexual activity and lower levels of condom use.
- Approximately 38 percent of in-school youth and 44 percent of out-of-school youth drank alcohol during the month before the interview.

Sexual Behavior

- The study showed that males began sexual activity at younger ages than females and were more likely than females to be sexually active and have multiple sexual partners.
- In-school youth engaged in less sexual behavior than out-of-school youth, but some patterns differed by age and gender.

Assessment of National STI Services
In 1991, the U.S. Centers for Disease Control and Prevention worked with FHI and the Epidemiology Unit of the Jamaican MOH to conduct a baseline assessment of the quality of STI case management in the Jamaican public sector. In 1996, the assessment was repeated during FHI/AIDSCAP in order to gauge improvements in STI case management. In June 2001, USAID/Jamaica asked IMPACT/Jamaica to conduct another follow-up assessment.

Collaborating with the MOH's ERTU, IMPACT/Jamaica conducted a facility assessment survey in 16 public STI service units throughout the country. The facilities were visited by two observers who assessed the clinics' ability to provide STI services (including an inventory of STI drugs). The observers also conducted exit interviews of patients who had received STI care, spent two days observing clinical practice and interviewed health care providers. The STI facility report was completed in January 2002 by the University of the West Indies (UWI) and MOH

researchers and reviewed by IMPACT/Jamaica technical staff and consultants. The final report was completed in March 2002.

Ashe Caribbean Performing Arts Ensemble and Academy
IMPACT/Jamaica worked with ASHE, a non-governmental creative arts organization made up of performers, peer educators and arts teachers. Consultants specializing in institutional capacity building helped ASHE develop a mission statement, document institutional goals and policies that govern their operations, and develop a strategic plan for the long-term financial sustainability of its projects. IMPACT/Jamaica helped ASHE produce an educational video on pregnancy and STI/HIV/AIDS prevention. IMPACT/Jamaica also supported the troupe's trip to the Bangkok AIDS conference.

Implementation and Management

During IMPACT activities in Jamaica, FHI did not maintain a permanent presence in country. Because of the relatively small scale of activities in Jamaica, planning and implementation were managed from the Institute for HIV/AIDS headquarters in Arlington, Va.

Implementing partners were selected for the activities, and funds were allocated to them through subagreements. IMPACT/Jamaica signed three subagreements with local research groups, including Hope Enterprises Ltd., MRSL and ERTU.

Senior program officers from FHI/Arlington and FHI/North Carolina traveled to Jamaica to help implementing partners as needed. IMPACT/Jamaica also hired consultants at different stages to provide support. Constraints to effective implementation included the lack of country office staff and the lack of capacity in country.

Jamaica Program Timeline

ACTIVITIES	1998				1999				2000				2001				2002				2003				2004				2005			
Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Addiction Alert Evaluation																																
Developed evaluation design																																
Signed subagreements with Hope Enterprises																																
TA in training interviewers																																
TA in data analysis and report writing																																
Final report dissemination workshop																																
BSS Assessment																																
Finalized BSS instrument																																
Finalized subagreement with MRSL																																
Trained supervisors and interviewers																																
Field tested and finalized BSS questionnaire																																
Submitted summary budget for BSS mission																																
TA in data analysis and report writing																																
MRSL presented preliminary BSS data to MOH																																
MRSL agreement extended to May 2001																																
MRSL and IMPACT resolved sampling for in-school youth																																
MRSL retrained and deployed interviewers																																
In-school survey completed																																
MRSL agreement amended through July																																
Final edits for BSS report																																
Preparation for dissemination presentation																																
Dissemination workshop for BSS																																
Executive summary of BSS disseminated																																
STI Facility Assessment																																
Signed subagreement with ERTU																																
STI report received by IMPACT from UWI and MOH																																
Final report completed																																
Ashe Caribbean Performing Arts Ensemble																																
Trip to Bangkok for AIDS conference																																
TA in management and planning																																
Strategic positioning/mission/goals																																

Program Results

Program outputs include the following:

- IMPACT/Jamaica supported development of *Addiction Alert Adolescent Program Evaluation: Baseline Report*, which was disseminated in the final quarter of FY 2000.
- IMPACT/Jamaica supported development of a final report titled *The Behavioral Surveillance Survey I*, which was disseminated in February 2002.
- UWI and MOH researchers completed the STI facility report in January 2002. It was reviewed by IMPACT/Jamaica technical staff and consultants.

These reports, along with lessons learned during the implementation process, were issued for use by the local government, local NGOs and the local mission to improve future programming of HIV/AIDS/STI interventions and to plan future interventions.

LESSONS LEARNED AND RECOMMENDATIONS

Recommendations for Youth Prevention Programming

- Target persons whose friends are involved in marijuana and alcohol use when developing future integration strategies (students whose friends engaged in activities such as smoking marijuana and drinking marijuana tea were significantly more likely to report low self-esteem and anti-social behavior).
- Consider the impact of home environments on alcohol and drug use among youth in future strategies (alcohol and cigarette use by other members of the household significantly increased the risk of alcohol and cigarette use by youth).

Recommendations for Use of BSS Data to Foster the Design and Implementation of SBC Programs

- Integrate BSS among vulnerable groups such as SW, MSM, youth, fishermen and beach boys into national surveillance systems.
- Promote specific aspects of HIV prevention, including the effects of correct, consistent condom use; monogamy; and abstinence.
- Dispel misconceptions about HIV transmission, including those concerning mosquito bites and meal-sharing.
- Improve knowledge about specific aspects of mother-to-child transmission of HIV, including the potential for transmission of the virus both during pregnancy and through breastfeeding in the postpartum period.
- Encourage delayed sexual debut among teenage boys and girls.
- Emphasize the risks of multiple and concurrent sexual partnerships and promote reduction of the number of sexual partners among youth and adults, especially males.
- Promote consistent condom use among youth who engage in sex for the exchange of money or with non-regular sexual partners.
- Address the associated risks of alcohol consumption and risky sexual behavior.
- Devote greater attention and support to youth, especially hard-to-reach, out-of-school youth, regarding issues of sexuality, sexual risk behavior and condom use.
- Devote greater attention and support to SWs and their clients to ensure that condoms are used correctly and consistently.
- Build the capacity of national entities to improve quality of data collection, analysis, dissemination and use.

Policy and Advocacy Recommendations

- Devote greater attention and support to youth, especially hard-to-reach, out-of-school youth, regarding issues of sexuality, sexual risk behavior and condom use.
- Try to ensure that SWs and their clients use condoms correctly and consistently in commercial or transactional sexual behavior.

Recommendations for Improving STI Facility Evaluations

- Evaluate the prototype for the STI clinic for SWs established in Montego Bay and extend it to other areas of activity involving SWs. These could include Negril/Savanna-la-Mar (western region), Ocho Rios/St. Ann's Bay (northeast region), and Comprehensive (southeast region). Identify and incorporate male sex workers into these activities.

- Ensure that nurse practitioners receive continuing education so they develop and maintain appropriate skills in STI care.
- Explore and address through counseling the reluctance of male health care providers to physically examine male patients.
- Evaluate the cost-effectiveness of running specialty STI clinics at health facilities that receive five or fewer patients per week. It may be more appropriate to integrate these services into general medical clinics.

HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES

Organization	Organization Type	Geographical Location	Target Population	Budget (in US$)	Intervention	Project Dates
Epidemiology Research Training Unit	Government	Kingston	STI facility clinics	31,116	STI facility assessment	08/01-03/02
Market Research Services, Ltd.	NGO	Kingston	In-school & out-of-school youth, 15-19 yrs., ICIs, FSWs	87,141	BSS	09/99-07/01
Hope Enterprises, Ltd.	NGO	Kingston	Youth	21,212	Evaluation of Addiction Alert project	04/99-09/00

ATTACHMENT

Jamaica Program Financial Summary

Since October 1998, USAID/Jamaica has committed $354,865 in program support funds to FHI's IMPACT/Jamaica project, of which $142,719 was allocated for subprojects. There were no funds allocated in FY02, FY03, FY04, or FY05. Activities since FY02 have been funded from the remaining pipeline.

Total project expenses as of September 2005 were $352,019.

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