Documentation of HIV programmes for children in Jamaica

Project Report

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ACRONYMS

AIDS	Acquired Immune Deficiency Disease
AIDSCAP	AIDS Control and Prevention Project
ALERT	Adolescent, Lifestyle, Education and Risk Reduction Tool
ARV	Antiretroviral
CAREC	Caribbean Epidemiology Centre
CBO	Community Based Organization
CCC	Caribbean Conference of Churches
CDA	Child Development Agency
CHARES	Center for HIV/AIDS Research and Education Services
CIDA	Canadian International Development Agency
CPTC	Creative Production & Training Centre Limited
CSJP	Citizen & Security Justice Programme
C&W	Cable & Wireless
DANIDA	Danish International Development Agency
DFID	Department for International Development
EDF	The European Development Fund
EDUCAIDS	Global Initiative on HIV/AIDS and Education
EFJ	Environment Foundation of Jamaica
EU	The European Union
FAMPLAN	Jamaica Family Planning Association
FBO	Faith-based Organization
GOJ	Government of Jamaica
GTZ	German Technical Cooperation (Deutsche Gesellschaft für Technische Zussamenabeit)

ACRONYMS (continued)

GIS	Geographic Information System
HIV	Human Immuno-deficiency Virus
HFLE	Health and Family Life Education
IDB	Inter-American Development Bank
JA- STYLE	Jamaica's Solution to Youth, Lifestyle & Empowerment
JFC	Jamaica Foundation for Children
JMD	Jamaica Methodist District
JWOW	Jamaica Women of Washington
KABP	Knowledge, Attitudes, Behaviour & Practices
MOEYC	Ministry of Education, Youth and Culture
MOH	Ministry of Health
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organization
NHCP	National HIV/STI Control Programme
OPEC	Organization of Petroleum Exporting Countries
OXFAM	Oxford Family Organization of London
PAHO	Pan American Health Organization
PCAJ	Peer Counselling Association of Jamaica
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPFC	Planned Parenthood Federation of Canada

ACRONYMS (continued)

REO	Regional Ecumenical Organization
SPSS	Statistical Package for the Social Sciences
SRH	Sexual Reproductive Health
STIs	Sexual Transmitted Infections
UBW	The Unified Budget and Work plan
UNAIDS	Uniting the World Against AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drugs and Crime
USAID	United States Agency for International Development (USAID)
UWI	University of the West Indies
UWI HARP	University of the West Indies HIV/AIDS Response Programme
VCCT	Voluntary Counseling and Confidential Testing
WestHELP	Western Health Education Learning Programme
WHO	World Health Organization
WKKF	WK Kellogg's Foundation
WRHA	Western Regional Health Authority

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EXECUTIVE SUMMARY

An estimated 1.5% (25,000) of Jamaica's population is living with HIV. While the HIV prevalence is not nearly as high as in the Caribbean islands of Haiti and the Dominican Republic, the numbers are still high. The Ministry of Health's AIDS report for the period January 1982 and December 2006 showed that a total of 11,739 cases were reported to the Ministry of Health, whilst the total number of reported AIDS deaths for this period was 6,673. The numbers of AIDS cases continue to increase island wide with the parishes of Kingston and St. Andrew and St. James being most affected

In 2006, a total of 73 new paediatric AIDS cases (children 0-9 years old) were reported compared to 78 paediatric AIDS cases in 2005. There were 13 paediatric AIDS deaths reported in 2006, compared to 19 paediatric AIDS deaths in 2005, representing a 0.6% decline.

Prevention programmes have been enhanced to maintain the high awareness of HIV among Jamaicans as well as to increase the capacity of individuals to accurately assess their risk for HIV infection and take the necessary precautions to protect themselves.

The goal of this project was to document HIV Programmes for children (up to 18 yrs) in Jamaica in order to compile this information, and suggest processes for enhancing and expanding programmes.

The specific aims of this report were to systematically describe HIV intervention programmes that address children in Jamaica, identify programming trends and tendencies in terms of the

target population, describe the HIV-related services provided and determine programme planning, implementation, monitoring and evaluation mechanisms.

The inventory methodology was influenced by the World Health Organization's Manual for the Documentation of Interpersonal Violence Prevention Programmes (WHO, 2004) and the Inventory of Agencies with HIV/AIDS Activities and HIV/AIDS Intervention in Uganda (African Medical & Research Foundation, 2001). Questionnaire items were also taken from Evaluating CDC-Funded Health Department HIV Prevention Programmes (Center for Disease Control and Prevention, 2001) and A Resource Inventory for Georgia HIV Prevention and Care Programme compiled by The Center for Applied Research and Evaluation Studies, Southeast Education and Training Center, Department of Family and Preventive Medicine & Emory University School of Medicine (2001). Organizations with programmes were identified using information gathered from the CCDC's Resource Room, the Directory of Services, compiled by the Jamaica Foundation for Children (2005), consultations with University of the West Indies HIV/AIDS Response Programme (UWIHARP) and other stakeholders.

The following steps were carried out: developing the survey instrument, identifying potential programmes for documentation, selecting programmes for documentation, contacting programmes and obtaining consent. Following this, data were collected (conducting documentation), data quality and gaps were assessed, information was entered into the electronic database and feedback was sought from programme operators and other stakeholders.

Forty programmes were identified that met the criteria for inclusion. The results were analyzed in terms of geographic scope, characteristics of the target population, their theoretical or philosophical orientation and monitoring and evaluation methods.

The programmes identified were mainly carried out by non-governmental organizations (NGOs). Programmes were located primarily in Kingston & St. Andrew and provided services for both males and females between the ages of 0-24 years. Most of the programmes provided HIV Prevention services and many did not have formal evaluations. However, there were various methods of monitoring and evaluating programme activities and services, particularly through progress and final reports written to funding agencies. Overall, there was a unanimous need for greater financial and technical assistance to support programme implementation and monitoring.

The inventory revealed a serious lack in psychosocial programming for HIV infected and affected children. Although many programmes provided educational interventions or policy development services, an emphasis on the spiritual, emotional, psychological and social needs is essential in providing successful treatment and care for HIV infected and affected children (WHO, 2007).

It was evident that most of the programmes had inadequate documentation on their activities. Very few programmes had printed materials or programme reports available.

Research into the programmes that provided HIV-related services served to identify the need for psychosocial interventions and formal evaluations in HIV programmes for children in Jamaica, and provided a compilation of programme offerings for the first time.

1. INTRODUCTION

1.1 Prevalence of HIV

About 2.4 % of the Caribbean's adult population is living with HIV. Jamaica is one of the Caribbean countries where the epidemic has spread from high-risks groups to the general population (PAHO, 2004). An estimated 1.5% (25,000) of Jamaica's population is living with HIV (UNICEF, 2007).While the HIV statistics are lower than the Caribbean islands of Haiti, Guyana and Trinidad and Tobago, the numbers are still very high (Table 1).

Table 1: Estimates of HIV/AIDS in the Caribbean at the end of 2005: Selected Countries*

Country	Population	Adult prevalence (15-49)
Trinidad and Tobago	1,328,000	2.6
Cuba	11,267,000	0.1
Barbados	293,000	1.5
Jamaica	2,699,000	1.5
Haiti	3,800,000	3.8
Dominican Republic	9,446,000	1.1
Guyana	9,615,000	2.4

**UNICEF: Information by country-Statistics*

The Ministry of Health's AIDS report for the period January 1982 and December 2006 showed that 11,739 cases were reported to the Ministry of Health, whilst the total number of reported AIDS deaths for this period was 6,673.

Overall, there were a total of 838 paediatric AIDS cases (children 0-9 years old) between the periods Jan. 1986 - Dec. 2006. The Ministry of Health reported that 52.5% (440) of these cases were males and 47.5% (398) were females (MOH, 2006), as shown in Table 2. In 2006, a total of 73 new paediatric AIDS cases were reported compared to 78 paediatric AIDS cases in 2005.

There were 13 paediatric AIDS deaths reported in 2006, compared to 19 Paediatric AIDS deaths in 2005.

Table 2: Summary of Paediatric AIDS Cases (Age 0 - 9 years)*

PERIOD	TOTAL	Male N (%)	Female N (%)
Cumulative 1986-Dec. 2006	838	440 (52.5)	398 (47.5)
Jan-Dec. 2001	65	39 (45.7)	26 (54.3)
Jan-Dec. 2002	81	37 (65.4)	44 (34.5)
Jan-Dec. 2003	67	36 (53.7)	31 (46.3)
Jan-Dec. 2004	61	29 (47.5)	32 (42.5)
Jan-Dec. 2005	78	42 (53.8)	36 (46.2)
Jan-Dec. 2006	**73**	**37 (50.7)**	**36 (49.3)**

*

****Ministry of Health- National HIV/STD Control Programme HIV/AIDS Epidemic Update (2006)***

Prevention programmes have been scaled up to maintain the high awareness of HIV among Jamaicans as well as to increase the capacity of individuals to accurately assess their risk for HIV infection by reducing risky behaviours and taking the necessary precautions to protect themselves (MOH, 2006).

1.2 Factors Driving the Epidemic

Jamaica's HIV/AIDS/STI National Strategic Plan (2002-2006) identified a number of social, cultural and behavioural factors driving the spread of the epidemic in the island (MOH, 2002). These included early initiation of sexual activity, dysfunctional gender relations, religious taboos, stigmatization of people living with HIV, and lack of a human rights approach to HIV. Young people, under 19 years, have increased vulnerability to infection due to early sexual

activity (UNICEF, 1989). Most of their sexual encounters reportedly take place without the benefit of consistent and correct use of a condom (MOH, 2002).

In Jamaica traditional beliefs about fertility and sexuality are based on centuries of practices (dated back to the slave plantation) that are difficult to erode. It is believed that women must bear children in order to rationalize their existence (Royes, 1999), whereas young men must prove their masculinity by impregnating women (Chevannes, 1998). These cultural factors have implications for condom negotiation and safer sex practices. This is reflected in the perceptions and negative attitudes toward modern contraceptive methods. These attitudes are not rooted in religious dogma but rather in traditional cultural understanding, which holds for example, that coitus is essential to the physical well being of men (Chevannes, 1998). Condoms are regarded as invasive objects that may cause more harm than good (Royes, 1999). A woman's sexuality is for the night and not the day, and she has little power in condom negotiation (Chevannes, 1998).

In Jamaica HIV is predominantly transmitted through unprotected heterosexual intercourse and is increasing faster among women than men (MOH, 2002). However, the percentage of HIV cases that result through male to male sexual contact may be higher. The fact that male homosexual sex is illegal, coupled with the strong stigma and discrimination associated with homosexual and bisexual behavior, may keep men who have sex with men from admitting such activity, while trying to access treatment and testing services (MOH, 2004). The majority of the cases of unknown transmission are among men (MOH, 2006). The National HIV/STI Prevention Control Programme (MOH, 2002) suggested that rates of male to male transmission may be higher than reported.

1.3 National Response to the Epidemic

The Government of Jamaica established the National HIV/STI Control Programme in the late 1980s (MOH, 2006). The National HIV/STI Programme is geared towards prevention and control of HIV and other sexually transmitted infections (MOH, 2006). It advocates for and coordinates the input of all sectors in society; including the private, public, international and non-governmental organizations (MOH, 2006).

The National AIDS Committee was established in 1988 to advise the Government on policy and to mobilize various sectors of the society in the fight against HIV (NAC, 2007). Parish AIDS Committees have been formed in all the 14 parishes to spread community awareness and improve response (NAC, 2007).

The National HIV/STI Programme has also been working to strengthen the island's capacity to effectively deal with the epidemic. Capacity building to that end involves the training of healthcare workers and forming partnerships among public sector entities, private sector members and various non-governmental organizations (MOH, 2006).

1.4 Aims of Documentation

The specific aims of this project were to systematically describe HIV intervention programmes that address children in Jamaica, and to identify HIV intervention programming trends and tendencies in terms of the target population, HIV-related services provided and programme planning, implementation, monitoring and evaluation mechanisms.

2. METHOD

2.1 Developing the Instrument

A structured questionnaire was created drawing from several other instruments: the Manual for the Documentation of Interpersonal Violence Prevention Programmes (WHO, 2004), the Inventory of Agencies with HIV/AIDS Activities and HIV/AIDS Interventions in Uganda (African Medical & Research Foundation, 2001), Evaluating CDC-Funded Health Department HIV Prevention Programmes (Center for Disease Control and Prevention, 2001) and A Resource Inventory for Georgia HIV Prevention and Care Programme (The Center for Applied Research and Evaluation Studies et al., 2001). The questionnaire included both quantitative and qualitative items, and asked for information on each programme's goals, locations and settings, HIV-related services provided, funding information, and programme planning and monitoring. The questionnaire was piloted and revised to better capture the data targeted. A copy of the questionnaire is shown in Appendix I.

2.2 Identifying and Selecting Potential Programmes for Documentation

A list of organizations with potential programmes for the inventory were compiled using an initial list at the CCDC, and information gathered from the Directory of Services (Jamaica Foundation for Children, 2005), the National AIDS Committee of Jamaica (NAC), and consultations with the Ministry of Health and University of the West Indies HIV/AIDS Response Programme (UWI HARP). Sixty-five programmes were identified with potential for inclusion.

There were specific criteria for including programmes in the documentation. Programmes had to: target children under the age of 18 years, though not necessarily exclusively; have been in

operation between 2001 and 2007, when the documentation took place; have services relating to the prevention or reduction of HIV transmission, or providing services that were directly or indirectly related to HIV or sexual reproductive health issues in youth.

2.3 Contacting Programmes and Obtaining Consent

The programmes were contacted initially by telephone and the programme managers or their designates were identified. The research officer determined whether they had a HIV programme that met the inclusion criteria and were willing to participate. A letter (Appendix II) explaining the purpose of the documentation was then sent to the programme managers and a time scheduled later for meeting. Of the 65 programmes it was determined that 40 programmes met the inclusion criteria.

2.4 Data Collection and Analysis

Face-to-face interviews were conducted with the programme managers or coordinators for the 40 programmes. Documents on the programmes were also collected. A few programmes (n=18) had websites and the information collected during interviews was cross-checked with these and additional information obtained. Data were collected over a period of 4 months (April-July 2007).

Data were entered onto the computer and double checked. The information on programmes was analyzed using the Statistical Package for the Social Sciences (SPSS) for Windows, version 12.0. Descriptive statistics were generated including descriptions of the target population, their geographic scope and implementation settings, the types of HIV services offered, as well as the monitoring and evaluation processes.

2.5 Entering the information into a database

Data for each programme were also entered into a purpose-designed database and made available online through the Caribbean Child Development Centre (CCDC) website at http://ccdcresearch.mona.uwi.edu/hivprogramme. The database template was constructed as a replica of the data collection instrument. The database is being hosted on the UWI Mona server.

2.6 Feedback to Programmes and other Stakeholders

A one-day workshop was held on November 23, 2007 with programme staff and coordinators of the HIV programmes included in the documentation, as well as other stakeholders. The objectives of the meeting were to present and discuss the results of the documentation, demonstrate the database, identify strategies to maintain the database, and formulate a plan to encourage others to use the database. A report of the meeting can be found in Appendix III.

The report outlines strategies recommended for improving the usefulness of the database, updating and maintaining the database, disseminating information on the database and encouraging its utilization.

2.7. Addition of GIS Functionality to the database

Specific data on each HIV programme (programme name, postal address, parishes served, main areas covered, and HIV activities) were integrated into a geographic information system (GIS), and the outputs displayed on a map of Jamaica and as tables. The map and the tables can be accessed on the website at http://ccdcresearch.mona.uwi.edu/hivprogramme/.

3. RESULTS

3.1 Programme Profiles

A brief description of each of the 40 programmes that met the inclusion criteria is presented below in alphabetical order (Table 2). The following parameters are given: 1) a brief description of the implementing organization and each programme, 2) the target groups and aims/objectives/goals of each programme, and 3) funding agencies supporting programmes. All programmes were ongoing at the time of the survey, except where noted.

1. ALERT Programme - HOPE Worldwide Jamaica

HOPE Worldwide Jamaica was an incorporated non-governmental organization, committed to improving health care. "Hope Worldwide has the focus of promoting health and well being to communities and individuals at risk by providing services in the area of health education, prevention and health care delivery."

The Adolescent Lifestyle Education Risk Reduction Tool (ALERT) was one of the programmes implemented by Hope Worldwide Jamaica. The programme was started in 2005. The goal of this programme was to encourage abstinence and increase education and awareness of peer pressure to be sexually active. Improving peer relationships between adolescents ages 14-19 years was also a focus of this programme. The main funding source for the ALERT programme was the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

Table 3: HIV Intervention Programmes for Children in Jamaica

#	**Programme Name**	**Organization Name**
1	ALERT Programme	HOPE Worldwide Jamaica
2	Building a Faith-based response to HIV/AIDS	Caribbean Conference of Churches (CCC)
3	Bureau of Women's Affairs	Bureau of Women's Affairs
4	Capacity Building of Ministries of Education for a strengthened and accelerated response to HIV/AIDS	United Nations Education Scientific and Cultural Organization (UNESCO)
5	Child Development Agency (CDA)	Child Development Agency (CDA)
6	Children & HIV/AIDS Programme	United Nations Children Fund (UNICEF)
7	Children & HIV/AIDS	Ashe Caribbean Performing Arts Foundation
8	Children of Faith Fund	Children of Faith Parenting Support
9	Community Counselling Project for Young Women	The Jamaica Family Planning Association (FAMPLAN)
10	Communities Youth Project (CYP)	The Jamaica Family Planning Association (FAMPLAN)
11	Dare to Care	Mustard Seed Communities
12	Expanding Educational Horizons	Young Women's Christian Association (YWCA)
13	Family Life Education & Reproductive Health	Peer Counselling Association of Jamaica (PCAJ)
14	Fighting AIDS Through Training & Education (FATE)	The Jamaica family Planning Association (FAMPLAN)
15	"Friends" Helpline	Jamaica Foundation for Children
16	Healthy Lifestyle	HOPE Worldwide Jamaica
17	HIV/AIDS Response Programme	Ministry of Education, Youth & Culture
18	Ionie Whorm's Inner-City & Counselling Centre	Ionie Whorm's Inner-City & Counseling Centre
19	Jamaica's Solution to Youth Lifestyle and Empowerment (JA-STYLE)	The United States Agency for International Development (USAID)
20	Jamaica Network of Seropositives (JN+)	Jamaica Network of Seropositives (JN+)
21	Kingston Paediatric Prenatal HIV/AIDS Programme	University Hospital of the West indies (UHWI)
22	Methodist Youth in Mission Everywhere (MYME)	The United Methodist Church in Jamaica
23	National AIDS Committee (NAC)	National AIDS Committee (NAC)
24	Our Own Voice: Youth Fighting AIDS Through the Media	Panos Caribbean

Table 3 (continued): HIV Intervention Programmes for Children in Jamaica

#	**Programme Name**	**Organization Name**
25	Power Peer Youth Initiative	The Jamaica Red Cross
26	Project Smiles	Jamaica AIDS Support for Life (JAS)
27	Psychosocial Support Group	Centre for HIV/AIDS, Research, Education and Services (CHARES)
28	S-Corner Clinic & Community Development Organization	S-Corner Clinic & Community Development Organization
29	St.James Public Health Services	Western Regional Health Authority (WRHA)
30	Sustaining Life through Prevention and Control	Combined Disabilities Association
31	The Bashy Bus	Children First
32	The National HIV/STI Control Programme	Ministry of Health (MOH)
33	" Together We Can" Peer Education Programme	The Jamaica Red Cross
34	United Nations Population Fund (UNFPA)	United Nations Population Fund(UNFPA)
35	Uplifting Adolescent Project	Mel Nathan Institute
36	Vibes in a World of Sexuality	Ashe Caribbean Performing Arts Foundation
37	Voluntary Counseling and Confidential Testing	The Jamaica Family Planning Association (FAMPLAN)
38	Youth Advocacy Movement (YAM)	The Jamaica Family Planning Association (FAMPLAN)
39	Youth Opportunities Unlimited (YOU)	Youth Opportunities Unlimited (YOU)
40	Youth as Promise Project	Peace Corps

2. *Building a Faith-based Response to HIV/AIDS* - Caribbean Conference of Churches (CCC)

The Caribbean Conference of Churches is a Regional Ecumenical Organization (REO) of the Caribbean concerned with holistic development in the Caribbean region.

"Building a Faith-based Response to HIV/AIDS" was one of its initiatives. The overall goal of the project was to mobilize and enhance the response of the faith-based organizations in the Caribbean to the HIV/AIDS epidemic. The purpose was to mobilize and strengthen faith-based HIV/AIDS projects and programmes, particularly in the areas of care and support initiatives, and education and awareness building at the level of the congregation and communities. Activities ranged across 14 CARICOM countries namely: Antigua & Barbuda, Anguilla, Barbados, Bahamas, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts & Nevis, St. Vincent & the Grenadines, Suriname and Trinidad & Tobago. The main funding agency was CIDA.

3. Bureau of Women's Affairs

The Bureau of Women's Affairs aimed "to enable women to achieve their full potential as participants in Jamaica's social, cultural and economic development and with equitable access to and benefits from the country's resources." Their mandate was "to act as a catalyst to ensure that government addresses the problems that confront women, given the impact of patriarchy and sexism." The problems addressed included: "high rates of unemployment, violence against women in various forms such as rape, spousal abuse, incest and sexual harassment."

The Bureau of Women's Affairs had no named HIV Programme. However, it collaborated with other agencies which implemented HIV intervention and prevention programmes, for example MOH HIV/AIDS Prevention and Control Project and the Jamaica Network of Seropositives. Their target groups were individuals 15-24 years. Teenage pregnancy, HIV/AIDS and sexual

reproductive health were priority areas for the Bureau of Women's Affairs. The main funding source for this programme was the Global Fund.

4. Capacity Building of Ministries of Education for a strengthened and accelerated response to HIV/AIDS - United Nations Education Scientific and Cultural Organization (UNESCO)

The UNESCO HIV programme was one of capacity building of the Ministry of Education for a strengthened and accelerated response to HIV. The programme covered multiple projects/activities with different funding sources and implementation periods. While the programme did not directly target children, since UNESCO's main implementing partner was the Ministry of Education, children and youth were direct beneficiaries. The programme was started in January 2006 and was scheduled to end in June 2008.

The objectives of the programme were to build and develop the Ministries of Education in the Caribbean for contribution to the development of national and regional plans of action on HIV, mobilizing financial support for sustaining such HIV programmes in the Caribbean, and coordinating and collaborating with donor agencies and key stakeholders for an effective HIV response.

The UNESCO office in Jamaica coordinated the implementation of the global initiative on HIV/AIDS and education (EDUCAIDS) which aimed to support countries as they developed comprehensive education sector-based responses to HIV & AIDS, with the dual objectives of:

- Preventing the spread of HIV through education, and
- Protecting education systems against the worst effects of the epidemic

The main funding sources were:

- The Jamaica EDUCAIDS project: Government of Japan (Funds-in-Trust)
- UNESCO Regular Budget: UNESCO Member States (listed on website)
- UNESCO Extra-budgetary sources: UNAIDS Unified Budget and Work plan (UBW)

5. Child Development Agency (CDA)

"The Child Development Agency was started 60 years ago (when it was called Children Services). It integrated the functions of three earlier entities in order to provide comprehensive delivery of services to children and their parents (clients). The Agency has statutory responsibility for children who are in need of care and protection. The CDA networks with agencies (governmental and non-governmental) to provide residence to orphans who were infected and affected with HIV."

The CDA has no named HIV programme. However, as part of its emphasis on promoting children's rights, the CDA monitored the adoption of international conventions locally and aimed at developing and promoting its position on children's issues internationally. The goals of the CDA were to provide the child with all the opportunities to realize their full potential. The main funding source was the Government of Jamaica.

6. Children and HIV/AIDS Programme - United Nations Children Fund (UNICEF)

The United Nations Children Fund was created by the United Nations General Assembly on December 11, 1946. UNICEF provides long-term humanitarian and developmental assistance to children and mothers in developing countries. A voluntarily funded agency, UNICEF relies on

contributions from governments and private donors. Its programmes emphasize developing community level services to promote the health and well being of children.

The Children and HIV/AIDS Programme (Jamaica) was started in January 2007 continuing earlier programmes, and is scheduled to end in 2011. This programme can be described as an integrated approach aimed at strengthening national community and family capacities to prevent HIV/AIDS infection and to care for children and adolescents affected by the epidemic.

The main goals of this programme were to achieve the following:

- 90% of HIV positive pregnant women accessing public health care receive VCCT and ARV treatment during pregnancy and after delivery.
- 90% of exposed infants receive ARV prophylaxis.
- 90% of HIV infected children receive quality ARV treatment.
- 30% of children orphaned/made vulnerable by HIV/AIDS receive core support and protection and education that decreases vulnerability to HIV.
- 60% of adolescents (especially vulnerable) have access to information, skills based education and services to reduce their risk and vulnerability to HIV positive unplanned pregnancies.

The implementing agencies were the Ministry of Health's PMTCT Programme, Children of Faith, Children First and Ashe Caribbean Performing Arts Foundation. Funding was from UNICEF.

7. Children & HIV/AIDS - Ashe Caribbean Performing Arts Foundation

Children & HIV/AIDS was one of the programmes implemented by Ashe Caribbean Performing Arts Foundation. This programme was specifically geared towards individuals 12-19 years of

age, and dealt with issues of stigma and discrimination through performance arts. The programme was started in 2006 and the main source of funding was UNICEF.

8. Children of Faith Fund - *Children of Faith Parenting Support*

Children of Faith Fund aimed to reach every child orphaned because of AIDS.

The Children of Faith Parenting Support programme provided children and young people affected by HIV with the tools they needed to "survive and thrive." The programme was started in March 1999, and provided services to orphans and young people. Children of Faith Parenting Support aimed to prevent STI/HIV transmission. The main funding agencies were CIDA, UNICEF, EFJ and Food for the Poor.

9. *Community Counselling Project for Young Women* – The Jamaica Family Planning Association (FAMPLAN)

The Community Counselling Project for Young Women was one of five programmes implemented by FAMPLAN. The programme was started in 2006 and ended in 2007. It was established to provide funding for a counselling and group work programme for young women ages 10-24 years.

The main goals of this programme were to:

- Create awareness and work on issues specifically related to young women, increasing knowledge and building skills for combating teenage pregnancy and prevention of HIV/AIDS,
- Build self-esteem and self worth and make decisions about their life.

This programme was funded by JWOW.

10. Communities Youth Project (CYP) – The Jamaica Family Planning Association (FAMPLAN)

The Communities Youth Project was one of five programmes implemented by FAMPLAN. The CYP project provided access to sexual reproductive health (SRH) information and services for young people. The aim was to promote positive decision-making and behavior change in the Roaring River and Hollywood communities in Steer Town Districts, St. Ann. The goals of the CYP were to:

- Reduce unwanted pregnancy, sexually transmitted infections and HIV/AIDS among adolescent men and women in selected communities in St. Ann, Jamaica,
- Improve access to a use of SRH and rights information in St. Ann,
- Empower persons in Steer Town to teach youth about SRH and rights issues,
- Increase the levels of education and skills training among adolescents and youth.

Planned Parenthood Federation of Canada (PPFC) and the Canadian International Development Agency (CIDA) funded the CYP.

11. Dare to Care - Mustard Seed Communities

Mustard Seed Communities was a charitable organization that served abandoned, disabled children and pregnant teenage girls for over 25 years. The Dare to Care programme, implemented by this organization, was established out of a need to provide care for abandoned or HIV infected children in Jamaica. It began in September 2000 serving children aged 3-16 years.

This home and residential based programme aimed to improve the quality of life of those in society who were marginalized. The objectives were to provide the best possible care to children orphaned or living with HIV, including providing medical care, shelter and housing, and to prepare the children to be functioning adults in society. Dare to Care worked closely with the

relevant state bodies such as Ministry of Health, National AIDS Committee and the Child Development Agency.

The main funding agencies were the Global Fund, service clubs, individuals and private organizations (international and regional).

12. *Expanding Educational Horizons* – Young Women's Christian Association (YWCA)

The YWCA of Jamaica is a member association of the World YWCA. This organization "exists for the promotion of the well-being of women and girls in all aspects of their lives." It works to unite them in a Worldwide Christian fellowship which seeks "fullness of life through physical, mental, social and spiritual development and through service to others and the nation."

The Expanding Educational Horizons programme was started in 1997 by YWCA. The programme was designed for children who were slow learners and for children at risk or vulnerable to abuse and illness. The age range of these children was 10-15 years. The goals of the programme were to:

- Get the children into the regular school system,
- Develop skills in food and nutrition, sewing, computer literacy and art and craft,
- Prevent the spread of HIV,
- Reduce HIV/STI transmission among at risk youth.

The main funding source was USAID.

13. Family Life Education and Reproductive Health - Peer Counselling Association of Jamaica (PCAJ)

The Family Life Education and Reproductive Health Programme was implemented by the Peer Counseling Association of Jamaica in 1990. The programme was organized to promote and advance the dissemination of sexual and reproductive health information with respect to the training of persons (regardless of sex, age or class) in life-coping skills with special emphasis on sexual and reproductive health. The programme also aimed to provide educational and support counselling in sexual reproductive health.

The goals of the programme were to:

- Promote the education of persons (adolescents, parents and children) in sexual and reproductive health care,
- Promote abstinence and reducing risky sexual practices,
- Collaborate with communities, parents, groups and other similar organizations in advancing the importance of support counseling and reproductive health.

The main funding agencies of the programme were the Japanese government, UNFPA, UNODC, MOH and PCAJ.

14. Fighting AIDS through Training (FATE) – The Jamaica Family Planning Association (FAMPLAN)

The Jamaica Family Planning Association (FAMPLAN) provided clinical and community services and integrated HIV and STD prevention into all the services provided. This integrated programme, launched in 1993, sought to promote sexual behavior change, increase condom use, and improve STD diagnosis and treatment.

FATE was one of five programmes implemented by FAMPLAN geared towards creating awareness on sexuality and reproductive health issues. This programme aimed to improve the sexual reproductive health status of Caribbean youth, ages 10-24 years, through changes in their behaviour and attitudes in HIV, STIs and teenage pregnancy. The main goals of this programme were to:

- Increased awareness and knowledge of family planning and reproductive health issues among Caribbean adolescents and youth,
- Reduced incidence of teenage pregnancy and transmission of HIV/AIDS and STIs as well as other related sexual and reproductive health problems among Caribbean youths through behavior change,
- Improve the quality of advice, counselling and services available to young people in schools, family planning associations and health clinics.

The main funding agency was the Caribbean Family Planning Association.

15. "Friends" Helpline - Jamaica Foundation for Children (JFC)

Jamaica Foundation for Children was a non-governmental organization, established in 1995. The Friends Helpline programme aimed to provide assistance for people up to 24 years who need counseling and information but do not have access to these services.

The main funding sources were Cable & Wireless Foundation, Global Fund and JFC's initiatives, primarily the annual Children's Expo.

16. Healthy Lifestyle - HOPE Worldwide Jamaica

HOPE Worldwide Jamaica was an incorporated non-governmental organization, committed to improving health care. It had the focus of promoting health and well being to communities and

individuals at risk by providing services in the area of health education, prevention and health care delivery.

The Healthy Lifestyle Programme was geared towards children between 10-13 years. The programme encouraged abstinence and aimed to increase the likelihood that students will make more informed life choices, for example healthier nutrition, choosing fulfilling career paths, avoiding drug abuse, sex and risky behaviours. The main funding source for the Healthy Lifestyle Programme was the Global Fund.

17. HIV/AIDS Response Programme - Ministry of Education, Youth & Culture

This programme was a curricula response which included curriculum development in the workplace and schools. This programme mobilized the education sector to address a broad range of challenges including prevention, access to treatment, support and care, impact mitigation and preventing stigma and discrimination. Their literature stated that, "by providing young people with the skills and knowledge to live healthy and productive lives in a world with HIV/AIDS, education can make a key contribution to poverty reduction and sustainable development in Jamaica."

The main goal of this programme was to strengthen the Health and Family Life Programme in schools. The funding sources were the Global Fund, The Ministry of Health, UNESCO, UNICEF, PAHO and the World Bank

18. Ionie Whorm's Inner-city Counselling Centre

Ionie Whorm's Inner-city Counselling Centre provided counselling, prevention and referral services. The focus of the centre was vulnerable, innercity and at risk groups. The main goals of the centre were to:

- Reduce stigma and discrimination among persons infected and affected with HIV/AIDS, drug abusers and drug traffickers,
- Increase HIV/AIDS awareness,
- Reduce drug and human trafficking.

Some of the funding agencies were the Jamaica Social Investment Fund (JSIF), UNDP, UNFPA and United Nations Theme Group (UN Agencies).

19. Jamaica's Solution to Youth Lifestyle and Empowerment (JA-STYLE) - The United States Agency for International Development (USAID)

The USAID is the U.S. government organization responsible for non-military foreign aid. Through JA-STYLE, USAID reached out to youth and adolescents with messages and activities to promote healthy lifestyles. Jamaica's Solution to Youth Lifestyle and Empowerment (JA-STYLE) was a USAID funded project that supported the Government of Jamaica to implement the Healthy Lifestyle Policy through the Ministry of Health. JA-STYLE's programme focused on youth between the ages of 10 and 19.

JA-STYLE's primary goals were to:

- Provide quality and friendly health services and interventions for young people,
- Support the implementation of policies that affect young people,
- Improve and increase the amount of information and messages (developed by and for youth) on healthy lifestyles,

- Strengthen NGOs ability to offer healthy lifestyle activities for young people,
- Improve the ability of communities to support youth and encourage healthy choices.

JA-STYLE's primary counterpart was the Ministry of Health, but the project also worked closely with Ministry of Education Youth & Culture, and the Child Development Agency. JA-STYLE also partnered with international agencies such as UNICEF, US Peace Corps and USAID. The main funding source for this programme was the US Congress.

20. Jamaica Network of Seropositives (JN+)

JN+ was a member of the National AIDS Committee and the UNAIDS Theme Group. The Network began in 1996 following the first regional meeting of people living with HIV/AIDS in Trinidad. In 1997 the JN+ was publicly launched with the support of the National HIV/STI Control and Prevention Programme (NHCP) and CAREC. The mission of the network was to advocate for the rights and concerns of people with and affected by HIV through empowerment, partnership and resource mobilization.

The specific objectives of the network were to ensure improvement in the quality of life of the people with HIV through counselling, training, education, nutrition, and access to care and treatment, to reduce stigma and discrimination against people with HIV, and to positively influence the perception of the wider society at all levels about people with HIV.

JN+ received final support from the Global Fund and the TIDES Foundation.

21. *Kingston Pediatrics Perinatal HIV/AIDS Programme* – University Hospital of the West Indies (UHWI)

The Kingston Paediatric Perinatal HIV/AIDS Programme was started in September 2002. The programme was hospital-based. The midwives and nurses were trained in prevention of mother-to-child transmission (PMTCT of HIV, Voluntary Counselling and Testing (VCT) and the management of paediatric and perinatal HIV. The programme followed protocol-driven management for the care of HIV-positive pregnant women and children.

The goals of the programme were to:

- Reduce mother to child transmission,
- Reduce incidence of paediatric HIV,
- Take general care of the family unit.

The funding agencies included the Elizabeth Glaser Paediatric AIDS Foundation, Pfizer Foundation, the Ministry of Health Jamaica and the University of the West Indies

22. *Methodist Youth in Mission Everywhere (MYME)* - The United Methodist Church in Jamaica

The Methodist District was one of 8 districts linked together in a "connexional" system to form the Methodist Church in the Caribbean and the Americas, popularly called the MCCA or the Connexion. MYME Jamaica was formed in June 2006 and comprised a group of Methodist young adults ranging from 18-39 years of age, who sought to "put their faith into action." Members of the MYME were also HIV Christian Peer Educators who had sought to be a part of the Methodist Church's response to the epidemic. The main goal of MYME was to build the capacity of the youth in the Jamaican Methodist District (JMD) for advocacy by improving their knowledge of HIV/AIDS and its related issues. The main funding agency was CIDA.

23. National AIDS Committee Jamaica (NAC)

The National AIDS Committee was a private non-governmental organization that was established in 1988 by the Minister of Health to coordinate the multi-sectoral response to the AIDS epidemic in Jamaica. The National AIDS Committee began with 18 members and had 100 member organizations by 2006.

The NAC has strong links with the National HIV/STI Control Programme (NHCP) with representatives from both public and private sector organizations, non-governmental organizations (NGOs) and community-based organizations (CBOs). The NAC was further facilitated by an Executive Committee, Sub-Committees (Education, Care and Counselling, Legal and Ethical, and Fundraising), thirteen Parish AIDS Committees and two AIDS Advisory Committees.

The goals of the NAC were to:

- Educate Jamaicans about HIV/AIDS,
- Promote safer sexual behaviours,
- Encourage the prevention of STIs,
- Encourage behavior change among those who practice high risk behaviours,
- Encourage communities to become actively involved with HIV prevention and the care of people infected with the condition,
- Eliminate stigma affecting persons living or affected with HIV/AIDS,
- Create a supportive environment for persons living with HIV/AIDS.

The main funding agencies were USAID, World Bank, UNICEF and Global Fund.

24. Our Own Voice: Youth Fighting AIDS through the Media - Panos Caribbean

Panos Caribbean aimed to "amplify the voices of the poor and the marginalized through the media and ensure inclusion in public and policy debate, in order to enable Caribbean communities and countries to articulate and communicate their own development agenda."

The goals of this programme were to:

- Promote the full participation of children and youth in the development process,
- Prepare them to effectively take part in activities aimed at reducing the negative impact of HIV/AIDS,
- Get young people who are infected/affected to play a more participatory role in the response to HIV/AIDS.

The programme also aimed to build the capacity of the media and community to understand and analyze child rights issues. The main funding agencies included UNICEF, UNAIDS, City of Kingston, CPTC, Panos Global AIDS Programme, DANIDA, DFID, UK Union and US Embassy.

25. Power Peer Youth Initiative - The Jamaica Red Cross

The Jamaica Red Cross began as a branch of the British Red Cross in 1948. The Jamaica Red Cross "acts as delegates of kindness and humanitarianism, caring for our neighbours most in need, reducing the effects of disasters." The Power Peer Youth Initiative was a programme implemented by the Jamaica Red Cross, and began in 2005. This programme utilized peer education as a strategy to train selected adolescents providing them with information on issues relating to adolescent reproductive health.

The programme aimed to equip a group of five young people with programme management skills to identify and respond to problems in their school community. The programme targeted adolescents 12-19 years. The main source of funding for this programme was UNICEF.

26. Project Smiles - Jamaica AIDS Support for Life

Jamaica AIDS Support began unofficially in November 1991 with a group of men coming to the aid of a friend dying with AIDS-related complications. In 1992, funding was received from USAID and Jamaica AIDS Support became a formal organization.

Project Smiles was a campaign to attract resources for the OVCs Programme. It was created to alleviate some of the financial burden placed on these children and families infected and affected with HIV. Project Smiles has assisted close to 700 children affected by HIV and their primary family members. The main funding source for this programme was the EFJ.

27. Psychosocial Support Group – Centre for HIV/AIDS, Research, Education and Services (CHARES)

CHARES is located at the University Hospital of the West Indies. The organization provided medical care and social services, such as nutritional information, HIV/AIDS prevention and awareness educational workshops, training programmes, occupational guidance and a psychosocial support group for children 6 to 18 years with parents who are HIV positive. The programme that provided psychosocial support for children began in 2003. The main goals were to:

- Increase HIV/AIDS Awareness,
- Encourage self esteem development,

- Provide education and information on HIV issues.

The main funding agencies were UNICEF and Children's Media Programme.

28. S-Corner Clinic & Community Development Organization

S-Corner Clinic & Community Development Organization was established to serve the community of Bennett Land, located in Downtown Kingston. S-Corner Clinic was a component of this organization, formed in 1990 by a local doctor and US Peace Corps Volunteers. The purpose of the clinic was to maintain and improve existing programmes of health, education and community development.

The specific goals of the clinic were to facilitate diagnostic services in HIV/AIDS, STIs and other conditions, to promote curative and preventative healthy lifestyle practices particularly as related to HIV and diabetes, to increase knowledge on reproductive health practices and provide contraceptives to individuals of child bearing age in Bennett Land and adjoining communities. The main funding agencies were CHARES, Christian Aid, WK Kellogg's Foundation and OXFAM.

29. St. James Public Health Services - Western Regional Health Authority (WRHA)

The Western Regional Health Authority is a statutory body of the Ministry of Health. It was one of four Regional Health Authorities formed as part of the Health Sector Reform. The WRHA expanded its HIV programme in the parishes of Westmoreland, Hanover, Trelawny and St. James, as part of efforts to reduce the spread of HIV in the region. The St. James Health Department provided assistance to the UNICEF supported teen peer counseling group WESTHELP, and assisted in coordinating activities. Safer sex and HIV issues were among the

issues addressed by WestHELP. The St. James Public Health Services was a treatment clinic for diagnosis, assessment of readiness for both clinical and psychological treatment.

The clinic served individuals of all ages, and the specific goals were to prevent transmission of STIs in the targeted population, to provide optimum care for persons living with HIV/AIDS, to have at least 75% of persons who need antiretroviral accessing and taking medication with 100% adherence. The main funding agencies were the World Bank, GOJ and IDB.

30. *Sustaining Life through Prevention and Control* - Combined Disabilities Association

The Combined Disabilities Association was a non-profit, non-governmental organization, formed in 1978 and officially launched in 1981. Its focus was advocacy. Prior to the activities of this organization disabled persons were only marginally involved in the decision making process. The Combined Disabilities Association networks with other agencies both governmental and non-governmental.

The objectives of the organization were to enable persons with disabilities to have a greater voice and active participation in their affairs, and to affirm the rights of persons with disabilities. The organizations target groups were ages 12 to 18 years and included all persons with physical, visual, learning and mental disabilities. The programme aimed to educate and sensitize people with disabilities in their community about HIV.

The main funding sources were the Global Fund, Tuberculosis and Malaria -disbursed by the Ministry of Health.

31. The Bashy Bus - Children First

Children First was an independent non-governmental organization established in 1989 with the support of the Save the Children Fund. This organization collaborated with the Ministry of Health, through the Global Fund, and with UNICEF to develop the 'Bashy Bus' project, a mobile reproductive health service for adolescents and youth.

The 'Bashy Bus' programme aimed to disseminate HIV/AIDS and sexual reproductive health information, and offer counselling services to adolescents and youth along major transport routes and in rural towns, bus terminals and popular spots for youth in the HIV/STI prevalent parishes of St. Catherine, St. Ann and St. James. The main funding source of this programme was UNICEF.

32. The National HIV/STI Control Programme - Ministry of Health (MOH)

"The National HIV/STI Control Programme started in 1988 as part of the government of Jamaica's response to the HIV epidemic. The programme was geared at the prevention and control of HIV/AIDS and other sexually transmitted infections (STIs). It advocated for and coordinated the input of all sectors of the Jamaican society including the private and public sectors. The main goals of the programme were to:

- Build an effective multi-sectoral response to the HIV/AIDS epidemic,
- Mitigate the socio-economic and health impact of HIV/AIDS in the society,
- Decrease individual vulnerability to HIV infection,
- Reduce the transmission of new HIV infection,
- Improve core support and treatment services of persons living with HIV/AIDS.

The Government of Jamaica, through a loan from the World Bank had expanded its support of the National HIV/STI Control Programme. The United States Government through its development agency USAID had been the lead international partner in supporting the National Programme with both financial and technical assistance. Other funding agencies were the Canadian International Development Agency (CIDA), German Technical Corporation (GTZ), PAHO/WHO, CAREC,UNAIDS and other UN Agencies.

33. "Together We Can" Peer Education Programme - The Jamaica Red Cross

The "Together We Can" Peer Education Programme was one of the programmes implemented by the Jamaica Red Cross. It began in 1992 as collaboration between the Jamaican Red Cross and the American Red Cross. The programme equipped peer educators with knowledge, skills and tools to pass information unto their peers, knowledge based on reproductive health, particularly HIV.

The main funding agencies were Norwegian and Netherlands Red Cross Society, International Federation of the Red Cross, American Red Cross, UNFPA, AIDSCAP, Digicel and Global Fund.

34. United Nations Population Fund (UNFPA)

"The UNFPA is an international development agency that promotes the rights of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect."

The UNFPA does not have a named HIV programme. However, it helps governments at their request to formulate policies and strategies to reduce poverty and support sustainable development, through culturally sensitive approaches. In Jamaica, the goals were to:

- Promote universal access to sexual and reproductive health,
- Address population, gender and sexual reproductive health issues in regional and national development frameworks,
- Contribute to poverty reduction,
- Enhance human rights and gender equality,
- Prevent HIV/AIDS transmission.

The funding agencies were the European Union (EU), the Organization of Petroleum, Exporting Countries (OPEC), and the European Development Fund (EDF).

35. Uplifting Adolescent Project - Mel Nathan Institute

The Mel Nathan Institute was a human community development agency of the United Church in Jamaica and the Cayman Islands. The Uplifting Adolescent Project was a programme of the Government of Jamaica (GOJ) and the United States Agency for International Development (USAID); however, it was implemented by several agencies, one of which was the Mel Nathan Institute that targeted children and adolescents. Most of the adolescents registered in the programme were from the inner-city constituency of Western Kingston. The main goals of the programme were to:

- Build self-esteem and improve children's focus in school,
- Reduce teenage pregnancy.

USAID was the main sponsor of this programme.

36. Vibes in a World of Sexuality - Ashe Caribbean Performing Arts Foundation

"Ashe Caribbean Performing Arts Foundation is an internationally acclaimed performing arts company committed to edutainment, entertainment, youth empowerment and social development." The Vibes in a World of Sexuality programme began in 1993 was specifically geared towards children ages 12-19 years, and dealt with issues of stigma and discrimination. This programme used the entertainment methodology (Ashe's EIC-Excitement Involvement Commitment) and involved conducting performances for young people and having discussions on the various issues that arise. The goals of the programme were to:

- Increase awareness and foster behavior change in issues related to sexuality and reproductive health and in particular HIV/AIDS
- Train guidance counselors, teachers, youth workers, social workers and parents in innovative methods of teaching sexuality and reproductive health
- Reduce stigma and discrimination against HIV infected and affected individuals.

The main funding agency was UNICEF.

37. Voluntary Counselling & Testing (VCT) – The Jamaica Family Planning Association (FAMPLAN)

The VCT was one of five programmes implemented by FAMPLAN. This integrated programme, launched in 1993, sought to promote sexual behavior change, increase condom use, and improve STD diagnosis and treatment.

The VCT Programme aimed to create HIV awareness and encourage voluntary counselling and testing among target communities. The goals of the VCT programme were to:

- Increase the capacity of the clinic to provide comprehensive VCT services,

- Raise awareness about the importance of access to VCT for HIV Prevention among target communities for youth 13-24.

The programme was funded by the International Planning Parenthood Federation (IPPF).

38. *Youth Advocacy Movement (YAM)* – The Jamaica Family Planning association (FAMPLAN)

The YAM is one of five programmes implemented by FAMPLAN. This integrated programme, launched in 1993, sought to promote sexual behavior change, increase condom use, and improve STD diagnosis and treatment. Through advocacy, YAM aimed to influence governments and other influential organizations toward implementing more youth friendly policies.

The main goals of YAM were to increase the reach of the programme throughout Jamaica targeting underserved communities.

The objectives of this programme were to:

- Increase access of adolescents to sexual and reproductive information throughout Jamaica,
- Address issues surrounding gender relations among adolescents by decreasing incidents of incidents of gender based violence,
- Increase two-way communication between parents and adolescents through hosting of parent/child forums and parenting skills training,
- Increase the awareness of the Jamaican public on adolescent pregnancy and HIV/AIDS/STI prevention.

This programme was not funded formally.

39. Youth Opportunities Unlimited (YOU)

Youth Opportunities Unlimited was established in Kingston in 1991. The organization trained 695 volunteer adult mentors and matched them with school students, facilitated 31 other organizations in setting up youth mentoring programmes, developed a network of programmes to empower families, students and communities.

Youth Opportunities Unlimited had no named HIV focused programme however, the organization was involved in individual and group mentoring, peer counselling, career guidance, parenting education, advocacy and public education, and a homework centre. The main funding sources for these services were USAID, C&W, CSJP, Digicel Jamaica,

40. *Youth as Promise Project* - Peace Corps

The Peace Corps is a United States Federal Agency. The purpose is to promote world peace and friendship through a Peace Corps, and make available to interested countries and areas men and women of the United States qualified for service abroad and willing to serve. Peace Corps volunteers worked in over 70 countries around the world with governments, schools, non-profit organizations, NGOs and entrepreneurs in the areas of education, health, HIV/AIDS, business, information technology, agriculture, and the environment.

The Youth as a Promise programme targeted youth ages 10-25 years. The goals were to:

- Build the capacity of youth,
- Build the capacity of youth serving agencies,
- Build the capacity of family and community.

The main funding source for this programme was Peace Corps International.

3.2 Programming Trends and Tendencies

3.2.1 Missing Information

Forty programmes were identified which were in progress or had been conducted during the period 2000-2007. It was difficult to acquire information on the target groups, geographical scope and programme settings for the HIV programmes of three organizations. These organizations did not implement programmes but were involved in developing, monitoring, and evaluating HIV programmes in Jamaica.

It was also difficult to obtain information on funding for some of the programmes identified. Although thirty-five programmes (88%) named their sources of funding, only 8 programmes (20%) reported the annual budget of their programmes. Eleven programmes (28%) provided information on the proportion of their budget requirement that was actually funded.

It was also difficult to acquire information regarding programme planning, implementation and outcomes for a many of the programmes.

The unattainable information was referred to as 'Information not Accessible.' There were also instances where the information inquired about was not relevant or applicable to the particular programme participating in the documentation. This missing information was referred to as 'Information not Relevant/Applicable.'

3.2.2 Types of Organizations carrying out Programmes

The HIV programmes were categorized according to the types of organizations which implemented the programmes (Table 4a). Most programmes were implemented by non-

governmental organizations (53%), while the remaining programmes were implemented by international organizations (18%), governmental organizations (15%), UN agencies (7%), faith-based organizations (5%), and hospitals (2%).

Table 4a: Types of Organizations carrying out Programmes

	Number of Programmes=40	
Types of Agencies/Organizations	Frequency	Percentage (%)
Non-governmental organizations	21	53
International Agency	7	18
Governmental organizations	6	15
UN Agency	3	7
Faith-based	2	5
Hospital	1	2
Total	40	100

3.2.3 Geographical Scope

The range of parishes in which the programmes were operating is shown in Table 4b. Of the 40 programmes identified, most programmes (36%) operated island wide and very few (2%) were localized in a single parish.

Table 4b: Geographical Scope of Programmes

	Number of Programmes=40	
Geographical Location	Frequency	Percentage (%)
Islandwide	14	36
1 parish only	1	2
2 or 3 parishes	12	30
4 or more parishes	11	27
Information Not Relevant	2	5
Total	40	100

3.2.4 Parishes Served by Programme

The numbers of programmes operating in each of the 14 parishes is shown in Table 4c. Most of the programmes operated in Kingston & St. Andrew (95%) and St. Catherine (71%).

Table 4c: Parishes Served by Programmes*

	Number of Programmes=40	
Parishes	Frequency	Percentage (%)
Kingston & St. Andrew	38	95
St. Catherine	27	71
St. James	25	63
St. Ann	25	63
St. Mary	24	60
Clarendon	20	50
Portland	20	50
St. Thomas	19	48
St. Elizabeth	19	48
Trelawny	19	48
Westmoreland	19	48
Manchester	18	45
Hanover	16	40
Information Not Relevant	2	5

**** Programmes may serve more than one parish***

3.2.5 Location of Target Population

The location of the target population is shown in Table 5. Most of the programmes (77%) targeted both urban and rural areas.

Table 5: Location of Target Population

	Number of Programmes=40	
Geographic Areas	Frequency	Percentage (%)
Urban & Rural	31	77
Urban only	7	18
Rural only	0	0
Information Not Relevant	2	5
Total	40	100

3.2.6 Description of Programme Settings

Most of the programmes (80%) were implemented across multiple settings (2 or more), and the remaining programmes operated at single settings (15%) as shown in Table 6a. The programmes were mostly implemented in schools, specifically secondary (69%) and primary (62%) schools (Table 6b).

Table 6a: Number of Programme Settings

	Number of Programmes=40	
Number of Sites	Frequency	Percentage (%)
Single	6	15
Multiple (2 or more)	32	80
Information Not Relevant	2	5
Total	40	100

Table 6b: Programme Settings*

	Number of Programmes=40	
Settings	Frequency	Percentage (%)
Secondary Schools	27	69
Primary Schools	24	62
Youth clubs	18	46
Neighborhoods	15	39
Churches	13	33
Community Groups	10	21
Health Centres/Clinics	8	20
Hospitals	7	18
Juvenile Centres	6	15
Workplaces	4	10
Households	4	10
Children' Homes	3	7
Early Childhood Institutions	2	5
Media	1	2
Tertiary Level Institutions	1	2
Helpline	1	2
Information Not Relevant	2	5

Programmes may be implemented in multiple settings

3.2.7 Age, Gender & Income Level of Target Group

As shown in Table 7a, the age groups served by most of the programmes were the 13-18 year age group (85%) and the 6-12 year age group (80%). Programmes targeted multiple age groups. All the programmes focused on both boys and girls, as shown in Table 7b. The target population served by the 40 programmes was mostly from low, middle and high income level families (45%) (Table 7c).

Table 7a: The Age of the Target Groups*

	Number of Programmes = 40	
Age Group (years)	Frequency	Percentage (%)
0-5	14	35
6-12	32	80
13-18	35	88
19 & over	21	53
General Population	6	15
Information Not Accessible	2	5

Programmes targeted multiple age groups

Table 7b: Gender of Target Group

	Number of Programmes= 40	
Gender	Frequency	Percentage (%)
Males only	0	0
Females only	0	0
Males & Females	40	100
Total	40	100

Table 7c: Income Level of Target Population

	Number of Programmes= 40	
Income Level	Frequency	Percentage (%)
Low only	12	30
Middle only	1	3
Low & Middle	5	12
Middle & High	1	3
Low, Middle & High	18	45
Information Not Accessible	3	7
Total	40	100

3.2.8 Primary Characteristics of the Target Population

Most of the programmes targeted orphans (31%) and/or HIV+ children (31%), as shown in Table 7d. Eleven programmes (26%) targeted HIV+ children and their families. The remaining programmes targeted other groups, such as: abused children, school children, HIV affected children and the general population. One programme targeted children with disabilities (3%).

Table 7d: Primary Characteristics of Target Group*

	Number of Programmes= 40	
Characteristics	Frequency	Percentage (%)
Orphans	12	31
HIV+ Children	12	31
Children with HIV+ Family Members	11	28
Street Children	7	18
School Children	7	18
General Population	2	5
HIV Affected Children	1	3
Abused Children	1	3
Children with Disabilities	1	3

Multiple responses possible

3.2.9 Theoretical/Philosophical Orientation

Most (65%) of the programmes did not name a theoretical or philosophical orientation, though several did identify theories and models (15%). The range of theoretical orientations reported is shown in Table 8.

Table 8: Theoretical/Philosophical Orientation

	Number of Programmes= 40	
Theory/Philosophy	Frequency	Percentage (%)
Theoretical/Philosophical Orientation used	6	15
No named Theoretical/Philosophical Orientation used	26	65
Information Not Accessible	8	20
Total	40	100
Types of Theoretical/Philosophical Orientation used*:		
▪ Social Learning/Cognitive Theory	5	12
▪ Theory of Persuasion	2	5
▪ Health Belief Model	1	3
▪ Theory of Reasoned Action/Planned Behaviour	2	5
▪ Stages of Change	1	3
▪ Freud- Psychoanalytic Theory	1	3
▪ Erikson's Psychosocial Development Theory	1	3
▪ Maslow's Hierarchy of Needs	1	3

Programmes may be based on multiple theories

3.2.10 HIV Services

Table 9a illustrates the various HIV services provided by the programmes. Programmes provided HIV Prevention (93%), HIV Care (53%) and Other HIV Services (68%). Other HIV Services included policy and curricula development, coordination, monitoring and evaluation of programmes, institutional and systematic capacity building, provision of funds and technical support, advocacy, and reducing or preventing stigma and discrimination.

Table 9a: HIV Services*

	Number of Programmes= 40	
HIV Services	Frequency	Percentage (%)
HIV Prevention	38	95
HIV Care	21	53
Other HIV Services	19	68
Types of Other HIV Services:		
▪ Policy Development	8	29
▪ Curricula Development	1	3
▪ Coordinating, Monitoring & Evaluating of Programmes	4	10
▪ Institutional & Systematic Capacity Building	5	13
▪ Provision of Funds & Technical Support	6	15
▪ Advocacy	3	8
▪ Reducing/Preventing Stigma & Discrimination	15	38

Programmes may offer multiple types of HIV services

3.2.11 HIV Care Services

HIV Care Services was summarized as Healthcare and Support Services (The Center for Applied Research & Evaluation Studies et al., 2001). Table 9b summarizes information on the HIV Health Care Services offered by the programmes. Thirteen programmes (33%) provided Health Care Services. Residential Orphan/Home-based Care (26%) and Mental Health Therapy/Counselling were the most frequently reported Health Care Services provided. Table 9c summarizes information on the HIV Support Services offered by the programmes. Nineteen programmes (47%) provided Support Services. Psychosocial Support Services (25%) and Income Generating Activities (23%) were the most frequently reported Support Services provided.

The definitions for the various Healthcare and Support Services are described in the Glossary of Terms (Appendix IV).

Table 9b: HIV Care Services - Health Care*

	Number of Programmes = 40	
Health Care	Frequency	Percentage (%)
Health Care Services Used:	13	33
No Health Care Services Used	7	18
Information Not Relevant/Applicable	19	48
Information Not Accessible	1	3
Total	40	100
Types of Health Care Services:		
▪ Residential Orphan /Home-based Care	9	23
▪ Mental Health Counselling/Therapy	8	20
▪ Nutritional Counseling	7	18
▪ HIV Treatment Adherence Counseling	7	18
▪ HIV Testing	6	15
▪ Medications & Pharmaceuticals	6	15
▪ Caring for HIV+ Pregnant Women	4	10
▪ Clinical care/ Follow Up	3	8
▪ Substance Abuse Treatment/Counseling	3	8
▪ Dental Care	2	5
▪ Facility-based Care	2	5
▪ Residential Hospice Care	2	5

Multiple Health Care Services may be provided by the programmes

Table 9c: HIV Care Services - Support Services*

	Number of Programmes = 40	
Support Services	Frequency	Percentage (%)
Support Services used	19	47
No Support Services used	2	5
Information Not Relevant/Applicable	18	45
Information Not Accessible	1	3
Total	40	100
Types of Support Services:		
▪ Psychosocial Support Services	10	25
▪ Income Generating Activities	9	23
▪ Financial Assistance	8	20
▪ Health Education/Risk Reduction	7	18
▪ Providing Placement & Shelter	7	18
▪ Client Advocacy	6	15
▪ Counselling-other than Mental Health	6	15
▪ Food Aid	6	15
▪ Case Management	5	13
▪ Legal Services	5	13
▪ Outreach Services	5	13
▪ Housing Related Services	4	10
▪ Assistance with Coping with Stigma & Discrimination	3	8
▪ Permanency Planning	3	8
▪ Housing Assistance	2	5

Multiple Support Services may be offered by the programme

3.2.12 HIV Prevention Services

HIV Prevention Services were summarized at the following levels: Individual Level, Group Level, Street & Community Outreach, Community Level, Public Information & Media Campaigns, and Counselling, Referral and Testing (The Center for Applied Research & Evaluation Studies et al., 2001; Center for Disease Control and Prevention, 2001). The definitions for these levels of HIV Prevention are described in the Glossary of Terms (Appendix IV).

Tables 10a – 10f summarize information about the HIV Prevention Services offered by programmes. Most programmes provided Group Level (75%), Community Level (70%) and/or Public Information/Media Campaign Services (70%). Individual Level HIV Prevention was provided by 63% of programmes, Counselling, Referral & Testing Services were provided by 53% of programmes, and Street & Community Outreach Services were provided by 45% of programmes. Programmes may have used multiple levels of HIV prevention as well as multiple strategies for any one level. The range of strategies used at each level is shown in the tables.

As shown in the tables, the common HIV Prevention strategies included: Risk Reduction Counselling, Peer Counselling, HIV & STI Risk Assessment, Promoting Safer Sex Practices, Peer Education, HIV/STI Prevention Education, hosting Community Wide Events, (e.g. health fairs), Social Marketing (condom distribution), use of print and electronic media and presentations in HIV prevention, Referrals and Linkages to Other Services, and Voluntary Counselling & Testing.

Table 10a: HIV Prevention Services - Individual Level Prevention*

	Number of Programmes= 40	
Individual Level Strategies	Frequency	Percentage (%)
Individual Level Strategies Used	25	63
No Individual Level Strategy Used	11	28
Information Not Relevant/Applicable	3	8
Information Not Accessible	1	3
Total	40	100
Types of Individual Level Prevention Services Used:		
▪ Risk Reduction Counseling	19	48
▪ Peer Counseling	16	40
▪ HIV& STI Risk Assessment	14	37
▪ Skills Development	8	21
▪ STI Diagnosis & Treatment	7	18
▪ Telephone Hotline	6	16
▪ Mentoring	2	5
▪ Referrals	2	5

Multiple Individual Level Strategies may be used by programmes

Table 10b: HIV Prevention Services - Group Level Prevention*

	Number of Programmes= 40	
Group Level Strategies	Frequency	Percentage (%)
Group Level Strategy Used	30	75
No Group Level Strategy Used	7	18
Information Not Applicable	3	7
Total	40	100
Types of Group level Strategies Used:		
▪ Promoting Safer Sex Practices	23	61
▪ Peer Education	19	49
▪ Risk Reduction Counselling	14	37
▪ Role Playing	14	37
▪ Training peers to impart HIV awareness & prevention	9	22
▪ Training caregivers to impart HIV related information	5	13
▪ Promoting abstinence	4	10
▪ Creative arts to promote HIV awareness & information	3	8
▪ Family therapy & support for HIV infected families	3	8
▪ Support groups for HIV infected/affected individuals	3	8
▪ Committees involved in HIV prevention and related issues	1	3

Multiple Group Level Strategies may be used by programmes

Table 10c: HIV Prevention Services - Outreach Strategies*

	Number of Programmes= 40	
Outreach Strategies	Frequencies	Percentage (%)
Outreach Strategy Used	18	45
No Outreach Level Strategy Used	18	45
Information Not Relevant/Applicable	3	7
Information Not Accessible	1	3
Total	40	100
Types of Outreach Strategies:		
▪ Safer sex kits/condom distribution	17	43
▪ HIV Risk Reduction Information/Pamphlets	17	43
▪ Abstinence Messages	2	5
▪ HIV+ persons share experiences	1	3
▪ Target anywhere young people gather	1	3

Multiple Outreach Strategies may be used by programmes

Table 10d: HIV Prevention Services - Community Level Strategies*

	Number of Programmes= 40	
Community Level Strategies	Frequency	Percentage (%)
Community Level Strategies Used	28	70
No Community Level Strategies Used	9	22
Information Not Relevant/Applicable	2	5
Information Not Accessible	1	3
Total	40	100
Types of Community Level Strategies:		
▪ HIV/STI Prevention Education	27	68
▪ Community Wide Events	15	38
▪ Social Marketing Condom use	12	30
▪ Community Mobilization for HIV-related activities	10	25
▪ Improve quality & availability of residential facilities	3	8
▪ Work with families(encourage care & support)	1	3

Multiple Community Level Strategies may be used by programmes

Table 10e: HIV Prevention Services - Public Information /Media Campaigns*

	Number of Programmes= 40	
Public Information & Media Campaigns	Frequency	Percentage (%)
Public Information & Media Campaigns Used	28	70
No Public Information & Media Campaign Used	8	20
Information Not Relevant/Applicable	3	7
Information Not Accessible	1	3
Total	40	100
Types of Public Information/Media Campaigns:		
▪ Print Media	19	48
▪ Presentations	18	45
▪ Electronic Media	15	37
▪ Website	5	13
▪ Creation of Specialized HIV-related library	2	5
▪ Congregational HIV Awareness	1	3

Multiple Public Information &Media Campaign Strategies may be used by programmes

Table 10f: HIV Prevention Services: Counselling, Referral & Testing*

	Number of Programmes= 40	
Counselling, Referral & Testing	Frequency	Percentage (%)
Counselling, Referrals & Testing Used	21	53
No Counselling, Referrals & Testing Used	15	37
Information Not Relevant/Applicable	3	7
Information Not Accessible	1	3
Total	40	100
Types of Counselling, Referral & Testing:		
▪ Referrals & Linkages to Other Services	19	48
▪ Voluntary Counselling & Testing	17	43
▪ Partner Counselling & Referral	7	18
▪ Perinatal HIV Prevention (Counselling & Testing)	6	15
▪ Prevention Case Management as a Strategy	5	13

Multiple Counselling, Referral & Testing Strategies may be used by programme

3.2.14 Funding Sources

Tables 11a and 11b summarize the information on funding for the programmes. Most programmes were funded by two or more sources. One programme did not receive funding from any named source. This programme operated by relying on the resources of other programmes implemented by its organization. Almost all programmes (90%) reported receiving funding from an international organization.

Table 11a: Number of Funding Sources

	Number of Programmes = 40	
Number of Funding Sources	Frequency	Percentage (%)
0	1	3
1	14	39
2	7	19
3	4	11
4	8	22
5	1	3
6	1	3
Information Not Accessible	4	11
Total	40	100

Table 11b: Source of Funding for the Programmes

	Number of Programmes = 40	
Sources	Frequency	Percentage (%)
International	36	90
Local	17	43
Funded by Parent Organization	2	5
Individual/Private Organization	1	3
Self as Funder	3	8

Programmes may be funded by more than one source

3.2.15 Resources

Table 11c provides information on the resources available to the organizations for use in their HIV programmes. Only 60% of the organizations provided information on the resources available for their HIV programmes. Just over half (53%) of the programmes had office space for their operation. The use of information technology was not very common as less that 50% of the programmes reported having computers and 28% had audiovisual equipment.

Table 11c: Resources Available to HIV Programmes

Resources Available	**Number of Programmes (N=40)**	
	Frequency	Percentage (%)
Resources Available	24	60
Information Not Accessible	16	40
Total	40	100
Types of Resources Available:		
▪ Office Spaces	21	53
▪ Computers	19	48
▪ Audio Visual Equipment	11	28
▪ Motor Vehicles	10	25
▪ HIV/STI Testing Lab	4	10
▪ Wheel Chairs	2	5
▪ Clinic Facility	1	3
▪ Rapid Testing Kits	1	3

3.2.15 Programme Planning, Implementation and Outcomes

Table 12a summarizes the information on programme, planning, implementation and outcomes. Although 18 programmes (45%) reported conducting a needs assessment, very few programme officers were able to describe the findings when asked, and only one programme officer provided a needs assessment report when it was requested. Another programme officer provided a project proposal that included a summary report for a situational analysis.

Although many of the programmes reported routinely documenting programme activities (85%) and using progress reports (73%) as a means of monitoring the progress of their programmes, the research officer was unable to verify these responses as programme officers could not provide the respective documents. Also, thirteen programme officers reported that a formal evaluation was conducted for their programmes (33%) and sixteen programmes (42%) reported achieving the goals of their programmes, yet only 5 programmes' reports were made available.

Table 12a: Programme Planning, Implementation & Outcomes

	Number of Programmes (N = 40)	
Programme Planning & Implementation	Frequency	Percentage (%)
Triggering Events	32	80
Needs Assessment	18	45
HIV-related training done with staff	29	72
Formal Evaluation	13	33
Routine Documentation	34	85
Progress Reports	29	73
Goals Achieved	16	42

Table 12b summarizes information on the outputs from the HIV programmes. Although 22 programmes (55%) listed outputs, only 3 programme officers provided copies of their outputs. Programmes listed multiple outputs. The common outputs listed were assessment tools, training manuals and curricula. Assessment tools included HIV risk assessment cards and instruments used to evaluate HIV services. Training manuals and curricula were used to provide guidance for practioners and caregivers working with the target population.

Table 12b: Outputs from Programmes*

Outputs	**Number of Programmes (N=40)**	
	Frequency	Percentage (%)
Outputs listed	22	55
No Outputs listed	13	32
Information Not Accessible	5	13
Total	40	100
Types of Outputs listed:		
▪ Assessment Tools	9	23
▪ Training Manuals	8	20
▪ Curricula	6	15
▪ Policy Documents	5	13
▪ Protocols	5	13
▪ Media production	3	1
▪ Directory of Services	1	3

**** Multiple outputs from programmes***

Table 12c summarizes information on the methods of disseminating the results of the programmes. Programmes used multiple methods of disseminating information. The common methods for disseminating information were meeting with stakeholders, conference presentations and media coverage.

Table 12c: Methods of Disseminating Information*

Methods of Dissemination	Number of Programmes (N=40)	
	Frequency	Percentage (%)
Meetings with Stakeholders	17	43
Conference Presentations	16	40
Media Coverage	15	38
Reporting to Community	11	28
Reporting to Policy Makers	11	28
Journal Publications	4	10
Workshops	1	3
Reporting to Committee members	5	13
Information Not Accessible	5	13

***** ***Programmes used multiple methods of disseminating information***

3.2.16 Perceived Achievements

Opinions were obtained from the programme officers on what they considered their achievements. Self-stated achievements were received for only 25 programmes. Table 13 summarizes the information on the various achievements that programme officers indicated. Achievements were perceived by subjective impressions and programme outcomes. The programmes measured their achievements qualitatively through observations of behaviour change and positive feedback received from beneficiaries of the programme or reporting on specific indicators for success (e.g. increased knowledge of HIV awareness and increased condom use).

Table 13: Perceived Achievements of Programmes*

	Number of Programmes (=40)	
Perceived/Self stated Achievements of Programmes	Frequency	Percentage (%)
Increased knowledge and awareness of HIV issues	4	10
Increased condom use	4	10
Reducing unwanted pregnancies	3	7
Increased awareness of safer sexual practices	3	7
Increased advocacy and leadership development	2	5
Collaboration and coordination with other agencies	2	5
Increased knowledge of family planning and reproductive health rights and issues	2	5
Prevention of STI's and HIV	2	5
Increased knowledge of relationship between drugs and HIV	1	3
Strengthen the relationship between caregivers and adolescents infected/affected with HIV	1	3
Training people and sensitizing them about HIV	1	3
Participation and empowerment of the beneficiaries of the programme	1	3
Beneficiaries satisfied with services and report benefits from participation	1	3
Research Promotion for education and HIV	1	3
Policy development & Dissemination	1	3
Capacity building and professional development	1	3
Increased lifespan and quality of life of children infected /affected with HIV	1	3
Increased and equal opportunity for education for children infected and affected with HIV	1	3
Openness to discuss issues on HIV and sexuality	1	3
Involvement, Participation and Creation of HIV Media Production	1	3
Increased health status of women	1	3
Observed behavior change in participants	1	3
Safe blood supply islandwide	1	3
Information Not Accessible	15	38

Programmes reported multiple achievements

3.2.17 Perceived Factors Contributing to Programme Success

Programme officers were also asked to state the factors that contributed to the success of their programmes. Table 14 summarizes the factors that were indicated. "Commitment and expertise of the team/staff" was the most common factor indicated. Programme officers believed that if the programme staff were not committed to the programmes and had the expertise, programmes would not be successful. Particularly if donor support for the programme was limited, staff commitments were perceived vital for the successful operation of these programmes.

Table 14: Perceived Factors Contributing to the Programme Success*

	Number of Programmes (=40)	
Perceived Factors Contributing to the Programmes' Success	Frequency	Percentage (%)
Commitment and expertise of the team/staff	13	33
Strengthened partnership, support and networking between partners and donor agencies	8	20
Communication with key stakeholders	3	7
A sound strategic approach to HIV prevention	2	5
Support and openness of target population to change	2	5
Voluntary participation	2	5
Strategically coordinating with other stakeholders and programmes	1	3
Commitment of government to improve Sexual Reproductive Health and HIV service delivery	1	3
Monitoring & Evaluation workshops	1	3
People giving testimony on HIV status	1	3
The use of various media to disseminate HIV prevention messages	1	3
Respect for ethical guidelines , for example confidentiality	1	3
Collaboration and strong support from other agencies	1	3
Participatory Action Methodology employed (designed by young people for young people)	1	3
Information Not Accessible	12	30

**** Programmes reported multiple factors***

3.2.18 Reported Constraints in HIV Programme Implementation

Programme operators were asked to identify major constraints in the implementation of their programmes. Table 15 shows a list of the constraints reported. Insufficient funding was the most frequently reported constraint (60%). Lack of trained staff (25%), lack of resources (not human or financial) (20%), for example motor vehicles and testing labs, difficulties in coordinating and collaborating with other organizations (18%) as well as difficulties with actually reaching the target population and successfully modifying values, attitudes and behaviours (15%) were other frequently reported constraints.

Table 15: Reported Constraints in Programmes' Implementation*

	Number of Programmes=40	
Constraints	Frequency	Percentage (%)
Insufficient funds	24	60
Insufficient human resources/manpower	10	25
Resources (excluding money & human resources)	8	20
Difficulties coordinating and collaborating with other organizations	7	18
Values/Attitudes/Availability of target population	6	15
Values & Attitudes of general population	3	8
Absence of monitoring & evaluation	2	5
Decentralization of relevant agencies	2	5
Absence of needs assessment /baseline assessment/situational analysis	1	3
Problems with disbursement of funds	1	3
Information Not Accessible	6	15

****Programmes reported multiple constraints***

3.2.19 Additional needs for the successful implementation of HIV Programmes

Most programmes reported needing technical assistance (70%) and/or additional staff (68%) for successful programme implementation (Table 16). Need for networking with organizations (48%), accessing additional information on children and HIV (45%) and greater work exposure (45%) were some of the other frequently reported needs.

Table 16: Needs for successful programme implementation *

	Number of Programmes=40	
Needs	Frequency	Percentage (%)
Technical assistance	28	70
Additional staff needed	27	68
Networking with other organizations dealing with children and HIV	19	48
Access to additional information on children and HIV needed	18	45
Greater exposure of your work needed	18	45
Consultants	1	3
Logistic assistance	1	3
Sustainable strategic plan	1	3
Need more office space	1	3
Volunteers	1	3
Information Not Accessible	9	23

**** Programmes could have multiple needs***

4. DISCUSSION

4.1 Summary of findings

This was the first attempt we are aware of to compile a database of current programmes addressing HIV programmes for children Jamaica.

The results showed that despite Jamaica's limited resources and the limited capacity of many organizations, a number of accomplishments in controlling and managing HIV have been realized through partnerships involving the government of Jamaica, NGO's, FBO's, CBO's and international agencies.

A comprehensive list of programmes was included in this documentation. It is likely, however, that some programmes were missed, and these should be followed up and included later, as should any programmes that have started since the completion of the data collection.

It was difficult to set appointments with some of the programme managers, though programme staff was generally cooperative and accommodating when eventually met with. The programme officers were willing to share a great deal of information. Some of the agencies did not have the required information readily available and additional information was slow in coming.

Many of the implementing agencies were unable to accurately describe the level of funding. Consequently, the analysis on this section was limited to the number and name of the funding sources. The possible reasons for being unable to acquire financial information were: some organizations with integrated programmes could not isolate funds going specifically to HIV activities and some of the organizations were reluctant to disclose total amounts (budgets and funding) and sources of funds.

It was planned initially to collect programme reports and other documents, and information from beneficiaries of programmes. There were, however, some difficulties in acquiring reports and documents as well as contacting beneficiaries. A fair number of programmes indicated that they disseminated reports to the communities, policy makers and other stakeholders. However, it was difficult to confirm these claims as many of these reports were not accessible. Many programme coordinators expressed concerns about sharing these reports disseminated as they were of the view that this information in the reports ought not to be considered public knowledge because of the vulnerability of the target population and the importance of securing information on funding sources and financial records.

Programme coordinators also expressed concerns about contacting beneficiaries for interviews because beneficiaries expect that information about their medical condition and care will be kept confidential. The problem here is that a beneficiary may feel that the confidentiality of his/her medical care had been compromised if contacted by a researcher who had not been directly involved in the medical care.

This attempt at seeking programme beneficiaries and programme reports was unsuccessful primarily because of poorly organized and or nonexistent records. It would be difficult or impossible to contact the programme beneficiaries if the programme ended before 2007 because programme coordinators were unable to track the participants.

Few programmes targeted middle income or high income families. This is probably due to the fact that middle and higher income level families are expected to be able to afford the private

services of a physician/consultant or counselor. Children in these households would likely be less exposed to poverty, violence and malnutrition.

Many programmes were unable to report on the theoretical/philosophical orientations that influenced the programme implementation strategies. However, the few programmes that reported using theories employed mainly behaviour change/modification theories that acknowledged both the cognitive (attitudes, knowledge and perceptions) and basic (stimulus/response) facets of understanding behaviour.

4.2 Gaps in Services Offered and Implementation

Most of the programmes provided HIV prevention services, as opposed to services for infected or affected children. Children orphaned by HIV are profoundly affected by the loss of parents or caregivers and are more susceptible to poverty, malnutrition and violence than children who are not exposed to the same variables. Providing intervention services to this vulnerable group is crucial to protect them from HIV infection and provide additional support. Other at risk groups, such as abused and disabled children were also not provided with even the few services offered to the other children.

Many of the programmes reported various accomplishments and seemed to be satisfying the needs of their target population, yet very few programmes actually conducted assessments or surveys such as needs assessments or situational analyses. In addition, for the programmes that reported conducting needs assessments very few were able to provide the actual reports.

The few programmes that conducted formal evaluations focused mainly on process evaluations, indicating the numbers of participants at workshops, the number of recorded visits to the clinic and so on. Very few reported procedures for measuring goal achievement.

Many of the programmes did not have strategic and operational plans for the activities implemented. Often the goals referred to were not clearly defined and not associated with the activities. The consequence of this was that there was difficulty in determining the achievement or success of the goals. Developing action plans and implementation are important in determining the success or failure of programmes. Programmes operators therefore, need assistance in developing action plans and implementation procedures for their programmes, and encouragement in carry them out.

Not having clearly defined target groups and geographical boundaries may be spreading the resource capacity of the programmes thin. This may also contribute to overlap in services provided to some groups, while other important at risk groups may be overlooked.

More clearly defined target groups and geographical locations will allow for identifying:

- The needs of the target group (based on target characteristics, age and gender).
- A clear analysis of the resources available to support the programme operation (for example, money, staff, governmental support, existence of similar programmes) in specifically defined geographical locations.
- The appropriate strategies that should be used for achieving the specific and identified goals of satisfying the needs of the target population.

4.3 Programme Monitoring & Evaluation

The National AIDS Committee provides excellent coordination of HIV programmes in Jamaica. Regular reporting from the various subcommittees allows for this. However, monitoring and evaluation is apparently a weak component of programme implementation in Jamaica. The level of monitoring and evaluation of the National HIV/STI Programme and the international agencies is well documented. However, the smaller organizations/programmes suffered from a general lack of supervision, monitoring, and evaluation necessary to guide implementation of strategic activities and to facilitate future programme design, strategy evolution and resource allocation. The few agencies that carried out monitoring and evaluation did so to fulfill requirements for their donors.

4.4 Research

The Ministry of Health generated a field report of the National Knowledge, Attitudes, Behaviour & Best Practices Survey in 2004 (KABP) which indicated that, in 2004, more adolescents and young adults in the 15- 24 age range delayed the start of sexual initiation and consistently used condoms in risky sexual situations, compared to 2000. However, there is need for a more current survey on knowledge and attitudes to access the changes in behaviour patterns ensuing from the HIV prevention and intervention efforts.

While there has been notable interest in research in the area of HIV in Jamaica, the process for initiating research needs to be coordinated and better organized. Programme implementers appear to largely unaware of recent research findings. There are research areas that should be emphasized or be given priority but have not been adequately addressed. For example, the

impact of psychosocial support services in paediatric HIV and the relative contribution by the various interventions in reducing HIV within Jamaica needs more research.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Expected Future Impact

The scope of HIV intervention programmes available for HIV infected and affected Jamaican children has been documented for the first time. This should make these existing programmes more visible to researchers, policy makers, other funding agencies and practioners, and individuals seeking to access these services. In addition, this should encourage a discussion among stakeholders on the needs of children infected or affected by HIV and how well the current programmes in Jamaica address these needs. Also, since the documentation outlines the services and programming trends of 40 HIV programmes, this should assist programmes to strengthen their focus and share successful strategies. The database should be useful in facilitating coordination and networking among programme operators and other stakeholders in Jamaica, and it should be a central source of information on HIV programmes, which may aid in improving services offered, reducing overlap in services provided, and assisting with referrals to specific services.

5.2 Recommendations

- The finding of the documentation should be disseminated among policy makers, academics, donor agencies, and others interested in HIV interventions for children.
- The government, funding agencies, stakeholders and the public should be kept informed about the progress of the programmes through regular reporting or the use of a centralized body of information (for example a database) that may be easily accessed by programme coordinators, funding agencies and the general public.
- A system should be developed to update the database regularly, including the ability of the users of the database to indicate any errors that are noticed.

- There should be increased involvement of the NAC and NHCP in the monitoring of programme implementation, seeking solutions to related problems and providing advice on policy and related matters.
- Monitoring and evaluation should be developed among programme operators, possibly with the assistance of donor agencies. Also it would be beneficial to carry out not only process based evaluations but goals based and outcome evaluations.
- Sustainability of successful programmes appears to be a major issue, and systems for institutionalizing the most successful programmes, or programme components need to be put in place.

6. CCDC RESPONSES TO THE RECOMMENDATIONS

Updating and maintaining the database: It was recommended at the workshop with programme operators that the information on programmes in the database be updated biannually or annually. The CCDC is currently developing a proposal to fund this activity on an ongoing basis, as well as to expand the database to include information on programmes for the rest of the Caribbean.

A feedback form has been added to the database to obtain information from users on the usefulness of the database and collect suggestions for its improvements.

Dissemination of findings: The database and the findings of the documentation have been presented to academics and child-focused audiences at the Caribbean Child Research Conference (October 2007), and UWI, Mona, Research Day (January 2008). They will also be presented at the XVII International AIDS Conference in Mexico City, August 3-8, 2008. Plans for further

dissemination through press releases, advertisements, and presentations at special events are also being addressed in the proposal being developed.

The database has been linked so far to the website for UNICEF, UWI HIV Response Programme (UWIHARP), National AIDS Committee (NAC) and National AIDS Programme (NAP). Contact has been made with each site's webmaster to have a link to the HIV Intervention Programmes database embedded in each site. The database will also be linked the Jamaica Information Service.

REFERENCES

Chevannes, B., Anderson, P. & Brown, J. (1989). "*Why Man Stay So"Tie the Heifer- Loose the Bull: An Examination of Gender Socialization.* Caribbean Child Development Centre, The University of the West Indies (Mona). Pear Tree Press, Jamaica.

Center for Disease Control and Prevention (2001). *Evaluating CDC- Funded Health Department HIV Prevention Programmes-Volume 1: Supplemental Handbook.* Retrieved April 3, 2007 from http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/index.htm.

Jamaica Foundation for Children (2005). *Directory of Services: For Children, Adults and Families.* Pear Tree Press, Jamaica.

National AIDS Committee of Jamaica (NAC) (2007). *About the National AIDS Committee*. Retrieved August 8, 2007 from http:// www.nacjamaica.com.

Royes, H. (1999). *A Cultural Approach to HIV/AIDS Prevention & Care: UNESCO/ UNAIDS Research Project, Jamaica's* Experience Country Report. Retrieved September 14, 2007 from http://unesdoc.unesco.org/images/0012/001206/120689e.pdf.

The African Medical Research Foundation (2001). *The Inventory of Agencies with HIV/AIDS Activities: HIV/AIDS Intervention in Uganda.* Retrieved April 3, 2007 from http://www.aidsuganda.org/pdf/hiv_agencies_inventory.pdf.

The Center for Applied Research & Evaluation Studies, South East AIDS Training & Education Center, Department of Family & Preventive Medicine & Emory University School of Medicine (2001). *The Resource Inventory for Georgia HIV Prevention and Care Programme*. Retrieved April 3, 2007, from http://www.seatec.emory.edu/research/Resource%20Inventory%202000-2001.pdf.

The Ministry of Health, Jamaica (2002). *The Jamaica HIV/AIDS/STI National Strategic Plan 2002-2006 (JHANSP).* Retrieved September 10, 2007 from http://www.jamaica-nap.org/docs/strat_plan_2002-2006.doc.

The Ministry of Health, Jamaica. (2004). *Report of National Knowledge, Attitudes, Behaviour & Practices (KABP) Survey*. Retrieved September 10, 2007 from *http://www.jamaica-nap.org/nationalKABPreport_2004%20Final.pdf*.

The Ministry of Health, Jamaica. (2006). *Ministry of Health National HIV/STI Control Programme Facts & Figures: HIV/AIDS Epidemic Update*. Retrieved September 10, 2007 from http://www.jamaica-nap.org/AIDS_dataJan_Dec06final.pdf.

The Pan American Health Organization (PAHO) (2005). *Epidemiological Trends of HIV/AIDS in Jamaica*. Retrieved July 10, 2007 from http:// www.journal.paho.org.

The Joint United Nations Programme on HIV (UNAIDS) (2006). *Report of the Global AIDS Epidemic*, Retrieved July 10, 2007 from http:// www.uniads.org/en/HIV_data/2006GlobalReport.

The United Nations Children Fund (UNICEF) (1989). *Jamaica HIV/AIDS Country Report*, Retrieved July 10, 2007 from http://www.unicef.org/jamaica/hiv_aids_1989.

The United Nations Children Fund (UNICEF) (2007). *Information by Country: Statistics*, Retrieved July 10, 2007 from *http://www.unicef.org/infobycountry/*.

The World Health Organization (WHO). (2004). *Handbook for the Documentation of Interpersonal Violence Prevention Progra*mmes. Retrieved January 14, 2005 from http://whqlibdoc.who.int/publications/2004/9241546395.pdf.

The World Health Organization (WHO). (2007). *Psychosocial Support*. Retrieved October 14, 2007 from http://www.who.int/hiv/topics/psychosocial/support/en/.

APPENDIX I: Data Collection

Caribbean Child Development Centre
University of the West Indies
Survey questionnaire for the documentation of HIV/AIDS programmes/projects for children in Jamaican

Id no.: _____ Date of interview: _____
Name of Interviewee and post: _____

Name of Organization: _____
Address: _____
Telephone: _____ Fax: _____
E-mail (interviewee's and organizations):_____
Website address: _____

What type of organization are you?

☐ Faith-based organization ☐ Non-governmental organization
☐ Community-based organization ☐ Government organization/department
☐ Academic institution ☐ Media
☐ Hospital ☐ UN Agency
☐ Other (please specify):_____

PROGRAMME/PROJECT INFORMATION

1.1 What is the name of your HIV Programme/Project for children? (Write full name)
_____

Please state the date of the start of this programme/project: _____

When will this programme/project end? _____

1.2 Please give a brief description of your HIV programme/project for children:
_____
_____
_____

1.3 (*Definition of a goal*) What are the main goals of your HIV programme/project?
i._____
ii._____
iii._____
iv._____

1.4 Where do you currently get funding for your HIV programme/project. (Record name of source(s) in full)

_____

_____

2.1 Please specify the geographic areas covered by your HIV programme/project:

☐ Parishes: _____

☐ Communities:_____

☐ Other: _____

2.2 These areas are mainly:

☐ Urban ☐ Rural ☐ Both urban & rural

2.3 In which settings is your HIV programme/project implemented or conducted? (Indicate all that apply)

☐ Primary schools ☐ Secondary schools ☐ Households

☐ Churches ☐ Neighbourhoods ☐ Youth clubs

☐ Juvenile centres ☐Hospitals

☐ Other (please specify): _____

3.1 What is/are the age(s) of your target group(s)? (Indicate all that apply)

☐ Children 0-5 yrs ☐ Children 6-12 yrs ☐ Children 13-18 yrs

☐ All ages (general pop.) ☐ Other (please specify): _____

3.2 What is/are the specific target groups of your HIV programme/project? (Indicate all that apply)

☐ Orphans (children who have lost a parent) ☐ Street children

☐ HIV + children ☐ children with HIV + family members

☐ Other (please specify): _____

3.3 What is the sex of your target group?

☐ Males ☐ Females ☐ Both males & females

4.1 How would you describe the income level of your target group(s) relative to that of the country as a whole? (Indicate all that apply)

☐ Low income ☐ Middle income ☐ High income

4.2 Please estimate the total number of children/people reached by your HIV programme/project in the last 12 months? _____

5.1 Is your HIV programme/project explicitly based on any theoretical assumptions?

☐ Yes ☐ No

(*If yes*) please specify: _____

INTERVENTION AND PREVENTION ACTIVITIES

6.1 Which of the following type(s) of service(s) is/are provided by your HIV programme/project? (Indicate all that apply)

☐HIV Care ☐ HIV Prevention

☐Other (please specify): _____

(*If HIV Care services*)Please indicate which of the following HIV care services you provide:

HIV/AIDS CARE SERVICES – Healthcare services	
Types of Healthcare services	**Service provided**
HIV Testing – Taking of Blood/Blood screening for HIV	☐
Medications/Pharmaceuticals - Prescription drugs provided to prolong life or prevent the deterioration of health	☐
Clinical Care/Follow-up – Provide clinical service and monitors the progress of clients	☐
Dental care - Diagnostic, prophylactic and therapeutic services	☐
Residential Orphan Care/Home-based care - Nursing care, counselling, physician services and palliative therapeutics provided to infected children in a residential institution	☐
Facility based care - Nursing care, counselling, physician services and palliative therapeutics provided to infected children/people at a health facility centre	☐
Residential Hospice Care - Nursing care, counselling, physician services and palliative therapeutics and room and board provided to patients (adults with AIDS) in the terminal stages of their illness in a residential setting	☐
Mental Health Therapy/Counselling - Psychological, psychiatric treatment and counselling services provided by a mental health professional	☐
Nutritional Counselling - Nutrition education and/or counselling provided by a dietician outside of a primary care visit	☐
Substance Abuse Treatment/Counselling - Treatment and/or counselling to address substance abuse issues	☐
HIV Treatment Adherence - Counselling or special programs to ensure readiness for and adherence to HIV treatments	☐
Caring for HIV infected pregnant women and their children before and after delivery	☐
Other Medical Services - Medical services not listed. Please specify _____	☐

HIV/AIDS CARE SERVICES – Support services	
Types of Support services	**Service provided**
Providing placement/shelter - Assistance in placing children 18 years of age or younger who have become orphans due to AIDS and are infected with HIV into temporary or permanent homes (fostering, adoption, orphanages/residential institution)	☐
Case Management - Client-centered services that link clients with healthcare, psychosocial and other services	☐
Client Advocacy - Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services	☐
Counselling Other than Mental Health Counselling - Individual and/or group counselling, other than mental health counselling, provided to clients, family, and/or friends by non-licensed counsellors	☐
Psychosocial support services – Ongoing process of meeting clients' emotional, social, mental and spiritual needs. Support groups for HIV infected children or people with AIDS emphasizing their psychological needs and their needs for social interactions	☐
Financial Assistance – Assistance in purchasing food, paying for transportation to access healthcare or psychosocial services provided to clients	☐
Food Aid -	☐
Health Education/Risk Reduction - Information dissemination or preparation/distribution of materials, about medical, psychosocial and counselling services to educate clients about HIV and AIDS	☐
Housing Assistance - Short-term or emergency financial assistance to support temporary and/or transitional housing	☐
Housing Related Services - assessment, search, placement, and advocacy services	☐
Legal Services - Legal services directly necessitated by a person's HIV status	☐
Outreach service- Identifying people with HIV so that they may become aware of and may be enrolled in care and treatment services	☐
Permanency Planning - Social service counselling or legal counsel regarding the drafting of wills, delegating powers of attorney, and preparation for custody options for legal dependents	☐
Referral - Directing a person to a service in person, or through written, telephone or other type of communication	☐
Income Generating Activities – Supporting clients to improve their income	☐
Other Support Services - Direct support services not listed above. Please specify:_____	☐

(*If HIV Prevention*) For each type of HIV prevention programme listed, please indicate the strategies used:

HIV PREVENTION PROGRAMMES	
Types of HIV Prevention Programs	**Strategies used**
☐ **One-to-one Level Interventions** *Please indicate strategies used:*	
Risk reduction counselling	☐
Diagnosis and treatment of STIs	☐
Peer counselling	☐
HIV & STI risk assessment	☐
Skills development programmes (eg. life skills approach/training programmes)	☐
Hotline-telephone service offering counselling, information and referral to local services	☐
Other One-to-one level strategies:_____	☐
☐ **Group Level** *Please indicate the strategies used:*	
Risk reduction counselling	☐
Promoting safer sex practices among adolescents	☐
Use of role playing to teach about HIV and STI prevention	☐
Peer education – use of role models or leaders within a peer group to conduct HIV prevention educational talks (youth clubs etc.)	☐
Other group level strategies: _____	☐
☐ **Outreach (Street & Community)** *Please indicate strategies used:*	
Safer sex kits/condom distribution and demonstration	☐
HIV risk reduction information/brochure distribution	☐
Bleach kit distribution and demonstration	☐
Other outreach strategies: _____	☐
☐ **Community Level** *Please indicate strategies used:*	
Social marketing- condoms/promotion of the use of condoms	☐
Community mobilization and organization for HIV related activities	☐

HIV PREVENTION PROGRAMMES	
Types of HIV Prevention Programs	**Strategies used**
☐ **Community Level cont'd** *Please indicate strategies used:*	
Improve the availability and quality of residential facilities for infected children	☐
Community Wide Events(for eg., Health Fair)	☐
HIV & STI prevention education in school	☐
Other community level strategies: _____	☐
☐ **Public Information/Media Campaigns -** delivery of HIV prevention message through one or more media: *Please indicate media used:*	
Electronic media-radio, television, public service announcements	☐
Print media-pamphlets, newspapers, magazines, billboards	☐
Use of a website to provide a responsive information service	☐
Presentations/lectures-information only activities conducted in group settings; often called "one-*off*" education interventions	☐
Message(s) of media campaigns include: safer sex practices HIV risk assessment HIV risk reduction promoting HIV testing reduce HIV & STI transmission other prevention message(s): _____	☐ ☐ ☐ ☐ ☐
Other public information strategies: _____	☐
☐ **Counselling, Referral and Testing and Partner counselling and Referral** *Please indicate strategies used:*	
Voluntary counselling and confidential testing (VCT)	☐
Pre-test counselling and testing of pregnant women for Mother-to-child-transmission (MTCT)	☐
Referrals and linkages to other services providers	☐
Partner counselling and referral	☐
Providing Perinatal HIV prevention services	☐
☐ **Prevention Case management –** One-to-one intensive, ongoing individualized client services for persons having difficulty initiating and sustaining safer sexual behaviour	☐
☐ **Other-** Types of HIV prevention (please describe): _____ _____	☐

RESOURCES

7.1 *Financial Resources*

What is the annual budget of your HIV programme/project (JA $)? _____

How much of this budget is funded(JA$)? _____

Please specify the contribution of each funding source to your programme's/project's total budget:

Source of funding	Source's contribution to total budget (JA$)
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____

7.2 *Human Resources*

What is the total number of people directly involved in the project/programme implementation (count of volunteers and paid staff)? _____

Please specify the number of volunteers: _____

Of the paid staff, please specify the:

number of administrative staff (e.g. accountant, secretary): _____
number of programme/project management staff (includes fieldworkers): _____
number of technical staff (e.g. nurses, lab technicians, data entry clerk): _____
number of support staff (e.g. caretaker, office attendant, driver): _____

7.3 *Other resources*

Please indicate the type and number of fixed assets used for your HIV programme/project:

☐Offices spaces: _____ ☐Computers: _____

☐HIV/STI testing labs: _____ ☐Bicycles/motorcycle: _____

☐Motor vehicles: _____

☐Other equipment/resources (please specify): _____

INFORMATION ON PROGRAMME/PROECT PLAN, IMPLEMENTATION AND OUTCOMES

8.1 *Planning*

What triggered the motivation to have this HIV programme/project?

_____
_____
_____

Was a needs assessment carried out to define the scale of the problem your HIV programme/project addresses? ☐ Yes ☐ No

(*If yes*) Please describe findings (request and collect report):

_____
_____
_____

Was HIV-related training done with your programme/project staff? ☐ Yes ☐ No

(*If yes*) Please specify the type of HIV-related training staff done with programme/project staff:

_____
_____

Does your HIV programme/project include a formal evaluation component?

☐ Yes ☐ No

(*If yes, complete table 1*)

(*If no*) Can you describe how you know that your HIV programme/project is achieving its objectives?

_____
_____
_____

8.2 *Documentation*

Are the activities of your HIV programme/project routinely documented?

☐ Yes ☐ No

(*If yes*) How often are activities routinely documented, and in what manner is this done? (Request and collect samples)

_____
_____
_____

Are progress reports written for your HIV programme/project?

☐ Yes ☐ No

(*If yes, request and collect samples*)
What other source(s) of information are there to monitor the progress of your programme/project? _____
_____
_____

List the outputs from your HIV programme/project (e.g. curricula, protocols, evaluation tools)- (Request and collect samples):
_____
_____
_____

8.3 *Outcomes*

Recall your programme's/project's goals stated earlier and indicate whether they are achieved as planned? ☐ Yes ☐ No

Explain: _____
_____
_____

What are the major achievements of your HIV programme/project? (Probe for both quantitative and qualitative results)
_____
_____
_____

How are the results of your programme/project disseminated? (Request and collect samples)

☐ Reporting to funder_____ ☐ Reporting to community
☐ Meetings with _____ ☐ Reporting to policy makers
☐ Conference presentations ☐ Journal publication
☐ Media coverage (please specify media):_____

What have been the major constraints in the implementation of your HIV programme/project?
_____
_____
_____

What factors would you say contributed to the achievements or success of your HIV programme/project?
_____
_____

8.4*Needs*

Should you need additional assistance**,** *excluding funds,* for the successful implementation of your programme, which of the following forms such assistance might take? (Indicate all that apply)

☐ Technical assistance, (e.g. computers, vehicles, office spaces)

☐ Additional staff (e.g. technical staff, administrative staff)

☐ Access to additional information on children and/or HIV

☐ Networking with other organisations dealing with children and HIV

☐ Greater exposure of your work (please explain): _____

☐ Other (please specify): _____

8.5 Can you suggest any other organizations with HIV-related programmes/projects/activities for children that should be included in this survey? If so, please list them: _____
_____
_____
_____

DETAILS FOR MAILING LIST:

Contact's name: _____

Contact's email address: _____

TABLE 1 MATRIX TO DESCRIBE FORMAL EVALUATION PROCEDURES AND MAJOR FINDINGS FOR EACH INTERVENTION WITHIN THE PROGRAMME.

Intervention	**Evaluation part of programme from outset?**	**Design of evaluation**	**Process measures**	**Outcomes measures**	**Major findings**	**Time period of evaluation**	**Cost-effectiveness (give details)**

APPENDIX II: Introductory Letter

Dear Respondent,

Re: Documentation of HIV/AIDS Intervention Programmes for Jamaican children

We are writing to you regarding an initiative by the Caribbean Child Development Centre of the University of the West Indies and the Inter-American Development Bank to identify HIV /AIDS intervention programmes for Jamaican children that have been implemented between the period 2001 and 2007.

HIV/AIDS has generated serious problems in our society that are affecting our children. Children have been orphaned or otherwise burdened because their parents or other family members have fallen ill or died. These children have to deal with the grief, dislocation, being discriminated against, as well as face the added burden of assuming responsibilities that are often beyond their capabilities: taking care of a sick or dying parent, running the household, raising younger siblings, substituting as a breadwinner, begging for survival on the streets. In addition to these affected children, many children are also infected with HIV.

A number of programmes aimed at assisting children burdened by HIV/AIDS have been developed. However, information on these programmes has not been documented in a way so that interested persons or others working in the area of HIV/AIDS interventions can easily access it. This survey seeks to obtain information on HIV/AIDS interventions targeting children, though not necessarily exclusively.

We are interested in talking to you about your programme and will contact you to arrange a time suitable for us to meet. We would be happy to provide any further information that you may need.

Thank you for your kind attention. Please contact Mrs. Natalie Irwin- Carby on 875-1415 (cell), 927-1618 or 977-6982 (work)

Yours sincerely,

Natalie Irwin-Carby
Research Assistant

APPENDIX III: Workshop Report

"Documentation of HIV Programmes for Children in Jamaica"

Report on Dissemination Meeting

Natalie Irwin - Carby
The Caribbean Child Development Centre,
The University of the West Indies, Mona

Introduction

A one-day workshop was held with stakeholders on November 23, 2007 at the Mona Visitor's Lodge located at the University of the West Indies, Mona Campus, to present and discuss the results of the documentation, introduce and demonstrate the database, identify strategies to maintain the database, and formulate a plan to encourage others to use the database. There were 15 persons in attendance, of which 9 were representatives of programmes (see list of attendees, page 6). The agenda for the workshop is on page 7.

Feedback and Comments following Presentation of findings from the project

The participants were very receptive to the presentation of the findings from the project. They were particularly interested in the theoretical orientations used by the programme as they believed that the use of appropriate behaviour change theories should be an integral aspect of HIV programming, and thus needs more attention.

Programme Planning as well as Monitoring & Evaluation mechanisms were also a point of interest. Participants expressed a need to have more discussion of this aspect of the presentation and expressed interest in acquiring the final report to read more on

programme planning issues. They were assured that a copy of the final report would be sent to managers of programmes that participated in the documentation as well as made available online to the public through the CCDC website at http://ccdcresearch.mona.uwi.edu/hivprogramme.

Results of Group Work on Sustainability, Linkages and the Way Forward

In groups participants discussed and responded to the questions outlined for group work (See page 8). The results for each question are outlined below:

1. What changes should be made to the database to improve its usefulness?

Participants suggested the following:

- Modifying the appearance of the navigation page so the database appears more user-friendly.
- Give the database an international look and appeal.
- Remove Jamaica from the front page of database or any heading that suggests the database is just for Jamaican programmes, since the long-term plan is to expand the database to the Caribbean.
- Set "Browse Programmes" action so that users will be able to browse programmes by country and browse all programmes, regardless of country when other Caribbean countries are added to the database.
- Add introduction (brief) on home page of database.
- Include geographic mapping of programmes by country.
- Database should include links to other relevant topics or websites.

- The information on programmes should be checked for accuracy.
- The layout and appearance of the database should be improved, for example uniformity of fonts

2. What agency is best suited to update the database?

Participants suggested the Caribbean Child Development Centre (CCDC) and the Ministry of Health (MOH) were best suited to carry out updating of the database.

3. How frequently should it be updated?

Participants suggested various times to update the database which included: quarterly, biannually and annually and whenever required. There were more suggestions for biannually or annually.

4. Suggestions on informing others about the database and encouraging utilization?

Participants suggested that:

- An option should be included on the database that would allow programme operators to have their programme information added to the database. This would facilitate those programmes which were not included in the initial documentation.

- The database should be 'marketed to the public' through the internet (for example on go-jamaica.com) flyers, television advertisements and programmes such as *Smile Jamaica*, *JIS* programmes and various radio talk shows. It was

suggested that flyers could be sent to umbrella organizations for distribution in order to spread information about the database.

- It would be beneficial to invite organizations providing HIV services, when printing their brochure or pamphlets, to include the web link for the database website as a source of information on HIV services in Jamaica for children.

- The database should be linked to major web pages such as The Gleaner's or The Jamaica Observer's web pages, and Google advertisements.

- Information on the database should be sent to stakeholders by direct mailing or emailing.

- The database should be demonstrated at various wellness or health fairs (specifically those hosted by the Ministry of Health).

These suggestions will be explored when disseminating information on the database and when encouraging its utilization.

4. Other Comments

The following were some of the other issues that were raised by participants:

- How to deal with funding agencies who might not want to be listed in the database.

- Inviting the Ministry of Health to be involved in being responsible for maintaining and updating the database.
- Modifying the database so as to encourage young people to access information on HIV programmes. This modification should include more graphics and appeal to the younger age group

Finally, feedback received from those who attended on the day suggested that it was both a stimulating and enjoyable morning.

Acknowledgements

I would like to acknowledge the help and support of Kisha Sawyers, Marilyn Brown and Marva Campbell of the CCDC in organizing this event. I would also like to thank Joan Thomas for giving the Welcome and Opening remarks and leading the discussion on the database and Kimberly Royes for taking notes.

I would particularly like to thank Rosemarie Ryder of the Jamaica AIDS Support for Life for chairing the workshop and for her continued support.

Workshop Attendees

#	**Name**	**Organization**
1	Francine Mcdonald	Children First
2	Stanford Watson	The Multicare Foundation
3	Gloria Wedderburn	Saxthorpe Methodist Church
4	Priya Anaokar	Tata Institute of the Social Sciences
5	Marlon Johnson	HOPE Worldwide
6	Rosemarie Ryder	Jamaica AIDS Support for Life (JAS)
7	Dennis Parchment	Inter-American Development Bank (IDB)
8	Nadine Lawrence	Jamaica Network of Seropositives (JN +)
9	Marilyn Brown	Caribbean Child Development Centre (CCDC)
10	Nicola Douse	Kingston Y.M. C. A.
11	Natalie Carby	Caribbean Child Development Centre (CCDC)
12	Kimberly Royes	Caribbean Child Development Centre
13	Craig Mears	Youth Opportunities Unlimited (YOU)
14	Petula Manboard	Youth Opportunities Unlimited (YOU)
15	Ms Gloria Goffe	Combined Disabilities Association

THE CARIBBEAN CHILD DEVELOPMENT CENTRE

HIV/AIDS PROGRAMME DOCUMENTATION
STAKEHOLDERS CONSULTATION

Mona Visitor's Lodge, U.W.I. Campus

November 23, 2007

WORKSHOP AGENDA

8:00am- 8:15am…….Welcome & Introduction/Icebreaker Activity

8:15am-9:30am……..Project Overview and Presentation of Findings

9:30am-9:50am……..Presentation of the Database

9:50am-10:00 am……Questions & Answers

10:00am-10:10am……BREAK

10:10 am-10:15pm……Group Work: Sustainability and Linkages, and The Way Forward

10:15am-10:55am……Group Reports

10:55am-11:00am……Closing

Caribbean Child Development Centre - HIV Prevention Programme Documentation

Group Work Instructions

In groups (as seated at tables), discuss and respond to the following questions.

1. What changes should be made to the database to improve its usefulness

2. What agency is best suited to update and maintain the database?

3. How frequently should it be updated?

4. Suggestions on informing others about the database and encouraging utilization.

5. Other Comments

APPENDIX IV: Glossary of Terms

- **Adolescent.** A young person who has undergone puberty but who has not reached full maturity; a teenager.

- **AIDS.** Acronym from "Acquired Immunodeficiency Syndrome". A disease of the immune system characterized by increased susceptibility to opportunistic infections and to certain rare cancers, especially Kaposi's sarcoma. It is transmitted primarily by exposure to contaminated body fluids, especially blood and semen.

- **Bleach kit**. A tool for sterilizing needles (using bleach and other chemicals), if one shares needles with others. This tool aids in reducing HIV transmission.

- **Caring for HIV infected pregnant women and their children.** Providing perinatal HIV services.

- **Case Management.** Client-centered services that link clients with healthcare, psychosocial and other services.

- **Child**. The Convention on the Rights of the Child defines a child as any person under the age of 18 years.

- **Client Advocacy**. Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services.

- **Community-based organization.** Organizations committed to helping members of an identified group obtain health, education and other basic human services.

- **Community level interventions.** These use participatory methods to develop and enact community campaigns reducing HIV transmission (e.g. involving community members in organizing marches or demonstrations, creating local theatre productions highlighting issues around sex and sexuality, development of

community support or action groups that may campaign for legal changes). Community campaigns may target certain parts of a community (e.g. young people) and can take the form of small local programmes; however, they may also be connected to large national campaigns.

- **Community Mobilization.** A process whereby a group of people have transcended their differences to meet on equal terms in order to facilitate a participatory decision-making process. Community mobilization uses deliberate, participatory processes to involve local institutions, local leaders, community groups, and members of the community to organize for collective action toward a common purpose. Community mobilization is characterized by respect for the community and its needs.

- **Counselling (other than mental health counselling).** Individual and/or group counselling, other than mental health counselling, provided to clients, family, and/or friends by non-licensed counselors.

- **Dental Care**. Diagnostic, prophylactic and therapeutic dental services.

- **Donor.** One that contributes something, such as money, to a cause or fund.

- **Evaluation.** A process that attempts to determine as systematically and objectively as possible the relevance, effectiveness and impact of activities in the light of their objectives (Last, 1983). Programme evaluation includes the phases of pre-intervention needs assessment; formative (or process-) assessment; and summative (or outcomes) assessment.

- **Facility based care.** Nursing care, counselling, physician services and palliative therapeutics provided to infected children/people at a health facility centre.

- **Faith–based organization.** Organizations that are religious in nature and distinguish those organizations from government, public or private secular organizations.

- **Financial Assistance.** Assistance in purchasing food, paying transportation to access healthcare or psychosocial services provided to clients.

- **Food Aid.** Food, meals, or nutritional supplements provided to clients.

- **Goals.** Goals are descriptions of what is planned to achieve.

- **Governmental organizations.** Any organizations created by legislation to perform a public purpose. This organization singularly accountable to and controlled by an internationally recognized nation state government.

- **Group Level Interventions.** Health education and risk reduction counseling that shifts the delivery of service from individual to groups of varying sizes. Group level interventions use peer and non-peer models involving a wide range of skills, information, education, and support.

- **Health Education/Risk Reduction Counselling.** Information dissemination or preparation/distribution of materials, about medical, psychosocial counselling services to educate clients about HIV and AIDS.

- **HIV.** Acronym from "Human Immunodeficiency Virus". A retrovirus that causes AIDS by infecting helper T cells of the immune system and is a cause of AIDS and AIDS-related complex.

- **HIV Treatment Adherence**. Counseling or special programs to ensure readiness for and adherence to complex HIV treatments.

- **HIV Testing.** Taking of Blood/Blood screening for HIV.

- **Home-based Hospice Care**. Nursing care, counseling, physician services and palliative therapeutics provided to patients in the terminal stages of their illness in their home setting.

- **Hospital.** A health facility where patients receive treatment and care.

- **Hotlines.** Hotlines include telephone help lines that provide varied information, counselling, support and advice for people who have experienced or are still experiencing child abuse, sexual assault, rape or may have questions about sex and sexuality and need a professional to talk to and seek advice.

- **Housing Assistance.** Short-term or emergency financial assistance to support temporary and/or transitional housing.

- **Housing Related Services.** This involves assessment, search, placement, and advocacy services.

- **Income Generating Activities.** Supporting clients to improve their income, by setting up small businesses etc.

- **Income level.** The target population's income relative to that of the country as a whole. ***Low income***: Little or no employment within the household. The employed involved in unskilled and/or seasonal labour at or below minimum wage. **M*iddle income***: Stable employment within the household. The income is sustainable and earnings are above minimum wage. ***High income***: Clearly affluent lifestyles. Family owns at least one home and a vehicle. Employed involved in professional or business labour. ***Mixed***: Families represents a mix of low income, mixed income and high income.

- **Individual Counselling.** Individual counselling includes individual psychotherapy, counselling and social casework which combines these with close supervision of the target individual and coordinated social services.

- **Intervention.** Interventions are sets of actions and decisions structured in such a way that their successful implementation would lead to clearly identifiable outcomes and benefits.

- **Legal Services.** Legal services directly necessitated by a person’s HIV status

- **Local**. Belonging to or characteristic of a particular locality or neighborhood; within a restricted geographical area, up to a certain mileage maximum.

- **Media**. Forms of mass communication. For example, newspapers, magazines, bus signs, radio, television etc.

- **Media campaigns.** Community-wide public information campaigns for the prevention of HIV/STI transmission, which aims to increase knowledge, raise awareness and change attitudes towards sexuality and sexual practices the at community level by giving educational messages to the community via mass media (e.g. television, radio, posters, internet, newspapers). Some initiatives have incorporated messages within popular radio or television dramas.

- **Medications/Pharmaceuticals.** Prescription drugs provided to prolong life or prevent the deterioration of health.

- **Mental Health Therapy/Counselling**. Psychological, psychiatric treatment and counseling services provided by a mental health professional.

- **National**. Of or relating to or belonging to a nation or country; limited to or in the interests of a particular nation.

- **Needs Assessment.** A systematic method of identifying unmet needs. It may involve one or more methods including epidemiological and qualitative approaches. The information from a needs assessment can be used to identify priorities and inform the development of a programme or services. (Wright, 1998).

- **Non-governmental Organization.** A non- profit organization which is independent from the government.

- **Nutritional Counselling.** - Nutrition education and/or counseling provided by a dietitian outside of a primary care visit.

- **Outreach Interventions.** HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in clients' neighborhoods or other areas where clients' typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.

- **One to one level Intervention.** These are individual level interventions. Health education and risk-reduction counselling provided to one individual at a time. Assists in clients making plans for individual behavior change and ongoing appraisals of their own behavior and include skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (eg, substance abuse treatment settings) in support of behaviours and practices that prevent transmission of HIV, they help clients make plans to obtain these services

- **OVC.** Acronym from Orphans & Vulnerable Children. OVC are the children who, in a given local setting, are most likely to left out of regular programmes, policies and traditional safety nets and therefore need to be given special attention when programmes and policies are designed and implemented. **"Orphans"**- children who have lost one or both parent to death by HIV. **"Vulnerable Children"-** refers to a child's need for protection.

  Examples of OVC are children in and of the street, children affected by HIV/AIDS, children with disabilities or chronic illnesses, children affected by armed conflict and children in hazardous forms of child labour.

  Examples of groups that could be eligible: children forced into early marriage, child substance abuse users, children in conflict with the law, albino children and ethnic or religious minority children.

- **Partner Counselling & Referral Services.** A systematic approach to notifying sex and needle-sharing partners of HIV infected persons of their possible

exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized, HIV testing, medical evaluation, treatment, and other prevention services.

- **Parent Organization.** That part of an organization which coordinates, supervises or exercises control over policy, fund-raising and expenditures, or assets or advises one or more branches, chapters or affiliates of that organization (Maine State Legislature, Office of Revisor Statutes, 2006).

- **Peer educatio**n. Role models or leaders within a peer group are selected to conduct educational talks. The peer educators are usually trained in areas such as substance misuse, conflict resolution skills and sexual health. The peer educators may either take a passive role (e.g. leading by example, informal discussions with peers) or have a more active role (e.g. participating in the design of teaching programmes, teaching or facilitating group work sessions). The intensity of training, continued support and supervision of peer educators can be of variable quality and length (Guiliano, 1994).

- **Permanency Planning.** Social service counselling or legal counsel regarding the drafting of wills, delegating powers of attorney, and preparation for custody options for legal dependents

- **Preventio**n. Prevention means a reduction of the risk of occurrence, or delay of occurrences of HIV in children. Prevention means to prevent the onset of HIV infection and transmission.

- **Prevention Case Management (PCM).** Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviours by clients with multiple, complex problems and risk-reduction needs, a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support and service brokerage.

- **Psychosocial Support Services.** The definition of psychosocial support is a long discussed issue and there is not only one definition for the term. Psychosocial support services are interventions and methods that enhance children's, families' and communities' ability to cope, in their own context and to achieve personal and social well-being; enabling children to experience love, protection and support and support that allow them to have a sense of self worth and belonging. Such interventions are essential for children to learn, develop life skills, participate fully, and have faith for the future.

- **Public Information/Media Campaigns.** The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.

- **Providing Placement & Shelter.** Assistance in placing children 18 years of age or younger who have become orphans due to AIDS and are infected with HIV into temporary or permanent homes (fostering, adoption, orphanages/residential institution).

- **Referrals.** Directing a person to a service in person, or through written, telephone or other type of communication

- **Rehabilitation Care**. Services provided to improve or maintain a client's quality of life and optimal capacity for self-care.

- **Residential Hospice Care**. Nursing care, counseling, physician services, palliative therapeutics and room and board provided to patients in the terminal stages of their illness in a residential setting.

- **Risk Assessment.** An identification of the danger of specific risky behaviours and an estimation of the probability of contracting an STI and or HIV.

- **Risk Reduction.** A selective application of appropriate techniques and management principles to reduce either the likelihood of occurrence, or the impact of HIV, or both.

- **Rural.** Refers to an area with mostly farmland and little human population, or characteristic of farming and country life.

- **Settings**. Demographics and the circumstances of that target population. Settings may include schools, health care facilities, old age homes, prisons, workplaces, neighborhoods, households and other public facilities such as bars and clubs. Identify in what settings the programme takes place, such as schools, neighborhoods, workplaces, old age homes, etc.

- **Skills development programmes.** Skills development interventions involve teaching the cognitive and social skills needed to develop and sustain positive, friendly and cooperative behaviour.

- **Social marketing.** Social marketing is the systematic application of marketing along with other concepts and techniques to achieve specific behavioural objectives for a social good.

- **Stakeholder.** One who has a share or an interest, as in an enterprise.

- **STIs.** Acronym from Sexually Transmitted Infections. Infections that are often or usually passed from one person to another during sexual contact. Also called STDs
- **Substance Abuse Treatment/Counseling.** - Treatment and/or counseling to address substance abuse issues.

- **Target Population.** The group of people for whom an intervention or programme is planned. Identify the populations that the programme aims to benefit in terms of characteristics such as age and sex, and whether they are victims, perpetrators or the general public.

- **UN Agency.** An agency of the United Nations.

- **Urban**. Relating to or concerned with a city or densely populated area; located in or characteristic of a city or city life; Places of 2,500 or more persons in incorporated places (cities and towns).

- **VCT.** Acronym for Voluntary Counseling & Testing.

    - **"Voluntary**" – This means that getting tested for HIV/AIDS is one's choice. One decides if and when they get an HIV test. This is the opposite of *compulsory* testing, in which someone is forced to undergo testing. Compulsory testing is an invasion of privacy and a violation of human rights. Therefore, the first step to Voluntary Counselling and Testing is your decision to seek testing.

    - **"Counselling**" – Voluntary Counseling and Testing includes counseling before and after the test for HIV. *Pre-test counseling* includes a private session with a counsellor, who explains the testing procedure and how the results will be given. One will have the chance to ask questions about the test, and share any fears or worries. One can then decide if you are ready for the test. In *post-test counseling*, the counselor will support you as they tell you the result of your test. The counselor will make sure you understand the result and allow you to express how you feel. They will help you make immediate plans and provide referrals for medical care, ongoing counseling and opportunities to talk to people who can help you understand more about HIV and AIDS, as needed.

    - "**Testing**" - The most common way of testing for HIV uses a blood sample, but there are oral-swab and urine tests available in some places. The blood sample will be tested in a laboratory to see whether there are *antibodies* in the blood. Antibodies are chemicals produced by our white blood cells to fight specifically against HIV**.**