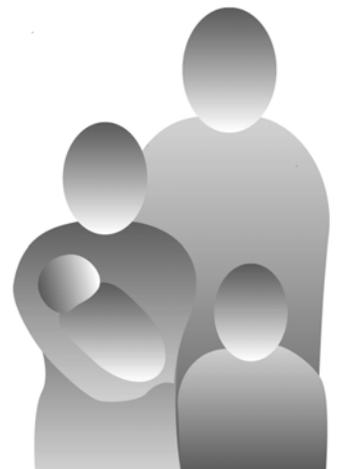

**Case Study of the
Contraceptive Technology Research Program
In Jamaica**

What was achieved and how?

**Susan McIntyre
Julie Solo
Pansy Hamilton
Jean Jackson**

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ACRONYM LIST

ANC	- Antenatal care
ARH	- Adolescent reproductive health
BCC	- Behavior, change and communication
CA	- Cooperating agency
CHC	- Comprehensive health clinic
COC	- Combined oral contraceptive
CTR	- Contraceptive Technology Research Program
CTU	- Contraceptive technology update
DP	- Dual protection
DPMA	- Depot-medroxyprogesterone acetate
EC	- Emergency contraception
ECPG	- Essential Care Practice Guide
FCO	- Final cost objective
FGD	- Focus group discussion
FHI	- Family Health International
FLE	- Family life education
FP/RH	- Family planning/reproductive health
GCP	- Good Clinical Practices
GOJ	- Government of Jamaica
HFLE	- Health and family life Education
IEC	- Information, Education and Communication
IMPACT	- Implementing AIDS Care and Prevention Project
IRB	- Institutional Review Board
IUD	- Intrauterine device
JHPIEGO	- Johns Hopkins Program for International Training in Reproductive Health
JRHS	- Jamaica Reproductive Health Survey
MCH	- Maternal and child health
MOE	- Ministry of Education
MOH	- Ministry of Health
NGO	- Nongovernmental organization
NFPB	- National Family Planning Board
OC	- Oral contraceptive
PHSC	- Protection of Human Subjects Committee (FHI's IRB)
RH	- Reproductive health
RtoP	- Research to Practice
SDP	- Service delivery points
STI	- Sexually transmitted infection
TA	- Technical assistance
TOT	- Training of Trainers
USAID	- United States Agency for International Development
WHO	- World Health Organization

Executive Summary

Introduction. Research provides important evidence to inform and improve reproductive health programs and policies. But how much is such information used, and what are the key factors that facilitate or hinder the process of turning research into practice? In order to address these questions, Family Health International (FHI) undertook a case study of its work in Jamaica.

Over the past three decades, FHI's activities funded by the Contraceptive Technology Research (CTR) Cooperative Agreement have responded to the evolving reproductive health needs of women in developing countries. The third CTR Agreement, which began in 1995, sought "to develop, evaluate and introduce a range of acceptable methods of family planning and to enhance the capacity of family planning researchers and programs in developing countries to provide those methods." Under this agreement, 22 separate project activities have been or are being conducted in Jamaica.

Methodology. Data collection took place between May and June 2004 and included interviews with FHI staff in North Carolina and with key collaborators and stakeholders in Jamaica. A total of 32 individuals were interviewed. The four-person team also reviewed relevant project documents and materials on reproductive health in Jamaica.

Results. Although the CTR projects in Jamaica were never based on a strategic, coordinated country plan, there was a high degree of continuity and connection among the different projects, as described below.

Impact/Utilization: What was achieved?

Adolescent Reproductive Health Projects. Eight projects addressed adolescent reproductive health. Six of these involved Ashe, a nongovernmental creative arts organization. The work with Ashe began with the development of the curriculum, *Preparing for the Vibes in the World of Sexuality*. Nearly 100 guidance counselors were trained to use the curriculum and they reached an estimated 26,500 students. An evaluation found that the program improved the guidance counselors' comfort level in discussing sexual issues, the students' reproductive health knowledge, and the Ashe staff's capacity to sustain and expand their work. In addition, the Ministry of Education agreed to integrate the Ashe curriculum into its Health and Family Life Education (HFLE) program, and a number of organizations have adopted the methodology of using performing arts for education. A manual called *Parenting Vibes in the World of Sexuality* was developed in 2002. An initial group of 108 parents were trained as trainers, which resulted in further dissemination of the curriculum.

Quality of Care Projects. Fourteen projects addressed quality of reproductive health care (QoC) in both the public and private sectors. Many respondents were aware of the following QoC projects: an assessment of the public sector services, a mapping study of private providers, and a study of users' perspectives on contraceptive methods and services. These studies identified several areas that needed improvement. For example, counseling, particularly on HIV and STIs, was inadequate. Also, unnecessary barriers to services existed, such as requiring clients to be menstruating in order to receive oral contraceptive pills. Many of the recommendations from these studies have been addressed, either by CTR projects (e.g. a new appointment system was piloted; both private and public sector providers were trained to improve their skills) or by other groups (e.g., updated family planning guidelines were developed with the National Family Planning Board). Other CTR projects, driven by global needs, were placed in Jamaica in part

because relations with skilled local staff were good and it was possible to appropriately address the question in Jamaica. For example, a study conducted for WHO tested the comprehensibility of instructions for what to do if a woman missed taking her contraceptive pills on schedule. Findings from this study suggested that instructions should sacrifice some medical accuracy for simplicity and better comprehension. The findings also suggested that graphic, rather than text-based, instructions should be developed. These findings are now being incorporated into World Health Organization (WHO) guidelines which should then lead to international-level impact.

Process: How was it done?

Respondents felt that both the projects inspired by local needs and those motivated by global questions were useful and provided “win-win situations.” For example, respondents highlighted the important capacity building that was gained both through training and direct experience in all aspects of project implementation. Respondents also spoke highly of the collaborative nature of FHI staff. Obtaining buy-in from key stakeholders was essential to FHI researchers when they were initiating and implementing a project. However, attempts to achieve this involvement sometimes focused on high-level individuals, rather than on the actual implementers such as providers at health facilities or counselors at schools. Respondents recommended that FHI engage a broader range of stakeholders, beginning in the early phases of an effort.

Sharing information was essential, and all projects included dissemination of findings, typically through country-level workshops, presentations at conferences, and/or publication in regional and international journals. However, impact would likely be improved by reaching a wider audience and by using more innovative dissemination methods, particularly for adolescents. The most significant gap is in follow-up after dissemination of research findings. This, in part, reflects how donors fund research: funding typically ends when a report is produced or disseminated. It is also difficult for FHI, without an in-country presence, to provide adequate follow-up after completion of projects. Without any or sufficient funds or follow-up, many recommendations from research studies are never acted upon.

Recommendations

1. **FHI would benefit by having a country or regional representative in Jamaica**, on a full- or part-time basis, to improve collaboration and coordination with other activities and follow-up on projects to enhance utilization of research findings.
2. **FHI should develop a strategic plan for its reproductive health program in Jamaica in collaboration with key country partners.** This would reduce fragmentation and make it possible to conduct a timely evaluation of the medium-term impact of the activities.
3. **Wider dissemination of research findings is necessary to promote greater use and implementation of results.** When appropriate, dissemination efforts should also use innovative methods of sharing information.
4. **Strategic alliances should be encouraged and developed among cooperating agencies at the national and international levels** to integrate portfolio responsibilities, avoid duplication, and maximize use of available resources.
5. **Resources should be identified to implement post-dissemination activities related to the utilization of research findings.**

Introduction

Jamaica's National Family Planning Board (NFPB) was established in 1967 by the Government of Jamaica (GOJ) to address the country's population and family planning concerns. Four years later, in 1971, Family Health International (FHI) was awarded its initial grant in contraceptive research by the United States Agency for International Development (USAID). Fourteen more years passed before, in 1985, a study investigating sickle cell disease and oral contraceptive pill use in Jamaica brought the first collaboration on family planning issues between FHI staff and Jamaican counterparts. Since then, there has been an unbroken tradition of collaboration in addressing questions and issues of relevance to the Jamaican family planning program and, in a number of cases, the international family planning community.

In 1995, USAID awarded FHI a new Cooperative Agreement for the CTR Program and, under this latest Agreement, 22 separate — albeit sometimes related — project activities have been, or are being, conducted in Jamaica. Prior to the conclusion of the current Cooperative Agreement, FHI is seeking to examine more closely its work since 1995 to assess both the *process* of project selection and implementation and the *impact* of these project activities, cumulatively more than singly, on the Jamaican program. For that purpose, this case study was conducted between May and June 2004.

The Jamaican Context

This country of 2.6 million people (see map below) has an annual population growth rate of 1.6. In 1997 the total fertility rate was 2.8; that rate dropped further to 2.5 in 2002. The Jamaican government officially recognized the need for family planning in 1963, some years before the NFPB was established as a statutory body under the Ministry of Health. With the National Family Planning Act of 1970, the NFPB became the government agency responsible for preparing, implementing, coordinating, and promoting family planning services in Jamaica. The focus of the family planning program since 1990 has been on increasing consumer access, improving service quality, and achieving financial sustainability. As of 2002, the NFPB no longer provides direct family planning services, as these are now integrated with other Ministry of Health (MOH) services. The NFPB, however, still implements family planning guidelines, policy, and training.

Map of Jamaica



With the objective of decreasing the number of unplanned pregnancies and reducing the total fertility rate to 2.5 by year 2005, the NFPB cited five strategies for 2000-2005:

1. Improve contraceptive method mix.
2. Introduce emergency contraceptive protection (ECP).
3. Improve efficacy of contraceptive method use.
4. Expand adolescents' access to reproductive health information and services.
5. Expand men's access to reproductive health information and services.

Family Health International in Jamaica

FHI is dedicated to improving lives, knowledge, and understanding worldwide through a highly diversified program of research, education, and services in family health and HIV/AIDS prevention and care. Since its inception in 1971, it has formed partnerships with national governments and local communities to address common interests in improving health.

While FHI's work in Jamaica began in 1985 with a single study under a prior Contraceptive Technology and Family Planning Research Cooperative Agreement, the work quickly expanded to include a variety of FHI programs funded by USAID. Those involving HIV/AIDS activities began in 1988 under the AIDSTECH Program and continue today with several activities under the IMPACT Program. FHI's Women's Studies Project (1993-1998) explored the impact of family planning programs on women's lives, and Jamaica was identified as one of the Project's key countries. Some of FHI's earliest work with adolescents in Jamaica began under this Project. Finally, the YouthNet Project, which seeks to improve youth reproductive health and HIV/AIDS preventive behaviors, was awarded to FHI in 2001, and has an ongoing study in Jamaica.

The variety and number of FHI programs has helped to foster long-term relationships with numerous organizations and individuals in Jamaica. While the programs have generally operated independently of one another within Jamaica, each has increased recognition of the organization. On occasion, findings or activities undertaken by one program have generated new activities in another. Similarly new collaborations in one program have sometimes built on ones established earlier by other FHI programs, resulting in a stronger FHI network.

FHI's longest running program, the Contraceptive Technology Research Program, is the focus of this case study. Over the past three decades, successive CTR Cooperative Agreements have responded to the evolving reproductive health needs of women in developing countries. The third CTR Agreement was awarded to FHI in 1995 "to develop, evaluate and introduce a range of acceptable methods of family planning and to enhance the capacity of family planning researchers and programs in developing countries to provide those methods." FHI has addressed this purpose at both the country and international level; similarly, FHI's activities in Jamaica have reflected questions of both global and country-specific interest.

Jamaica's Fertility and Contraceptive Profile 1993 - 2002

Jamaica's contraceptive profile has undergone significant changes since the introduction of a public-sector family planning program in the latter half of the 1960s. Changes in the contraceptive profile have been reported in successive Contraceptive Prevalence Surveys. These national surveys were first introduced in 1979 and have subsequently been carried out every 5 years, initially among women in the childbearing age group. Men have been included in the sample since 1993.

During the period of FHI's work in Jamaica under review, 1995 to 2004, significant changes in both the total fertility rate and age-specific fertility rates occurred. The data provided by the 1993 Jamaica Contraceptive Prevalence Survey serves as the baseline for the past decade. Two subsequent surveys have been conducted, one in 1997 and the second in 2002, which track recent fertility trends. The name of the survey itself changed in 1997 to the Jamaica Reproductive Health Survey (JRHS), reflecting the change in national focus from strictly family planning to the wider concept of reproductive and sexual health issues among women and men.

There has been a general decline in the total fertility rate from 4.5 in 1975 to 2.5 in 2002 (Jamaica Reproductive Health Surveys, 1997 & 2002). As shown in Table 1, all age groups show declines from the 1993 fertility rate baseline measurements. The decline reflects progress towards the achievement of replacement fertility, which has been a goal of the national family planning program since the 1980s. Age specific fertility rates of the most fertile age groups, with the exception of the 25-29 year age group, have substantially declined between 1997 and 2002.

Table 1: Jamaica's Total and Age Specific Fertility Rate 1997- 2002

Year	Total Fertility Rate	Age Specific Fertility Rate			
		15-19	20- 24	25 - 29	30 - 34
2002	2.5	79	124	118	91
1997	2.8	112	163	112	101
1993	3.0	107	160	131	99

Sources: Jamaica Reproductive Health Surveys 1997 and 2002; Jamaica Contraceptive Prevalence Survey 1993

In 1997, contraceptive prevalence was already high at 66 percent and almost all the women (15-49 years) were using a "modern" method. In 2002, contraceptive prevalence increased to 68.8 percent and the majority of women, as in 1997, were using "modern" methods defined as condoms, oral contraceptives, tubal ligation, injectables, Norplant, emergency contraception and vasectomy (Jamaica Reproductive Health Surveys 1997 & 2002).

Use of "modern" methods in the 1997 JRHS, by rank, saw oral contraceptives (21 percent) as the most popular family planning method. This trend has been maintained over many years; with the condom (17 percent) second; tubal ligation (12 percent) third; closely followed by injectables (11 percent) and intrauterine device (IUD) (1 percent). In the 2002 JRHS, there was a change in the 1997 mix of contraceptives with the condom becoming the most popular method at 23.5 percent and oral contraceptives in second place at 17.8 percent. Tubal ligation and injectables maintained their 1997 proportions and in 2002 were basically equal at 11.6 percent and 11.4 percent, respectively; while the IUD was at 1.2 percent, and both Norplant and emergency contraception accounted for only 0.2 percent. Emergency contraception was only recently introduced into the method mix and is accessible from behind the counter in pharmacies. The female condom is also available in some pharmacies, although the impression of those we spoke to was that it is little used. The notable 6.5 percent increase in condom use between the 1997 and 2002 JRHS may be due to the efforts of the Ministry of Health programs and nongovernmental agencies involved in HIV/AIDS to promote behavioral change with respect to consistent condom use and also dual method use (one of the methods must be a condom) for HIV/STI protection.

During the review period, the source from which Jamaicans received their contraceptive supplies notably shifted. The public sector, through its network of clinics, had been the primary supplier of contraceptives (60 percent), with private sector supplying the remaining 40 percent.

Between 1994 and 1998, the market share was reversed and the private sector became the major distributor of contraceptives. This occurred under a strategic marketing program by SOMARC, which promoted the sale of pills, IUDs and injectables in the private sector. USAID no longer provides commodities to the Jamaican family planning program.

While Jamaica continues to maintain a fairly high rate of contraceptive prevalence, well-recognized challenges persist. The 1997 JRHS found 60 percent of all pregnancies were either mistimed or unplanned. In addition, in the 1997 and 2002 JHRS, 34 percent and 31 percent, respectively, of women in union were not using a reliable contraceptive method. This problem is particularly acute among adolescents. Forty percent of Jamaican women have been pregnant by age 19, and 85 percent of these pregnancies are unintended. These same challenges, along with an under-funded health care infrastructure, are seen in many of the countries where FHI and USAID work, making any “lessons learned” in Jamaica all the more relevant.

Methodology of the Case Study

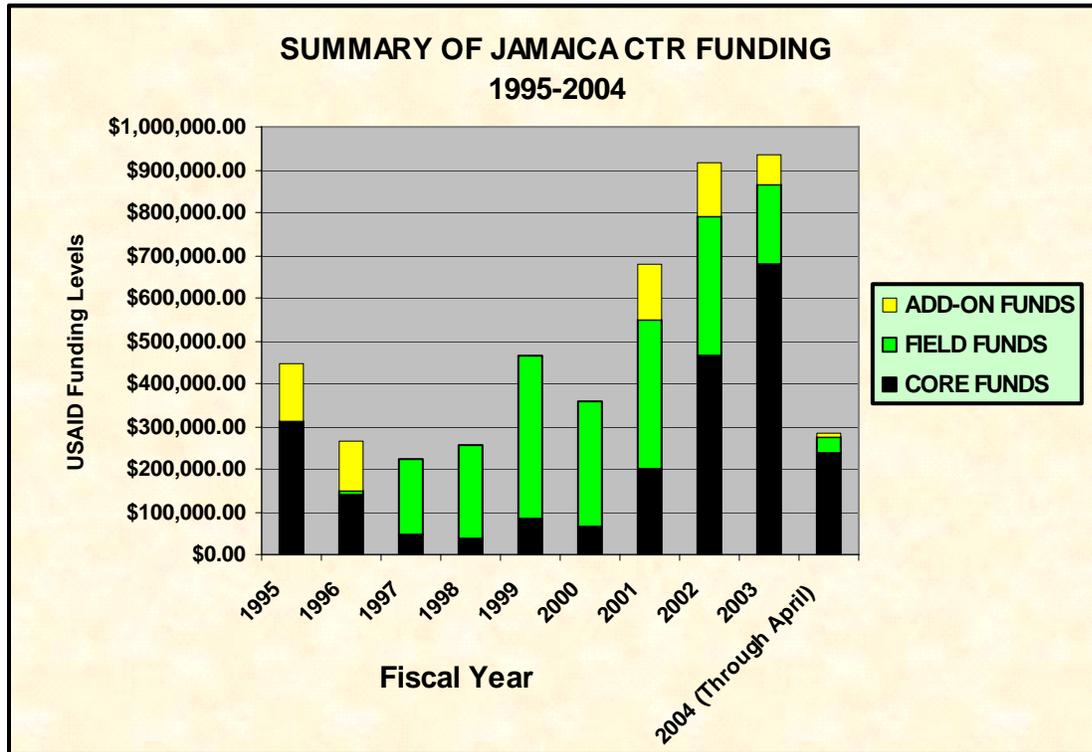
To conduct this case study, an extensive review of FHI records and professional literature was undertaken. A record of past activities was compiled and a Popline search of articles pertaining to family planning and Jamaica was done. In addition, USAID’s Data Experience Clearinghouse was checked for relevant reports from other USAID-supported efforts in Jamaica. A team of four persons was identified for the case study. Susan McIntyre, Director of Evaluation for the Contraceptive Technology Program at FHI, served as Team Leader. Pansy Hamilton and Jean Jackson, currently Research Fellows at the University of West Indies, Mona added their knowledge and familiarity of Jamaica’s family planning program. The final member of the team was Julie Solo, an independent reproductive health care consultant with knowledge of USAID and experience with case study methodology. Julie Solo and Susan McIntyre interviewed nine FHI staff persons involved in Jamaican projects (eight in person and one by telephone), enquiring both about the process and outcomes of their work. Finally, key informant interviews were arranged for mid-June 2004 in Jamaica where the four-person team interviewed 22 persons. All interviewees represented key health-related organizations in Jamaica and/or had been or were actively engaged in CTR-funded projects in Jamaica. Appendix A provides a list of the 32 respondents. Interviews were conducted using a semi-structured questionnaire.

Because the projects in Jamaica have taken place over a long period of time, obtaining thorough documentation for the earlier years of work was sometimes difficult. In addition, staff changes have occurred at various organizations, institutional memory is often incomplete, and—despite repeated efforts—interviews could not be secured with some individuals. Nonetheless, with the large number of interviews conducted and documents reviewed, it was possible to be able to obtain a fairly accurate picture of the process and outcomes of FHI’s work in Jamaica.

The Contraceptive Technology Research Program in Jamaica

FHI’s contraceptive technology activities in Jamaica have been varied in terms of objectives, size, scope and in-country counterparts. It has not been a country program in the sense of having 5- or 10-year funding for objectives that are specifically part of the NFPB, MOH, or — more broadly — the GOJ’s strategic plans. Rather, the program has responded to issues identified through various means. All projects, however, have sought to expand knowledge about contraceptive technology methods and family planning services and/or have addressed adolescent reproductive health (ARH) issues.

CTR projects in Jamaica have been funded by both core support (provided directly by USAID/Washington) and by USAID Mission funds (field support and Add-on funds). As shown in the chart below, the level and source of USAID support to FHI's activities in Jamaica has varied markedly since 1995. Between fiscal years 1997 and 2001, Mission funding dominated; since fiscal year 2002, core funding has dominated.



As one might anticipate, training and institutional support activities are funded primarily by Mission funds (e.g., training seminars or workshops, technical assistance to in-country groups). Research activities have typically been funded by the Mission when the question to be answered is of specific interest to Jamaica (e.g., what is the quality of family planning care in Jamaica's public sector services?). By contrast, research has typically been core-funded when FHI sought to address a question of international significance or interest (e.g., whether graphic instructions developed by the World Health Organization (WHO) for clients using oral contraceptives were well understood).

Results

The discussion of the utilization and impact of project activities has been divided into two groupings. The first, adolescent reproductive health, reflects a priority of the Government of Jamaica. The second grouping bundles projects that relate to quality of care issues, and includes both research and training efforts.

Impact/Utilization: What was achieved?

Adolescent Reproductive Health Projects

Over the last decade, there has been a movement toward increasing reproductive health programs and services for adolescents in Jamaica, and toward developing youth-friendly training materials. FHI and collaborators have played a major role in testing and implementing educational programs that help to improve and sustain adolescent reproductive health. In order to strengthen Jamaica's institutional capacity for promoting adolescent reproductive health, FHI has also hosted a symposium to educate medical professionals on ARH and the law, and provided technical assistance to several nongovernmental organizations (NGOs), most notably Ashe.

Table 2: Summary of FHI's Adolescent Reproductive Health CTR Projects in Jamaica (September 1995 - May 2004)

Project Title	Objective(s)	Key Findings/Outcomes
Symposium on Adolescent Reproductive Health and the Law 2/24/99 - 9/30/99	To educate and inform medical professionals from Jamaica and the Caribbean about the legal and ethical issues concerning adolescent reproductive health and services, during a 2½-hour symposium on adolescent reproductive health and the law.	<ul style="list-style-type: none"> • The symposium was held June 1999 in conjunction with the MAJ Annual Meeting. Two doctors, two lawyers, and one adolescent representative presented and the Ashe Ensemble performed. Over 150 people attended this particular session as compared to other sessions, which had only 50–100 participants.
Adolescent Reproductive Health Program (Phase I) 8/01/97 - 9/30/99	To improve the knowledge, attitudes, and technical capacities of public sector school nurses, guidance counselors, and NGO personnel so that they may serve as skilled advisors to Jamaican youth on reproductive health matters. Note: This objective was refined to include NGO personnel based on the Mission's request to contract a local NGO, the Ashe Ensemble, to conduct this project. Subgrantee: The Ashe Ensemble	<ul style="list-style-type: none"> • 50 school nurses, NGO personnel, and guidance counselors, were trained August 1998 on innovative and effective ways to teach sexuality and reproductive health to adolescents. They worked with 100 adolescents and were followed up for a year after the initial training workshop. Many remained until the end, but many more made it at least part way through the process. • Training materials, such as the manual and activities kit were created.

Project Title	Objective(s)	Key Findings/Outcomes
<p>Adolescent Reproductive Health Program (Phase II)</p> <p>4/12/99 - 3/31/04</p>	<p>1) To increase the number of trainers and facilitators capable of using the Ashe Adolescent Reproductive Health (ARH) Manual, <i>Preparing for the Vibes in the World of Sexuality</i>, as developed under FCOs 3408 and 3416; 2) to develop and disseminate interactive material that trainers and facilitators will use to conduct future ARH training activities; 3) to expand the number of public school guidance counselors who can effectively utilize the ARH Manual to improve their students' knowledge of pregnancy and STD prevention; 4) to continue reaching adolescents with performances via school activities and make additional copies of the Manual available; and 5) to develop an ARH manual and video/audio cassette for parents, to train a core group of expert parent trainers to work with other parents using the manual, and to follow-up and evaluate the impact of the manual and training for their usefulness.</p> <p>Subgrantee: The Ashe Ensemble</p>	<ul style="list-style-type: none"> • Three efforts implemented to disseminate and ensure utilization of new approaches to teaching ARH through school nurses, guidance counselors, NGO staff, and youth groups: 1) Training of Trainers (TOTs) and peer education — total of 150 of the target groups were trained to use the reproductive health (<i>Vibes</i>) manual; 2) training activities workbook — a workbook with interactive materials was developed to complement the <i>Preparing for the Vibes in the World of Sexuality</i> manual and video; 3) Ministry of Education Training Project — 40 guidance counselors were trained to use the ARH manual/<i>Vibes</i> curriculum and methodology. • A Parenting Vibes show, manual and video. 108 parents were trained across the island to implement the Ashe Parenting Kits, each subsequently reached about 50 parents on parenting skills, resulting in some 5,400 trained. An additional 4,000 parents attended one of 20 Parenting Vibes performances.
<p>Adolescent Reproductive Health Program (Phase III)</p> <p>7/19/00 - 9/30/01</p>	<p>To institutionalize the family life education curriculum developed by FHI, the Ashe Ensemble and the Jamaican Ministry of Education (MOE) during 1998 - 2001 and expand on certain aspects of the program.</p> <p>Subgrantees: Ashe Ensemble; Berl Francis; Social Impact</p>	<ul style="list-style-type: none"> • Eight staff from the MOE were trained as Master Trainers resulting in 88 guidance counselors being trained, a cohort that has the potential to reach 26,500 students. • A new theater piece on ARH was developed. • Over 30 performances took place, reaching over 10,000 students, teachers and others. • MOE made commitment to fully fund the Vibes program beginning in 2004.
<p>Curriculum and Training Evaluation</p> <p>9/23/99 - 6/30/02</p>	<p>1) To assess the effectiveness of the VIBES family life education (FLE) curriculum in improving factors that contribute to adolescents' reproductive health; and 2) to assess the relative benefits of peer training versus direct-training educators in order to reach a target population of adolescents.</p>	<ul style="list-style-type: none"> • Knowledge scores for girls in the Vibes classes increased significantly more than for girls in traditional FLE classes, but there was no difference for boys. • In the fall of 2000, Vibes was withdrawn from the schools because of public controversy and the MOH was uncomfortable in conducting the final round of the evaluation during the 2000/01 school year. • Dissemination: Preliminary results presented to cooperating agencies meeting in Jamaica and DC; informally presented to MOE and Ashe, in March 2002; final results presented to MOE, Hope, Ashe and USAID. Final report was distributed by the MOE to guidance counselors and other stakeholders.

Project Title	Objective(s)	Key Findings/Outcomes
		<ul style="list-style-type: none"> Information from this study was used to inform the training of counselors for the reintroduction of Vibes and for the new evaluation scheduled for 2002/03. (See below).
<p>Evaluation of Guidance Counseling Training in the VIBES Curriculum</p> <p>6/20/01 - 06/30/04</p>	<p>To evaluate the effectiveness of guidance counselor training in the Vibes Family Life Education curriculum on the reproductive health attitudes, beliefs, and practices of 12-14 year old students in Jamaica.</p> <p>Subgrantee: Hope Enterprises, Ltd.</p> <p>[Note: this study built on the earlier evaluation, described above]</p>	<ul style="list-style-type: none"> The report, <i>Evaluation of Guidance Counselor Training for Vibes</i>, was written in November 2003. Focus group discussions with guidance counselors identified several barriers to implementation of the curriculum: lack of administrative or community support, lack of equipment and private space to use while teaching, lack of time for individual lessons, inadequate supervision, and lack of guidance regarding integration of Vibes with the standard HFLE curriculum. Highly motivated guidance counselors did use the curriculum. Positive outcomes included: in one school, it inspired the creation of a drama club; in another, songs from the curriculum were used in conflict-resolution situations. Impact on students was evaluated at treatment and control schools. Those at treatment schools were more likely to say they were taught about abstinence and to have made a commitment to abstain from sex or protect themselves. There was not an overwhelming effect of the integrated HFLE curriculum compared to the standard one, but this is not surprising given the short time frame. There was much support for the curriculum by the guidance counselors. MOE has made a statement of support for continuing the integrated curriculum.
<p>Social Impact Technical Assistance for Jamaica</p> <p>6/27/01 - 9/30/02</p>	<p>To have the U.S. consulting firm, Social Impact, provide institutional capacity-building technical assistance to Ashe Caribbean Performing Arts Ensemble and Academy (Ashe), Jamaica Network of HIV+ persons (JN+), the Jamaica AIDS Support (JAS) and the Uplifting Adolescents Project (UAP). These organizations all work to improve the health of Jamaican youth.</p> <p>Subgrantee: Social Impact</p>	<ul style="list-style-type: none"> Social Impact provided capacity building assistance in revising mission statements, strategic objectives, institutional structure, and implementation plans for each of these organizations. Following these activities, capacity building was evaluated using tools developed by FHI/DC. Each NGO had specific by-products as a result of the technical assistance provided. At Ashe, these included a new manual on policies and procedures, job descriptions and the revitalization of Ashe's Board of Directors.

Project Title	Objective(s)	Key Findings/Outcomes
Addiction Alert Curriculum & Training Project 6/27/01 - present	To revise, pre-test, pilot and print the training curriculum for the NGO, so that it is more user-friendly and appropriate. Subgrantee: Addiction Alert	<ul style="list-style-type: none"> • A 2001 evaluation of Addiction Alert by FHI recommended that materials from the program be made more accessible to the public. This project provided TA to make that happen. • A more user-friendly training manual and supporting materials were developed and tested at community meetings. • Although training has been completed, the final version of the training manual has yet to be printed. • TOTs were conducted, with 30 teens trained. This is mentioned in the MOH's own Annual Report 2001.

As reflected in Table 2, eight CTR-funded adolescent reproductive health projects spanned the period of 1997 to 2004:

- Symposium on Adolescent Reproductive Health and Law
- Adolescent Reproductive Health Program (Phase I)
- Adolescent Reproductive Health Program (Phase II)
- Adolescent Reproductive Health Program (Phase III)
- Curriculum and Training Evaluation
- Evaluation of Guidance Counseling Training in Vibes Curriculum
- Social Impact Technical Assistance for Jamaica
- Addiction Alert Curriculum & Training Project

FHI's work on adolescent reproductive health in Jamaica has largely focused on the innovative Ashe project, a non-governmental creative arts organization. In fact, six of the eight projects listed above involved Ashe. The defining concept used in this work was "edutainment" -- an interactive approach to reproductive health education that incorporates drama, music, and self-esteem and relationship building skills. Ashe's creative and holistic methodology was designed to fully engage adolescents with comprehensive reproductive health and interpersonal messages empowering them to make healthy decisions and to pursue healthy relationships. The most effective sexual health programs have included more than just reproductive health information. As noted by an FHI researcher, "these programs also help youth to enhance communication and negotiation skills, clarify their values and change risky behaviors." (Waszak, 1997)

FHI's work with Ashe began in 1997, in part due to urging from the USAID Mission, which was impressed with the adolescent reproductive health work several NGOs were doing. It evolved into a multi-phase project spanning seven years. The work involved four basic components: 1) curriculum development; 2) training for guidance counselors and parents; 3) capacity building; and 4) evaluation.

1. Curriculum Development

One of the primary outputs from FHI's work with Ashe was the development of a curriculum, *Preparing for the Vibes in the World of Sexuality*, which included a manual, video, and workbook. Together, these materials explain the "edutainment" teaching approach and provide structure for facilitating Family Life Education (FLE) classes. The idea, several respondents explained, was to get away from the "chalk and talk approach", in which a teacher or guidance

counselor stands at a blackboard and lectures. The goal of the “edutainment” approach is to influence more than just knowledge, as exemplified by this statement from one performer with the Ashe Ensemble: “Ashe has made me more focused and improved my self esteem. At one point in school I was going astray with peer pressure, but I’m different now.”

While many embraced the new methodology, certain elements of this curriculum (in particular, the mention of homosexuality) were controversial and were called “culturally unacceptable” by several of those interviewed for this case study. As a result, the curriculum was pulled from the schools during the fall of 2000. Modifications were subsequently made and the Ministry of Education has now formally adopted the curriculum.

Having developed the curriculum for teachers and counselors, Ashe and others saw a need for offering a curriculum, using the same methodology, for parents. In 2000, the *Parenting Vibes in the World of Sexuality* curriculum was developed through interviews and focus groups with Jamaican parents. It, as well as a video and show developed on the topic, were designed to equip parents with basic knowledge about youth reproductive health, HIV/AIDS, and other skills such as communication, discipline, and giving clear messages that help them guide their children toward becoming healthy adults. In particular, the manual and video prepare parents to talk with their children about their personal values around sexual issues. Through games, interactive sessions and group learning methodologies, parents learn how to avoid negative parenting tools such as ignorance, preaching, corporal punishment and mixed messages, and to effectively apply positive parenting tools such as knowledge, communication, discipline, and role modeling.

Stakeholders from a variety of settings cited the current cost of the Vibes curriculum (US \$50 for the manual and video) and the cost of working with Ashe as being prohibitive. Although the curriculum itself was too expensive for some NGOs, the methodology of educating using the performing arts has been adopted by a number of organizations, including the Women’s Center Foundation of Jamaica. As one respondent explained, “the methodology was so fresh and different.”

2. Training Guidance Counselors and Parents

Training school nurses, guidance counselors, NGOs, staff and youth groups in the Vibes methodology was as important as developing the curricula. In 1998, the first 50 persons were trained in the Vibes methodology and they, in turn, worked with 100 youth. Counselors described the training as an exciting experience that focused on self-awareness and provided an opportunity to process personal beliefs and issues. These introspection exercises were a cornerstone of the trainings, helping to prepare adults to teach adolescents about sensitive issues. In the Phase II scale-up of the work with Ashe, 150 guidance counselors were trained and Ashe estimates that, based on the counselors’ student population, they were able to collectively reach approximately 13,500 students with the curriculum. The Ministry of Education Training Project reinforced the Phase II efforts by supporting the training of 40 guidance counselors.

During Phase III, 88 guidance counselors were trained as Master Trainers, reaching approximately 26,500 students. Moreover, 10,000 students, a number of teachers, and ARH providers were exposed to performances of a new theater piece on adolescent reproductive health developed by Ashe.

Using the *Parenting Vibes in the World of Sexuality* manual, a core group of 108 parents were trained as trainers for other parents. Each of these was to train 50 more parents, for a cascade potential of reaching 5,400 parents. In addition, a select group of 97 inner-city parents and guardians participated in a year-round developmental program to learn life and parenting skills to empower and transform themselves as individuals and as parents. In this program over 85 percent of the parents who participated became employed and became active community workers. The personal impact of the manual and training of the parents could be gleaned from talking with pre-adolescents whose mothers had attended the training. One noted, "I can talk to my mother because she listens now." Another said, "Since my mother went to the meetings, she don't quarrel as much with me."

3. Capacity Building

FHI's work with Ashe led to important capacity building for Ashe staff. At the individual level, it included both simple "lessons learned" cited by Ashe's executive director when describing how an FHI staff member had helped him with development of the Vibes manual. It also included the training of a young adult Ashe staff member during an internship lasting several months at FHI. At the institutional level, capacity building included one project whereby FHI contracted with the U.S.-based group Social Impact to offer assistance in revising mission statements, strategic objectives, institutional structures, and implementation plans. Ashe, which was just one of the three NGOs with which Social Impact worked in Jamaica, focused on the development of a business plan to identify other funding sources so that "they would not have to rely on money from FHI every year." Ashe noted that the number of donors has grown markedly. Currently, the IMPACT project is providing additional assistance to Ashe in this area, and the work with Ashe is currently the "biggest link" between the CTR and IMPACT projects in Jamaica, according to one respondent.

4. Evaluation: Direct and Indirect Benefits

Several evaluations were conducted under the CTR to assess the progress and success of Ashe's program. The first evaluation involved a survey conducted among 40 classrooms in September 1999, and again in May 2000. Half of the classrooms had counselors who had been instructed in the use of the Vibes methodology and curriculum. The others, serving as the controls, did not. The curriculum's contribution to adolescents' reproductive health was evaluated by examining levels of self-esteem, reproductive health knowledge, positive attitudes toward sexuality, and reproductive health decision-making capabilities. The results revealed notable gender differences. For example, girls in the Vibes classes had a significantly higher increase in knowledge scores than girls in traditional Health and Family Life Education (HFLE) classes; among boys there was no difference. Boys' "ever use" of family planning was significantly higher in the Vibes group at the post-test compared to the control group. Finally, while girls in the Vibes group had significantly higher increases in self-esteem and self-efficacy scores, boys in Vibes group did not.

In another form of evaluation, focus group discussions were held with the guidance counselors. These identified a number of barriers facing the counselors as they tried to implement the Vibes manual: lack of administrative and/or community support; lack of equipment and private space to teach the manual; lack of time for individual lessons; inadequate supervision; and lack of guidance regarding integration of Vibes with the standard HFLE curriculum. On a more positive note, some guidance counselors were more committed than others and those who were highly motivated to use the manual found ways around the barriers. These findings parallel the comments of many of those interviewed when asked about the implementation of the Vibes

program in the schools. Focus group discussions also elicited information on positive outcomes of the introduction of the Vibes manual that exceeded expected outcomes. For example, in one school, Vibes classes sparked the creation of a drama club. In another, songs taught in the Vibes classes have become popular among all students and have been used to resolve conflicts.

The most rigorous evaluation involved a quasi-experimental design to assess the impact of the implementation of the Vibes curriculum within secondary school classes by 160 guidance counselors who were trained in 2001 and 2002. Analyses of the baseline and post-intervention surveys found that guidance counselors who received the Vibes training utilized their skills in their HFLE classes. There was a clear difference between the integrated HFLE classes (Vibes) and the standard HFLE classes in the kinds of activities engaged in and the topics taught. Of particular note, integrated curriculum students were more likely to say they were taught about abstinence and were more likely to have made a commitment to abstain from sex or to protect themselves.

“With the new curriculum, the Ministry hasn’t had any negative feedback... I think its working; if you go to the schools you can see it. There are changes in the students regarding openness and dealing with issues, relationships with counselors. It’s a good way to support the HFLE curriculum with creative teaching, learning and participation. The Ashe strategy had to be incorporated.... You make adults more comfortable talking to kids about sex.”

(A MOE representative)

As noted previously, the Vibes curriculum has been adopted by the MOE and incorporated into their HFLE program. The MOE has also made a commitment to fund the Vibes program in 2004. Still, whether it is realistic to expect them to fully fund the program is in question. The inclusion of the Vibes curriculum in the MOE’s 2004 program is a significant accomplishment, but one that is tempered by the observation of one respondent who stated, “It is hard for Ashe to be all things to all people”. For Ashe to have a national impact it would need to work more extensively with the MOE and that would require “a major infusion of resources.”

Importantly, the Ashe model has influenced ARH beyond its immediate reach. It is being implemented in over nine other Caribbean countries including Barbados, Guyana, St. Lucia, St. Vincent, St. Kitts, Trinidad and Tobago, the Bahamas and Suriname. The Ashe Ensemble has also received numerous invitations to perform their health “edutainment” internationally, most recently at the 2004 International AIDS Conference in Bangkok.

Quality of Care Projects

Table 3 presents a listing of 14 Jamaica-based CTR projects, focused broadly on quality of care and completed or ongoing since September 1995. The following discussion focuses on those projects that are completed and that address quality of care in the public and private sectors, including counseling provided by pharmacists in the latter. There are three projects for which data is still being collected or analyzed. For these, it is far too early to identify any long-term outcome or impact from the project:

- ‘Choice of Condom on Incident STI’ study - Follow-up is being completed.
- ‘Evidence-based Pill Provision’ - Follow-up is being completed.
- The ‘Appointment System Pilot Study’ - Data analysis is being completed.

While the results of these studies are not yet known, the capacity built from working on them was cited as a benefit by those involved in two of the three studies. Both USAID/Kingston and The Policy Project expressed keen interest in the findings from the appointment system study, as this is an idea that has been long discussed in Jamaica.

**Table 3: Summary of FHI's Quality of Care CTR Projects in Jamaica
(September 1995 - May 2004)**

Project Title	Objective(s)	Key Findings/Outcomes
<p>Dual Method Use and Factors Associated with STDs among Jamaican Family Planning Clients</p> <p>10/01/93 - 9/30/00</p>	<p>1) To evaluate prevalence and correlates of dual-method use among family planning clients; and 2) to assess methods of identifying family planning clients at increased risk of STD.</p> <p>Subgrantee: Ministry of Health, Epidemiology Unit</p>	<ul style="list-style-type: none"> • STDs were prevalent among mainly asymptomatic FP clinic attendees (26.9 percent had at least one STD, n = 767). • 20 percent reported some dual method use during the prior month. Analysis suggested use may be more likely among clients who had a new partner in the past 3 months; know which FP methods offer STD protection, or who talk with their partners about STD protection. • None of the evaluated decision models can be considered a good alternative to case detection using lab diagnosis. • The modified WHO risk-inclusive algorithm appeared inappropriate for asymptomatic women. • Urine leukocyte esterase dipstick tests may be useful when pelvic examinations are not feasible. • Available STD control strategies should be maximized, such as condom promotion, treatment of symptomatic patients and partners, and education. • Dissemination: preliminary findings presented in Jamaica, paper presented at APHA in 1998, conference in Zimbabwe in 1998, papers in <i>International Family Planning Perspectives</i>, <i>Sexually Transmitted Infections</i>. • Outcome: The study is cited in the <i>Jamaica FP Service Delivery Guidelines</i> in the section on STDs and FP, and there is a Dual Methods promotion policy of the MOH in these guidelines: "FP providers must promote the use of a condom as a protection against STDs as well as the other contraceptive methods."
<p>Public Sector and NGO Quality of Care</p> <p>1/1/95 - 8/31/96</p>	<p>To improve the quality of care in the Jamaican public sector and NGO services by assessing the training, information, administrative and support needs of workers to provide quality family planning services.</p> <p>Subgrantee: McFarlane Consultants</p>	<ul style="list-style-type: none"> • Due to time constraints, counseling is the one activity most often neglected. Clients receive inadequate information, hearing little or nothing about the importance of protection against STDs or HIV. • 87 percent of providers thought that a woman needed either to be menstruating or to have a negative pregnancy test before starting any contraception. • Recommendations: a) Increase information given to clients by improving providers' knowledge and practices; continuing to train providers; updating FP course curricula and training manuals; emphasizing counseling and STD/HIV risk assessment; providing more client-oriented materials, and targeting FP information to specific groups, such as adolescents; and b) improve health care facilities and the working environment. E.g., upgrade bathroom facilities, ensure privacy,

Project Title	Objective(s)	Key Findings/Outcomes
		<p>and decrease waiting time.</p> <ul style="list-style-type: none"> • Dissemination: Seminar in April 1996 for MOH, NFPB, USAID and other RH groups. Final report, September 1996, which was published in <i>West Indian Medical Journal</i> in 2001 stating, "many of these aspects of QOC are being improved in Jamaica's public sector health facilities."
<p>Secondary Analysis of Public Sector and NGO QOC Study</p> <p>12/18/96 - 8/31/98</p>	<p>To provide the Ministry of Health (MOH) and the National Family Planning Board (NFPB) with additional information on the quality of care in public sector and NGO family planning health facilities through secondary analysis of the data collected during the 1995 study of "The Quality of Public Sector and NGO Family Planning Services in Jamaica: Perspectives of Providers and Clients."</p>	<ul style="list-style-type: none"> • Only 15 percent of FP workers provide referrals for the IUD and only 4 percent actually provide IUD insertion or removal. • 37 percent of FP workers provide Depo-Provera. • Supervisors received more training than the workers received. • Norplant was the method least likely to have been covered in formal training. • Dissemination: Analysis was provided to NFPB, MOH, and USAID/Kingston in September 1997 to use for future training.
<p>Family Planning Seminars for Private Sector Physicians</p> <p>2/27/95 - 9/30/98</p>	<p>1) To provide current, accurate information to private sector physicians on contraceptive methods and family planning services; and 2) to encourage the participation of private sector physicians as providers of family planning services by presenting current contraceptive information through educational seminars.</p> <p>Subgrantee: Medical Association of Jamaica (MAJ)</p>	<ul style="list-style-type: none"> • Eight seminars were conducted between April 1995 and November 1997. Each seminar was conducted in three locations — Kingston, Montego Bay, and Mandeville — for a combined total of approximately 200 physicians and health care providers at each seminar. • Six trainers provided TOT training. • CTU Manuals were used in subsequent trainings. • Outcome: MAJ developed expertise in the planning, organization, and management of CME seminars
<p>Training Workshop in Contraceptive Technology and Counseling for Jamaican Nursing Tutors</p> <p>12/05/95 - 3/31/97</p>	<p>1) To enhance nursing tutors' capabilities to provide accurate information on contraception through improved understanding of: oral contraceptives, injectables, IUDs, barrier methods, postpartum methods (including LAM), STD treatment, and prevention of STDs, including HIV; and 2) to enhance nursing tutors' capabilities to provide more comprehensive information on counseling to their students through improved understanding of principal issues involved in counseling family planning clients.</p>	<ul style="list-style-type: none"> • Five-day workshop was held from October 26 to November 1, 1996 to update 25 nurse-tutors on contraceptive technology and service delivery issues, including counseling. This workshop was conducted in response to a training need for nurses identified in the "public sector and NGO quality of care study." Such training was highly recommended for sustaining Jamaica's contraceptive prevalence trend. • NFPB and the Nurses Association of Jamaica participated in planning and implementation
<p>National Family Planning Board Library Technical Assistance</p> <p>11/01/96 - 9/30/99</p>	<p>To improve the collections and services of the library of the National Family Planning Board (NFPB) of Jamaica.</p>	<ul style="list-style-type: none"> • FHI's Information Services Manager traveled to Jamaica in 1997 to assess current resources and recommend a plan for improvement • Follow-up activities included a second visit that included Popline and internet training to library staff. However, insufficient funding slowed the development of the library.
<p>Users' Perspective on Methods and Services</p> <p>10/31/96 - 8/31/00</p>	<p>To ascertain the views of various target populations on: 1) their access to contraceptive and reproductive health care and the quality of services they have received; and 2) the experience users have had with contraceptive acceptance and continuation.</p>	<ul style="list-style-type: none"> • A woman whose partner wanted her to use FP was 2.5 times more likely to continue using FP compared to those whose partners did not. • Women who were married or in common-law relationships were twice as likely to continue use.

Project Title	Objective(s)	Key Findings/Outcomes
	<p>Subgrantee: University of West Indies, Institute of Social and Economic Research</p>	<ul style="list-style-type: none"> ● Counseled women who did not experience side effects were three times more likely to continue use than women who had side effects and did not have counseling. But counseled women with side effects were no more likely to continue use than those without counseling. ● Women who used injectables were the most likely to continue with their method and with FP compared with pill users. ● Women who were satisfied with waiting time and who had not heard adverse rumors about FP were significantly more likely to continue FP use. ● Recommendation: The quality of counseling needs to be improved. An appointment system was also suggested to reduce waiting time. ● Dissemination in February 2000. Results were also presented at the Caribbean Health Research Council in April 2000.
<p>Symposium on Long-term Safety of Hormonal Methods</p> <p>10/17/96 - 7/31/98</p>	<p>1) To present research results in Jamaica on the long-term safety of hormonal contraceptives, particularly in relation to cancer and cardiovascular disease (CVD); and 2) to disseminate data from both the FHI-Jamaican cervical cancer study and a risk/benefit modeling assessment using Jamaican data.</p>	<ul style="list-style-type: none"> ● FHI staff attended the annual meeting of the MAJ in June 1997 to present the findings for FHI's analysis of the modeled estimates of cardiovascular mortality among OC users in the US—this fit with the theme of the conference—cardiovascular topics and long-term safety of hormonal contraceptives.
<p>Comparison of Four Methodologies for Measuring Staff Time Used to Provide Reproductive Health Services</p> <p>2/20/98-6/30/01</p>	<p>To compare the results obtained from an observational time-motion study with results from three alternative methodologies for measuring staff time, including Patient Flow Analysis (PFA), self-administered timesheets, and structured interviews with key staff.</p>	<ul style="list-style-type: none"> ● Neither staff interviews nor self-administered time sheet are consistently accurate reflections of actual time use in clinics—in particular, unproductive time is only reliably measured through activity sampling ● Unproductive time found in these clinics suggested that there are higher than necessary costs per visit ● Report was written and results disseminated to appropriate local organizations, USAID, CAs
<p>Quality of Information for Over-the-Counter OC Clients</p> <p>10/01/98-present</p>	<p>To assess the quality of counseling provided by pharmacists to clients who obtain oral contraceptives over-the-counter.</p> <p>Subgrantee: Hope Enterprises, Ltd.</p>	<ul style="list-style-type: none"> ● Most clients obtaining their OCs at pharmacies were continuing users who reported MDs were their most important source of information. ● Clients were given very little information on proper pill use and side effects. If a protocol does not already exist, it was recommended that the Pharmacy Council draft guidelines on the essential information to be given to new pill clients. Also cashiers and technicians should ask pill clients if they are new users or continuing users with questions, and then refer to the pharmacist. ● Access was restricted unnecessarily for adolescents. Recommendation made to give adolescent clients the pill unless there is reason to believe that they have health problems. ● All but two clinics denied access to the pill for women who were not menstruating. The report states, “even as we recommend using a checklist developed by FHI to rule out pregnancy in these cases—and to provide pills in advance to women for whom pregnancy

Project Title	Objective(s)	Key Findings/Outcomes
		<p>cannot be ruled out—we urge the public sector to find an alternative to systematic denial of contraceptive methods to non-menstruating women.”</p> <ul style="list-style-type: none"> • Dissemination: Preliminary results were presented at APHA in 2002. After significant delays in obtaining a suitable date from all parties, a June 2004 seminar was held in Kingston with NFPB support. The final report was shared at that meeting, during which pharmacists recommended ways to better address counseling needs.
<p>Choice of Condoms on Incident STI</p> <p>11/01/00-present</p>	<p>To evaluate the impact of providing STI clients a choice of male condoms by measuring: 1) incidence of STIs; 2) self-reported condom use; 3) condom acceptability; and 4) condom uptake during follow-up visits.</p> <p>Subgrantee: Ministry of Health, Epidemiology Research and Training Unit</p>	<ul style="list-style-type: none"> • Ongoing research. Recruitment goal dropped from 1000 to 400 due to decreased caseload at study clinic. Inclusion criteria ruled out many. • The last follow-up occurred in August 2004. Data analysis has begun.
<p>Appointment System Pilot Study</p> <p>5/30/01-present</p>	<p>To examine the feasibility of an appointment system to improve scheduling for family planning visits in Kingston’s public sector health clinics. This study was to address the fact that long waiting time is the primary complaint of public sector FP clients.</p>	<ul style="list-style-type: none"> • One of the two pilot clinics withdrew from the study because many of the staff never believed that the system would work or that clients would keep scheduled appointments. • Preliminary findings indicate that both providers and clients found the appointment system acceptable. • -Problems from the client perspective arose when nurses didn’t start at appointment times, medical records were misplaced, clients with later appointments were seen before those with earlier appointments, or when appointment times were scheduled during clients’ work times. • From the provider perspective, problems included clients not keeping the appointments. Only half of the clients visited on their scheduled day. Other problems were staff not arriving on time for the workday, and client records not being pre-pulled. • Data analysis and dissemination plans are ongoing.
<p>Evidence-based Pill Provision</p> <p>12/22/00-present</p>	<p>To compare continuation rates, side effects, and client satisfaction among new pill clients who receive either one or four cycles of pills at method initiation, in order to provide an evidence base for recommendations for OC provision.</p> <p>Subgrantee: Hope Enterprises, Ltd.</p>	<ul style="list-style-type: none"> • Data analysis is ongoing. • 965 clients were recruited and 817 successfully followed up. • Preliminary results are expected by December 2004.
<p>Comprehensibility of Instructions for Missed Pills</p> <p>7/30/03-present</p>	<p>To test the comprehensibility of graphic instructions on what to do if pills are missed.</p> <p>Subgrantee: Hope Enterprises, Ltd.</p>	<ul style="list-style-type: none"> • Women did poorly in identifying steps to take when multiple pills were missed. • The group that received the graphic instructions had higher comprehension score than the group that received text instructions. • Recommendations to sacrifice some medical accuracy for simplicity, and to strive for simple graphic presentations, especially for multiple missed pill instructions, were presented at the April 2004 WHO Selected Practice Recommendations meeting in Geneva. A

Project Title	Objective(s)	Key Findings/Outcomes
		journal publication is planned to disseminate the results further.

1. Private Sector and the Medical Association of Jamaica

In keeping with the government of Jamaica's interest in involving private physicians, FHI conducted a series of projects, ranging from in-depth research to two one-time training symposia, targeted at the private sector. These projects were:

- Family Planning Seminars for Private Sector Physicians
- Symposium on Long-term Safety of Hormonal Methods
- Symposium on Adolescent Reproductive Health and the Law (noted in the ARH Table 2)

Another important CTR study pertaining to the private sector deserves mention, even though it was completed before the current cooperative agreement, because several of the 1995-2004 projects can be traced to it. This study, conducted in the early 1990s, involved an island-wide mapping of all service delivery points and in-depth interviews with all 367 private physicians who offered family planning services or counseling. FHI conducted the study with the University of the West Indies and The Futures Group. Results showed that, while providers expressed a desire to provide high quality services, a client might be provided a particular method by one provider and not another. Medical eligibility criteria were sometimes unnecessarily restrictive. Recommendations of the study included that: 1) Jamaica's service delivery guidelines be revised and provided to both public and private sector physicians; 2) refresher training be provided; and 3) legal/regulatory barriers that restrict access to some contraceptives for certain age groups be removed (Hardee et al., 1995, McDonald et al., 1995).

Subsequently, each of these recommendations was addressed and, in two of the three cases, FHI projects directly responded to the recommendations. Following up on the need for training, FHI launched the project "Family Planning Seminars for Private Physicians" in collaboration with the Medical Association of Jamaica in 1995. Family planning experts from both Jamaica and the U.S. presented information on contraception and reproductive health. As the President of the Medical Association at the time said, "We made the case that the private sector was providing a lot of the family planning services but all the training was going to the public sector." Ultimately, a series of eight seminars were conducted, with approximately 200 attending each seminar topic. In addition to this seminar series, FHI also collaborated with the MAJ on a 1997 "Symposium on Long-term Safety of Hormonal Methods" and on a 1999 "Symposium on Adolescent Reproductive Health and the Law". Both symposia were held in conjunction with the Association's annual meeting.

Participant evaluations compiled after each seminar series reflected high participant satisfaction; pre-post questionnaires indicated improved participant understanding of the topics covered. A long-term evaluation of the eight seminar series was not conducted and participant names and addresses were neither available at FHI nor from those interviewed in Jamaica.

However, one of the clear legacies of the training was the extent to which MAJ developed their own skills in offering continuing medical education. For example, a computer was provided and a computerized system created to handle the logistics. The long-term effect of establishing such systems was underscored during these interviews, when one of those who helped organize the MAJ workshops turned to retrieve a document from her computer and noted she "had FHI to thank" for introducing her to computers. Capacity building was also illustrated when the Medical Association selected six persons to go to North Carolina in 1997 for a weeklong Expert Presenters Training. In order to decentralize the expertise, individuals were chosen from various regions. Seven years later, in 2004, at least four of the six are known to still be practicing in their regions.

In addition to expanding the Association's capacity to organize and conduct training, one respondent noted, "It was good for the Medical Association's own institutional strengthening. We traveled around and the doctors got to know us." She noted that headway has since been made on continuing medical education, with physicians recognizing its importance and applying for certificates through MAJ, even though there are not yet requirements for CME credits in Jamaica.

2. Public Sector Assessment and Training

Six CTR projects, involving public sector family planning services, have been completed since 1995:

- Public Sector and NGO Quality of Care
- Secondary Analysis of Public Sector and NGO QOC Study
- Training Workshop in Contraceptive Technology and Counseling for Jamaican Nursing Tutors
- Dual Method Use and Factors Associated with STDs among Jamaican Family Planning Clients
- Comparison of Four Methodologies for Measuring Staff Time Used to Provide Reproductive Health Services
- Comprehensibility of Instructions for Missed Pills

Complementing the work done in the private sector, FHI did another study in 1995, entitled "Public Sector and NGO Quality of Care". In all, 344 of the 346 public sector health facilities that offer FP services were studied and over 1,200 workers interviewed. In addition, 20 female clients visited 50 randomly selected health facilities covering each parish. Although it is widely acknowledged that provider practices and attitudes greatly influence clients' choice of methods, some service delivery practices or guidelines were found to be incompatible with current scientific information. As noted in the findings cited in Table 3, the vast majority of providers thought that a woman needed either to be menstruating or to have a negative pregnancy test before starting any contraception. This finding was confirmed by the simulated client study that showed many providers would not even talk to potential FP clients unless they were menstruating (McFarlane, 1996).

The "Secondary Analysis of Public Sector and NGO Quality of Care" study further examined the original findings. While never published, the data tables and notations were provided to the NFPB and USAID/Kingston who used them to guide subsequent trainings. The findings and analysis of the overall study were controversial among some of the providers. This was particularly true of the findings drawn from the simulated client component to which some of those working in the public sector and NGO setting objected. One of the nursing officers at the time recalled that the initial dissemination of results was not well received by many of the nurses. She subsequently carried the results around to many of the nurses with whom she worked, further explaining their importance. "The real impact of the study," she said, "was that people started to take an interest in quality assurance. You just heard more about it after that."

FHI again helped to address the need to improve providers' knowledge and practices by working in collaboration with the Jamaican MOH on a "Training Workshop in Contraceptive Technology for Nursing Tutors" that updated 25 nurse-tutors on contraceptive technology and service delivery issues, including counseling. FHI's Contraceptive Technology Modules, developed for international audiences, were used in this training and, as with the Medical Association of Jamaica, NFPB personnel spontaneously noted the usefulness of these modules in other training events held over the years.

“The public sector study really set the stage for the revision of the Guidelines.”
An NFPB official

An important impact of the Quality of Care study was the subsequent 1999 revision of the *Family Planning Service Delivery Guidelines*, undertaken at the request of the NFPB by the Quality Assurance Project (QAP), through its partner, JHPIEGO Corporation. As detailed in a case study by QAP, “A major source of information for the guidelines revision was the 1996 survey of public sector and NGO providers.” (Marquez, 2000)

These Guidelines are still used in Jamaica today, although updates are sent out periodically. The Guidelines addressed many of the issues noted in the quality of care studies, such as the barrier imposed by overly strict menstrual requirements for contraceptive provision. They also cited another CTR study “Dual Method Use and Factors Associated with STDs among Jamaica Family Planning Clients” in the section on STDs and Family Planning. Hence CTR-funded research clearly informed Jamaica’s *Family Planning Service Delivery Guidelines*.

As a complement to the study of private, public and NGO providers, research on “Users’ Perspectives on Methods and Services” was undertaken beginning in 1997. Conducted in collaboration with the University of West Indies, the study sought to obtain more in-depth information on users’ experience with and access to contraception. The results indicated that women who were satisfied with waiting time and who had not heard rumors about family planning were significantly more likely to continue family planning use. Based on this finding, it was recommended that an appointment system be tested to reduce waiting time.

A subsequent study conducted by FHI beginning in 2001 examined the feasibility and acceptability of an appointment system for family planning visits. Preliminary analysis is complete and the final report is eagerly awaited. The Policy Project hopes to use findings from this study to inform their own plans to institute appointment systems in a broader array of health services in Jamaica.

Two other CTR-related projects completed in the public sector, “Comparison of Four Methodologies for Measuring Staff Time Used to Provide Reproductive Health Services” and “Comprehensibility of Instructions for Missed Pills,” have one thing in common. Both were conducted to address questions that were as significant globally as they were to Jamaica. In the study of different measures of staff time, the hope was that a less expensive alternative methodology could be found to replace the current standard—observational time-motion studies. None of the alternatives, however, proved as accurate. Negative findings do have value and in this case they reaffirmed the existing methodology as the “gold standard.” While this is potentially useful information for Jamaica, and the results were disseminated there, the reaffirmation of time-option studies is as important to any program interested in accurately measuring staff time.

The recently completed study on the “Comprehensibility of Instructions for Missed Pills” was undertaken to address a specific question raised by WHO regarding graphic pill instructions that the organization had developed. In this case, WHO was the primary audience and the results were presented to them in April 2004 for their international use.

3. Crosscutting Study on Quality of Care

Extending the work on quality of care done with private, public and NGO providers, FHI undertook a study on “Quality of Information for Over-the-Counter OC Clients”. Conducted in collaboration with Jamaica’s Ministry of Health, the Pharmaceutical Society of Jamaica, and Hope Enterprises, Ltd. the study had three parts: 1) a survey of pharmacists to assess knowledge, attitudes, and practices in dispensing oral contraceptives; 2) an intercept survey of exiting clinic clients; and 3) a mystery client study to obtain the perspective of those who sought counseling advice from pharmacists.

Key study findings are cited in Table 3. In general, pill users often did not receive the basic information necessary for safe and effective OC use. Adolescents in pharmacies and women who were not menstruating during their clinic visits were often denied OCs. These findings indicate that in the pharmacy setting, the amount and quality of information given to potential new pill users needs improvement. In the clinic setting, providers should attempt to determine whether a non-menstruating woman is pregnant rather than resort to systematic, wholesale denial of methods and services. FHI’s pregnancy checklist may be an inexpensive and useful tool for this purpose.

The results of the study were shared in June 2004 with the 52 representatives of the MOH, members of the Pharmaceutical Society of Jamaica, public sector nurses and other invited health organizations. Dissemination had been greatly delayed as a suitable venue and date were negotiated with two successive Presidents of the Pharmaceutical Society. Ultimately, the NFPB assisted in setting a date and venue and the NFPB Executive Director presented the findings. Some nurses challenged the findings from the clinic setting and asked how they can be expected to find time to do more with no additional staffing. Time was also a critical issue for pharmacists. One interviewee quoted a pharmacist at the seminar who said it was the first time he had heard “both sides of the story” and that he now better understood the client perspectives and needs. Recommendations were discussed at the meeting and the NFPB has agreed to disseminate the discussions notes to participants.

Process: How was it done?

1. Project Initiation: *Making It a Win-Win situation*

A project can begin in various ways. Some of the CTR Projects were initiated to address local needs identified in the country (e.g., the “Quality of Information for Over-the-Counter OC clients”) while others were initiated to address global questions (e.g., “Choice of condoms on Incident STI”, and “Comprehensibility of Missed Pills Instructions”). Interestingly, respondents saw both these reasons for initiating a project as being useful in Jamaica. As one senior program administrator noted, even when FHI staff suggests a study to address a global research question, “we can find common ground that will meet their objective and our objective.” Many organizations were strengthened via additional training and/or resources, and were able to address specific questions that they were interested in, while answering a global question. As another program administrator pointed out, they are able to make it “a win-win situation.”

FHI has worked with the WHO on a number of studies to answer global questions. But how well do findings from such global studies filter down to the country level? This can be difficult to measure, because impact can take place in at least two ways. First, the findings will typically be disseminated locally and recommendations for action in the local context will be developed.

Necessary planning and budgeting to achieve these goals, however, does not always occur. For example, the findings from the “Comprehensibility of Missed Pill Instructions” study were not disseminated locally in Jamaica. However, a more indirect route for impact exists. WHO will often use information from these studies to create or modify guidelines, as it did in the case of the ‘Comprehensibility of Missed Pills Instructions’ study. These guidelines will then typically be distributed internationally and, with the widely respected imprint of WHO, can have a significant impact on services in many countries. One FHI staff member explained that information coming from WHO would have much more impact than information coming from a single FHI-sponsored study. There is often resistance to such globally-driven studies that do not directly meet a local need, but it is important to recognize that these studies are essential and, in the context of a global community, are in everyone’s best interest.

When initiating a project, it is important to obtain buy-in from a number of key stakeholders. Typically, this has meant working with high-level individuals, such as administrators of schools or heads of health institutions. Such support from the top is essential for facilitating approval, initiation, and implementation of a project. For example, as one respondent explained, “it is a policy that FLE is to be taught, but if there is no support from the administrators, it won’t be taught.” But working only with those in high level positions neglects another key level of support: the actual project implementers, such as providers at health facilities or teachers and counselors at schools. “We need to get them on board,” said one of the Jamaican policymakers interviewed. Echoing this sentiment, staff with a local research organization noted that if there wasn’t sufficient attention paid to those who would implement the project, then there were problems in both implementation and utilization, because “they just see it as additional work” and so with “any studies where you need their participation, it’s a bottleneck.” When asked how to secure the buy-in of project implementers, one respondent noted that it is important not to impose a fully formed idea at initial workshops or discussions, but to “leave it to evolve out of the discussion.”

In many cases, projects start somewhat informally; “it usually starts with a conversation with FHI”, noted one public health official. This highlights the importance of networking and of establishing good relations, two capabilities for which FHI staff receive high praise. Although programmatic collaborations between the two FHI Institutes are often limited, respondents mentioned many examples in Jamaica of the CTR and IMPACT Programs (or IMPACT’s predecessor, AIDSCAP) sharing contacts. Likewise, respondents shared multiple examples of organizations working first with one Institute or group at FHI and this leading to subsequent projects with a second group or Institute.

2. Implementation: *Benefits from the Process*

FHI has no permanent local presence in Jamaica, but respondents frequently spoke of the good relations they had with FHI staff from North Carolina. Jamaican partners consistently described the collaborative nature of their interactions with FHI, how FHI staff work well and with good cultural sensitivity, and that “they don’t come in and dominate.” Monitoring visits from FHI/NC staff were viewed as very useful. However, activities sometimes clustered around visits from NC staff, with a burst of activity followed by a period when there was little feedback.

FHI and partners in Jamaica have collaborated closely throughout the implementation of the CTR studies. As one respondent explained, “You are always included and part of the decision process.” And often there is important capacity building along the way. For example, staff from the Comprehensive Health Center stated that participation in the condom choice study has been “a learning experience” for them and has given them important skills that they can now employ

in a vaccine trial in which they are involved. Hope Enterprises emphasized that extensive learning (aside from actual training) has occurred and this has been “absolutely invaluable.” This shows the benefits of the process as well as from the results. “Even before the findings, we benefited from training,” explained another respondent.

FHI staff also described how they liked working in Jamaica. One staff member said this was “because I can get things done quickly there.” The story of the ‘Comprehensibility of Instructions for Missed Pills’ study is a perfect example. WHO and FHI discussed the possibility of the study in June of 2003 and WHO said they needed results by April 2004. The study was completed on time, results were presented to WHO in April 2004, and WHO is now incorporating the findings into their guidelines.

A number of factors can hinder the implementation of projects. As one example, many people cited Jamaica’s conservative elements as having a strong impact on the Ashe project and the development of the Vibes curriculum. The original curriculum contained several controversial sections, most particularly references to homosexuality. These brought protests, leading to project delays and adjustments as the curriculum was modified.

There were also institutional review board (IRB) requirements that sometimes slowed implementation. For example, recruitment in the condom choice study was much slower than expected. In part, this was due to a very lengthy informed consent process, which discouraged some clients from participating. Problems with the inclusion criteria also became evident. Jamaican study coordinators’ suggestions to modify the criteria helped to increase recruitment, but first obtaining approval through FHI’s IRB was a time-consuming process.

It is important during implementation to have adequate time to assess the effects and impact of an intervention. For example, the full-scale implementation of the Vibes curriculum had only been going on for about six months when the evaluation was done. This is likely a reason the quantitative results showed little impact. By contrast, the qualitative findings showed the intervention’s real potential. In addition to highlighting the need for an adequate time period for implementation, this example also reflects the strength of having both quantitative and qualitative data to better understand the effects of a project. Without both kinds of data, findings can give an incomplete picture. For example, a respondent noted that the “Quality of Information for Over-the-Counter OC Clients” project found that many OC clients stop using pills for a period of time, but there was no explanation for why they did so.

USAID staff spoke highly of the approach of FHI’s work with Ashe and its strategic and logical sequence of activities: producing a manual, implementing trainings, conducting an evaluation, and finally feeding that information back to the Ministry of Education. They felt that other activities could benefit from following a similar type of process.

3. Dissemination: Getting the Word Out

A project typically ends with production of a report and sharing of results through dissemination meetings. Such workshops are a key way to share information from a study. In addition, they often involve a number of stakeholders in the process of developing recommendations, often through small working groups. The effectiveness of dissemination workshops could be improved in a number of ways. First, expanding workshop audiences would often be helpful. From interviews it seemed that too frequently only those directly involved in the projects were invited; while by being more inclusive, the potential impact could have been increased. For

example, representatives of FHI's dissemination efforts seldom included schools of nursing though they are a key audience for improving delivery of reproductive health services. FHI and other organizations should also explore more creative ways to disseminate information and to communicate "in a language that people will understand," said a representative of a large Jamaican health project. Staff at Ashe had the idea of using a play about self-esteem to describe the findings from the curriculum evaluation, rather than simply presenting the report, which was seen as somewhat difficult to understand. Another respondent suggested sharing preliminary findings with key implementers before the end of a project, thereby creating a greater sense of involvement and earlier planning for utilization.

Another challenge is how best to present findings that are seen as negative or politically sensitive. If not done well, this can just lead to a defensive response from participants, who feel that they are being unfairly criticized. One researcher noted, "They just shut down and put up a wall and they don't listen. We need to find a way to present it to them where they can't shut down." Negative findings can lead to organizations blocking and delaying workshops. Such findings must be presented with sensitivity. In particular, the message needs to come from people with clear expertise or authority. It is often preferable to have local representatives rather than "outsiders" present findings.

In addition to dissemination workshops, FHI project typically have final reports. Findings have often been published in international peer-reviewed journals (these are listed with asterisks in the references in Appendix 3). Results have also often presented at conferences, such as the American Public Health Association Annual Meetings.

There are a number of methods of sharing information beyond project-specific efforts. For example, one busy clinician noted his desire for brief, readable summaries of research, noting he rarely found time for full-length articles or reports. Reaching a much broader, public audience, *the Daily Gleaner* newspaper in Jamaica has a 'health page' on Thursdays, and articles on reproductive health issues frequently appear there. FHI's publication *Network* was noted as another important source of information. Respondents called it "an excellent resource for students" and said they found it very useful. The Internet is a less-used resource in Jamaica. While some seek information from Web sites, such as FHI's, only 11 percent of people in Jamaica have Internet access, and it is rare for health facilities to have this capability. There are indications, however, that internet usage is increasing rapidly as FHI's web site had 1,461 visits from Jamaica in 2002; it had 2,813 in 2003; and in only the first five months of 2004, there were 1928 visits from Jamaica.

4. Follow up: Actions Speak Louder Than Words

Getting the word out is not enough; just hearing research findings will not necessarily change practice. One of the weakest areas in the process of implementing projects is conducting adequate follow up to ensure that the research is put into practice. Efforts in this regards have been fairly minimal. This is due in part to the way research is funded, typically ending with the dissemination of findings and production of a report.

According to respondents, the main barrier to research utilization is the lack of funds. Both planned and actual "follow up may not totally reflect all the needs" because there is not enough funding. Recommendations are viewed as a "wish list" of items that need to be prioritized given the limited funding. "To do more, resources would have to be made available," noted one program manager. For example, the MOE wants to expand the use of the Vibes curriculum, but says it will "have to find creative ways to make sure the materials are available." Research is

already often viewed as expensive, as “elitist”, and as a luxury. Thus it would be difficult, although hopefully not impossible, to convince donors to provide additional funds to cover follow up activities. It would be useful to have discussions with donors about ways to fund research so that more follow-up activities can be undertaken, and so the practical benefits of research can be maximized.

People in Jamaica are generally supportive of and receptive to research. As one respondent explained, “Nothing will be decided without research, but that doesn’t mean people will act on the findings.” Providers are often guided by what they learned in school or from peers, and it can be very difficult to change these beliefs, no matter what research findings indicate. For example, the study “Dual Method Use and Factors Associated with STDs among Jamaican Family Planning Clients” found syndromic management to be largely ineffective in this population. But when faced with these findings, providers were hesitant to stop using this method of STI management; as one clinician and researcher said, “What else are we going to use? This is the best that we have.”

Cultural context and beliefs can also affect use of research. For example, studies in 1993 and 1995 in Jamaica demonstrated that women are often denied contraceptive methods if they are not menstruating when they come for services (Stanback et al, 1997). Recommendations to address this have been made, and the FHI checklist to rule out pregnancy has been adapted and included in the *Jamaica Family Planning Service Delivery Guidelines*. Nevertheless, this barrier to access remains, as indicated in recent findings from the “Quality of Information for Over-the-Counter OC Clients” project. A number of respondents believed that a woman who says that she has not had sexual intercourse since her last menstrual period cannot be trusted and that she might be trying to get contraceptive pills in order to try to have an abortion. “It is very risky to give [pills] to first time users because you don’t know the intent of persons,” said one health care provider. Hence, in addition to informing providers about the availability of a tool like the checklist, it is also essential to address negative provider attitudes in order to effectively improve access to care.

A number of respondents mentioned the importance of having someone in-country to push things along and to bring together all the different components of FHI’s work in Jamaica. Otherwise, it is more difficult to be fully aware of and responsive to local issues; “The culture of the country is so integral to what you do, and the environment is very dynamic,” noted a respondent with years of experience with USAID supported programs. Also, having an in-country presence (either a local country representative or a small country office) can greatly facilitate closer collaboration among different agencies. Although this happens even in the absence of an FHI country representative, respondents emphasize that there could be a lot more sharing and interaction; they believed having a person in Jamaica could make a significant difference. This is essential for research organizations such as FHI. Establishing and fostering closer links with service delivery groups is an important step to facilitate utilization of research findings.

Typically it is the health providers, teachers, and guidance counselors who must put researchers’ findings into actual practice. But how can they be motivated to do this? One respondent suggested that follow-up training would help providers see the usefulness of their participation. This point refers back to the beginning of the process. For effective implementation and utilization of research, it is essential that providers be involved early in the process. Researchers need to get their buy-in, to make them part of the process so that they do not feel that things are being imposed on them, and to give them opportunities for active involvement and ownership of the projects.

Conclusions and Recommendations

FHI has undertaken a range of project activities in Jamaica from 1995 to 2005. Utilizing a variety of strategies, these activities have sought to strengthen and expand aspects of the reproductive health program in both the public and private sectors. The major approach has been to expand, through research under the CTR projects, knowledge and understanding of critical factors that impact the quality of reproductive health on key issues. These issues include the use of contraceptive methods, the quality of information offered by providers, and user perspectives on methods and services. In addressing these and other related issues, FHI has focused on adolescents, a priority target group for the Ministry of Health's reproductive health services. For adolescents, emphasis has been placed on the development of curricula; educational materials; innovative teaching methodologies; training of guidance counselors, school nurses and youths; and evaluation as outlined in the Adolescent Reproductive Health Programs I - III implemented by Ashe.

The CTR project activities in Jamaica have provided opportunities for interaction with important stakeholders in reproductive health (mainly in the public and to a lesser extent in the private sectors) to address both national and global concerns. Capacity strengthening has also been a focus of CTR projects the FHI-Jamaican collaboration has strengthened of technical and management capacities, broadened data collection and analytical skills, improved computer expertise, exposed health professionals to international standards of clinical practice and ethical review procedures, enhanced knowledge and information among adolescents, increased access to both human and material resources, and yielded the opportunity to articulate and address areas of need in the national reproductive health program. The mutually rewarding, professional and collaborative relationships that have been established between FHI and their Jamaican counterparts have facilitated problem solving and uninterrupted project implementation. Multiple project activities have been implemented concurrently and completed successfully without the continuous presence of FHI personnel in Jamaica.

FHI did not articulate a comprehensive program for Jamaica as part of the CTR Agreement. However, FHI took into consideration the findings of research studies previous to 1995, in particular the Private Providers Quality of Care Survey, and undertook further research activities to investigate the issues that were identified. This resulted in the training of private and public sector nursing tutors. Likewise, a pilot study of appointment scheduling was conducted after research on users' perspectives on the quality of care found that long waiting times were a common complaint. As a final example, the parenting component of the Vibes curriculum followed the finding that parents need to be educated along with adolescents. The CTR program's record of adding on new activities, to address the recommendations or issues identified in earlier efforts reflects a responsiveness not always seen in programs—particularly those which have neither a country representative nor a defined role in a sustained bilateral program. In doing this, FHI has demonstrated a measure of sensitivity to national needs while simultaneously addressing items on the global agenda for reproductive health.

FHI staff working on CTR projects were reported to be very collaborative and willing to discuss constraints and alternatives in project implementation. The majority of the informants were aware of varying degrees of FHI's involvement in reproductive health in Jamaica and of its resources, such as publications and Web site. However, utilization of these resources could be improved still further with broader dissemination of the publications and the Web address. .

The CTR has clearly stimulated a research approach to addressing issues in reproductive health and increased the capacity of the health and education sectors in the subject area.

Nevertheless, the absence of a CTR strategic program in Jamaica has led to fragmentation of project activities. These activities, while relevant and useful, were not integrated and systematically linked. Thus the use of resources to achieve the greatest involvement and participation at appropriate stages of direct and indirect beneficiaries was not maximized. This deficit has manifested itself in the limited dissemination of research results that are useful not only for those directly involved but also to the institutions training health professionals, health planners, quality control personnel, and others. Additionally, it has been noted that there is no definite provision for follow-up of the findings of the research initiatives once they are completed and the results have been disseminated. While it is not always feasible for FHI to provide resources for follow-up, utilization of research findings could be facilitated by negotiating the location of the responsibility and possible resources for recommendations stemming from the research.

The following major recommendations synthesize 1) recommendations emerging from the interviews with key informants familiar with the CTR project activities during the period under review and 2) The Case Study Team's analysis of the relevant data and information.

The following are the recommendations:

1. **FHI would benefit by having a country or regional representative in Jamaica**, on a full- or part-time basis. This individual could oversee projects to improve the speed and quality of project implementation, increase collaboration and integration with related reproductive health activities, and monitor and suggest appropriate changes. The activities of this representative would also enhance and increase FHI's visibility in Jamaica
2. **FHI should develop a strategic plan for its program in reproductive health in Jamaica in collaboration with key country partners, and in keeping with the MOH's own plan.** This would reduce fragmentation and to enable the timely evaluation of the medium term impact of the activities.
3. **Wider dissemination of research findings is necessary to promote greater use and action on the results.** FHI's Research to Practice initiative should be further implemented in Jamaica. Efforts should be strengthened to engage policy-makers and implementers in the definition and design of research activities, as well as involving both in the dissemination of results. When appropriate, dissemination efforts should utilize innovative methods of sharing information.
4. **Strategic alliances should be encouraged and developed among cooperating agencies at the national and international levels** to integrate portfolio responsibilities, avoid duplication, and maximize the use of available resources. USAID staff can assist in this effort by encouraging service delivery organizations to work with research-based CAs and vice versa.
5. **Resources should be identified to implement post dissemination activities related to the utilization of research findings.** Most research activities in Jamaica have included an in-country dissemination of results, but there has rarely been funding for following up on recommendations stemming from the dissemination. Donors and FHI should work together to identify resources needed to implement cost-effective solutions suggested by research findings. Strategic alliances, as called for above, may help in this regard.

Appendix A: Key Informants Interviewed

In Jamaica:

Mrs. Beryl Chevannes, Reproductive Health Consultant and Past Executive Director of the National Family Planning Board, 1992-1999

Professor Joseph Frederick, Director, Advanced Training and Research in Fertility Management, the Faculty of the Medical Sciences, University of the West Indies, Mona

Ms. Kristin Fox, Sir Arthur Lewis Institute of Social and Economic Research, University of the West Indies, Mona.

Dr. Margaret Green, Medical Associates Hospital, Past President of the Medical Association of Jamaica

Karen Hardee, Director of Research, Futures Group

Mr. Henry Harris, President, Pharmacy Association of Jamaica

Mrs. Monica Holness, Acting Chief Education Officer, Ministry of Education

Dr. Tina Hylton Kong, Medical Officer of Health, Comprehensive Health Centre, Ministry of Health

Mrs. Kathy McClure, Country Manager for Policy 2 Project, Futures Group

Dr. Olivia McDonald, Executive Director, National Family Planning Board

Mrs. McFarquhar, Retired, Nursing Trainer, Public Sector Program

Mrs. Marcia Hyman-McKay, Nursing Tutor, Kingston School of Nursing

Dr. Richard Reid and Nurse Melody Pariola, FAMPLAN

Mr. Joseph Robinson, Executive Director, ASHE,

Dr. Pauline Russell-Brown, Chief of Party, Youth.now, Futures Group

Mrs. Margaret Sancho & Mrs. Jennifer Knight-Johnson, United States Agency for International Development

Professor Monica Smikle, Dept. of Microbiology, University of the West Indies, Mona

Mrs. Maxine Wedderburn, Mrs. Deborah Bourne & Ms. Kamille Thompson, Hope Enterprises

Mrs. Beryl Weir, Executive Director, Women's Centre Foundation of Jamaica

At Family Health International:

Dawn Chin-Quee, Senior Research Associate, Health Services Research

Bill Conn (by phone), Senior Program Officer, HIV/AIDS Institute

Carmen Cuthbertson, Research Associate, Health Services and Delivery

Cindy Geary, Senior Scientist, Behavioral and Social Sciences

JoAnn Lewis, Senior Vice President, Reproductive Health Programs Department

Susan Palmore, FHI Consultant and Director of Policy and Research Utilization at the time of the CTU Trainings, Jamaica

Beth Robinson, Director, Field Information & Training Services

Alan Spruyt, Senior Research Associate

Markus Steiner, Epidemiologist II, Clinical Research

Appendix B: Question Guide

Case Study on the Outcomes and Impact of FHI's Contraceptive Technology Research Activities in Jamaica (1995 - 2004)

Overview questions

1. What is your experience with FHI/CTR in Jamaica?
2. From your experience, what is the general impression of FHI in Jamaica? (Probe about distinguishing between the two institutes of FHI, etc.)
3. How have you learned about FHI's contraceptive technology work? (Probe about past meetings, local press, other CAs, or other local references)
4. Do you know of and use any of FHI's information resources on a regular basis? (Probe about the quarterly publication Network, and FHI's Web site).

Project-specific questions

5. Who initiated the project? Was it NC looking for a suitable site for a global question, or was it addressing a need specific to Jamaica?
6. Who was involved in designing the study? In implementing the project? In analyzing results? In developing recommendations? In disseminating findings?
7. Did the study accomplish its objectives?
8. How were the results disseminated? (Probe on all ways)
9. Were there explicit plans when designing/implementing the study for how findings could be used?
10. When appropriate: Were there specific efforts to encourage utilization of results at the end of the study? Describe facilitators and barriers to this process.
11. How could things have been done differently to enhance impact?

Project-specific/and general (ask everyone)

12. Do you know of any specific examples of how FHI's research, training or information dissemination was useful...? [at both national and international level]
 - a. To change attitudes?
 - b. To change knowledge?
 - c. To change programs?
 - d. To change policies?
 - e. To lead to further research?
 - f. To influence donor funding

13. Were there any factors in the social-cultural-political-economic environment that facilitated the utilization of the research?
14. Were there any factors that hindered the utilization of the research?
15. In general, can you point to any contribution that FHI has made in improving reproductive health in Jamaica?
16. Do you have any suggestions for how FHI could have more impact on improving reproductive health in Jamaica?
17. What are the key research questions in Jamaica now regarding contraceptive technology? What are the key factors that hinder access or use?
18. Do you have any suggestions for people that we should speak with or documents that we should look at for our case study?

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