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**STRATEGIC AND IMPLEMENTATION PLAN FOR  
HIV/AIDS PREVENTION AND CONTROL IN JAMAICA**

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT  
KINGSTON, JAMAICA**

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## 1. EXECUTIVE SUMMARY

The purpose of this document is to propose HIV/AIDS prevention strategies to expand USAID funded AIDS prevention activities in Jamaica. This document describes technical strategies to best prevent the spread of HIV and then applies them to selected target groups. Proposed strategies and activities are designed to build upon ongoing USAID activities.

The AIDS/STD Prevention and Control Project (532-0153), referred to as the Project Paper, was initiated in 1988 by USAID to address the growing HIV/AIDS epidemic and the accompanying dramatic increase in other sexually transmitted diseases (STDs) in Jamaica. The original project had two strategic objectives:

- o Measure and monitor the extent of the AIDS epidemic
- o Prevent and control the spread of HIV and other STDs island-wide.

An amendment to the Project Paper in 1992 recast the original project and extended it for an additional four years. The amendment added a focused strategy that concentrated on three key interventions:

- o Expand and improve access to condoms
- o Encourage reduction in number of sexual partners
- o Improve diagnosis and treatment of STDs

The Project Paper identifies two U.S. organizations, Family Health International (FHI) and the U.S. Center for Disease Control (CDC) as key providers of technical assistance (TA) to local non-governmental organizations (NGOs) and the National HIV/AIDS/STD Control Program of the Ministry of Health (MOH). In mid-1992 a USAID-funded team found the project conceptually and technically sound, but insufficiently funded to assure sustainable national-level impact, particularly in the following areas:

- o Private sector
- o Policy advocacy and development
- o Behavior change communication (BCC)
- o Management
- o Behavioral, formative and operations research
- o Evaluation

All activity components were viewed to be particularly important in helping to establish a capacity for an effective, sustainable national program to prevent and control the spread of HIV. USAID agreed to design an expanded program with augmented resources from the Bureau for Latin America and Caribbean (LAC Bureau). The additional resources will specifically add the following new components to the ongoing USAID project:

- o A policy initiative to encourage the private sector to participate in HIV/AIDS

- o prevention and the public sector to commit national resources and make necessary policy changes
- o A BCC development component
- o A capacity building component for both public and private sector
- o A research component to focus on high risk behaviors of target groups, and influences for community mobilization
- o A comprehensive evaluation component of each sub-project as well as the USAID program

The USAID program is not meant to stand as an isolated program; rather it is designed within the strategic framework of the Agency AIDS Technical Support Project (ATSP) and in collaboration with the Epidemiology Unit (EPI Unit) of the MOH, the National AIDS Control Program, and the LAC Bureau, as well as other bilateral and multilateral donor agencies. The intention of this collaboration is to ensure that the program fits within the Medium Term Plan (MTP) for AIDS Control in Jamaica and addresses national HIV/AIDS prevention program requirements and to ensure that activities are not duplicated.

Implementation of the strategy and relevant activities will be the responsibility of indigenous NGOs, the EPI Unit of the MOH, and the commercial sector, all working in conjunction with USAID. In addition, in order to alleviate some of the public sector burden and to assure that some services and projects will be sustained beyond the participation of donors it is necessary for the private/commercial sector to become more involved in prevention projects. Specifically, the commercial sector will be encouraged to take up the burden of condom distribution and supply.

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

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

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

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

## 2. COUNTRY SITUATION ANALYSIS

### 2.1 Country Profile

Jamaica is a country of approximately 2.5 million people with a total fertility rate of 2.6% as of 1990. Forty-nine percent of Jamaicans reside in urban areas (the population of Kingston is 525,000), while the remaining 51% live in rural areas. The life expectancy of Jamaica's population is approximately 69.3 years for men and 72.7 years for women.

The per capita gross domestic product (GDP) in 1991 was J\$17,393 (US\$770). Jamaica's GDP was composed of 59% services, 19% manufacturing, 9% construction, 8% mining, and 5% agriculture. The inflation rate through FY1991/1992 was 68.6%, which led to a decline in real per capita GDP. The unemployment rate in 1991 was estimated to be 15.4%.

Government expenditures for fiscal year 1991/1992 were J\$14.8 million (US\$668 million), of which 43% represented debt servicing. Health spending represented only 6.6% of government recurrent and capital expenditures.

### 2.2 Epidemiology

In Jamaica the first case of AIDS was diagnosed in 1982. The epidemiological pattern is primarily heterosexual. Currently there are approximately 432 cases of AIDS in Jamaica, a low number of cases in comparison to other Caribbean countries. The prevalence rate is estimated at 0.1%.

Despite relatively low HIV prevalence rates in Jamaica, the AIDS epidemic could have devastating effects on Jamaica's health, economic and political institutions if the stable rates of HIV within the general population grow as they have among individuals practicing high risk behaviors in select groups of the Jamaica population. Individuals with high risk behavior include STD clinic attenders, CSWs, adolescents, adults with multiple sex partners, and MWM. Additional information on these groups follows:

- o **STD clinic attenders**  
Studies in 1986 and 1987 indicated that prevalence among 4,000 STD attenders was between 0.1% and 0.3%. By 1990 this prevalence had reached 3.1% and was expected to continue rising in the foreseeable future. Gonorrhoea rates are twice as high as the U.S. average. Infection rates for primary and secondary syphilis are

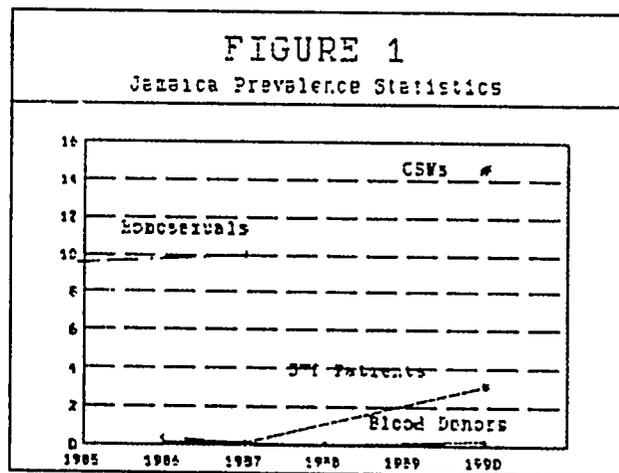


FIGURE 1

3 times those of the U.S. for 1990-1991. Currently one out of every 30 STD clinic attenders in Kingston is infected with HIV.

- o **CSWs**  
The prevalence of HIV was 12% among 110 female CSWs in Kingston, compared to an estimated national prevalence among CSWs of approximately 1%. Other studies in the group were likewise higher in Kingston, with syphilis rates reaching 41%, compared to 3.6% for sex workers throughout the rest of Jamaica.
- o **Adolescents**  
Prevalence estimates for HIV and other STDs are currently not available for this target population. However, given the early age of sexual experience in Jamaica, it is expected that this population is at high risk.
- o **Adults with Multiple Sex Partners**  
The prevalence of HIV among this target group is uncertain. However, between 1986 and 1991 syphilis has increased 106%, nongonococcal urethritis (NGU) 68% and chancroid 191%. Among antenatal clinic (ANC) attenders in 1990, prevalence of congenital syphilis had reached 16.9% and among blood donors, it had reached 3.3%
- o **MWM**  
A prevalence study in 1986 indicated that prevalence among 125 men (60 were homosexual and 65 were bisexuals) had reached 12%. To date there has not been a follow-up study.

Figure 1 illustrates that the prevalence in the general population has remained relatively stable, but prevalence among select groups is high. Given the island's large commercial sex industry, high rates of alcohol and drug abuse, substantial number of migrant laborers, and high rates of STDs, the potential for an explosion in HIV infection throughout the island's population is high. Figure 2 illustrates the projected prevalence for other regions of the world<sup>1</sup> which currently have urban prevalence which is comparable to that of Jamaica (approximately 3 HIV-infected individuals per 1,000 adults).

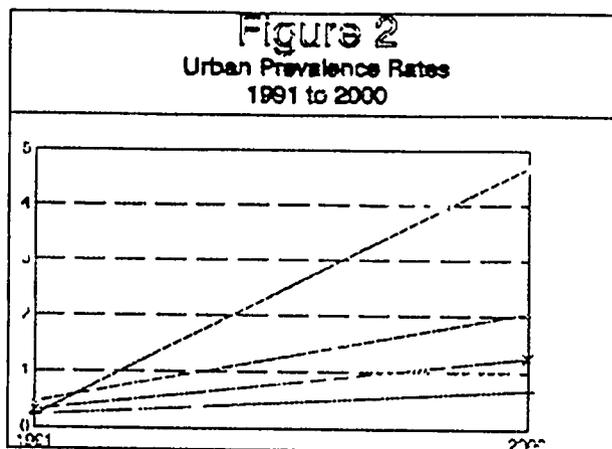
This suggests that if Jamaica follows the expected path of Western Europe, prevalence in urban areas of Jamaica may reach 7 per 1,000 in the next 7 years. However, if Jamaica's epidemic is comparable to that expected in Southeast Asia, the prevalence may reach 50 per 1,000. Regardless of which scenario is followed, the impact of HIV/AIDS on Jamaican society will certainly be significant.

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<sup>1</sup>Mann, Jonathan. AIDS in the World. 1993.

### 2.3 Response to Date

The Government of Jamaica (GOJ) initiated an AIDS prevention campaign in 1987 following a national conference on AIDS. The MOH called for the establishment of a National Committee on AIDS (NAC) that would provide advice on AIDS policies. The Committee includes representatives of the MOH, the Ministry of Labor, the Ministry of Education, life and health insurance companies, the Jamaican Council of Churches, the Association for the Control of Sexually Transmitted Diseases (ACOSTRAD), the National Family Planning Board (NFPB), and private sector organizations. The HIV/AIDS/STD control program is housed in the EPI Unit of the MOH. The components of the program include: surveillance, laboratory facilities, control of STDs, counseling, health promotion, condom promotion, management, and evaluation.



In order to implement these components, the GOJ has received assistance from multiple donors including USAID, the Pan American Health Organization (PAHO), the Caribbean Epidemiology Center (CAREC), the European Economic Community (EEC), the German Cooperation for Technical Assistance (GTZ), United Nations Fund for Population Activities (UNFPA), and the Canadian International Development Agency (CIDA).

- o USAID has funded AIDS prevention activities since 1988. Activities have included surveillance, education, condom promotion and STD treatment and diagnosis. USAID has funded AIDSCOM and CDC to provide TA for these activities. USAID is the major donor and other organizations are now developing their programs based around USAID activities.
- o PAHO has provided guidance to the NAC through the development of the MTP, financial support and TA in a number of different areas such as: prevention and control of blood and perinatal transmission, care for persons with HIV, and project management. PAHO has also supported three staff positions in the EPI Unit: communications, coordination, and administration.
- o CAREC has been supportive in the area of training, including policy development workshops and maternal development. CAREC's role has primarily been to include Jamaica in regional activities in the Eastern Caribbean rather than developing projects in Jamaica.
- o The EEC has provided long-term TA and other support for expansion of surveillance activities.

- o The GTZ has supported the establishment of the National Reference Laboratory in Kingston; maintained the HIV Diagnostic Laboratory in Cornwall Regional Hospital; identified and trained health care workers in HIV/STD prevention; supported HIV/STD sentinel surveillance activities, implemented intervention-linked research; and developed and implemented information, education, and communication (IE&C) components for target groups including migrant farm workers, STD repeaters, informal commercial importers (ICIs or higglers), and CSWs. The majority of funds and TA are directed towards assistance in the laboratories.
- o UNFPA has developed projects targeting disenfranchised youth in the 15-19 age category. Activities include development of a radio broadcast and a comic book and training peer counselors. Funding for this activity is approximately US\$12,000.
- o CIDA has provided support to purchase equipment for laboratories.

There is also a plethora of NGO-supported prevention efforts currently underway in Jamaica. Over the years numerous organizations have initiated prevention activities independently. Consequently, duplication of activities has occurred. USAID plans to provide assistance to coordinate all AIDS prevention activities. Some of the organizations and activities are as follows:

- o ACOSTRAD is currently operating outreach projects targeted to CSWs and other high-risk populations (women and adolescents) in Kingston.
- o The Family Center, a private voluntary organization (PVO) affiliated with the University of West Indies (UWI), operates care and treatment projects for HIV-positive individuals as well as primary prevention activities.
- o Face-to-Face, a project of the EPI Unit, emphasizes interpersonal communication as a way of reinforcing media messages. This project is not currently targeted to high-risk individuals.
- o Twenty two schools have been selected for a model project aimed at incorporating HIV/AIDS content into school curricula. In addition, the Red Cross operates HIV education and risk-reduction projects countrywide, including a pilot project for youth in and out of school.
- o MWM are served primarily by Jamaica AIDS Support (JAS), which is based in Kingston but has expanded services to the north coast cities of Ocho Rios and Montego Bay.

- o An MOH-implemented condom social marketing (CSM) initiative is underway with a private sector effort being planned by the SOMARC project.

## **2.4 Problem Statement**

Current efforts to control the spread of HIV infection are predominately confined to the public sector through the EPI Unit. The EPI Unit also manages a large and complicated portfolio that includes chronic diseases, disaster responses to cholera and typhoid, public health and education, road traffic accidents as well as STDs and HIV. The program is also necessarily focused on Jamaica's poor and is tied to the country's worsening economic situation, which is putting tremendous pressure on free public health services.

In order to alleviate some of the public sector burden and to assure that some services and projects will be sustained beyond the participation of donors, it is necessary for the private/commercial sector to become more involved in prevention projects. Specifically, the commercial sector should be encouraged to take up the burden of condom distribution and supply. Jamaica's commercial sector is capable of sustaining a number of condom brands at a range of prices that are both competitive and commercially viable. The public sector divestment of socially marketed condoms is long overdue and a welcome first step in the direction of sustainable condom projects. It may be necessary to subsidize (through marketing and research) socially marketed condoms for a short period of time, but it is expected that the market for condoms in Jamaica is sufficiently strong to be sustained without long-term supporting subsidies.

The private sector also has a direct role to play in the expansion of health services to the public, particularly STD diagnosis and treatment services. While private sector health care remains relatively expensive, initial impressions suggest that there is a market for much broader access to private health care facilities. The project will assist in assessing opportunities for private/commercial sector projects to prevent and control the spread of HIV/AIDS.

Finally, even as Jamaica faces difficult economic adjustments the GOJ must commit itself to supporting HIV/AIDS prevention projects now or face the potential for a far more devastating epidemic in the future. Numerous examples across the globe are testament to the destruction of AIDS if the epidemic is not controlled while general levels of HIV infection are still low. This means that donor resources and TA for HIV/AIDS prevention must be accompanied by financial and human resource commitments from the GOJ, including counterpart contributions. Even with the present efforts of multiple donors and the GOJ, resource gaps remain and the rate of HIV infection grows.

## **2.5 Lessons Learned**

After three years of project implementation, USAID, the MOH and the NGO/PVO community working in AIDS prevention have learned a number of important lessons concerning effective implementation strategies and interventions geared for greater impact. Many of these lessons were identified in the MOH's January 1992 report on its National HIV/AIDS/STD Control

Program (NACP). An external project evaluation in May 1990 also highlighted areas for improvement. The lessons learned and evaluation recommendations have been applied in the design of this project. These lessons are:

- o Treatment and diagnosis of STDs play a major role in prevention and control of HIV infection. STD facilities island-wide must be further strengthened. The role of the STD contact investigators is critical, and their training and supervision must be sustained by the MOH.
- o There is a need to increase demand for and access to condoms in STD clinics as well as through retail outlets and other commercial distribution systems.
- o While PVOs and the private sector have played an important role in reaching various segments of the population, these groups for the most part are small and understaffed and require TA to carry out HIV/AIDS prevention efforts.
- o Identifying effective communication approaches for promoting safer sex and partner reduction is complicated by the worsening economic conditions. Careful assessment is required before initiating communication interventions.
- o Reaching out of school youth requires an effective communication and condom marketing strategy.
- o The TA provided by USAID and other donors must be effectively integrated within the overall structure of the EPI Unit.
- o Each component of the program must be supportive of the overall program and not isolated into separate functions.
- o Findings from research studies need to be more widely disseminated.
- o Interventions should be targeted to high-risk groups.
- o Condom promotion activities need to incorporate AIDS messages.
- o Multiple donors have fragmented the EPI Unit's activities.

### **3. STRATEGY**

#### **Strategic Interventions**

The major components of the USAID program are:

- o STD Prevention and Control
- o BCC
- o Condom Distribution and Promotion
- o Behavioral Research
- o Private Sector Support
- o Policy Development and Dialogue
- o Family Planning
- o Capacity Building and Sustainability.

#### **3.1 STD Prevention & Control**

##### **Rationale**

The proper case management of STDs is a fundamental component of the project because diagnosis and treatment interrupts the chain of transmission of STDs, reduces the chances of HIV infection during sexual contact and improves the general health of sexually active Jamaicans. Epidemiological data indicate that STDs are a growing public health problem in Jamaica.

Congenital syphilis reported to the MOH has increased from 8 cases in 1985 to 60 in 1990. Total number of visits to the public sector STD clinics has increased between 1987 and 1990 from 34,187 to 43,275.

Laboratory-based data from the Comprehensive Health Clinic (CHC) showed that in 1991, a total of 23,809 male and 25,983 female STD patients were tested for VDRL. Each individual presenting at the STD clinic for a new disease episode was tested for VDRL and 20.8% of the sera from male patients and 20.1% of the sera from female patients had a positive VDRL. During the first 8 months of 1992, 20.1% of the male and 25.7% of the female patients had a positive VDRL. The MOH also reported that in 1991, 3.6% of blood donors and 4.1% of antenatal women had a positive VDRL.

These statistics do not represent the total number of persons treated for STDs as the EPI Unit estimates that at least 50% of all STD care is delivered in private or traditional places, and reporting mechanisms do not capture this information.

##### **Current Activities**

Although collaborators within the MOH have worked for years to improve STD case management mainly in the public sector, their efforts have been hampered by grossly inadequate resources.

In an attempt to address insufficient funding, ACOSTRAD was developed in 1978. Consequently, the National STD Program includes both public and private resources. The goal of the national program is to reduce the economic and psychosocial burden of STDs and their complications by decreasing overall morbidity and mortality. The strategies to achieve this goal are as follows:

- o Early detection and management of asymptomatic disease;
- o Appropriate management of clinical cases;
- o Health education/promotion for risk behavior.

The target for these objectives are as follows:

- o reduce primary and secondary syphilis by 30%;
- o reduce congenital syphilis by 10%;
- o increase number of contacts named as primary and secondary syphilis to 1:3 from 1:1.5;
- o interview at least 60% of primary and secondary syphilis contacts (if vehicles in place, then 75%);
- o treat at least 60% of critical syphilis contacts;
- o ensure that contact investigators cover all parishes;
- o increase % of STD facilities distributing condoms to clients to at least 75%;
- o stabilize incidence of HIV in STD clients.

The current STD component utilizes resources and TA from international donors, including CDC and GTZ. CDC has concentrated its efforts on contact investigator training, surveillance, and TA for improving the diagnosis and treatment of STDs. GTZ has been supporting HIV screening of blood donors.

The Project Paper has listed improved STD treatment and targeted counseling for HIV, AIDS, and STD patients as one of its outputs. The Project Paper identifies CDC, FHI, as well as the MOH with bilateral funds as implementers to reduce STDs. Current USAID-funded activities focus on improving the standard of care in the public sector.

### Proposed Strategy

The goal of this component is to reduce the rate of STDs in Jamaica. The three broad areas are:

- o Biomedical and behavioral interventions for the diagnosis, treatment, and prevention of STD/HIV
- o Institutional strengthening for capacity building and sustainability
- o STD-related research

USAID will focus on strengthening STD case management of services at the point of first encounter between the patient and the service provider and will give priority to STD interventions which involve:

- o Individuals whose behavior puts them at high risk
- o Urban/high density areas with high STD prevalence, and symptomatic individuals in urban/high density areas.

Treatment of patients at the point of first encounter is a priority because it may be the patients only contact and may influence future health-seeking behaviors. Therefore, during this first encounter efficient diagnosis and treatment are critical, along with counseling to promote risk reduction, condoms, and instructions on their proper use. Partner notification is also initiated at this point. Since most STD patients are seen in the public sector, USAID will focus on upgrading diagnosis and treatment in public clinics. Once private physicians are identified as points of first encounter they will be included in training and information dissemination activities.

#### STD management at points of first encounter:

- o Improve STD care for individuals seeking care in ~~the~~ both the public and private sector.
- o Establish procedures to motivate and maintain counseling activities by providers.
- o Link clinics and other points of first encounter to ~~the~~ CSM project for a regular supply of condoms.
- o Improve contact investigating.
- o Establish links with outreach workers in the community for specific target groups.

#### Strengthening STD clinical, laboratory and educational services:

- o Strengthen syphilis testing capabilities so all STD and antenatal centers can perform immediate syphilis serology on-site.
- o Improve follow-up and treatment of named contacts so that 60% of named syphilis contacts are tested and treated.
- o Design services for individuals who are at risk for HIV/STD infection.
- o Improve the quality of HIV/STD treatment services offered through private sector outlets.
- o Develop educational materials for STD patients.
- o Explore opportunities to increase private sector STD service delivery capacity

#### Institutional strengthening for capacity building and sustainability:

- o Strengthen the laboratory and educational capabilities of CHC.
- o Enhance the capabilities of the epidemiology branch of the MOH to collect and use surveillance data.
- o Increase consumer demand for HIV/STD treatment services through private sector outlets.
- o Increase private provider interest in operating STD-related clinics.
- o Develop continuing education seminars on STDs through the Jamaica Medical Society.

- o Develop materials to educate private physicians on STD case management.
- o Increase the availability of HIV/STD information and treatment as well as healthy life-style behavior information and counseling through employment-related channels.

**STD-related research:**

- o Clinical study to determine the etiology of genital ulcer disease (GUD)
- o Clinical study to determine the prevalence of chlamydia disease and sensitivity of gonococcal isolates
- o Logistics audit for drug and diagnostics distribution
- o Physician survey to determine the proportion of STD patients treated in the private sector
- o Managerial, operational and logistical audit of CHC

**3.2. Behavior Change Communications**

**Rationale**

At the present time, IE&C to prevent HIV is the primary weapon to control its spread. HIV transmission can be controlled by motivating individuals to change behaviors that put them at risk. In order to encourage individuals to make behavior changes, it is essential to develop and deliver prevention messages in the right context to the appropriate audience consistently over time.

Research in Jamaica has shown the existence of several sexual sociocultural constructs that have significant implications for HIV/STD communication interventions:

- o Sex is natural and the suppression of sexual activity is considered unnatural.
- o Males impregnating females is a sign of virility, a rite of passage.
- o Female pregnancy is desirable, also a rite of passage.
- o Virginity is not a positive value.
- o Sex outside of unions is not illicit.
- o Peer pressure to be sexually active exists.
- o An intense social stigma is attached to homosexuality.
- o AIDS is perceived as a homosexual disease, and hence stigmatized.
- o STDs are a natural and normal correlate of sexual activity.
- o Although it is changing, strong male and female antipathy toward condom use remains.<sup>2</sup>

A major challenge of a BCC component is recognition that these sociocultural aspects as well

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<sup>2</sup>AIDS in the Caribbean, Chevannes

as other barriers, such as opposition from churches to provide sexuality education and promote condoms, can influence or impede behavior change. These factors should be incorporated into targeted, culturally sensitive prevention projects.

The USAID project will build upon ongoing projects and further develop communication interventions that promote sustained behavioral change through selection of appropriately targeted audiences, messages, message sources, and channels.

### **Current Activities**

The Project Paper identified the following key target audiences which are at the greatest risk for acquiring and spreading the disease:

- o Young adults with multiple sex partners
- o STD clinic attenders
- o CSWs
- o Gay and bisexual men
- o Migrant farm workers, ICIs, and sailors.

The current project involves the implementation of a mass media campaign as well as targeted communication interventions to reach specific at-risk audiences.

Three media campaigns have been completed: "AIDS Kills"(1988), "Get The Facts" (1988), and "AIDS Helpline" (1991). Both of the 1988 campaigns used mass media and were designed to raise awareness of AIDS. The first campaign used "scare" tactics to raise awareness while the second campaign, "Get the Facts," provided basic AIDS transmission and prevention information to the public. The 1991 "AIDS Helpline" campaign raised awareness of Jamaica's AIDS Helpline number and urged the public to call the number for answers to AIDS questions.

The current campaign is "Keep on Keeping It On" -- a condom use campaign targeting sexually active young adults. The campaign consists of a six-week blitz of paid mass media radio, television, and print advertisements started in September 1992, and is now in a maintenance mode.

The communications component also involves interpersonal communication outreach to core target audiences (prostitutes and gay/bisexual men) conducted through ACOSTRAD and JAS. Additionally USAID funds Little People's "VIBES In The World of Sexuality," an HIV prevention musical education project targeted to adolescents. The project has also initiated outreach to the media and influential groups.

### **Proposed Strategy**

The BCC strategy is designed to affect the social environment and sexual norms thus supporting the adoption of low-risk sexual behaviors among Jamaicans so as to reduce the rate of HIV

infections. Specifically, BCC interventions seek to promote awareness of HIV health risk vulnerability, an understanding of condom efficacy (benefits of use, risks of non-use, access, and availability), and a change in sexual normative behavior (condom use, partner reduction, and/or delayed initiation of sexual intercourse).

The goal of this communication component is to develop strategies to reduce the sexual transmission of HIV/AIDS and the incidence and prevalence of STDs in Jamaica through changing behavior that places individuals at risk of infection. Specifically:

- o Create awareness and increase relevance of HIV/AIDS.
- o Create demands for products, such as condoms.
- o Create demand for services, such as STD treatment.
- o Enhance and teach skills necessary for behavior change.
- o Create a supportive social climate.

### **3.3 Condom Distribution and Promotion**

#### **Rationale**

The correct regular use of condoms inhibits the sexual transmission of HIV/STD infection. Consequently, increasing correct regular use of condoms among individuals practicing high risk sexual behaviors will decrease the rate of HIV/STD infection, which is the purpose of the condom component.

The primary segments of the general population at whom condom related activities will be aimed are:

- o Sexually active individuals between the ages of 15-30
- o Individuals with multiple sex partners
- o Individuals with STDs or already HIV infected

Segments of the condom distribution infrastructure will also be targeted. These include:

- o Condom retailers and potential retailers
- o Condom importers/distributors
- o Public sector policy makers

#### **Current Activities**

At least 15 brands of condoms are available on the commercial market. Seven of these are manufactured by Ansell and distributed in Jamaica by Central Trading Company. (Among the Ansell brands is the very popular Rough Rider.) Durex, a condom manufacturer in the United Kingdom, is represented by several brands including Golden Tops, the most expensive brand on the market. Durex condoms are distributed by Facey Commodity Company. The GOJ family planning social marketing project distributes Panther, the least expensive, best known, and most

widely sold brand in Jamaica. Commercial prices range from Panther's US\$ 0.06 package of three condoms to Ansell brands' approximately US\$ 0.90 package of three to Golden Durex at US\$ 1.36 package of three. Facey Commodity, however, plans to introduce a low-end Durex condom during 1993 priced at US\$ 0.45-54/package of three.

Commercial distribution, including social marketing of condoms, occurs primarily through the nation's approximately 200 pharmacies and through those additional shops (grocery, general merchandise, etc.) which choose to purchase condoms from the 100 wholesale outlets (50 to 60 of which are considered major) located around the country. It is estimated that each major wholesaler may sell products of some sort directly to as many as 200 to 300 small shops, but all of those small shop owners may not choose to purchase condoms for resale to their customers.

It is reported that ICIs are also a significant source of condoms in the commercial market. ICIs are individual entrepreneurs who travel out of Jamaica, especially to Miami, to purchase consumer goods for resale in Jamaica. Products supplied through this informal system are not necessarily available consistently in the marketplace.

The MOH distributes condoms through its system of 400 health centers throughout the country. The public sector condom is a generic Ansell product, donated to the government by USAID. It is distributed free within the public health system, but contributions are sometimes requested from those who receive the product. The MOH provides condoms free or nearly free because its targeted clientele are, at least theoretically, those Jamaicans who are unable to pay for the services/products they need. This distribution system will require some TA to improve efficiency.

NGOs serve clients who are socioeconomically similar to MOH clients. These organizations also distribute condoms, usually free, as part of their community education and services delivery projects. NGOs receive USAID-donated Ansell condoms through the MOH for their distribution efforts.

Total condom distribution in Jamaica in 1991 was estimated and compiled by the EPI Unit of the MOH as follows:

- o Public sector: 3.5 million condoms
- o Formal commercial sector: 1.9 million
- o ICIs, NGOs: 1.2 million
- o Social marketing project (Panther): 1.9 million

It is worth noting that in 1991 at least 60% of all condom consumption in Jamaica was paid consumption.

The existing Project Paper design identifies two constraints to increased condom use within the Jamaican market:

- o Accessibility, defined as the targeted consumer's ability to reach the product geographically and financially (the distribution system controls these elements of place and price)
- o Acceptability, defined as the willingness of the consumer to purchase/acquire the product and to use it (marketing has an impact on consumer behavior in this regard)

### **Proposed Strategy**

The proposed strategy for condom activities is three-fold:

- o Increase the accessibility of condoms to targeted consumer populations
- o Increase the sustainability of condom accessibility
- o Increase the acceptability of regular, correct use of condoms among the targeted populations.

While this strategy is not new, the proposed focus of its implementation is in many respects different from that in the existing Project Paper. For example, more emphasis will be given to ensuring that sustainable, i.e. commercially feasible, interventions are employed; the whole of the condom market (including the commercial sector) will be considered in developing indicators and evaluating impact; the need for policy-level commitment within the GOJ to ensure regular and adequate supply of condoms to "safety net" consumers will be highlighted; and more retail-specific communications campaigns (aimed at both consumers and retailers) will be developed and implemented.

Social marketing of condoms in Jamaica will not be limited to a single social marketing-specific brand specially imported or donated for the social marketing project. The assumption is that at least one brand already on the market through commercial channels will be priced accessibly for the middle- to lower-income segments of targeted consumers. The very poor segments of the target population, or "safety net" consumers, will be served by the public and NGO sectors. USAID communications/advertising and research interventions will support the overall condom category, since a purpose of USAID is to increase total condom use. It will be left to the efforts of each condom distributor to promote and increase its own brand share of the expanding condom market.

### **3.4. Behavioral Research**

#### **Rationale**

Behavior research in Jamaica has demonstrated the existence of certain sociocultural constructs which have significant implications for high-risk behavior and the spread of HIV. It is, consequently, fundamental to the further development of behavior change interventions to explore these constructs and to help researchers identify new strategies aimed at decreasing the incidence and prevalence of HIV/AIDS and other STDs.

The research conducted under this project will be designed to advance the broader scientific understanding of sexuality and risk behaviors and methods of modifying those behavior for HIV/AIDS prevention. Studies designed to promote the generalization of findings across research sites or countries will also be promoted, as well as studies that explore intra-cultural variation.

### Current Activities

A number of knowledge, attitudes, beliefs and practices (KABP) baseline studies have been conducted in Jamaica. In January 1989 Don Anderson Market Research Services and the Futures Group completed a KABP related to HIV and other STDs. This was followed in June 1992 by a "mini" baseline survey by Hope Enterprises on use, image, and attitudes towards condoms. Evaluative behavioral research that has been completed includes an impact assessment of the National AIDS Communication Campaign in June of 1990 and a pretest of the 1992 campaign. Hope Enterprises conducted the latter survey while the Futures Group completed the former work.

UWI is conducting research on the behaviors of CSWs and the NFPB is studying the sexual beliefs and behaviors of Jamaican males. The first phase of a four-year joint research project between UWI and UCLA on Sexual Decision-Making among Jamaicans is nearing completion. This study of AIDS-related sexual decision-making explores sociocultural and psychosocial factors related to decision-making among Jamaicans and will identify new intervention strategies; phase one of the study surveyed 3,000 households nationwide using a survey instrument designed for focus groups. A sub-sample survey of 300 households is being conducted currently; a follow-up survey will question in more depth individuals practicing high-risk sexual behaviors, including:

- o MWM
- o Transactional sex practitioners
- o Individuals with multiple sex partners
- o Individuals practicing anal sex
- o ICIs and higglers (small entrepreneurs).

And finally, the International Center for Research on Women (ICRW) is conducting a survey of sexual behaviors and sexual decision-making among free-zone workers in Jamaica, mostly women employed in the garment industry.

### Proposed Strategy

The USAID Behavior Research component for Jamaica will be composed of three elements:

- o Competitive thematic grants
- o Rapid response studies
- o Country-identified research.

The Competitive Thematic Grants provide for theory-based research and capacity building. It will consist of multi-year research grants awarded jointly to a developing country and developed country pair. Grant proposals submitted for competitive funding under the Thematic Grants must focus on a theoretical, thematic or disciplinary approach to HIV/AIDS prevention.

Rapid response research will allow investigators to pilot interesting research ideas, test innovative approaches, and respond to identified research needs. This will assist investigators in the preparation of larger scale proposals, either to USAID or other funding sources. These projects will be of two types: one- to two-year small-scale research activities and larger, longer grants to develop and test interventions.

Finally, the country-identified research projects can include a wide range of activities, including training and capacity building, and both large and small scale grants. These research projects will investigate specific problems identified in country and test approaches essential to the development of national efforts to prevent and control HIV/AIDS. The intent of these research activities is to inform prevention interventions and maximize their impact.

Through these three mechanisms USAID will pursue research that goes beyond descriptive goals and explores the context and antecedents of behavior. Potential topics of interest to USAID and Jamaica are:

- o normative sexual practices
- o the development of sexual identities and related sexual behaviors
- o the role of social stigma in regulating sexual behaviors
- o the synergy of alcohol, drugs, and high-risk sexual behavior
- o the role of the church and other social institutions in behavior regulation and change
- o knowledge and behavior change
- o dynamics of sexual decision making within the household.

### **3.5 Private Sector Support**

#### **Rationale**

There are three primary reasons for including private sector interventions within the overall USAID project:

- o To enhance and expand the outlets available for HIV/AIDS/STD treatment services delivery.
- o To enhance long-term program sustainability by mobilizing the technical and financial resources within the private sector.
- o To utilize the power of the private sector to influence public opinion and effect change.

The segments of the general population targeted by private sector interventions will, therefore, include:

- o People infected with STDs or HIV who have the ability to pay the cost of treatment services delivery
- o Private health care practitioners (especially general practitioners and pharmacists)
- o Potential investors in health services delivery
- o Opinion leaders within the private sector
- o The general and specific publics (such as condom retailers, teachers of adolescents, parents, GOJ policy and budget makers) that can be influenced by private sector opinion leaders

### **Current Activities**

While the project rationale of the existing Project Paper acknowledges that "In order to broaden skills available and enhance sustainability, it is necessary to expand use of the private sector...", no specific interventions were proposed or budgeted other than those related to the institutional strengthening of two organizations. ACOSTRAD and the NAC.

### **Proposed Strategy**

To achieve the purposes of including private sector activities within USAID activities, the following strategy is proposed:

- o Improve the quality of HIV/STD treatment services offered through private sector outlets.
- o Increase consumer demand for HIV/STD treatment services through private sector outlets.
- o Increase private provider interest in operating STD-related clinics.
- o Increase the availability of HIV/STD information and treatment, healthy life-styles behavior information, and counseling through employment-related channels.
- o Increase the management/social marketing skills of private non-profit providers of HIV/STD related services.
- o Increase the involvement of private sector opinion leaders -- both individual and corporate -- in shaping public opinion and creating the GOJ commitment necessary to ensure adequate resources and support for services delivery and healthy life-style behaviors.

## **3.6 Policy Development and Dialogue**

### **Rationale**

An expanded HIV/AIDS Policy Initiative will be a significant component to the USAID program. The rationale for this proposal is the recognition that promoting support among policy makers

is a critical first step to creating an environment that encourages, rather than discourages, HIV/AIDS interventions. If this initiative succeeds, Jamaican policy makers will become strong advocates for HIV/AIDS interventions, leading Jamaican society by promoting supportive policies and legislation, and leveraging resources that would not otherwise be available (e.g., championing appropriate family life education in schools, promoting government commitment to condom purchases). The creation of such an environment can assure that available human and financial resources are used most efficiently.

The target audience of Jamaica's HIV/AIDS Policy Initiatives will be policy makers and opinion leaders in the public and private sectors. Public sector leaders have been identified due to their role in shaping regulations, legislation, and general public opinions that relate to the spread of HIV/AIDS. Private sector leaders have been chosen because of their role as opinion-leaders, as well as their ability to access human, capital, and financial resources.

The long-term success of this integrated policy approach is contingent upon identifying strong Jamaican collaborators to lead and sustain a policy dialogue over time. While USAID is committed to offering TA to Jamaican collaborators by transferring the technologies necessary to implement sustainable policy dialogues, the impetus and leadership for changing policies must come from Jamaicans.

### **Current Activities**

Despite the potentially devastating impact that AIDS may impose on Jamaican society, the policies that may affect the efficient implementation of an AIDS prevention program have not yet been fully addressed. As a result, various policy issues continue to hinder the effective implementation of an AIDS program in Jamaica (e.g., opposition to a "family life" curriculum in schools and universities, tariffs on commercially imported condoms, stigmatization of persons infected with HIV).

It is important to note that Jamaica has made the first step in organizing groups to address policy issues. For example, the National AIDS Committee is an interdisciplinary organization that meets regularly to address the many issues related to AIDS. Furthermore, the MOH has hired Berl Francis and Company Ltd, a public relations and business communications firm, to perform such activities as "AIDS at the Workplace" forums. In addition, the Planning Institute of Jamaica (PIOJ) has worked in collaboration with other government agencies to promote the Population Planning Coordinating Committee (PPCC) and is currently developing a policy unit, which will address issues such as AIDS from a policy perspective.

One component of the Project Paper involved policy, project planning, and monitoring. The accomplishments of this phase were expanded and improved AIDS/STD surveillance activities, including on-going reporting from the Ministry of Labor (for farm workers) and the American Embassy (for testing of immigrants).

## **Proposed Strategy**

Jamaica's AIDS Policy Initiative will have four integrated components, each of which will address both the public and the private sector. These four components are designed to assess the policy issues, evaluate the magnitude of the impact of AIDS, identify sustainable solutions to the AIDS problem, and evaluate the use of resources used by the various interventions.

The Policy Analysis Component will identify those public and private sector policies in Jamaica that may prevent the successful introduction and implementation of AIDS prevention interventions. This component will also address the stigmatization and fear of persons infected with HIV. In addition, key policy makers who can lead and influence others in the Jamaican community will be identified.

The Impact Assessment Component will inform policy makers as to the current and projected health impacts associated with the spread of HIV/AIDS (estimated AIDS deaths, orphans, tuberculosis cases, etc.). Concurrently, an economic impact assessment will allow policy makers to equate the epidemiological loss from HIV/AIDS to a corresponding economic impact, and therefore to identify the economic benefits of various prevention strategies.

The Policy Dialogue Component will be the forum in which public and private sector policy makers gain awareness of the consequences of various policy issues and identify and evaluate policy options. This forum will allow them to develop, implement, and reinforce policies that will ensure that interventions are effective.

The Sustainability Component will allow project implementors the opportunity to improve the financial and institutional sustainability of their efforts. Financial sustainability will be promoted by performing recurrent cost and cost-effectiveness analyses (CEA) in order to assess the effectiveness and efficiency of interventions, and to compare intervention strategies. Thus CEA will be applied to STD and condom distribution interventions. Furthermore, this component will address the institutional sustainability of AIDS prevention projects over time.

A comprehensive listing of the policy issues to be addressed will be derived in conjunction with the Jamaican collaborators after a comprehensive policy analysis has been performed. Priority will be given to policies that meet the following criteria:

- o They must significantly influence current or proposed AIDS projects, and
- o They can feasibly be addressed during the life of the project.

The following list identifies some of the issues that may be addressed during this initiative. A preliminary prioritization has been made based on the two criteria listed above.

### First Tier Priorities:

- o Government policy makers and private sector executives must be encouraged to

change policies that hinder successful implementation of HIV/AIDS prevention projects and to promote policies likely to contribute to the success of projects. These policy makers must also be encouraged to speak out against stigmatization of persons infected with HIV.

- o The potential health and economic impact of Jamaica's AIDS epidemic needs to be fully projected and presented to critical policy makers to promote greater awareness of the full development impact that AIDS may have on Jamaica. This should, in turn, allow policy makers to appreciate more fully the social and economic benefits of HIV prevention.
- o The GOJ needs to establish a budgetary "line-item" for condom purchase.
- o The GOJ needs to identify clearly its plans for purchasing STD drugs.
- o The Ministry of Education should implement fully a "lifestyle curriculum" in schools for youth and adolescents.
- o The resources and social influence of Jamaica's churches needs to be encouraged to vocally oppose the stigmatization of persons infected with HIV and to promote AIDS prevention.
- o The cost-effectiveness of the various interventions needs to be assessed so that the mix of proposed HIV/AIDS prevention investments can be improved.

#### Second Tier Priorities:

- o Regulations concerning the limited role of nurses and nurse practitioners in diagnosing and treating STDs need to be changed to improve the availability and timeliness of care.
- o The commercial sector needs to be informed about the full impact that AIDS may have on such variables as absenteeism and health insurance costs. The sector also needs to be informed of the importance of providing resources and resource leveraging for HIV/AIDS interventions.

#### Third Tier Priorities:

- o Employers need to be convinced to develop workplace policies for addressing the health concerns of employees (e.g., treating STDs, policies related to HIV-infected employees).
- o The elasticity of demand for condoms and STD services needs to be estimated so that prices can be set at affordable levels.

### **3.7 Family Planning**

#### **Rationale**

In order to increase awareness of AIDS and promote safer sex amongst sexually active people, USAID will incorporate AIDS messages into family planning activities.

#### **Current Activities**

The International Planned Parenthood Federation (IPPF) has received funds through AID/Washington to incorporate AIDS prevention activities into family planning activities in the emphasis countries identified in the Agency AIDS Technical Support Project (ATSP) (No. 936-5972). IPPF has delineated three levels of integration of AIDS work into family planning: 1) Enhance the staff's awareness and knowledge of issues and facts related to HIV, STDs, and sexuality; 2) Promote HIV/AIDS/STD materials in clinics and activities; 3) Enhance the staff's awareness of clients behaviors that put them at risk of contracting HIV.

IPPF will work with its affiliate, the Jamaican Family Planning Association (JFPA) to promote safe sex practices. Specifically IPPF will do the following:

- o Improve the general counseling skills of staff.
- o Integrate HIV prevention into all levels of education and counseling.
- o Make available a diversity of educational materials that address and relate family planning, HIV and STDs.
- o Explore the possibility of incorporating STD diagnosis and treatment into family planning services.
- o Promote and distribute condoms.

The Family Planning Initiatives Project (FPIP) is a 2 million dollar USAID financed project to enhance family planning in Jamaica by ensuring that long term cost-effective contraceptives are available. Given that the public sector is the major provider of family planning services, and will remain so for the foreseeable future particularly in counselling and in the delivery of clinical services, the majority of this project's activities focus on the public sector. Activities targeted to the public sector include institutional strengthening of the NFPB, policy analysis and research, contraceptive supplies and logistics, family life education activity with the Ministry of Education, and clinical methods ensuring that cost-effective, long-term contraceptive methods are available.

#### **Proposed Strategy**

USAID will ensure that both family planning projects will coordinate activities with AIDS prevention activities. Specifically, the forecasting of private sector condoms will be conducted jointly on an annual basis. Condom distribution information will be shared in regular meetings amongst all cooperating agencies working in Jamaica on family planning activities and the major organization working in AIDS prevention. In addition, whenever possible research topics will

be combined and information dissemination will be coordinated.

### **3.8 Capacity Building and Sustainability**

#### **Rationale**

The burden of national debt, diminished export earnings, and externally-enforced economic restructuring combine to inhibit the public sector's ability to finance and deliver "health for all" from its budgets alone. New solutions involving public and private partnerships are needed to solve the critical problems of public health, including HIV transmission and the resultant devastation of AIDS.

The Mission's strategic objective to help Jamaica attain healthy, smaller families through USAID health and family planning projects is based on a de facto strategy of helping to re-align the public and private responsibilities for the financing and delivery of these services. This strategic approach seeks to shift substantial responsibility for financing and service delivery to the private sector while strengthening the "safety net" capacity of the public sector to deliver more effective and efficient services for the public good and to those least able to pay. In the public sector, the Mission's health projects support appropriate policy and management reforms for decentralization, cost recovery, and informing or changing consumer behavior to prevent/treat the disease.

Furthermore, support for the Mission's HIV/AIDS prevention project will encourage the long-term viability of AIDS activities by promoting the institutional sustainability of the various organizations involved in HIV/AIDS prevention in Jamaica. This includes improving the management capabilities of these organizations, transferring appropriate technology and training to USAID collaborators, and integrating HIV/AIDS/STD components within various public and private sector organizations (e.g. the Ministry of Education, the Ministry of Finance, business organizations, and corporations). The goal of this institutional strengthening will be to develop a truly national mobilization of resources.

#### **Current Activities**

The current USAID plan for sustainability involves long-range planning, strengthening public and private organizations, and linkages with other social projects with similar target populations, such as the family planning and substance abuse projects. Project design is also based on a gradually increasing role of local TA, contractors, and other resources. It is expected that the MOH, which is currently financing the costs of HIV test kits, 60% of the pharmaceuticals for diagnosis and treatment of STDs, and all condoms during the second half of the project, will continue to absorb a substantial portion of project costs. It is expected that the private sector will also contribute to the financing of the national program, but the nature and levels of commitment have not been specified.

## **Proposed Strategy**

Under the expanded HIV/AIDS prevention project the Mission will continue to strengthen public and private organizations and the gradually increasing role of the private sector in the delivery of health and support services. The private sector's role in the financing and provision of pharmaceutical and condoms is expected to continue to grow during the life of project. Commercial viability of the condom market in Jamaica should be achieved during the life of this project. However, the need for publicly-financed condom stock for public sector clinics will remain.

Sustainable capacity building, the process of technology transfer such that the national HIV/AIDS program can be maintained in terms of financial, institutional, and human resources, is an explicit objective of the Mission's HIV/AIDS project. In order to ensure sustainability of the project and maximize cost-efficiencies, the Mission will decrease use of TA over the life of the project and increase use of local TA and contractors. The long-term local specialists hired within the EPI Unit will work with short-term U.S. TA advisors to develop specific technical and/or managerial expertise. TA needs will be identified by the MOH, USAID, and the subcontractor. Moreover, the local technical specialists will work closely with appropriate public and private sector organizations to strengthen linkages among related health and social projects, including substance abuse, disease prevention, and family planning. It is envisioned that after four years, at the end of the project, these skilled areas and functions will either be absorbed into the GOJ or will provide expertise for NGOs and the private sector.

USAID will support a PVO/NGO component. Several US PVOs work in Jamaica. There is also an active network of NGOs working in AIDS that meet together regularly in collaboration with the MOH. A grant has already been awarded to the Red Cross of Jamaica to complement activities in the USAID program. This grant component will provide \$200-400,000 of funds over three-and-a-half years.

In addition, the Jamaican NGOs can benefit from the \$50,000 per year available to strengthen their capacity to implement HIV/AIDS prevention activities. This money would be available to (1) provide "rapid response funds" for requests for financial assistance through a streamlined process, (2) support project management training and TA, or (3) support networking activities.

## LOGFRAME

Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions (IA)
<p><b>Goal:</b> Reduce the rate of sexually transmitted HIV in Jamaica.</p>	<p>1.1 Stabilization or decrease in gender group and/or age-specific HIV prevalence and incidence.</p>	<p>1.1 HIV sentinel surveillance.</p>	<p>(Goal to supergoal) Sexual intercourse is the primary mode of HIV transmission.</p>
<p><b>Purpose:</b> Decrease STDs, increase condom use, and reduce the number of sexual partners in selected target groups.</p>	<p>1.1 30% decrease in gender- and age-specific syphilis prevalence</p> <p>1.2 70% increase in reported condom use among the target populations in high-risk sexual encounters.</p> <p>1.3 10% decrease in congenital syphilis by end of project (EOP)</p>	<p>1.1 Target population based surveys.</p> <p>1.2 Syphilis sentinel surveillance.</p> <p>1.3 Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>(Purpose to goal)</p> <p>1.1 Reducing the number of sexual partners and STDs has an impact on HIV transmission.</p> <p>1.2 Appropriate condom use reduces HIV/STD transmission.</p> <p>1.3 Condoms are available and accessible to the target population.</p> <p>1.4 STD diagnosis and treatment services are available and accessible to the target population</p>
<p><b>Outputs:</b> 1. Enhance communication interventions to promote behavior change in primary prevention target populations. STD patients, CSWs, adolescents, adults with multiple sex partners, MWM, and HIV+ individuals</p>	<p>1.1 90% of target groups name condoms as acceptable way of preventing HIV.</p> <p>1.2 80% of target population(s) reached by communication activities, by target population, by gender.</p>	<p>1.1 KABP surveys</p> <p>1.2 Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>1.1 Accurate mobilization of target population to participate in project activities exists.</p> <p>1.2 Communication activities lead to behavior change.</p> <p>1.3 Communication strategies will be consistent with social, cultural, and religious norms for various segments of society</p>

<p>2. Increase access and availability of condoms in the commercial and public sectors.</p>	<p>2.1 30,000,000 condoms sold or distributed by EOP. (based on CPS at 20% use rate)</p> <p>2.2 70% of target population(s) report condom use in high risk situations</p> <p>2.3 20% increase in condoms being purchased in the private sector.</p>	<p>2.1 Provider assessments</p> <p>2.2 KABP surveys.</p> <p>2.3 Process data/logistic reports/surveys</p> <p>2.4 Retail audits.</p> <p>2.5 Information Management System (if it's available and includes condoms.)</p>	<p>2.1 Condom logistics infrastructure exists.</p> <p>2.2 Constant and consistent supply of quality condoms is secure.</p> <p>2.3 GOJ allows budget allocation for increased availability to the public sector.</p> <p>2.4 Increased accessibility will increase use</p> <p>2.5 Pricing structure allows purchase in the commercial sector by target population.</p>
<p>3 Increase access to improved STD prevention and treatment services in the public and private sectors.</p>	<p>3.1 80% of target population with STDs receive treatment according to standard STD diagnosis and treatment protocols</p>	<p>3.1 Provider assessments</p> <p>3.2 Target population surveys.</p> <p>3.3 Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>3.1 Target population(s) will feel empowered to access STD diagnosis and preventive services.</p> <p>3.2 Laboratory and technical capabilities to manage effectively will improve with increased demand on STD diagnosis and treatment services.</p> <p>3.3 STD service providers will want to work with target population(s).</p> <p>3.4 Target populations are easily identified.</p> <p>3.5 Sociocultural norms permit activities focusing resources on target population(s)</p> <p>3.6 Physical, human, and financial resources will be available throughout life of project.</p> <p>3.7 Private practice providers are willing to treat STD clients.</p>

<p>4. Strengthen capacity of host country institutions to manage and implement effective HIV/AIDS prevention projects in the public and private sectors.</p>	<p>4.1 All institutions funded by NACP implement integrated HIV/AIDS prevention programs that include strategic and implementation planning.</p>	<p>4.1 Pre- and post-institutional assessments that include both quantitative and qualitative methodologies.</p>	<p>4.1 Institutions with appropriate mission statement/philosophy exist to implement USAID mandates.</p> <p>4.2 Sociopolitical support for capacity-building is constant throughout life of project.</p>
<p>5. Facilitate dialogue and collaboration among non-profit, commercial, and public sector to positively address AIDS-related policy issues</p>	<p>5.1 400 policy makers/opinion leaders in all key sectors, representing public and private institutions, at the central and regional levels, involved in policy dialogue activities</p>	<p>5.1 Training curricula and attendance records.</p> <p>5.2 Meeting minutes.</p>	<p>5.1 Multi-sector policy environment that is conducive to the development and implementation of comprehensive AIDS prevention activities is created.</p> <p>5.2 Government policies strongly influence effectiveness of intervention strategies</p>

## 5. IMPLEMENTATION PLAN

It should be clear that given the dynamic nature of this epidemic and the relative inexperience of countries in attacking HIV/AIDS, this implementation plan is only one step in an ongoing process that should remain flexible and responsive to the epidemic. Evaluation and monitoring data are, consequently, critical to the continuing understanding of intervention impact and the potential need for revising plans.

Finally, the activity descriptions presented in this implementation plan will be further articulated and supported by subagreements with implementing agencies, which will include detailed workplans, timelines and budgets for each of the components.

### Rationale for Target Groups

While the prevalence of documented HIV and AIDS among the general population is low, it is high among certain groups that practice high-risk behavior such as: adolescents experimenting with sexual practices; people with multiple sex partners; those who have STDs; CSWs; MWM, including an undetermined number who do not self-identify as homosexual or bisexual due to homophobia in the society; and those in the informal commercial sector who are exposed to the

virus in their travels out of the country.

The following chart indicates known seroprevalence status for some of these groups:

GROUP	YEAR	SEROPREVALENCE
MWM	1986	12.0%
CSWs	1990	10.0%
STD Patients	1986	0.37%
STD Patients	1990	3.1%

The USAID strategic and implementation plan is designed in accordance with and in proportion to these patterns of transmission as well as data from KABP surveys that indicate at-risk behavior. Hence, USAID will implement a program that focuses on the following "target groups:"

- o STD Patients
- o CSWs
- o Adolescents
- o Adults With Multiple Sex Partners
- o MWM
- o Persons Who are HIV+

These groups represent separate risk categories, but there is much overlap. For example, an adolescent male with multiple sex partners might also have an STD, and could be bisexual as well; he could also be a member of the general public who watches TV and listens to the radio. Communication interventions aimed at separate target groups are therefore likely to have a synergistic effect, reinforcing messages and support for behavior change through multiple channels and trusted sources. At the same time, demand creation will be met by "supply side" interventions of improved STD services and increased access to condoms.

Jamaicans have a relatively high level of awareness of HIV/AIDS and how it is transmitted but surrogate measurements of high-risk sexual behaviors (rising STD levels) indicate that awareness has not led to behavior change. Consequently the USAID strategy will focus on behavior change interventions across all target groups in a concerted effort to move from awareness to safer sexual behavior.

The program also identifies "intermediaries" such as health care providers, the commercial sector, policy makers, and other socially influential groups (church leaders, teachers, and performing artists) or individuals as important targets of normative change interventions and sustainability strategies. Where appropriate these target groups will be addressed through interventions described below.

## **5.1 Target Group Component: STD PATIENTS**

### **Description**

The total number of STD clients served through the MOH system in 1990 was 53,964 (including repeat visits). Of these, 30,479 sought treatment in CHC. One hundred to three hundred clients per day at this clinic is not considered unusual. MOH clinics in other sites around Jamaica also offer STD treatment services. The MOH system is generally agreed to be operating beyond its capacity to ensure the availability of drugs and reusable supplies as well as trained professional staff necessary in treating this number of STD clients. Available data indicate that the incidence of HIV has increased four and a half times amongst STD clinic attenders during the period of 1986-1990.

It is unknown how many people seek treatment for STDs in the private sector. The national STD component is currently in the process of conducting a survey to assess the private sector caseload and the quality of care patients receive.

### **Objectives**

1. To initiate the following improvements in clinic services at public sector STD clinics:
  - o Reduce waiting time.
  - o Assure that all registered patients are examined the same day.
  - o Guarantee adequate supplies of condoms available at clinics.
  - o Provide basic education and counseling on condom use, compliance with medication, risk reduction, and partner treatment for all STD patients.
2. To strengthen syphilis testing services so all STD centers can perform immediate syphilis serology on-site; and ensure turn-around time for ANC testing of less than 1 week.
3. To improve contact investigation so that 60% of named syphilis contacts are tested and treated.
4. To strengthen the laboratory and educational capabilities of CHC with the ultimate goal of having it serve as a center of excellence for laboratory, clinical and field training.
5. To improve treatment and case management of STD patients served by private physicians such that 60% of patients seen in the private sector receive adequate therapy and appropriate education/counseling.
6. To identify STD service needs for high-risk populations and pilot appropriate services for these groups.
7. To strengthen the capacity of the private sector to serve STD patients.

8. To improve the private sector's ability to report STD cases.
9. To strengthen the EPI Unit's capacity to design, implement, and effectively manage and utilize the epidemiological surveillance system with a focus on HIV/STD data.
10. To assist the EPI Unit, in collaboration with other ministries and agencies, to utilize the surveillance data to identify special research and targeted interventions, as part of national STD/HIV policy planning and project development.

## **Major Project Areas**

### Diagnosis and Treatment of STDs

Institutional strengthening of STD service delivery for capacity-building:

- o Conduct a managerial, operational and logistical audit of CHC.
- o Conduct a planning workshop to evaluate CHC and STD clinics as requested by clinic directors.
- o Provide necessary equipment for performing syphilis testing.
- o Develop and implement training workshops to provide training for implementation of syphilis testing.
- o Improved syphilis screening in ANC attenders through utilization of improved syphilis services
- o Evaluate syphilis testing sites as a means to assist the MOH with the determination and recommendation for suitability of T.R.U.S.T. testing in Jamaica.
- o Adapt generic STD curriculum and training modules for use by Jamaican health training institutions to improve STD clinical management.
- o Upgrade the STD laboratory in CHC to improve diagnostic and training capability.
- o Improve educational and counseling services at clinics.

### STD Research

- o Carry out a clinical study to assess the etiology of GUD in Jamaica, prevalence of chlamydia disease, and sensitivity of gonococcal isolates.
- o Conduct a logistic audit for drug and diagnostic distribution.

### Behavior Change/Communications

- o Conduct research to provide a profile of STD repeat patients.
- o Develop materials on STD symptom recognition and correct condom use.
- o Develop individual and small group counseling training and education materials. In the health care setting, develop a system to identify men and women at risk of HIV infection. Design and implement targeted education projects to change the behaviors of those at risk.

- o Produce small media promoting health-seeking behaviors, awareness of symptoms, and where to seek treatment (includes low-literacy print materials, videos, posters, and counseling guides).
- o Provide training for clinic personnel, pharmacists, and other STD health care givers in education, counseling, and condom promotion.
- o Assure that client-appropriate educational materials are available to private practice physicians, nurses, and pharmacists in treating and educating targeted populations.
- o Develop and implement an appropriate consumer-targeted communications campaign that promotes the availability of treatment services in the private sector.
- o Provide TA to community-based NGOs and other private organizations in establishing systems for referring their clients, where appropriate, to private sector practitioners for treatment.
- o Develop and implement a public relations effort targeting top condom users that diminishes the embarrassment associated with purchasing condoms.
- o Develop and implement communications materials that promote the benefits of condom use and the risks of non-use in sexual practices.

### Condoms

- o In collaboration with SOMARC, explore the feasibility of commercial condom distributors making branded condoms available for sampling within public sector STD clinics.
- o Facilitate the development of a standard practice in regard to distribution of condoms to STD clients (i.e., occasion at which condoms are distributed, number of condoms to be supplied on each occasion, types of clients who will be encouraged to purchase future condom needs in the commercial sector, etc.).
- o Facilitate the development and implementation of GOJ policies that ensure a consistent, adequate supply of condoms to serve "safety net" consumers in the MOH and NGO systems.
- o Assess the MOH stock delivery system, if necessary, to identify areas of particular weakness in relation to condom supply.
- o Provide TA to ensure the existence and operation of an efficient logistics infrastructure within the MOH so that condom stock outages do not occur for either public health centers or NGO providers.
- o Implement market research necessary for developing consumer profile for this target population. Ascertain favored outlets for condoms as part of this profile.
- o Implement qualitative or other appropriate research to ascertain the impact that distribution versus communications interventions can have in resolving time and place accessibility barriers to increased condom use for this target population.

## **Technical Assistance**

### **AIDS Control and Prevention Project (AIDSCAP)/UNC:**

- o Conduct a managerial, operational and logistical audit of the CHC.
- o Adapt generic STD curricula and training modules for health training institutions to improve STD clinical management.
- o Upgrade STD laboratory in CHC to improve diagnostic and training capabilities.
- o Conduct clinical study to assess etiology of GUD in Jamaica, the prevalence of chlamydia disease, and sensitivity of gonococcal isolates.
- o Provide necessary equipment for STD laboratory.
- o Conduct training for implementation of syphilis testing.
- o Implement improved syphilis screening in ANC attenders through utilization of improved syphilis testing services.
- o Evaluate syphilis testing sites.
- o Develop materials to educate private physicians on STD case management.
- o Determine the STD health-seeking behavior and health services needs of individuals from high-risk groups.
- o Improve passive STD surveillance, including the review and revision of STD reporting forms, improved reporting protocols, and strengthened data management.
- o Complete physician "mail survey."

### **CDC:**

- o Conduct a supervisory training course for contact investigators.
- o Conduct on-site supervisory training of supervisors.
- o Evaluate contact investigators' activities.
- o Sponsor Jamaican MOH personnel to attend training courses at CDC.
- o GC testing

### **Suggested Implementing Agencies**

The implementing agencies for these proposed activities will be the service institutions of the EPI Unit of the MOH, the Medical Association of Jamaica (MAJ), pharmacies, and NGOs such as ACOSTRAD. Other agencies to implement activities in behavior research and condom promotion/availability will include the UWI and SOMARC, as well as commercial distributors such as Grace Kennedy and Wisynco.

OAR	Ogilvy, Adams and Rinehart
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PPCC	Population Planning Coordinating Committee
PPI	Priority Prevention Indicators
PSOJ	Private Sector of Jamaica
PVO	Private Voluntary Organization
STD	Sexually Transmitted Disease
TA	Technical Assistance
TB	Tuberculosis
UCLA	University of California, Los Angeles
UNC	University of North Carolina
UNESCO	United Nations Education, Science and Culture Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWI	University of the West Indies
WHO/GPA	World Health Organization/Global Program on AIDS

## **ABBREVIATIONS/ACRONYMS**

ACOSTRAD	Association for the Control of Sexually Transmitted Diseases
AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSCOM	AIDS Communication
ANC	Antenatal Clinic
ATSP	AIDS Technical Support Project
BCC	Behavior Change Communication
CAPS/UCSF	Center for AIDS Prevention Studies/University of California, San Francisco
CAREC	Caribbean Epidemiology Center
CATC	Caribbean Applied Technology Center
CDC	Center for Disease Control
CEA	Cost-effectiveness analysis
CHC	Comprehensive Health Clinic
CIDA	Canadian International Development Agency
CSM	Condom Social Marketing
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
EEC	European Economic Community
EPI Unit	Epidemiology Unit (Ministry of Health)
EOP	End of project
FHI	Family Health International
FPIP	Family Planning Initiatives Project
GFM	Gay Freedom Movement
GOJ	Government of Jamaica
GTZ	German Cooperation for Technical Assistance
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
ICI	Informal Commercial Importers
IE&C	Information, Education, and Communication
JAS	Jamaica AIDS Support
JHU	Johns Hopkins University
JIS	Jamaica Information Services
JSI	John Snow Inc.
KABP	Knowledge, Attitudes, Beliefs and Practices
MOH	Ministry of Health
MTP	Medium Term Plan
MWM	Men Who Have Sex With Men
NACP	National AIDS Control Program
NAC	National AIDS Committee
NFPB	National Family Planning Board
NGO	Non-Governmental Organization

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>STD PATIENTS</b>																
Implement consumer intercept surveys					X	X										
Develop a strategy for condom accessibility based on results							X	X								
Develop and implement a communication campaign		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop public relations efforts targeting condom users		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conduct research to provide profile of STD repeat patients		X	X		X	X			X	X						
Develop materials on STD symptoms and correct condom use.		X	X				X				X					
Develop small group counseling training and education materials			X				X				X					
Produce and distribute small media promoting health-seeking behaviors			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Provide training for clinic personnel, pharmacists, and other STD health care givers			X	X	X			X	X	X			X		X	
Strengthen syphilis testing so all STD centers can perform immediate syphilis serology.		X	X	X	X	X	X									
Improve contact investigation.	X	X	X	X	X	X	X									
Strengthen laboratory and educational capabilities of clinics.		X	X	X	X	X	X									
Improve treatment and case management of STD patients		X	X	X	X	X	X									
Conduct a managerial, operational, and logistical audit of the comprehensive health clinic.		X														
Provide necessary equipment for syphilis testing			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop and implement works on condom promotion			X	X	X											
Evaluate syphilis testing sites to assist MOH laboratory upgrade of STD laboratories			X	X												

## **5.2 Target Group Component: COMMERCIAL SEX WORKERS**

### **Description**

With the declining economic situation in Jamaica, one can expect to see an increase in the number of women exchanging sex for money or goods. Kingston probably has the largest concentration of CSWs in Jamaica. However, the Montego Bay and Negril resort communities on the north coast of the country, also have a large CSW population. The commercial sex industry is illegal in Jamaica and consequently CSWs operate outside any formal organization. Some CSWs work in brothel houses but primarily they use bars, clubs, hotels, and/or streets.

The Women's Health Study was conducted among CSWs in Kingston in 1989. The objectives of the study were:

- o To assess the prevalence of HIV infection and other STDs in female CSWs in Kingston.
- o To determine if high-risk sexual practices leading to the prevalence of STDs can be reduced by educational interventions.

Results of this study found that the prevalence of HIV was 12% among 110 female sex workers in Kingston, compared to an estimated national prevalence of approximately 1%. Other STDs in the group were likewise higher (positive tests for syphilis 41% compared to 3.6%).

Given the correlation between the presence of STDs and a dramatic increase in susceptibility to HIV infection (related to behavior and biomedical factors) it can be assumed that these women and men are at increased risk of HIV infection and represent a vector for further spread of the infection into a broader population.

Outreach educational services via a drop-in education and counselling center are currently being provided by ACOSTRAD in Kingston. Other projects to reach CSWs in Kingston and in resort communities such as Ocho Rios and Negril with AIDS prevention education, condoms, STD services and counseling have not been identified, indicating that significant need exists for services for these women and men.

### **Objectives**

1. To promote better knowledge, self-care and confidence among CSWs to enhance skills in preventive behaviors including increasing condom use negotiation skills and increasing STD treatment-seeking behavior.
2. To increase accessibility and correct use of condoms by clients and CSWs.
3. To decrease the level of STDs by strengthening services and accessibility to public and private clinics.

## Major Project Areas

Activities to reach women (and if possible men) who trade sex for money and/or goods will begin by strengthening treatment and support services through public and private (NGO) systems including improved access to condoms, better trained personnel and procedures at clinics and intensified peer education projects to promote safer sexual practices. CSWs will also be trained as peer educators to conduct community outreach services including condom promotion and distribution.

### STD Treatment and Diagnosis

- o Ensure that improved STD case management interventions are also directed toward CSWs and that treatment-seeking counseling, including follow-up and partner notification, is made available to this population.
- o Maintain effective linkages between CSWs and STD services through trained outreach workers, including peers.

### Behavior Change/Communications

#### Planning/Development

- o Develop a peer education project using small group activities promoting skills-building for self-protection and risk reduction behaviors.
- o Develop an outreach project with trained field workers to conduct STD and HIV/AIDS education and promote/distribute condoms.
- o Develop and implement a communications campaign targeted specifically to condom consumers that promotes the price and time/place availability of condoms in the commercial sector.
- o Develop and implement a communications campaign promoting the concept of planning ahead and being prepared -- e.g. buying condoms in time to put them in your pocket as part of getting dressed to go out. This intervention would target both the client and the CSWs.

#### Implementation

- o Produce targeted small media for CSWs seeking HIV/AIDS education (includes low-literacy materials, posters, videos).
- o Develop individual and small group counseling training through workshops and nontraditional channels such as performance-based educational interventions; design and disseminate education materials targeted to peer educators and the general CSW population
- o Establish a peer counseling project (NGO-based) to perform the above outreach to CSWs.

Condoms

- o In collaboration with SOMARC, explore the feasibility of commercial condom distributors making branded condoms available for sampling within public sector STD clinics and through contact case workers, including peer distributors.
- o Facilitate the development of a standard practice for distributing condoms to MOH clients (i.e., occasion at which condoms are distributed, number of condoms to be supplied on each occasion, types of clients who will be encouraged to purchase future condom needs in the commercial sector).
- o Implement market research necessary for developing a consumer profile for this target population. Ascertain favored outlets for condoms as part of this profile.
- o Implement qualitative or other appropriate research to ascertain the impact distribution versus communications interventions can have in resolving time and place accessibility barriers to increased condom use for this target population
- o In collaboration with SOMARC, develop a strategy for condom accessibility based on the results of these studies.
- o Implement consumer intercept surveys to monitor success in reaching targeted populations with condom sales.

**Technical Assistance:**

**AIDSCAP/UNC:**

- o Improve quality of and access to STD services.

**AIDSCAP/Program for Appropriate Technology in Health (PATH):**

- o Conduct Training of Trainers for outreach to CSWs.

**Suggested Implementing Agencies**

Potential implementing agencies include ACOSTRAD and Women's Center affiliate.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>COMMERCIAL SEX WORKERS</b>																
Assess prevalence of HIV/STD				X				X				X				X
Conduct educational activities at regular sites				X	X	X	X	X	X	X	X	X	X	X	X	X
Implement peer education outreach project				X	X	X	X	X	X	X	X	X	X	X	X	X
Increase accessibility and correct use of condoms			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conduct consumer intercept surveys					X	X										

### **5.3. Target Group Component: ADOLESCENTS:**

#### **Description**

A study on adolescent behavior in 1988 indicated that by age 16, over 36% of females and 75% of males had initiated sexual activity. Even at age 14, the figures were 15% and 50% respectively. Young people are a primary target group because their infection rates are lower than other groups and their sexual attitudes and behaviors are still in the formative stage. This experimental/formative stage also presents the greatest risk factor among adolescents because it is combined with limited knowledge of sexuality and related risks associated with certain sexual practices including multiple partners.

In an effort to promote awareness and create healthy sexual behaviors, a pilot educational project was conducted in 1992 for students in grades 6 - 9 on HIV/AIDS and other STDs. Results of this pilot project are encouraging:

- o Increased recognition of the relevance of HIV/AIDS to the females in the target group
- o Increased recognition of HIV/AIDS as a life-threatening disease by the total sample
- o Increased ability to state a correct method of HIV transmission
- o Increase in consistent condom use among those of the target group who are sexually active, with the percent of those who claim to protect themselves every time through condom use increasing from 32% to 41%.

Although these results are encouraging, the pilot project was limited in scope. In order to effect broader impact, all youth in and out of school should be targeted.

#### **Objectives**

1. To reduce the potential for HIV infection among youth in and out of school by eliciting the adoption of safer sexual behaviors and attitudes including delaying the onset of sexual activity.
2. To ensure accessibility to and correct use of condoms by adolescents who are sexually active.
3. To educate adolescents about sexuality, the risks and consequences of HIV infection, symptoms of other STDs, and the appropriate treatment-seeking behavior.

#### **Major Project Areas**

Activities in support of the objectives listed above will build on previous and continuing activities to increase knowledge/awareness, explore attitudes/perceptions, and foster healthy behavior adoption. Continuing efforts in support of pilot school education projects, which include the development of a sexuality education curriculum at the primary and secondary schools, along

with teacher training and community education, and the use of mass and small media to support safer sexual behaviors, will be complemented by community-based, peer education interventions.

### Behavior Change/Communications

#### Research

- o Identify resources to conduct a targeted mass media situational analysis including media use, availability of local resources, and an assessment of audience, message source, channel, and message development.
- o Conduct research examining the accessibility of condoms to youth and the sexual decision-making.

#### Planning/Development

- o Assess the development of mobile, interactive video kiosks (with literature take-away materials) for placement at youth-oriented activities (schools, churches, dances, health fairs).
- o Design and disseminate education materials and discussion guidelines to be used by peers and counselors in interpersonal communications activities.
- o Assist with the development of a sexuality education curriculum in primary and secondary schools to include teacher training and community education.
- o Develop materials and provide skill-building training for condom negotiation and use skills.

#### Implementation

- o Develop a comprehensive plan for BCC for youth.

#### Curriculum Development

- o Develop curriculum on sex education to be used nation-wide.
- o Develop curriculum for high schools and train teachers in curriculum.

#### Small Media

- o Produce targeted small media materials (low literacy brochures, comic books/novellas, posters, videos).
- o Produce and distribute promotion materials (pencils, key chains, magnets, rulers, pins) promoting youth oriented risk-reduction behaviors (delayed onset of sex) and the AIDS Helpline telephone number.

#### Interpersonal

- o Identify and support forums for youth-focused activities (sports, religious and social groups) that can support positive normative youth behaviors (delayed onset

- o of sex, responsible behavior).
- o Support teen empowerment groups that promote positive attitudes, self esteem, and HIV/AIDS education.
- o Support and promote performing arts groups presentations and dramatic productions addressing sexuality decision making and HIV/AIDS awareness (e.g. Little People "Vibes").

#### Mass Media

- o Assess current adolescent media project; develop a targeted mass media campaign (youth-oriented programming) based on KABP data, communication behavior models, and qualitative research. Produce message concepts, test with audiences, and implement project on a continuous basis. The campaign will include media relations materials, productions and public service advertising.
- o Produce and place youth-oriented radio shows (dramas, talk shows, serials) that explore sexuality and promote delayed onset of sex, as well as condom use for those who are sexually active.
- o Encourage production of reggae songs promoting delayed onset of sex and HIV/AIDS awareness.
- o Through qualitative research identify sports/entertainment role models who can promote delayed onset of sex, HIV/AIDS awareness, and risk-reduction behaviors.
- o Use Jamaica Information Services (JIS) to disseminate HIV/AIDS messages, especially in rural communities.
- o As appropriate, use social marketing to increase condom sales and use.
- o Provide communications TA to groups and organizations targeting youth (churches, social and sports organizations) to increase their capacity to disseminate effective sexuality and HIV/AIDS messages.

#### Condoms

Activities related to condom availability in the commercial and public sector are referred to in general discussion of condom promotion and distribution as it affects availability and consumer habits. The issue of condom use within this target group is necessarily a sensitive issue and any intervention related to the promotion and distribution of condoms would be conducted within the socially acceptable norms of Jamaica.

- o Conduct market research to ascertain community perceptions on the acceptability of condom sales and distribution to youth.
- o Develop a consumer profile for this target population; ascertain favored outlets for condoms as part of this profile.
- o Develop and implement a communications campaign targeted specifically to youth that includes a variety of messages, including condom use if youth choose to become sexually active.
- o Develop and implement efforts to diminish the embarrassment associated with purchasing condoms.

- o Examine other non-media channels of communications for youth.

**Technical Assistance**

**AIDSCAP/PATH:**

- o Train trainers for outreach and counseling.

**AIDSCAP/Ogilvy, Adams and Rinehart (OAR):**

- o Develop and implement mass media campaign.

**Berl Francis**

- o Develop and implement public relations campaign.

**Suggested Implementing Agencies**

The Red Cross of Jamaica will implement a project to reach adolescents in school throughout Jamaica. ACOSTRAD will implement a project to reach youth out of school. Teen Players and Little People will perform plays to reach youth primarily in schools.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>ADOLESCENTS</b>																
Educate adolescents about sexuality.				X	X	X	X	X	X	X	X	X	X	X	X	X
Assess, develop, and implement communication campaign for youth.				X	X			X	X	X						
Develop materials for condom negotiations and use skills.				X	X							X				
Produce youth-orientated radio shows.					X			X				X				X
Identify sports/entertainment role models who can promote delayed onset of sex.				X	X		X				X				X	
Use social marketing to increase condom sales.		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**5.4. Target Group Component: ADULTS WITH MULTIPLE SEX PARTNERS**

**Description**

Data from previous national KAP surveys indicate that the majority of people start sexual activity at an early age and that they have multiple partners. STD levels are indicative of sexual activity that places persons at risk and the presence of STDs substantially facilitates the transmission of HIV. Between 1986 and 1991 syphilis has increased 106%, NGU 68%, and chancroid 191%.

### Objectives

1. To raise the awareness of HIV infection among adults with multiple sex partners.
2. To persuade this population that certain sexual behaviors place them at risk of HIV infection.

### Major Project Areas

STD diagnosis and treatment and condom accessibility activities within this target group are not distinct from the overall program to increase the availability of services and to encourage safer sexual practices, including condom use. The BCC component, however, does have specific, target-related interventions detailed below.

### Behavior Change/Communications

#### Research

- o Conduct research examining the accessibility to condoms and condom use in casual, secondary, and primary relationships.
- o Identify resources to conduct a targeted analysis of channels of communication, including media interpersonal networks and institutional networks. The mass media situational analysis will include a media use survey, availability of local resources, assessment of previous mass media campaigns, and an assessment of targeted communications in terms of audience, message source, channel, and message.
- o Identify male and female support groups to conduct HIV/AIDS awareness, education, behavior change and condom promotion (e.g. Fathers Inc., Women Inc.).
- o Assess efficacy of developing and placing 35mm motion picture advertisements.
- o Assess development of mobile, interactive video kiosks on HIV/AIDS and risk-reduction behaviors. Place in areas frequented by target audience (shopping centers, Parent/Teacher Association (PTA) meetings, churches, health fairs).
- o Assess efficacy of a mass direct mail to adults about healthy life styles including STD, HIV/AIDS, and risk-reduction messages.
- o Assess HIV/AIDS communications infrastructure regarding project management across planning, coordination and implementation functions.

#### Planning/Development

- o Develop materials and provide skill-building training for condom negotiation and use.
- o Identify and train peer community leaders to generate support for consistent risk-reduction behaviors.
- o Design and disseminate educational materials and discussion guides to be used by counselors in interpersonal interventions.
- o Develop targeted mass media campaign using KABP data, advertising tracking studies, and behavior communications models.
- o Identify messages and channels, concept development process, and focus group testing of selected messages.
- o Coordinate family planning and HIV control activities regarding condom promotion.
- o Identify sports/entertainment role models who promote risk-reduction behaviors.

### Implementation

- o Produce targeted small media for those seeking HIV/AIDS education.
- o Promote Helpline and collect/analyze call data quarterly.
- o Develop and distribute promotional materials (coasters, key chains) promoting risk reduction behaviors, condom use, and the AIDS Helpline.
- o Support a Resource Center clearinghouse to coordinate the production, storage, fulfillment, and dissemination of HIV/AIDS small media materials. Conduct quarterly evaluations.
- o Develop a comprehensive media relations project to include regular placement of feature articles, placement of new stories and captioned photos, placements on interview shows, and sustained outreach to journalists, columnists, reporters, and commentators to educate them on HIV/AIDS developments and promote sustained coverage.
- o Issue monthly news releases and photo captions on HIV/AIDS prevention activities, collect media coverage, and analyze quarterly.
- o Develop new or use existing radio soap operas to promote risk-reduction messages among adult audience segments.
- o Develop and place short stories on HIV/AIDS and risk-reduction behaviors (The Star and Flair).
- o Encourage radio and television talk show hosts to discuss HIV/AIDS, risk-reduction behaviors, and condom use.
- o Develop project to encourage entertainment figures and disk jockeys to include risk-reduction and condom use messages in their materials (e.g. Shabba Ranks, Buju Banton, Tiger).
- o Use the JIS regional services to disseminate HIV/AIDS messages to rural areas.

### Technical Assistance

AIDSCAP/PATH:

- o Conduct Training of Trainers for communications activities.

**AIDSCAP/OAR:**

- o Develop and implement mass media campaign.

**Berl Francis:**

- o Conduct public relations campaign.

**Suggested Implementing Agencies**

The EPI Unit will be responsible for conducting communications activities. In addition, ACOSTRAD will implement a project to reach people with multiple partners in marginalized communities.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>ADULTS WITH MULTIPLE SEX PARTNERS</b>																
Develop materials to provide training for condom negotiations and use.			X	X						X						
Identify and train peer community leaders.		X					X				X				X	
Develop and implement targeted mass media campaign				X	X	X			X	X	X	X	X			
Coordinate family planning and HIV control activities.		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Promote Helpline and collect analysis call data quarterly.				X	X	X	X	X	X	X	X	X	X	X	X	X
Issue monthly news releases and photo captions on HIV/AIDS prevention.				X	X	X	X	X	X	X	X	X	X	X	X	X
Develop radio soap operas to promote risk reduction messages					X		X				X				X	
Design integrated communications strategy.			X	X	X											
Develop a consumer profile			X	X			X				X					

**5.5. Target Group Component: MEN WHO HAVE SEX WITH MEN**

**Description**

The total population of MWM in Jamaica is represented across all social and economic groups;

they are predominantly urban and the majority of these men do **not** self-identify as homosexual but rather describe themselves as bisexual. While bisexuality is generally tolerated as long as men can display overt trappings of machismo and can operate **successfully** in mainstream culture, homosexuality is heavily stigmatized. It is likely that this **social intolerance** results in a large number of homosexual men choosing to integrate into **heterosexual** society through bisexual lifestyles.

One of the largest known subgroups of MWM is composed of **young men** (19-25 years) with little formal education and occasional employment, representing **lower socioeconomic groups**; however, this is not the extent of the MWM target group.

In September 1977 a gay activist group, the Gay Freedom Movement (GFM), was formed; the group met regularly and had a monthly newsletter, "The Gaily News." However, with the conservatism of the 1980s and the onset of HIV/AIDS, the **social environment** for MWM worsened and many men migrated or integrated into mainstream life, bringing a gradual end to this organization.

In 1991, a second support group for MWM was established. **JAS** was formed by friends of AIDS patients. The focus of JAS is to provide care and support to persons with HIV/AIDS, as well as HIV/AIDS prevention information to the larger **homosexual** community. The group has a regular membership of approximately 150 people who meet **weekly**; the JAS outreach to the larger MWM community goes well beyond this membership. In addition to weekly meetings, the group sponsors parties where safer sex messages are **incorporated** into performances. JAS is a growing organization and USAID is currently providing **resources** for HIV/AIDS prevention activities undertaken by the organization.

MWM are a primary target group because their infection rates in **1986** were more elevated than those of the general population, and the presence of a large **bisexual** population may facilitate the spread of the virus to a broader segment of the general population. Furthermore, as a highly stigmatized segment of society, MWM are less likely to openly **seek** safer sex information and treatment for some STDs.

## Objectives

1. To reduce the potential for HIV infection within this **population** by eliciting the adoption of safer sexual behaviors and attitudes related to their **sexual lives**.
2. To ensure access to and correct use of condoms.
3. To educate MWM about symptoms of STDs and encourage **treatment-seeking** behavior to reduce the rates of STDs and lower the concomitant **increased risk** of HIV infection.

## Major Project Areas

### Diagnosis and Treatment of STDs

- o Promote STD services among MWM to increase treatment-seeking behavior.
- o Develop linkages between MWM organizations and STD treatment and diagnostic services; investigate the private sector as a potential resource.
- o Develop and distribute educational information on STD facts specific to MWM, including: symptoms, treatment, transmission and prevention (includes low-literacy print materials, videos, posters, and counseling guides).

### Behavior Change/Communications

- o Provide the necessary information, education, and counseling to MWM to change behaviors that put them at risk of HIV infection.
- o Expand existing peer education projects and develop new information resources, especially for men who do not self-identify as homosexual.
- o Expand existing capacity for individual and small-group counseling and the development of accompanying educational materials.
- o Expand current capacity for workshops to promote safer sex for MWM, especially outside the Kingston area.
- o Organize community support activities to work with MWM to design intervention strategies (e.g. JAS).
- o Identify and train community leaders to generate community support for consistent risk-reduction behaviors.
- o Produce small media targeted within the MWM community to men seeking HIV/AIDS education materials (includes print materials, videos, posters, and counseling guides).

### Condom Promotion and Distribution

Ensure that condoms are affordable and accessible to the MWM community:

- o Determine the appropriate mix of free, socially-marketed and commercially sold condoms as well as the most appropriate distribution system(s) to stimulate condom use by MWM.
- o Develop and implement a communications/marketing strategy to promote condom use and identify the risks of non-use.
- o Develop and distribute educational materials on safer sex techniques including condom use.

### **Technical Assistance**

The EPI Unit within the MOH will provide TA in material development and capacity-building.

### **Suggested Implementing Agencies**

Among the groups with access to the MWM is JAS, which will continue to implement its projects and will expand its activities to reach MWM communities outside the Kingston area and to provide services for men who do not self-identify as gay. SOMARC will establish an in-country presence to develop its social marketing project, which is being transferred from the public to the commercial sector. UWI, which is currently conducting behavioral research on KABP, may also be asked to collaborate on MWM-related behavioral research.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>MEN WITH MEN</b>																
Expand existing peer education projects	X	X	X	X	X	X	X	X								
Organize community support activities	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identify community leaders to generate community support.		X	X	X												
Train community leaders		X				X				X				X		
Produce and distribute education materials.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Promote STD services among MWM.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Develop and distribute education materials on safer sex	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Conduct research on identifying perception of risk				X	X	X					X	X	X			
Measure HIV and syphilis rates as part of sentinel surveillance				X				X				X				X

## 5.6. Target Group Component: HIV POSITIVE PERSONS

### Description

It is estimated that in Jamaica there are 3-4,000 people who are HIV positive. Discrimination against people with HIV/AIDS results in few people coming forward to reveal their HIV status. In addition, limited medical and support services also inhibit individual testing. Jamaica's current contact investigating policy includes informing people that they have been exposed to HIV. Contact investigators conduct pre-HIV test counseling and inform people of their results. Currently little follow-up of HIV positive people is possible under the existing system.

### Objectives

1. Provide long-term counseling and support services for people who are HIV positive to

mitigate negative reaction to their status and encourage safer sexual practices to minimize transmission of the virus.

2. Assess feasibility of a communication project designed to destigmatize HIV/AIDS. If relevant, design and implement project.

### **Major Project Areas**

STD diagnosis and treatment and condom accessibility activities within this target group are not distinct from the overall program to increase the availability of services and to encourage safer sexual practices, including condom use. The BCC component, however, does have specific, target-related interventions detailed below.

#### Behavior Change/Communications

##### **Research**

- o Assess efficacy of development of a communication project designed to destigmatize HIV/AIDS, including small media and mass media. Conduct assessment of current messages and environment.
- o Identify support groups for people with HIV/AIDS to provide medical and counseling support.

##### **Planning/Development**

- o Develop individual and small group counseling training and education materials.

##### **Implementation**

- o Produce small-media materials and conduct workshops for health care workers on educating people at risk of spreading HIV (e.g. The Family Center).
- o Identify and train peers to generate target audience support for consistent, responsible, risk-reduction behaviors.
- o Produce targeted small media for those seeking HIV/AIDS information.
- o Possibly develop a mass media project to destigmatize HIV/AIDS.

### **Technical Assistance**

Potential sources of TA for this component would be provided through the AIDSCAP Latin America and Caribbean (LA/C) Regional Office, AIDSCAP Headquarter staff, and collaborators such as PATH, OAR (for assessment of feasibility of media campaign), and the Center for AIDS Prevention Studies at the University of California, San Francisco (CAPS/UCSF).

## Suggested Implementing Agencies

ACOSTRAD, JAS, and the Red Cross of Jamaica in conjunction with the MOH may be the primary NGOs implementing activities for this target group.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>HIV POSITIVE PERSONS</b>																
Conduct support groups for people with HIV/AIDS to provide medical counseling					X	X	X	X	X	X	X	X	X	X	X	X
Produce small-media material and conduct workshops for healthcare workers on educating people with HIV			X	X		X				X				X		
Identify and Train Peers to reach target audiences			X	X			X				X				X	

## INTERMEDIARIES

The following target groups represent policy makers, opinion leaders, the medical community, the commercial sector, and other influential segments of Jamaican society whose participation in HIV/AIDS prevention activities is essential if the epidemic is to be controlled. Therefore the USAID project has identified specific strategic interventions to solicit participation, change policy, provide private sector services and in general engage these individuals in a national campaign to prevent the continuing spread of HIV in Jamaica.

### 5.7. Target Group Component: MEDICAL/HEALTH COMMUNITY

#### Objectives

1. Improve and expand the delivery of health services, public and private, in the areas of importance to the HIV/AIDS epidemic, particularly STD diagnosis and treatment.

#### Major Project Areas

##### Diagnosis and Treatment of STDs

- o Provide TA to the MAJ as required to develop and publish a standards of care protocol for treatment of HIV/STD clients.
- o Provide TA to the MAJ as required to develop and implement a system for

- o monitoring compliance with the published standards of care.
- o Provide TA to the MAJ, Pharmacists Association, Nurses Association, and relevant educational institutions as required to develop improved curricula for use in training future practitioners in the area of STDs, HIV/AIDS, healthy life-style behaviors, and client counseling.
- o In conjunction with the appropriate professional associations (including at least physicians, pharmacists, and nurses), develop and implement a series of continuing education seminars for current practitioners in the area of diagnosis, treatment, and counseling of HIV/STD clients.
- o Provide TA in the development of a feasibility study and business plan for the establishment and operation of a private sector STD-related clinic(s) in selected pilot site(s) in Jamaica.
- o Develop a presentation package, based on the studies described above, and implement presentations to selected groups of private physicians (eg. existing HMO or health management groups) or health care investors to encourage establishment of private sector STD treatment centers
- o Provide TA, if required, in facilitating the formation of potential investment groups.
- o Provide management and social marketing training for NGOs.
- o Provide TA in the development of strategic plans and annual management/marketing plans to selected organizations.

#### Behavior Change/Communications

- o Identify and survey key medical personnel in the public and private sector to assess concerns and perceptions of Jamaican health issues generally and specifically, STDs and HIV/AIDS.
- o Provide assessment to the medical community, policy makers and, if appropriate, the media.
- o Develop a project in conjunction with the MAJ to destigmatize HIV/AIDS and promote HIV/AIDS education and training.

#### **Technical Assistance**

##### **AIDSCAP/UNC:**

- o Provide TA to MAJ stated in project areas.

##### **AIDSCAP/PATH:**

- o Provide training in developing appropriate educational materials.

#### **Suggested Implementing Agencies**

MAJ and the EPI Unit will be primarily responsible for this component.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>MEDICAL HEALTH COMMUNITY</b>																
Provide TA to the MAJ, pharmacists, nurses, etc to develop maternal to train future practitioners.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop messages to promote STD treatment centers				X	X											
Survey key medical personnel to ascertain concerns and perceptions of Jamaican health issues					X	X										

### **5.8. Target Group Component: POLICY MAKERS AND OPINION LEADERS**

#### **Description**

Policy makers are defined as individuals and groups located in the public, parastatal, and NGO sectors. Opinion leaders are individuals and groups located in the private, commercial, and social organization sectors who can reach people at social access points (e.g. church leaders, the media, and business and labor leaders). Together they may influence the creation, adaptation, interpretation, and implementation of formal and informal laws and policies. They also can influence the knowledge, attitudes, and behaviors of others in their social spheres.

Influential groups also harness community support for behavior change by reaching people at social access points and can positively influence knowledge, attitudes, and behaviors of others in their social spheres. They can assist in placing HIV/AIDS on national agendas and help facilitate the development of effective prevention projects and behavioral changes. In Jamaica, these influential groups include churches, the media, PTAs, school principals, and business and labor organizations such as the Rotary, Lions, Chamber of Commerce, and the Private Sector of Jamaica (PSOJ).

#### **Objectives**

1. Foster a supportive environment for effective prevention projects implementation and generate increased and ongoing support for HIV/AIDS projects.
2. Encourage a dialogue among Jamaican policy makers and opinion leaders concerning the public and private sector policies that may hinder or facilitate successful implementation of the AIDS control efforts.

3. Promote the institutional sustainability of Jamaica's AIDS control effort and provide training and technology to improve the capacity of the various institutions.
4. Encourage policy makers within the GOJ to develop national policies that facilitate AIDS interventions and discourage the stigmatization of persons infected with HIV.
5. Encourage community leaders to publicly discuss and support HIV/AIDS prevention projects.
6. Project the potential socioeconomic impacts of Jamaica's AIDS epidemic, present findings to key public and private sector policy makers, and offer specific recommendations as to how these impacts may be mitigated. In part, this will involve demonstrating to policy makers that AIDS is a development issue as well as a health issue.
7. Assess the recurrent costs and effectiveness of various intervention approaches so that an appropriate mix of HIV/AIDS prevention investments can be demonstrated and implemented.

### **Major Project Areas**

The activities proposed under this component should work synergistically with other project components to create and maintain a positive HIV/AIDS prevention environment. The following interventions will support Jamaica's AIDS Policy Initiative:

#### Policy Analysis

- o Identify a collaborative partner (individual or organizational) familiar with the policy process in at least two of the following sectors: national and local government, NGOs and community-based groups, business and labor, cultural and religious.
- o With the collaborative partner, prepare a policy assessment which identifies problems that relate to national and sectoral HIV/AIDS prevention policies and sets out at least three intervention options, with supportive rationale, for the national and sectoral categories chosen. In conjunction with BCC activities, this assessment will identify and survey key influential groups (churches, PTAs, business and labor organizations, social networks) to assess concerns and perceptions of HIV/AIDS in Jamaica. This assessment may include recommendations for further strengthening the institutional/managerial capacity of the NAC.
- o Building on the policy assessment, hold two "policy strategy" workshops (each two to three days long) to identify and assign priority to policy initiatives within each sector which can support HIV/AIDS prevention efforts. The outcomes of the workshops will include a set of recommended options/strategies for implementing the policy initiatives.

#### Impact Assessment

- o Survey commercial sector leaders in order to: (i) identify and analyze the economic impact of HIV/AIDS on businesses; and (ii) identify existing policies related to workplace responses to persons with HIV.
- o Design a formula with which businesses can themselves evaluate the impact of HIV infection in their work force, focusing not only on the costs of infections but also on the benefits derived from preventive interventions and non-discriminatory policies.
- o Develop projections as to the health impact of HIV/AIDS in Jamaica using a surveillance database and available projection models.<sup>3</sup>
- o Perform a survey of public and private hospitals to assess the costs of treating persons with AIDS. Results of the study should: (i) focus on planning for appropriate health care; (ii) assess the informal costs to families of ill, hospitalized, and home care patients; and (iii) identify cost-effective and human treatment strategies.

### Policy Dialogue

- o Help facilitate a policy dialogue with policy makers and influential groups (including government decision makers, church leaders, business community leaders, etc.) so that they may develop a comprehensive and integrated strategy for destigmatizing HIV/AIDS in Jamaican society. This is a necessary step in creating an effective and sustainable national HIV/AIDS prevention program.
- o With national collaborators, design two to three "commercial sector workshops," including formal and informal sectors of the economy, business associations, and worker representatives. The workshops will address the impact of HIV/AIDS on the work force and business productivity using data derived from #1 under "Impact Assessment."
- o Assist national collaborators in preparing at least two "national impact" workshops that include government policy makers from various ministries. Using information, scenarios, and strategies devised in the "Policy Analysis" and "Economic Impact" activities, these workshops will, (i) make policy makers fully aware of the potential developmental, health and economic impacts of HIV/AIDS and (ii) allow policy makers to assess and select policy alternatives for further implementation.
- o Assist national collaborators to undertake various other policy dialogue activities as developed in the policy assessment, "policy strategy," and "national impact" workshops.

### Institutional and Financial Sustainability

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<sup>3</sup>The National Institute of Health (NIH) is currently developing an AIDS baseline file for Jamaica. AIDSCAP will collaborate with NIH and will share and compare projections as appropriate.

- o Condom logistics and health care economists will collaborate to conduct recurrent cost analyses in public condom delivery and STD diagnosis and treatment systems and generate unit costs for the different interventions.
- o Policy dialogue implementors will encourage the NAC to form a policy sub-committee that will regularly initiate, promote, and monitor national and sectoral policies related to HIV/AIDS prevention.

**Technical Assistance**

**AIDSCAP:**

- o Conduct a policy assessment, initiate a policy dialogue through a series of workshops.

**AIDSCAP/PATH/OAR:**

- o Develop communication materials for policy dialogue.

**Berl Francis:**

- o Conduct a public relations campaign.

**Suggested Implementing Agencies**

The EPI Unit will be primarily responsible for implementing this component. In addition, PSOJ and UWI will participate.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>POLICY MAKERS</b>																
Conduct policy assessment			X	X												
Develop projections			X	X	X											
Estimate cost of AIDS care					X	X	X									
Perform a survey of public and private hospitals to assess the costs of treating person with AIDS.					X	X	X									
Implement commercial sector workshops						X	X	X	X	X	X	X	X	X	X	X
Perform national impact workshops							X	X	X	X	X	X	X	X	X	X
Develop a plan for destigmatization of HIV positive people					X	X	X	X	X	X	X	X	X	X	X	X
Recurrent cost analysis					X					X			X			X
Organize NAC Policy Committee.					X	X										

## 5.9. Target Group Component: CONDOM RETAILERS/COMMERCIAL SECTOR

### Description

Within the Jamaican context, the commercial distribution infrastructure is the primary sustainable source of condoms and already supplies more than half of all condoms distributed annually. Approximately 200 pharmacies and more than 10,000 other retail locations represent actual or potential outlets for condom distribution to consumers.

The commercial distribution infrastructure includes not only retail outlets but also:

- o at least four importers/distributors of condoms (large firms with extensive distribution networks);
- o approximately 100 wholesale outlets (which sell to shop owners who come for goods at the wholesalers' fixed locations); and
- o an unknown number of small-scale individual entrepreneurs who buy from wholesalers and travel throughout the countryside to resell these goods to small shops.

### Objectives

1. Facilitate more effective use of the existing distribution infrastructure for condom distribution to targeted populations.

2. Facilitate use of more effective promotional activities both to the trade and to the consumer.
3. Encourage commercial sector provision of condoms in a broad range of consumer prices.
4. Encourage commercial sector contribution of brand-specific advertising and promotion within the context of USAID interventions.
5. Promote consumer use of commercial channels for acquiring condoms and diminish consumer embarrassment in acquiring condoms through these channels.

## **Major Project Areas**

### Condoms

#### Condom Availability

Activities necessary to enhance consumer use of the commercial sector for obtaining condoms are described under the target populations above.

- o Develop accurate profiles of target consumers appropriate for commercial sector condom distribution.
- o Develop a sustainable plan for motivating retailers at the bar, club, hotel, small shop, etc. level to buy and resell condoms.
- o Assess the financial and logistic feasibility of more direct distribution of condoms to the types of retailers listed above.
- o Assess the feasibility of interventions at the level of the wholesaler/haberdasher to facilitate product "push" into small retail outlets such as those listed above.
- o Develop a coordinated strategy for condom marketing/distribution to targeted consumers in Jamaica.
- o Develop and implement communications campaigns targeted specifically to condom retailers that promote price and place availability of condoms in the commercial sector.

#### Condom Acceptability

- o Develop and implement, as part of the BCC Strategy, communications and public relations efforts targeted to condom retailers that will ameliorate retail conditions and retailer attitudes contributing to consumer embarrassment in purchasing condoms.
- o Develop Point of Sales and other strategies (such as placement of product near the cash register or in other locations where it does not have to be requested verbally) that make purchase of condoms in retail outlets less embarrassing for the consumer.

## Technical Assistance

### AIDSCAP/SOMARC/JSI:

- o Increase access to condoms.

### AIDSCAP/OAR:

- o Assist in developing condom promotion campaign.

## Suggested Implementing Agencies

Commercial sector firms already expressing interest in participation in USAID condom distribution activities include Facey Commodity, Grace Kennedy, Central Trading Company, Gideon Richter, and Wisynco. A variety of local market research and communications/advertising/public relations agencies exist in the Jamaican market. USAID has already had experience in working with a number of them: Berl Francis, Hope Enterprise, Dunlop, Corbin, Compton.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
<b>RETAILERS AND COMMERCIAL SECTOR</b>																
Increase accessibility and acceptability of condoms		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop Point of Sales material		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conduct consumer intercept studies		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Provide TA in the development of a coordinated strategy for condom marketing		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

## 6. MONITORING AND EVALUATION

### Proposed Strategy

Each individual sub-project within the Jamaica Country Program will be monitored and evaluated and the summary outcome and impact of all of the components will be monitored and evaluated by USAID.

The evaluation plan will use "core" measures similar to those being developed by the WHO/GPA/AID AIDS Priority Prevention Indicators (PPI) process. The PPIs are in the process of being refined by WHO/GPA/AID as country-level, HIV/AIDS prevention indicators of program impact. The purpose of developing this set of indicators is to provide a standardized protocol for monitoring and evaluating HIV/AIDS prevention and control programs that will allow cross-national comparisons. The basic constructs within the PPIs that will be measured

within the USAID Project include the following:

1. HIV and syphilis seroprevalence shifts assessed over the medium term (5 years);
2. Survey-based (as well as qualitatively measured) reported behavior change (eg. partner-type specific condom use, number and types of partners) assessed over the short (2 years) and medium term;
3. Survey-based knowledge of HIV prevention in the general population assessed over the short and medium term;
4. A facility-based assessment of STD case management (biomedical and condom/communication aspects) at the onset of activities in the STD component, and re-evaluated in the final year; and
5. Condom distribution and sales figures regularly aggregated from participating organizations and institutions, with an additional assessment of condom outlets in the initial (and final) years of program activity.

These PPIs are not intended to provide the Jamaica MOH/EPI Unit and/or the NACP or USAID with all the information necessary to monitor the implementation of prevention projects, nor to measure the impact of all prevention and control activities. The Jamaica MOH/EPI Unit and/or the NACP will include other monitoring and evaluation protocols. Whenever feasible, USAID will utilize and complement these protocols and additional indicators depending on the specific components.

### Research

Intervention-linked and supportive research will be necessary to evaluate and improve the effectiveness of project activities. Four types of research will be supported by the project:

1. Formative research directly related to baseline assessment activities for individual interventions with specific target groups;
2. Behavioral research that will contribute to the broad understanding of behaviors associated with transmission of HIV, determinants of these behaviors, and methods of modifying them;
3. Applied biomedical research to evaluate diagnostic and treatment tools and approaches; and
4. Operations and evaluation research to test and analyze new intervention approaches related to changing sexual behavior, condom use, and the reduction of STDs.

A distinction should be drawn between research activities related directly to evaluation of

interventions, and biomedical or behavioral research activities whose results would benefit many countries in a region or worldwide as well as providing information for locally-based interventions. The latter set of activities are generally more extensive and more costly.

### Monitoring and Evaluation

Monitoring and evaluation of the USAID project will encompass measurements of process, outcome and impact, addressed at both the country program level and the sub-project or component level, and measured in locations with and without project intervention. Both quantitative and qualitative data collection methods will be used during all phases of evaluation.

The phrase "country project evaluation" as used in this document refers to a summary evaluation activities in Jamaica among these at-risk target groups: STD clinic attenders, CSWs, adolescents, adults with multiple sex partners, MWM, and persons with HIV. The following intermediaries will be targeted: health care providers, retailers/commercial distribution channels, policy makers, and influential groups and individuals. Each individual "component" described in previous sections of this document refers to one or a set of "sub-projects" defined by one or more "subagreements" or contracts. The phrase "sub-project evaluation" refers to sets of indicators and activities designed specifically to monitor and evaluate individual interventions supported by USAID.

### Jamaica Project Indicators

Impact and outcome indicators will be measured at baseline and follow-up. Process indicators will be reported monthly. In addition to Priority Prevention Indicators, additional country-specific indicators will also be tracked. Depending on the results of continued development of the PPIs by WHO/GPA and AID, the measurement and/or wording of the PPIs is subject to revision. The Jamaica evaluation plan can then be adjusted to reflect changes. Additional country-specific indicators may be identified by project collaborators during sub-project development and can be incorporated into the set of country project indicators.

### Implementation of the PPIs

#### 1. HIV and syphilis seroprevalence rates

These two indicators will be monitored in the following populations in specific sites, both within the regions of project activity and in regions not included in project activity - throughout the life of the project:

- o 15-24 year old women presenting for antenatal care
- o food service employees
- o sailors
- o ICIs
- o homosexual/bisexual men
- o female prostitutes

- o [migrant farm workers] GTZ
- o hospital admissions
- o prisoners
- o STD clinic attenders
- o STD clinic repeaters

The project will not collect independent serologic results, but will assist in expanding sentinel surveillance data collection by the Jamaica MOH/EPI Unit.

It is anticipated that both HIV and syphilis seroprevalence rates should remain level or decrease slightly in areas of project activity after five years, and continue upward slightly, or perhaps stabilize in non-project areas.

## 2. Reported behavior change

Using two-stage cluster sampling techniques, population-based surveys will be conducted among independent samples of men and women aged 15-34 in both project and non-project areas at baseline and as needed during the life of the sub-project to assess reported behavior change. If possible, key indicators will also be incorporated into on-going or planned surveys by other agencies such as CDC, Johns Hopkins University (JHU), Demographic Health Survey (DHS). USAID supported surveys will provide the bulk of indicators including, but not limited to, measures of:

- o Condom use - stratified by gender and age of respondent, and type of partner, reported as use of a condom during the most recent act of sexual intercourse;
- o Knowledge of prevention - to be measured in an unprompted fashion;
- o Self-reported STD history - a time-bounded measure of male history of STD will be assessed by a validated series of questions as they become available.

## 3. STD case management assessment

STD prevention and control projects will incorporate measures of appropriate levels of diagnosis and treatment, in accordance with national standards. Adequacy of case management includes condom distribution and advice on partner notification, among other management guidelines. Case management assessment will be conducted as part of the general needs assessment to be undertaken at the onset of STD clinic-based prevention activities. A follow-up evaluation will be conducted in the last year of the project in the context of routine facility supervision. The three PPIs captured with this methodology are:

- o Proportion of clients (male and female) presenting with a specific syndrome (GUD or discharge) who are assessed and treated according to national guidelines;
- o Proportion of clients presenting for treatment of any syndrome who receive condoms and instructions in their use;
- o Proportion of clients presenting for treatment of any syndrome who receive counselling

to promote partner notification and treatment.

#### 4. Condom distribution and availability

The key outcome indicators for this component are:

- o 30,000,000 condoms sold or distributed per year during the life of the project;
- o Percentage increase of target population(s) reporting condom use in high-risk situations;
- o Percentage increase in condoms being purchased in the private sector.

Process indicators include:

- o 200,000 condoms per month distributed in the public sector;\*
- o 650,000 social marketed condoms per quarter sold,\*
- o Percentage increase in the number of condoms distributed;
- o Increase in the number of outlets participating in activities;
- o Decrease in number of people reporting difficulty getting condoms;\*
- o Decrease in stock-outs in public clinics.\*

A baseline assessment of the condom component will include an assessment of condom supply, distribution, and promotion, as well as retail audit studies. In addition, a consumer intercept survey of private sector condom purchasers will be conducted to develop a consumer profile and determine private sector (commercial and socially marketed brands) condoms.

The number of condoms distributed by participating organizations and institutions will be tracked on a monthly basis and aggregated on a quarterly or semi-annual basis by type of outlet to monitor progress in this area.

#### 5. Additional Country Level Indicators

USAID and the MOH/EPI Unit will select additional country-specific indicators to be measured at baseline and assessed again at the end of the intervention (outcome indicators), and to be used during monitoring of project activities (process indicators). At this point, we are focusing on private sector, policy, and sustainability/capacity building issues, and will use qualitative and quantitative methodologies to measure these.

The key outcome indicator for the private sector is a percentage increase in the number of STD/HIV/AIDS treatment provided by the private sector.

Process indicators would include but not be limited to:

- o Number of private practice physicians successfully completing continuing education courses;

- o Number of pharmacists successfully trained;
- o Number of IE&C materials produced and available for distribution by private sector physicians;
- o A communication campaign that promotes private sector providers.

Some of the baseline assessment being conducted addresses the private sector.

The key outcome indicator for the sustainability/capacity building component is the percentage of institutions trained by the project that implement integrated HIV/AIDS prevention projects.

Process indicators include the following:

- o Number of meetings/workshops/seminars/presentations/training sessions held with and for public and private sector institutions and community groups that include training in administrative management by type;
- o Number of subagreements signed with public and private sector institutions and community groups;
- o Number of people reached by the public and private sector institutions;
- o Number of people trained as trainers/educators;
- o Number of materials produced and distributed to and by public and private sector institutions;
- o Number of public and private sector institutions which have received institutional support that includes direct TA by type.

A baseline assessment for the capacity building/sustainability component will include:

- o Institutional assessments of public and private sector organizations involved or potentially to be involved in HIV/AIDS interventions. These will include both quantitative as well as qualitative methodologies. [Institutional assessments with recommendations for change were conducted by the World Bank in 1988.]
- o An analysis of public/private sector coalition building.

The key outcome indicator of the policy component will be the degree to which policy makers/opinion leaders in all key sectors, representing public and private institutions at the central and regional levels, are involved in policy dialogue activities.

Process indicators: Involvement of key policy makers/opinion leaders in policy dialogue will be measured by:

- o Number of presentations and site visits made by key individuals to community groups, professional associations, and social organizations;
- o Numbers of policy makers/opinion leaders attending policy workshops/presentations, by sector and by region;
- o Baseline policy analysis conducted by Aug. 93;

- o Number of national collaborators trained in policy analysis, impact assessments, and policy marketing through life of project;
- o Number of public, commercial and non-profit policy makers included in policy dialogue activities coordinated by national collaborators;
- o Number of CEAs conducted on public sector interventions by EOP.

Public commitment to HIV/AIDS prevention will be measured qualitatively by reviewing the content of newspaper articles, radio/television shows, and the records of public discussions supporting AIDS prevention activities. Changes in policies will be measured by the removal of identified restrictions or tariffs.

### Baseline assessment

At baseline, a policy assessment will be conducted by the PIOJ, the Policy Subcommittee of the NAC, and USAID. The assessment will begin with a logical framework-style exercise that will set a hierarchy of objectives for the assessment, as well as for policy activities during the life of the project. The baseline assessment will identify and assign priority to desired policies for condom distribution, STD prevention, and the promotion of safer sexual behavior. It will also identify social and economic policies that contribute to increasing or reducing the spread of HIV infection.

During the assessment, quantitative and qualitative measures of accomplishment will be developed. Process indicators could include the "number of policy makers contacted" or the "numbers of newspaper articles published about AIDS." Policy dialogue might be more effectively monitored through qualitative methods such as periodic papers on the country's policies that document public discussions influencing policy, and changes occurring from one period to another.

Additional country-level indicators might include:

- o Reported delays in onset of sexual activity among youth (< 20 years);
- o Sources of HIV/AIDS information in the past 3 months, and the most useful of these sources;
- o Percentage of population who specifically mention condom use as a way to protect themselves from HIV infection;
- o Percentage of population surveyed who believe that a majority of their friends and peers use condoms (or other risk reduction behaviors);
- o Awareness of and perceived accessibility of condoms, STD services, etc.;
- o Personal acquaintance with HIV carriers or persons with AIDS, particularly in low prevalence countries;
- o Perceived risk of HIV/AIDS in the population and reasons for expressed level of risk;
- o Changes in policies assessed to be ineffective or impediments to AIDS prevention and control initiatives;
- o Number of facilities or organizations "upgraded", including number of

- staff/educators/clinicians trained;
- o Amount (days/weeks) of TA (by technical area) that is provided to projects;
- o Number of contacts/meetings with NACP, MOH, other donors and policy makers;
- o Number of appropriate newspaper/magazine articles published about HIV/AIDS.

### Qualitative research

Many of the aspects of HIV prevention are difficult to measure or fully comprehend in a quantitative manner. Thus, there will be qualitative data collection activities conducted to complement quantitative assessments, both at baseline and throughout the life of the project. The content of these qualitative efforts will be designed to complement the quantitative measures at both the Jamaica country program and sub-project level.

### Internal reviews

During the life of the country project USAID may support a team to visit and assess the then-current level of implementation, as well as the detailed plans for following years. These visits should not be viewed as official external evaluations, but rather as internal procedures to critically assess the progress of the project to date.

### Sub-Project Evaluation

Each sub-project within the country program portfolio will be designed in cooperation with locally designated NGOs, PVOs, and USAID. Each sub-project proposal will contain an evaluation plan incorporating those PPIs or additional country program indicators which are relevant to the particular sub-project, along with process and outcome indicators specific to the sub-project, developed with input and oversight by the designated Evaluation Unit staff member.

Sub-project evaluations will often provide interim estimates of progress to objectives for the country program as a whole, in addition to their primary purpose of assessing the success of a particular sub-project. Sub-project evaluations should be as participatory in nature as possible to facilitate the utilization of evaluation results at the local level and to strengthen implementing agencies' capacity and inclination relative to evaluation.

Many of the indicators listed above are applicable at the sub-project level, but some additional sub-project process indicators designed to enhance the prevention component of a national STD component might include:

- o Number of STD patients counseled about STD and HIV prevention;
- o Number of patients receiving condoms and number of condoms distributed; and
- o Number of persons contacted through outreach activities.

Examples of outcome indicators for the same project might include:

- o Proportion of patients intending implementation of risk reduction behaviors (eg. condoms, reduced numbers of partners);
- o Proportion of clients who are repeat attenders at the STD clinics; and
- o Proportion of counselors who exhibit satisfactory skill levels at assessment and supervisory visits.

USAID will fund a person to identify, categorize, and develop a database of all research conducted in Jamaica relating to AIDS/STDs, behavior change, marketing/private sector, and family planning.

### Technical Assistance

The following table summarizes the components of the baseline assessment and those organizations responsible for TA to ensure completion of the activities.

Component of Baseline Assessment:	Budgeted under:	Potential Implementing Agency:
Conduct epidemiological surveillance (HIV and syphilis) seroprevalence of target groups and general population *	Evaluation component	MOH/EPI Unit PAHO, FHI AIDSCAP Evaluation Unit, AIDSCAP/UNC AIDSCAP LA/C Regional Office
Literature review that includes identification and categorization of behavioral and survey research conducted in Jamaica that relates to STDs, HIV/AIDS, behavior change, marketing, family planning. Develop and maintain database of all research	Evaluation component	Hope Enterprises, FHI AIDSCAP Evaluation Unit, AIDSCAP LA/C Regional Office
Assessment of condom supply, distribution, and promotion	Condom component	Hope Enterprises, FHI AIDSCAP Condoms Unit
Analysis of elasticity of demand of condoms as related to price increase (social marketed and commercial sector condoms)	Policy component	Hope Enterprises, FHI AIDSCAP Policy Unit
Consumer intercept survey of private sector condom purchasers (to develop profile of consumer and determine private sector affordability)	Condom component	Hope Enterprises, FHI AIDSCAP Condom Unit
Consumer intercept survey of public sector STD clinic attenders (to explore potential for switching to private sector)	STD component	Hope Enterprises, FHI AIDSCAP STD Unit, AIDSCAP/UNC AIDSCAP LA/C Regional Office

STD case and facility management in STD clinics	STD component	AIDSCAP/UNC FHI AIDSCAP STD Unit; AIDSCAP LA/C Office
Policy analysis	Policy component	PIOJ, FHI AIDSCAP Policy Unit AIDSCAP LA/C Regional Office
Health/economic impact analysis	Policy component	FHI AIDSCAP Policy Unit
CEA of the public sector	Sustainability component	FHI AIDSCAP
Institutional assessments (as related to capacity strengthening)	Sustainability component	To be determined
Public/Private sector coalition building analysis	Sustainability component	To be determined
Develop instruments for MWM KABP and focus groups discussions (perhaps to accompany sentinel surveillance of MWM)	Evaluation component	JAS, FHI AIDSCAP
Focused ethnographic study of key ethnocultural barriers to change	Behavioral research component	Hope Enterprises, FHI AIDSCAP
Tracking studies as related to behavior change 2x/year	Evaluation component	Hope Enterprises, FHI AIDSCAP
Lessons learned from a low prevalence country	Behavior research component	To be determined
Community mobilization	Behavior research component	CAPS
KABP of marginalized communities	Evaluation component	ACOSTRAD
National KABP post IE&C campaigns includes developing and maintain a database to ensure sustainability	Evaluation component	Hope Enterprises, FHI AIDSCAP Evaluation Unit

\* targeted for surveillance include: ANC attenders (as proxy for general population), food service employees, sailors, ICIs, homosexual/bisexual men, female prostitutes, migrant farm workers (funded by GZT), hospital admissions, possibly prisoners, STD clinic attenders, STD clinic repeaters.

TIMETABLE	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
OVERALL EVALUATION																
Literature review and database	X	X	X													
MWM questionnaire development (short & long versions)	X	X														
Tracking studies	X		X		X		X		X		X		X		X	
KABPs for target groups			X	X	X							X	X	X		
National KABP							X								X	
Develop database and maintain database (post IE&C campaign)				X				X				X				X

## 7. MANAGEMENT

In an effort to reduce the management burden required for both the MOH and USAID staff, funds will be committed through the Agency ATSP. The current ATSP is an umbrella project under which a wide variety of HIV/AIDS prevention activities, including AIDSCAP are funded. In addition, USAID will hire a support person to track progress and follow-up on requests.

### 7.1 Agency AIDS Technical Support Project and AIDSCAP

The ATSP was originally approved in 1987 with a budget ceiling of \$69 million and authorized through 9-30-95. In April 1991, the length of the project was extended to 9-30-97, the funding level was increased to \$168 million and the project was redesigned based on lessons learned from three years of implementation.

The amended ATSP, and AIDSCAP specifically, support the concentration of resources and the development of a targeted HIV/AIDS prevention programs in 10 to 15 priority countries. This strategy is based upon prevention interventions in the key areas of BCC, condom promotion and the prevention and control of STDs. It also identifies cross-cutting interventions including policy development and evaluation and monitoring in support of the primary strategic interventions.

### 7.2 AIDSCAP Project Management

#### In-Country Project Management

The project will be implemented through the AIDSCAP/Jamaica Country Office in Kingston which is managed by a Resident Advisor. The Country Office will be staffed by technical and support personnel. Contracts for staff positions are funded through a subagreement with the Caribbean Applied Technology Center (CATC). The Resident Advisor will be responsible for

supervising staff; facilitating all interventions; providing technical assistance to project activities; assisting the EPI Unit and NAC as needed; and providing reports to the EPI Unit, AIDSCAP LA/C Regional Office and USAID.

The Resident Advisor will be responsible for developing and monitoring all AIDSCAP-funded sub-projects. For each sub-project, a subagreement will be developed with the implementing agency or agencies. Subagreements are contractual documents that incorporate the sub-project plan and obligate funds and technical assistance. All subagreements will be reviewed and approved by AIDSCAP's LA/C Regional Office and Headquarters.

All subagreements will delineate the progress reporting and the monitoring and evaluation data collection requirements of the implementing agencies. Implementing agencies will collaborate with AIDSCAP to facilitate the baseline, process and outcome/impact evaluation of sub-projects and if applicable, the organization/management assessments during the life of the subagreements.

Once subagreements are approved, the Resident Advisor is responsible for monitoring sub-project activities, identifying additional technical assistance needs, and mobilizing resources to ensure that implementing agencies receive proper guidance to implement their activities. Regular reports will be collected from the implementing agencies to determine the extent to which they are conforming to the subagreements on which their funding is based.

### **In-Country Financial Management**

A Country Office accountant will be hired to monitor the disbursement of funds to the sub-projects and the transaction of accounts. The accountant will ensure that financial reports are prepared regularly and that all required documentation is submitted. The accountant will conduct financial review and assessment of implementing agencies in Jamaica to assure financial management capabilities prior to the authorization of sub-project subagreements. He will also strengthen implementing agencies' accounting systems if necessary. The overall responsibility for country office expenditures will be the responsibility of the Resident Advisor through support and assistance provided by the AIDSCAP/Jamaica accountant.

### **AIDSCAP LA/C Regional Office Project Management**

The Resident Advisor reports to the Director of the LA/C Regional Office. The Regional Director reports to the Office of the Director at AIDSCAP's Headquarters. The AIDSCAP LA/C Regional Office will monitor all project activities through monthly reports and close communication with AIDSCAP/Jamaica. The Regional Office together with the AIDSCAP/Jamaica country office and in consultation with USAID/Jamaican and Washington will review sub-project monitoring and evaluation reports to decide on sub-project modifications to ensure that project activities fulfill USAID's Strategic and Implementation Plans.

All communications from AIDSCAP/Jamaica will be handled through the Resident Advisor to AIDSCAP's LA/C Regional Office. Communications between AID/Washington to

AIDSCAP/Jamaica will be channeled through the AIDSCAP LA/C Regional Office

### **AIDSCAP LA/C Regional Office Financial Management**

Subagreement budgets and expense reporting is guided by the AIDSCAP Finance and Administration Division which provides templates and report forms to facilitate financial planning and reporting. The overall financial oversight of project expenditures will be the responsibility of the LA/C Regional Office through support and assistance provided by the Regional Financial Officer.

### **AIDSCAP LA/C Regional Office Technical Monitoring**

The Resident Advisor will identify technical assistance needs through periodic monitoring of sub-projects. The Resident Advisor will channel requests for technical assistance to the LA/C Regional Office. The Regional Office will identify and recruit technical assistance in response to local needs. If appropriate technical support is not available locally, assistance will be provided in the following order: (1) Regional Office Technical Staff, (2) AIDSCAP Headquarters Technical Staff, (3) Project Subcontractors, and (4) External Consultants.

The proposed subcontractors working in Jamaica include: CAPS/UCSF, OAR, PATH, and UNC. CAPS will conduct behavioral research on community mobilization. TA will be provided by OAR and PATH in developing communications material, and by UNC in improving diagnosis and treatment of STDs. It is anticipated that international TA will be provided early in the project and in later years local TA will be relied upon. Additional subcontractors or TA may be identified as the program is implemented. An illustrative budget for TA follows:

<b>SUBCONTRACTOR</b>	<b>FY 93</b>	<b>FY 94</b>	<b>FY 95</b>	<b>FY 96</b>
CAPS/UCSF		100,000		
OAR	15,000	40,000	10,000	
PATH	30,000	50,000		
UNC	90,000	90,000	20,000	20,000

## **8. BUDGET**

The following are notes to the budget:

- o The budget is illustrative and includes all activities funded directly by USAID and the LAC Bureau.

- o Most line items under Expanded Program will be funded through AIDSCAP unless indicated by other.
- o The "Other" column includes funds for CDC and IPPF. The administration of these funds is separate from AIDSCAP funds.
- o The "Core" column includes AIDSCAP's Headquarters and LA/C Regional Office monitoring and TA.
- o Implementing agencies included in the budget may change.
- o International TA may vary depending on the possibility for local TA.
- o Under "Management," the CATC contract includes staff positions in the AIDSCAP Country Office.
- o FHI overhead costs are calculated at 34.7% of the first \$25,000 for each subagreement and 34.7% for all other line items.
- o Funds for the support person at USAID will not be channeled through AIDSCAP.

USAID Jamaica Country Budget Detailed Annual Budget #/ Source of Fund	USAID	LAC Region	AIDSCAP Core	Other	Total	USAID	LAC Region	AIDSCAP Core	Other	Total
			Year 1 - FY 1993			Year 2 FY 1994				
<b>Bilateral</b>										
Administrative Support					0				50	50
U S Technical Assistance					0					0
Training					0					0
Overseas			(GOJ)	100	100				100	100
Local Costs					0					0
Policy/Program			(GOJ)	50	50				50	50
Institution Strength					0				60	60
Evaluation/Audits	56				56	8				8
Contingency					0				50	50
<b>Subtotal Bilateral</b>	<b>56</b>	<b>0</b>	<b>0</b>	<b>150</b>	<b>206</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>310</b>	<b>318</b>
<b>Expanded Program</b>										
<b>STDs</b>										
ACOSTRAD		78			78		150			150
<b>CSWs</b>										
ACOSTRAD		28			28		100			100
<b>Adolescents</b>										
Red Cross			96		96			132		132
Performing Arts Group	46				46	21				21
ACOSTRAD		1			1		10			10
<b>Multiple Partners</b>										
ACOSTRAD		38			38		50			50
Performing Arts Group *					0	21				21
<b>MWM</b>										
JAS	56				56	50				50
<b>HIV+</b>										
EPI Unit	10				10	20				20
Family Center					0	13				13
<b>Medical/Health Community</b>										
MAJ		9			9		30			30
Other Associations					0		13			13
TA Support UNC	81				81	60	30			90
EPI Unit	72				72	125				125
CDC				100	100				*	0
<b>Policy Makers</b>										
Implementing Agency					0		91			91
TA			41		41			100		100
<b>Retailers</b>										
SOMARC	91				91					0
Implementing Agency					0	40				40
<b>Family Planning</b>									50	50
<b>Supporting Components</b>										
<b>Evaluation</b>										
Hope Enterprises			91		91			150		150
Surveillance EPI Unit	21				21	20				20
TA			20		20			20		20
<b>Behavior Research</b>										
TA CAPS			91		91					0
					0			30		30
<b>Communications</b>										
Hotline EPI Unit					0		25			25
Workshops EPI Unit		30			30		70			70
Material Development EPI Unit		50			50		190			190
Face-to Face EPI Unit					0		50			50
Advertising Agencies *					0	151				151
TA OAR	10				10	37				37
TA PATH	21				21	50				50
<b>Technical/Management Support</b>										
Country Office	31		34		65	65		65		130
Local TA					0		33			33
CATC	203				203	180				180
Capacity Building			34		34		31	50		81
RO/HQ TA/Planning/Monitoring		11	130		141			150		150
USAID Support		5			5		7			7
Training/Conferences		5			5		13			13
FHI Overhead	84	37	145		266	71	52	44		167
<b>Subtotal for Expanded Program</b>	<b>726</b>	<b>289</b>	<b>683</b>	<b>150</b>	<b>1 850</b>	<b>925</b>	<b>945</b>	<b>750</b>	<b>50</b>	<b>2 670</b>
<b>Total for Jamaica</b>	<b>784</b>	<b>289</b>	<b>683</b>	<b>300</b>	<b>2 056</b>	<b>933</b>	<b>945</b>	<b>750</b>	<b>360</b>	<b>2 988</b>

\* To be determined

USAID Jamaica Country Budget Detailed Annual Budget w/ Source of Fun	USAID	LAC Region	AIDSCAP Core	Other	Total	USAID	LAC Region	AIDSCAP Core	Other	Total
	Year 3 - FY 1995					Year 4 - FY 1996				
<b>Bilateral</b>										
Administrative Support				50	50				50	50
U S Technical Assistance					0					0
Training					0					0
Overseas				100	100				110	110
Local Costs					0					0
Policy/Program				50	50				60	60
Institution Strength				60	60				50	60
Evaluation/Audits					0	58				58
Contingency				50	50					0
Subtotal Bilateral	0	0	0	310	310	58	0	0	280	338
<b>Expanded Program</b>										
<b>STDs</b>										
ACOSTRAD		150			150		140			140
<b>CSWs</b>										
ACOSTRAD		100			100		50			50
<b>Adolescents</b>										
Red Cross			158		158					0
Performing Arts Group	30				30	30				30
ACOSTRAD		10			10		10			10
<b>Multiple Partners</b>										
ACOSTRAD		50			50		50			50
Performing Arts Group *	30				30	30				30
<b>MWM</b>										
JAS	50				50	40				40
<b>HIV+</b>										
EPI Unit	15				15	15				15
Family Center	25				25	20				20
<b>Medical/Health Community</b>										
MAJ		20			20		10			10
Other Associations		10			10		10			10
TA Support UNC		20			20		20			20
EPI Unit	125				125	75				75
CDC				*	0				*	0
<b>Policy Makers</b>										
Implementing Agency		100			100		70			70
TA			100		100			70		70
<b>Retailers</b>										
SOMARC					0					0
Implementing Agency	40				40	40				40
<b>Family Planning</b>				50	50				50	50
<b>Supporting Components</b>										
<b>Evaluation</b>										
Hope Enterprises			150		150			200		200
Surveillance EPI Unit	20				20	22				22
TA			20		20			50		50
<b>Behavior Research</b>										
TA CAPS					0					0
			50		50					0
<b>Communications</b>										
Helpline EPI Unit		25			25		25			25
Workshops EPI Unit		150			150		75			75
Maternal Development EPI Unit		190			190		192			192
Face to Face EPI Unit		50			50		40			40
Advertising Agencies *	160				160	100				100
TA OAR	10				10					0
TA PATH					0					0
<b>Technical/Management Support</b>										
Country Office	46		65		111	46		82		128
Local TA		33			33		20			20
CATC	160				160	151				151
Capacity Building		26	33		59		25	25		50
RO/HQ TA/Planning/Monitoring			78		78			100		100
USAID Support		7			7		7			7
Training/Conferences		13			13					0
FHI Overhead	20	41	94		155	24	27	93		144
<b>Subtotal for Expanded Program</b>	751	995	748	50	2 544	593	771	620	50	2 034
<b>Total for Jamaica</b>	751	995	748	380	2 854	651	771	620	330	2 372

\* To be determined

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USAID Jamaica Country Budget Annual Budget All Sources Combined	USAID	LAC Region	AIDSCAP Core Project Total	Other	Total
<b>Bilateral</b>					
Administrative Support	0	0	0	150	150
U S Technical Assistance	0	0	0	0	0
Training	0	0	0	0	0
Overseas	0	0	0	410	410
Local Costs	0	0	0	0	0
Policy/Program	0	0	0	210	210
Institution Strength	0	0	0	180	180
Evaluation/Audits	122	0	0	0	122
Contingency	0	0	0	100	100
Subtotal Bilateral	122	0	0	1 050	1 172
<b>Expanded Program</b>					
<b>STDs</b>					
ACOSTRAD	0	518	0	0	518
<b>CSWs</b>					
ACOSTRAD	0	276	0	0	276
<b>Adolescents</b>					
Red Cross	0	0	386	0	386
Performing Arts Group	128	0	0	0	128
ACOSTRAD	0	31	0	0	31
<b>Multiple Partners</b>					
ACOSTRAD	0	188	0	0	188
Performing Arts Group *	81	0	0	0	81
<b>MWM</b>					
JAS	196	0	0	0	196
<b>HIV+</b>					
EPI Unit	60	0	0	0	60
Family Center	58	0	0	0	58
<b>Medical/Health Community</b>					
MAJ	0	69	0	0	69
Other Associations	0	33	0	0	33
TA Support UNC	141	70	0	0	211
EPI Unit	397	0	0	0	397
CDC	0	0	0	100	100
<b>Policy Makers</b>					
Implementing Agency	0	281	0	0	281
TA	0	0	311	0	311
<b>Retailers</b>					
SOMARC	91	0	0	0	91
Implementing Agency	120	0	0	0	120
<b>Family Planning</b>	0	0	0	200	200
<b>Supporting Components</b>					
<b>Evaluation</b>					
Hope Enterprises	0	0	591	0	591
Surveillance EPI Unit	83	0	0	0	83
TA	0	0	110	0	110
<b>Behavior Research</b>					
TA CAPS	0	0	91	0	91
	0	0	89	0	89
<b>Communications</b>					
Hotline EPI Unit	0	75	0	0	75
Workshops EPI Unit	0	325	0	0	325
Maternal Development EPI Unit	0	622	0	0	622
Face-to-Face EPI Unit	0	140	0	0	140
Advertising Agencies *	411	0	0	0	411
TA OAR	56	0	0	0	56
TA PATH	71	0	0	0	71
<b>Technical/Management Support</b>					
Country Office	168	0	246	0	434
Local TA	0	86	0	0	86
CATC	714	0	0	0	714
Capacity Building	0	82	142	0	224
RO/HQ TA/Planning/Monitoring	0	11	458	0	469
USAID Support	0	25	0	0	25
Training/Conferences	0	31	0	0	31
FHI Overhead	199	157	376	0	732
<b>Subtotal for Expanded Program</b>	2 998	2 999	2 801	300	9 098
<b>Total for Jamaica</b>	3 116	2 999	2 801	1 350	10 266

\* To be determined

USAID Jamaica Country Budget Total Budget All Sources Combined	Total Year 1 FY 93	Total Year 2 FY 94	Total Year 3 FY 95	Total Year 4 FY 96	Total
<b>Bilateral</b>					
Administrative Support	0	50	50	50	150
U S Technical Assistance	0	0	0	0	0
Training	0	0	0	0	0
Overseas	100	100	100	110	410
Local Costs	0	0	0	0	0
Policy/Program	50	50	50	60	210
Institution Strength	0	60	60	60	180
Evaluation/Audits	56	8	0	58	122
Contingency	0	50	50	0	100
Subtotal Bilateral	206	318	310	338	1172
<b>Expanded Program</b>					
<b>STDs</b>					
ACOSTRAD	78	150	150	140	518
<b>CSWs</b>					
ACOSTRAD	26	100	100	50	276
<b>Adolescents</b>					
Red Cross	96	132	158	0	386
Performing Arts Group	48	21	30	30	128
ACOSTRAD	1	10	10	10	31
<b>Multiple Partners</b>					
ACOSTRAD	36	50	50	50	186
Performing Arts Group *	0	2	30	30	61
<b>MWM</b>					
JAS	56	50	50	40	196
<b>HIV+</b>					
EPI Unit	10	20	15	15	60
Family Center	0	13	25	20	58
<b>Medical/Health Community</b>					
MAJ	9	33	20	10	69
Other Associations	0	13	10	10	33
TA Support UNC	61	90	20	20	211
EPI Unit	72	125	125	75	397
CDC	100	0	0	0	100
<b>Policy Makers</b>					
Implementing Agency	0	91	100	70	261
TA	41	100	100	70	311
<b>Retailers</b>					
SOMARC	91	0	0	0	91
Implementing Agency	0	40	40	40	120
<b>Family Planning</b>	50	50	50	50	200
<b>Supporting Components</b>					
<b>Evaluation</b>					
Hope Enterprises	91	150	150	200	591
Surveillance EPI Unit	21	20	20	22	83
TA	20	20	20	50	110
<b>Behavior Research</b>					
TA CAPS	91	0	0	0	91
	0	39	50	0	89
<b>Communications</b>					
Helpline EPI Unit	0	25	25	25	75
Workshops EPI Unit	30	70	150	75	325
Material Development EPI Unit	50	190	190	192	622
Face-to-Face EPI Unit	0	50	50	40	140
Advertising Agencies *	0	151	160	100	411
TA OAR	10	37	10	0	56
TA PATH	21	50	0	0	71
<b>Technical/Management Support</b>					
Country Office	65	130	111	128	434
Local TA	0	33	33	20	86
CATC	203	180	180	151	714
Capacity Building	34	81	59	50	224
RO/HQ TA/Planning/Monitoring	141	150	78	100	469
USAID Support	5	7	7	7	25
Training/Conferences	5	13	13	0	31
FHI Overhead	266	167	155	144	732
Subtotal for Expanded Program	1 850	2 670	2 544	2 034	9 098
Total for Jamaica	2 056	2 988	2 854	2 372	10 268

\* To be determined