Draft JICA Strategy for HIV/AIDS Prevention Education in Jamaica

Presented to Japan International Cooperation Agency (JICA) Jamaica Office

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Introduction

While Japan Overseas Co-operation Volunteers (JOCV) have been working in Jamaica since 1989, their assignments have been decided largely on an ad-hoc basis in response to individual requests from government and non-government partners. The purpose of this consultancy is to devise a five-year strategy for the selection, dispatch, and assignment of of JOCVs in Jamaica in the field of HIV/AIDS education, as well as subsequent technical cooperation to be considered by JICA.

HIV/AIDS has become a serious and growing concern in Jamaica, especially among adolescents. Improving and expanding education for the prevention of HIV/AIDS in the formal education sector may be the one of the best means of reaching the target population and stemming the spread of this epidemic in Jamaica. It is an area that has not received significant attention to date. Most donors (including USAID, GTZ, UNAIDS, World Bank) are supporting the Ministry of Health in their HIV/AIDS activities, but no other bilateral donors are supporting the Ministry of Education, Youth and Culture (MOEYC) directly in its response to the HIV/AIDS epidemic. JICA's support for the MOEYC would be in coordination with UNESCO and UNICEF.

This report presents a brief overview of the HIV/AIDS situation in the Caribbean and Jamaica, the framework of JICA, CARICOM, and the Government of Jamaica in formulating a response to HIV/AIDS, strategies and lessons learned in the region and in Jamaica in addressing HIV/AIDS through the education sector. The report then briefly summarizes the activities implemented and planned by other multilateral and bilateral donors in HIV/AIDS, with a particular focus on activities related to HIV/AIDS prevention and prevention education. The following section outlines the MOEYC's request to JICA as well as other needs identified. Finally, a recommended strategy for JICA is presented based on this information.

I. The HIV/AIDS situation in the Caribbean and Jamaica

Caribbean

The Caribbean region has the **world's highest HIV prevalence rate outside of sub-Saharan Africa**. HIV/AIDS is the leading cause of death for people age 15-44 in the Caribbean. According to UNAIDS figures, over 360,000 people in the region are living with AIDS, but the actual number is probably over 500,000 due to underreporting. AIDS has orphaned more than 80,000 children in the Caribbean and the infection rate is estimated at more than 12% in some urban areas. In the last twenty years, approximately 6,600 people are reported to have died from AIDS in the Caribbean, though the actual number is probably higher.

HIV/AIDS is increasingly recognized as a major development problem in the region, as stated by CARICOM's Caribbean Task Force on HIV/AIDS in its August 2000 *Caribbean Regional Strategic Plan of Action for HIV/AIDS*. **HIV/AIDS now threatens to reverse the region's development achievements of the last three decades** by placing

a heavy burden on health care systems and on the labor force. The labor force in the Caribbean—those age 15 to 54—account for 83 % of the AIDS cases. Thus, the epidemic has a great potential to negatively impact key sectors, including agriculture, tourism, mining, and trade. According to a University of the West Indies study, the total direct and indirect cost of HIV/AIDS in the Caribbean could reach $80 million by 2020. It was estimated that GNP would fall by 4.2%-6.4% in Trinidad and Tobago and Jamaica and savings would fall by 10.3% in Trinidad and Tobago and 23.5% in Jamaica.

The prevalence among adults age 15-49 in the Caribbean has reached 2%. In Haiti, where the situation is the worst, estimates are as high as 12% for the urban population and 5% for the rural population. In Jamaica, Haiti, the Bahamas, Barbados, the Dominican Republic, and Guyana, the epidemic has spread beyond the high-risk population to the general population. Once the prevalence rate in the general population reaches approximately 5%, the virus spreads rapidly.

Jamaica

While the HIV/AIDS prevalence in Jamaica is relatively low for the Caribbean region (at about 1.4%), **HIV/AIDS and sexually transmitted infections are the leading causes of death for women age 20-29 (and for men and women age 30 to 34).** Eighty-five percent of HIV/AIDS cases occur among people age 20 to 59. HIV/AIDS thus has an enormous impact on the most economically productive sector of the Jamaican population. **Young people age 15-19 have the highest HIV rates of 2.5%**, followed by 25-29 year olds at 2%. HIV/AIDS has also been the second leading cause of death of children under four since 1999. By the end of 2001, 24,000 to 32,000 people were estimated to be infected with HIV and about 3700 had died from AIDS in Jamaica. This is the **third largest population of people living with AIDS in the Caribbean** (after Haiti and the Dominican Republic). According to UNAIDS, the **AIDS mortality rate is an alarming 61%, due to delayed diagnosis and lack of treatment and care**.

HIV is spreading steadily in Jamaica and putting significant stress on the country's well-established health care system. **The epidemic has spread from high-risk groups to the general population**. Sixty-one percent of cumulative reported HIV/AIDS cases in Jamaica are through heterosexual contact. (Another 8% are reportedly through mother-to-child transmission and 6% through men who have sex with men.) UNAIDS estimates that infection rates among young women have been increasing by about 40% every year since 1999. The World Bank notes that reported new infections in adolescents have been doubling each year since 1995. HIV/AIDS prevention efforts in Jamaica are critically needed to stop the spread of the epidemic. According to UNAIDS, Jamaica is at a turning point, and if efforts are not expanded to effectively manage the epidemic, it could spread to crisis levels.

There are a number of HIV/AIDS risk factors in Jamaica, including early initiation into risky sexual activities among young people. (According to the World Bank, 41% of adolescent males and 10% of females age 12-14 reported sexual activity in 1996. Among those, only 29% of males and 35% of females reported last-time condom use with a non-regular partner. The median age of sexual initiation for males and females in 2000 was

14.) Multiple sexual partners, a culture which supports male promiscuity, gender inequality, and poverty also contribute to people's vulnerability to HIV/AIDS. In addition, there is a strong stigma and discrimination against people living with HIV/AIDS, making prevention and care efforts more difficult.

II. Formulating a Response to HIV/AIDS

JICA's HIV/AIDS Strategy

HIV/AIDS in developing countries is an issue of increasing importance to the Government of Japan and to JICA. Japan's Official Development Assistance in the health and medical care sector has grown from 15 billion yen in FY 1995 to 24 billion yen in FY1999. Over the same period, the number of trainees has grown from 1281 to 3154 and the number of experts dispatched from 478 to 553. JICA's cooperation in the health and medical sector increased from 13 billion yen in FY 1995 to 15.5 billion yen in FY 1999, with HIV/AIDS related issues being allocated 550 million yen. JICA's assistance on anti-HIV/AIDS measures has been primarily through technical cooperation, provision of equipment, and training.

As emphasized in JICA's *Approaches for Systematic Planning of Development Projects: Anti-HIV/AIDS Measures*, HIV/AIDS should be understood as not only a health and medical care problem, but also as a concern of both social and economic development. JICA's three development objectives in the field in general are: 1) prevention and control of HIV/AIDS, 2) care and support for people living with HIV/AIDS and their families, and 3) implementation of effective measures at the national level. JICA recognizes that "the prevention of HIV infection appears to be the most essential measure to reduce the rate of infection." This should include awareness activities for safe sex targeting high-risk groups (such as commercial sex workers, truck drivers, and sexually active youths); improving testing techniques and strengthening systems of early detection of HIV; and providing technical assistance for early diagnosis and early treatment for sexually transmitted infections that are closely related to HIV infections.[1]

While JICA has not developed a regional or country strategy as yet for addressing the HIV/AIDS epidemic in the Caribbean or Jamaica specifically, JICA recognizes the importance of activities in this area.

CARICOM Regional Plan of Action

The 1999-2004 *Caribbean Regional Strategic Plan of Action for HIV/AIDS* is being overseen by the Caribbean Task Force on HIV/AIDS under CARICOM's leadership. The final version of the plan, published in February 2000, includes six priority areas: 1) advocacy, policy development, and legislation; 2) care and support of people living with HIV/AIDS; 3) prevention of HIV transmission among young people; 4) prevention of HIV transmission among vulnerable populations (men who have sex with men, sex

[1] JICA, *Approaches for Systematic Planning of Development Projects: Anti-HIV/AIDS Measures*, May 2002, p.44.

workers, drug users, institutionalized populations, uniformed populations, and mobile populations); 5) prevention of mother-to-child HIV transmission; and 6) strengthening regional and national response capabilities. Strategic actions for preventing HIV transmission among young people include supporting the implementation of the Health and Family Life Education (HFLE) initiative, integrating HIV prevention into adolescent programs including reproductive health programs, promoting condom use, research and innovation in methodology, peer counseling, and sexual health education for youth in and out of school.

Government of Jamaica

The Government of Jamaica has been responsive early on to the HIV/AIDS epidemic. In the late 1980s, the Ministry of Health began a National HIV/AIDS/STI Program (NAP), and a National AIDS Committee (NAC) was established to advise the Ministry of Health and mobilize a response from various sectors of society. Under the NAC, 14 Parish AIDS Committees (PAC) were established to take charge of the community response in each parish in the country. The last NAP medium-term plan of 1997-2001 was recently superseded by the **HIV/AIDS National Strategic Plan (NSP)** (2002-2006), approved by the Parliament in June 2002.

While the medium-term plans achieved remarkable results, the 2002 NSP was designed to correct a number of shortcomings in the earlier plans. According to the World Bank, success of the earlier plans can be seen for example in the high HIV/AIDS awareness levels of the general public (96% of the adult population know at least 2 methods of HIV prevention), an increase in condom use with non-regular partners and a decrease in the proportion of people reporting non-regular partners, a marked decline in the number of reported syphilis cases, and a relatively safe blood supply. While earlier plans contributed to containing the epidemic, however, the number of AIDS cases and deaths has been increasing steadily in Jamaica and the epidemic is far from being stabilized or reverted.

According to an analysis conducted for the design of the NSP, **one key shortcoming of previous government strategies was the lack of a multisectoral response** and insufficient capacity building beyond the Ministry of Health. An expanded response to HIV/AIDS requires the active participation of actors who can engender behavior changes among the population, and the Ministry of Health can not do this by itself. Jamaica's NSP includes a multi-sectoral response taken by various government agencies as a priority outlines responsibilities of various agencies including the Ministry of Education, the National AIDS Committee (NAC), the Ministry of Tourism, the Ministry of National Security and Justice, and others.

Behavior change among high-risk and vulnerable groups is at the center of the NSP's prevention strategy. The analysis also identified the need for wider involvement at the highest levels of government, an increased focus of prevention efforts on marginalized high-risk groups, and strengthening the surveillance system to better understand the behaviors driving the epidemic.

III. Addressing HIV/AIDS in the (formal) education sector

The AIDS epidemic in the Caribbean region continues to expand despite over a decade of engagement. As CARICOM recently emphasized, a multi-sectoral approach, including several ministries, the private sector and NGOs is only beginning to emerge. Education has a central role to play in preventing HIV and reducing its deleterious effects (through the reduction of risk and vulnerability) by providing information and skills (especially to children and youth before they become sexually active) and reducing the impact on the teaching force.[2]

As Professor Michael Kelly and Professor Brendan Bain explain in their new book on *Education & HIV/AIDS: A Caribbean Strategy*, education plays a critical role in combating HIV/AIDS in three complementary ways. First, it helps remove the ignorance, poverty and female disempowerment that make people more vulnerable to HIV infection. Second, it increases the capacity of individuals to assimilate information, evaluate situations, and consider future benefits, thereby reducing the likelihood of their engaging in behavior that increases their risk of HIV infection. Third, it promotes the development of personal value systems and attitudes that, along with the necessary knowledge and skills, will help them avoid HIV infection.

As explained in the Joint Program Identification Study (JPIS) undertaken in April to May 2003 for the planned UNESCO/IDB/CARICOM Caribbean Education Sector HIV/AIDS Response Capacity Building Programme, most educators, health professionals, and parents see the HFLE Program as the vehicle for responding to the HIV/AIDS crisis in the education sector in the region as a whole. A number of weaknesses in the HFLE program, however, have been identified and need to be corrected in order to strengthen the response to HIV/AIDS through the education sector. The weaknesses and threats to the program's effectiveness across the region include the following:

1) The content of HFLE is extensive, making HIV/AIDS appear less urgent
2) It is difficult to teach "life-skills," which is not fact-based and depends on participatory approaches and specific teaching skills
3) HIV/AIDS and sexuality is not dealt with openly enough
4) The subject has low priority because it is not an examination/qualification subject
5) **Teacher training has not been effective**
6) There is sometimes opposition from churches and parents
7) **Youth have not been involved** directly and consistently in the content, planning and delivery of HIV/AIDS and sexuality components
8) **Students want confidentiality; they want 'outside' providers, not their own teachers.**
9) Interactive media are required, not merely talk.
10) **Many teachers are not comfortable dealing with sexuality with students.**
11) Education sectors (and civil service reform programs) are not actively considering recruitment and promotion issues for specialty teaching.

[2] CARICOM Secretariat Project Synopsis for "Caribbean Education Sector HIV/AIDS Response capacity Building Program."

Among the lessons learned:

1) The target group of **young people should be involved in the development, planning, implementation, evaluation and redesign of HIV/AIDS curricula** (as they can gain a broader perspective and are more likely to assume ownership of the problem and solutions).
2) **HIV/AIDS education should be part of a comprehensive health education program** preferably delivered in partnership with others within the school environment (such as teachers, school nurses, and counselors), and while maintaining close links with parents and the community at large.
3) For reasons of confidentiality, **sex education services are sometimes more effective if delivered by individuals other than a young person's own teacher**, whether in or out of school.
4) **Effective teaching methods for HIV/AIDS prevention are different from traditional teaching** and are based on participatory, interactive teaching and learning with open discussion, and using various media in order to engage students (e.g. stories, role playing, lectures, self tests).
5) Simple **monitoring and evaluation**, such as pre-tests and post-tests comparing behavior, skills, attitudes, and knowledge, **is necessary to assess the effectiveness of programs** in particular contexts.

Additional lessons learned in Jamaica:

Donors and others working in the HIV/AIDS field in Jamaica note several additional challenges and lessons learned for addressing the HIV/AIDS epidemic in Jamaica:

- There is insufficient access to HIV/AIDS specialty care and support.
- There is not an appropriate system to address discrimination and stigmatization.
- The infrastructure for systematically planning, conducting, and following up on training for health care professionals is weak.
- There needs to be more sex education in the classrooms.
- While knowledge about HIV/AIDS is quite high (according to surveys), people have not internalized this knowledge and changed their behavior.
- Youth need to be taught the skills to think carefully about what they are doing and how to make the best decisions. The focus of education should be on healthy lifestyle choices, not just AIDS specifically.
- Messages should remain constant and consistent and reinforce each other. Messages delivered in schools need to be reconfirmed from other sources in the community.
- AIDS needs to become normalized, and discussed openly in order to reduce stigma.
- Most teachers and guidance counselors are not comfortable talking about sex or AIDS.
- Youth often do not have anyone with whom to talk with openly about these issues, especially due to weak family structures.
- There is a lot of misinformation.
- Youth often hear different messages from peers and churches--they need to hear messages that are not at either extreme.
- The out-of-school program is not well developed.
- The Ministry of Health (MOH) has a limited number of staff for HIV/AIDS programs.
- Parish AIDS Committees need more capacity-building.

- Non-governmental organizations (NGOs) need more capacity-building.
- The MOEYC is not very good in data collection and monitoring and evaluation.
- There has not been adequate evaluation of the impact of HFLE.
- The HFLE program needs to be scaled up to be taught in all primary and secondary schools, but teachers are overburdened. Schools need people to come in and teach.
- There's not enough school-based education, so JICA's approach would fill a great gap.

Government of Jamaica HIV/AIDS Education Response

As emphasized by John Junor, Minister of Health of Jamaica, at the UN Special Session on HIV/AIDS in 2001, the Jamaican government believes prevention should be the primary response to the epidemic.

To date, the focus of the education sector response to HIV/AIDS in Jamaica has been the Health and Family Life Education (HLFE) Programme, managed by the Guidance and Counseling Unit, and focused mainly on adolescents. According to the JPIS, HFLE has been piloted and the full-time HIV/AIDS Coordinator in the Ministry of Education is the focal point, but there is a slow implementation period. There is no monitoring of youth exposure to HIV/AIDS in schools, no school policy [there is currently one under review], no inclusion of HIV/AIDS in teacher training, no parents-based activities, and no teaching materials for schools.

On the other hand, the JPIS notes that there are HIV/AIDS activities outside HFLE, community-based activities, international support for HIV/AIDS activities in schools, private commercial sector involvement, and KAPB surveys on youth sexual behavior. The Ministry of Education has good intentions to scale up its response and is collaborating on externally funded projects with the Ministry of Health. There is a great need to provide HIV prevention efforts with keeping kids off the (violent) streets, for example through centers that offer a place to meet counselors and use the Internet.

Until 2002, the **Government of Jamaica's response to HIV/AIDS** has been mainly through programs coordinated by the Ministry of Health. However, the National Strategic Plan for HIV/AIDS 2002-2006 demonstrates the government's strong commitment to address the epidemic through all sectors, including education. The Ministry of Education, Youth & Culture (MOEYC) recognizes that it must strengthen its capacity to implement major HIV/AIDS activities. With the creation of the position of National HIV/AIDS Coordinator in the MOEYC in December 2002 (funded by UNICEF), the MOEYC has developed a program for an expanded response to HIV/AIDS. The MOEYC is currently planning to scale up its activities at the central and regional levels with the assistance of the World Bank, UNICEF, UNESCO, and JICA.

Gaps in HIV/AIDS education specifically identified by the MOEYC include the following:
- **There are no programs for younger students**.
- **There are no programs for teachers' trainees in Teachers' Colleges** to teach about HIV/AIDS

- Classroom **teachers do not have the training or instructional materials** to be able to effectively deliver HIV/AIDS epidemic prevention and mitigation messages

The **Ministry of Education, Youth and Culture's HIV/AIDS Strategic Plan 2002-2007** has the aim of developing or expanding and managing a national program of HIV/AIDS/STIs awareness for the school age population (grades 1-11). The goals are: 1) to promote and sustain equity in all aspects of the school program, and 2) to empower the school community with the knowledge and skills to initiate and sustain healthy relationships and reduce its vulnerability to HIV/AIDS. The MOE's strategy has five objectives:

1) to regain the momentum of the HIV/AIDS/STIs component of the National HFLE program by 2005
2) to provide adequate training for teachers to ensure more effective delivery of HIV/AIDS/STI education in the school system
3) to provide appropriate resource materials and strategies to operate awareness and sustain the interest and participation of students in the teaching/learning process
4) to increase the capability of the MOEYC to develop and apply relevant policies to ensure the delivery of adequate HIV/AIDS/STI education.

Following are the components of the **MOEYC's Expanded Response to HIV/AIDS**:

1. Education Ministers retreat to discuss impact of HIV/AIDS on their division and encourage management support of response-8/03 (UNICEF)
2. (Endorsement and) dissemination of National HIV/AIDS Schools' Policy to all educational institutions (UNICEF)-9/03
3. Review and revision of HFLE program to increase its HIV/AIDS content (IBRD/World Bank HIV/AIDS Prevention & Control Project) [consultant needed to administer questionnaire to # of schools & create new policy document-9/03]
4. Production of HIV/AIDS materials for pre-primary, primary, and secondary schools (IBRD, WB) [consultant needed-distribution 1/04]
5. Establishment of HIV/AIDS workplace strategic plans and a policy document (IBRD/ WB)-1 & 6/03
6. Establishment of HIV/AIDS response team to strengthen education sector's response to HIV/AIDS nationwide (UNESCO Capacity Building Project -10/03)
7. Review of tertiary level curriculum to include HIV/AIDS education and production of materials for use by all (17) Teachers' and community Colleges and all (2) Literacy Centres (UNESCO)-10 & 11/03

<u>MOEYC request to JICA</u>

The assistance of Japan Overseas Cooperation Volunteers (JOCVs) is requested by the Ministry in order to help implement its expanded HIV/AIDS response program and to work with other donors (including UNDP, UNESCO, UNICEF, and the World Bank) in the implementation of their activities. The assistance of JOCVs is especially needed in the six MOEYC's regional offices, where there is limited capacity to implement the Ministry's HIV/AIDS program. The highest priority areas are those with the highest HIV

prevalence—Region 6 (including St. Catherine), Region 4 (St. James), and Region 3 (Ocho Rios). However, all regional offices need support.

Suggested placement:
-Senior volunteer to be based at HQ reporting to Chief Education Officer through the HIV/AIDS Coordinator and the Assistant Chief Education Officer.
-JOCVs to be posted in field, one in each of the six regional offices of MOEYC, reporting to the Regional Director through the Health Promotion Facilitator and Education Officer.

IV. Approaches/activities of other donors/NGOs (current & planned) in HIV/AIDS education sector in Jamaica

UN Agencies

UNESCO

The Caribbean Community Secretariat (CARICOM), the UNESCO Office for the Caribbean and the Inter-American Development Bank (IDB) jointly financed and conducted a Joint Programme Identification Study (JPIS) to prepare the **Plan of Operations for the Caribbean Education Sector HIV/AIDS Response Capacity Building Technical Cooperation Project** that is expected to be launched later in 2003 (pending approval from the Government of Japan). This Project will develop innovative approaches to strengthen the education sector in the short and long term in implementation of the national strategic plans on HIV/AIDS prevention, mitigation and care, and creating an enabling environment to support a much stronger role for education in combating AIDS.

The UNESCO Office for the Caribbean hosted the 2nd Caribbean Regional Consultation on the Education sector & HIV/AIDS in Jamaica on July 31, 2003. On October 29-31, 2003 in Trinidad, it will co-host with the Caribbean Association of Universities and Research Institutes (UNICA), the University of the West Indies St Augustine Campus (UWI) and UNESCO's International Institute for Educational Planning (IIEP), the first Caribbean Conference on Education and HIV/AIDS. The Conference theme is HIV/AIDS: The Power of Education. Over a dozen university Presidents from the Caribbean will attend.

Complementary to the Caribbean Technical Cooperation project, UNESCO is planning **bilateral assistance for three Caribbean countries most badly affected** by the HIV/AIDS epidemic: **Jamaica, Guyana and Suriname**. The projects are to be financed by the Government of Japan ($234,000) through its Fund-in-Trust for Human Resource Development managed by UNESCO, subject to Japan's formal approval.

Assistance to Jamaica and Guyana specifically target the role of education in fighting HIV/AIDS, and UNESCO will collaborate with Ministries of Education in all three countries.

As a result of UNESCO/Japan's assistance, the Ministry of Education, Youth & Culture will have a team of professionals at both central and regional levels to implement its national HIV/AIDS strategic priorities. UNESCO 's assistance is concentrating on human resource development in order to develop a strengthened base for long-term sustained and relevant responses to the epidemic in the education sector. Jamaica's coordinated HIV/AIDS response in the education sector will provide a model for other CARICOM countries.

UNESCO New Delhi has published a manual providing information on knowledge and development of attitudes, values, skills and practices related to the prevention and control of HIV/AIDS entitled "HIV/AIDS and Life Skills Education: A Manual for Teacher Educators." It includes sections on how to integrate HIV/AIDS preventive education within the curriculum; the use of learner-centered strategies, life skills techniques and media in HIV/AIDS preventive education; and **a**ssessment tools for use in HIV/AIDS preventive education.

UNESCO leads the UNAIDS Inter-Agency Task Team on HIV/AIDS and Education**.**

UNFPA

The overall goal of UNFPA's program in the Caribbean is to reduce poverty and improve quality of life of populations by promoting sexual and reproductive health and rights, gender equality and equity, and integrating population-related factors into development strategies and plans.

UNFPA is working on the CARICOM program for HIV/AIDS to strengthen communication messages for adolescents through peer education. They are using the performing arts as one means of disseminating messages, and also provide life skills counseling and a mobile outreach program. In Jamaica, UNFPA is working to strengthen commodity supply and to address vulnerable groups. They are also targeting vulnerable groups with support from the European Union. In coordination with UWI/HARP, they are working to develop curriculum on HIV/AIDS at the tertiary level.

UNFPA is now developing a new program for the Caribbean, including Jamaica, in coordination with the Ministry of Health. This program will include:
1) a focus on vulnerable youth in Jamaica to meet reproductive health needs
2) peer groups counseling to address drug use
3) commodity supplies
4) peer education in vulnerable areas

UNICEF

UNICEF's Jamaica country program uses an integrated approach to strengthen national, community, and family capacities to prevent HIV/AIDS infections and to care for children and adolescents affected by the epidemic. Focus areas are prevention of mother-to-child transmission, increasing access of young people to information, and care and support to children and adolescents infected or affected by HIV/AIDS.
In disseminating information to young people, UNICEF is working with the MOH, MOEYC, and NGOs. With the MOEYC, they supported the position of HIV/AIDS coordinator in the HQ (now supported by the Ministry) and are working on revising the content of the HFLE program to increase its focus on HIV/AIDS. UNICCEF is also working with the Behavior Change Communication program in the MOH producing materials for young people and using a participatory action approach.

UNICEF's global Right to Know Initiative is being implemented in Jamaica with 13 NGOs, and several multi-media participatory communication initiatives are underway. UNICEF has also designed adolescent-friendly materials with the participation of adolescents (for example, "10 Facts" about HIV/AIDS for Jamaican youth). In addition, UNICEF has expanded the Youth Information Center network and is supporting some training and computers for these Centers.

UNICEF has seen important results in areas such as: integrating the health and education agenda for early childhood development, broadening the HIV/AIDS response to a wider social context, expanding opportunities for meaningful adolescent participation at research, policy and program levels, and mainstreaming child rights on the national and sub-regional political agendas.

UNDP

UNDP chairs the UN Theme Group on HIV/AIDS and is working together with partners on possible advocacy, building national capacity, and public education activities.

UNDP completed a leadership development program in HIV/AIDS in the Caribbean, training people in the public and private sector and NGOs in countries with the highest incidence rates.

In Jamaica, UNDP worked with the Ministry of Health in developing a proposal to the Global Fund. They started discussions in the MOH in support of the World Bank's HIV/AIDS prevention control project, particularly the HIV/AIDS Demand-driven Subproject.

Through UN Volunteers, UNDP had a Greater Involvement of Persons with HIV/AIDS project.

U.S.: USAID & Peace Corps

USAID

USAID provided over $10 million in funding to the Government of Jamaica's Ministry of Health for HIV/AIDS prevention between 1998 and 2000. USAID remains the largest grantee to the Ministry of Health. In a project that will last through 2004, USAID has been providing $1 million a year to the Ministry of Health for HIV/AIDS activities in support of the National Strategic Plan. The grant focuses on strengthening four components of the NSP:

1) behavior change intervention and communication through targeted community interventions, media campaigns, public service announcements, and advocacy activities
2) capacity building initiatives (including training and conferences, support to non-governmental organizations, assistance to regional health authorities, salaries for voluntary counseling and testing, and purchase of supplies and commodities)
3) reducing the incidence and prevalence of sexually transmitted infections
4) improving surveillance

USAID is currently developing a new five-year HIV/AIDS strategy that will follow the 1999-2004 strategy. Under the new strategy, USAID will continue to work mainly with the Ministry of Health as well as non-governmental organizations. The three key areas of the new strategy will be: 1) improving the information base/data on the HIV/AIDS epidemic in Jamaica; 2) addressing HIV/AIDS through a multi-sectoral approach (including, for example, workplace prevention, anti-discrimination legislation, training people working in the tourist industry, improving primary school education in the 72 poorest performing schools, and grants to 12 NGOs to work on at-risk out of school youth); and 3) behavior change communication, focusing on service provision at the local level by enhancing NGO capacity.

In a program that will start in a few weeks, USAID is providing the MOEYC (central office) with technical assistance (hardware, software, and training) for a school assessment software program. USAID is interested in collecting other indicators such as lifestyle changes and the impact of its reproductive health and violence prevention programs.

Peace Corps

Peace Corps Volunteers in Jamaica work with community organizations in urban and rural areas to develop and strengthen programs such as after school sports, literacy, life skills, reproductive health and HIV/STD education and prevention.

The Peace Corps has been working on HIV/AIDS in Jamaica since 1995. The focus has been HIV education in mostly non-formal settings (such as community groups and churches), peer education—youth to youth, support for People Living With HIV/AIDS (PLWHA), prevention, and institutional strengthening. Most volunteers work with NGOs, including Jamaican AIDS Support (very fruitful) and CHARES. Currently there

is also one volunteer working with the MOH office in Mandeville and one working with the Parish AIDS Committee (under the MOH) in Portland.

Training program

The Peace Corps trains volunteers using a community-based approach, with local experts providing the training. Volunteers receive 2 weeks of training with the entire group of new volunteers (beginning in July) and another 5 weeks focused on the area in which they will be working (such as HIV/AIDS). All volunteers (currently 132), even those not working in HIV, will be trained in HIV 101 (about 6 hours during 1st week) and basic strategies to teach and talk to people. Volunteers working as HIV information providers (currently 11) will also get training materials including the Life Skills Manual (used worldwide). The contents of their training includes an introduction to the Ministry of Health program, an explanation of what NGOs (eg. CHARES & Jamaica AIDS Support) are doing in this field, Red Cross peer education training, ASHE teaching creative approaches to teaching HIV, 3 summer camps teaching about HIV to young people in the community, and meeting people living with HIV/AIDS. Jamaica AIDS Support provides the HIV/AIDS training. According to the Peace Corps, more volunteers are needed in this field.

The majority of Peace Corps Volunteers serving in health programs have a bachelor's degree (which can be in any discipline) and a strong interest in health, while some have degrees in a health-related area. Some have significant construction experience and an interest in water and sanitation.

Health Volunteers help at the grass-roots level, working with local governments, clinics, non-governmental organizations, and communities where the need is most urgent and the impact can be the greatest. Their efforts are concentrated on outreach, awareness, and prevention programs that teach public health, hygiene, and sanitation.

World Bank

In April 2002, the World Bank approved a $15 million loan to the Government of Jamaica to fight HIV/AIDS. The project is expected to last 5 years (ending Dec. 2006) and has three components: 1) curbing the spread of the HIV/AIDS epidemic by scaling up preventive programs targeted to high-risk groups, and expanding awareness of HIV/AIDS among the general population; 2) improving treatment, care, and support; and 3) strengthening Jamaica's multisectoral capacity to respond to the epidemic. Forty-seven percent of the loan ($7.82 million) is focused on preventive programs (project component 1).

The prevention component of the project will support scaling up of six areas of intervention: 1) Behavior Change Communication (BCC), 2) Voluntary Counseling and Testing (VCT), 3) Condom social marketing programs, 4) Syndromic management of STI, 5) Prevention of mother-to-child transmission of HIV; and 6) Strengthening the capacity of the blood bank to provide safe blood. It will target high-prevalence groups

such as commercial sex workers, men who have sex with men, people with a history of STIs, and prisoners. The project also targets the young, especially out-of-school youths.

Activities for targeting high-risk groups are of two kinds: 1) identifying high-risk groups; and 2) providing BCC, VCT, condoms, and STI management to high-risk groups. The broad-based program for young people as well as the general community includes, *inter alia*, mass media awareness campaigns, training of peer educators to provide peer education with gender-sensitive messages, training of teachers and counselors, condom promotion and increased condom availability in traditional and nontraditional outlets, and targeted community campaigns in high prevalence areas.

The project contributes to the objectives of the National Strategic Plan (NSP) and therefore shares the same impact and outcome indicators of the NSP. (Emphasis is placed on outcome indicators because improvements in the impact indicators are likely to be marginal in only 5 years). Among other indicators, the World Bank uses the KAPB Survey for the majority of knowledge, attitudes, and behavioral indicators required by the project, as well as Behavioral Surveillance Surveys. The World Bank will conduct a mid-term review in June 2004 in partnership with other external partners (PAHO/WHO, UNAIDS, USAID, CAREC).

PAHO/WHO

PAHO has been providing technical cooperation to the Ministry of Health (MOH) as well as support for local NGOs. They spent $50,000 US for 2 years for the HIV/AIDS sector. Their support of the MOH has included help in the development of the National Strategic Plan, support for the purchase of kits for mother-to-child HIV/AIDS screening, and printing of health education materials for prevention. In the next year, PAHO intends to continue working with the MOH in health education in HIV/AIDS, including development of materials for the general population, working with NGOs that address high-risk groups, and providing training curricula to NGOs.

University of the West Indies (UWI)/HIV/AIDS Response Programme (HARP)

UWI is the largest university in the region, with campuses in Jamaica, Barbados, and Trinidad & Tobago. HARP was established in 2001 as a multidisciplinary team with task forces on each campus. Their mission is to build and harness the capacity within the university to contribute maximally to the national, regional, and international effort to control the HIV/AIDS epidemic and mitigate the impact of HIV/AIDS on the university and the society at large. Activities include research, teacher training, updating the HIV/AIDS policy for the university, curriculum review and development, and social marketing.

UWI/HARP's Educational Action Plan includes curriculum development for sensitization and training for staff and students and training and capacity building in HIV/AIDS, and

stimulating and sustaining behavior change through the education sector. Professor Brendan Bain, chairman of UWI HARP, is in the forefront of mobilizing the education sector against HIV/AIDS and is collaborating with UNESCO. UWI/HARP also manages the UWI component of the CARICOM/EU Strengthening Institutional Response to HIV/AIDS project (SIRHASC) and is active in the Pan-Caribbean Partnership Against AIDS.

IDB

IDB's 2000-2003 Operational Strategy for Jamaica focuses on five main areas with an estimated total loan amount of US$407.5 million: (1) financial sector restructuring and reform, (2) private sector development, (3) public sector modernization, (4) social development, promoting accessibility of social services, better management and efficiency, and (5) environmental management. Support for the social sectors focuses on basic, primary and post secondary education, reform of the social safety net, youth training and citizen safety and justice reform.

IDB is providing technical cooperation to the Ministry of Health in the field of HIV/AIDS through the Japan Special Fund (to be completed in May 2004). Activities include a lab information system (pilot project) and medical and home-based care manuals.

IDB is also working with CARICOM and UNESCO on the regional Capacity-Building Project for the Caribbean.

In partnership wit h the MOEYC and in cooperation with UNICEF, IDB's loan is also supporting work with the National Center for Youth Development (MOEYC) and youth organizations in training Youth Empowerment Officers (to be placed at the Youth Information Centers) and the expansion of the Youth Information Centers.

NGOs:

Several NGOs in Jamaica have been active for many years in HIV/AIDS prevention and care and are widely recognized to be filling important needs in the community. They have all received funding in the past from other bilateral donors, either directly or through the Ministry of Health. However, they are all in continuous need of additional support.

These NGOs include the Jamaica AIDS Support (JAS), the Center for HIV/AIDS Research, Education and Services (CHARES), the Jamaican Network of Seropositives (JN+), and ASHE.

Jamaica Aids Support provides home-based care, public education (including lectures to schools and public sector bodies), targeted interventions to specific high-risk groups,

workshops in the prisons, support services for people living with or affected by HIV/AIDS (including counseling, support groups, and an income generation program), and free HIV testing.

CHARES, at the University Hospital of the West Indies, provides medical care, social services including counseling, nutritional information, HIV/AIDS prevention and awareness educational workshops, training programs (for home based care, volunteer training, peer support, and support group facilitation), occupational guidance, a program for adolescents with parents who are HIV positive, home based care, research, assistance for school needs, and assistance for funeral arrangements.

JN+ is unique in that it is run by people living with HIV/AIDS (PLWHA) or people affected by AIDS. The organization is run almost entirely by local volunteers. Their focus is on offering support groups around the country to PLWHA, empowering PLWHA to demand services (which they are not getting due to stigma and discrimination), and advocating for anti-discrimination legislation.

ASHE uses performing arts to creatively deliver messages to youth and the general population regarding HIV/AIDS.

<u>Additional needs identified by various sources</u>:
-Need better information and data collection
-Need a better surveillance system
-Need capacity-building for NGOs to be able to provide care and support services
-Need to address sexual abuse and violence to reduce HIV
-Need to work both in and out of schools to address high-risk youth
-Need to improve care and counseling
-Need better availability of treatment
-Need to distribute information more openly and make preventive measures more accessible to youth
-Parish AIDS Committees could use volunteers to travel between parishes and assist committees in capacity-building
-The MOEYC's Youth Information Centers need more funding. (IDB has done some studies on strengthening these centers. Three have opened so far. It is hoped that there will be one or two in each of the 14 parishes.)
- Need more coordination between MOEYC and MOH
- Need a forum for volunteers to meet

V. JICA's HIV/AIDS Prevention Education Strategy

Purpose: **To reduce HIV/AIDS prevalence in Jamaica through HIV/AIDS prevention education activities targeted at the adolescent population through the formal education sector.**

The Government of Jamaica has recognized that the HIV/AIDS epidemic needs to be addressed as more than a health concern. The MOEYC has requested JICA's support to enhance the response to the HIV/AIDS epidemic in the education sector. With primary enrollment rates among the highest in the region, schools may be one of the most effective points of access to youth.

JICA's advantages:
- JICA can send junior and senior volunteers who have various kinds of skills to tackle HIV/AIDS: e.g. rural development, social work, nursing, statistics, computer science, youth activities, primary school teaching, communication technology, etc. We recruit volunteers based on specific needs identified.
- Low drop out rates: most volunteers complete the assigned period, usually two years.

JICA Jamaica & JOCVs
- JICA Jamaica's budget is approximately $5-6 million/year for technical cooperation and $1 million for provision of equipment and materials.
- JICA Jamaica has had 180 volunteers since 1989 and currently has 38 JOCV; approximately 10-17 new volunteers arrive each year.

Overall goals:
- To support the National Strategic Plan (2002-2006) of Ministry of Health, especially by using a multi-sectoral approach, as HIV/AIDS can not be stopped through health sector alone
- To reduce HIV/AIDS prevalence among adolescents, one of highest risk groups (young people age 15-19 have highest HIV rates in Jamaica, and HIV/AIDS & STIs are leading causes of death for women age 20-29)
- To reduce the stigma against HIV/AIDS (AIDS mortality rate in Jamaica is about 61% due to delayed diagnosis and lack of treatment and care)
- To change adolescent behaviors that increase the risk of HIV/AIDS
    - to delay age of 1st sex
    - to increase condom use
    - to decrease number of partners
    - to empower girls
    - to reduce HIV/AIDS stigma

What JICA will do:
- Help fill the gap in addressing HIV/AIDS in the education sector by supporting the MOEYC's new HIV/AIDS Strategic Plan (2002-2007) in cooperation with other donors (such as UNESCO and UNICEF).

Specific objectives for JICA's cooperation with the MOEYC:
- To develop the capacity of the MOEYC to improve HIV/AIDS education in primary, secondary, and tertiary schools.
- To strengthen the commitment and understanding about HIV/AIDS among all education officers and school administrators.
- To improve the curriculum for teaching students about HIV/AIDS and life skills.
- To enhance the ability and effectiveness of teachers to teach about HIV/AIDS.

STRATEGY (1st Stage):
JICA will work first with the MOEYC to develop their capacity in the formal education sector (primary and secondary education), where the most adolescents can be reached (both before and after their sexual initiation) by sending junior and senior volunteers.
- Budget: US$ 0.5 million for 6 JOCVs and 1 Senior Volunteer

- In April 2004, JICA will send a Senior Volunteer (SV) to the HQ of the MOEYC.
  - The SV (to be recruited as a "Program Manager") will work with the HIV/AIDS Response Coordinator in the MOEYC to coordinate HIV/AIDS activities under the MOEYC's Strategic Plan. The SV will also serve as a coordinator of the 6 JOCVs who will be posted at the MOEYC's Regional Offices several months later.
  - We expect the SV to have working experience in education sector (e.g. school teacher, school inspector, educational administrator) and a very good command of English (preferably more than 2 years of working or studying experience in English speaking countries).

- In summer 2004, we will send 1 JOCV (Japan Overseas Cooperation Volunteers) to each of the 6 regional MOEYC education offices for 2 years
  - The JOCVs will work directly with the Health Promotion Facilitator in each Regional Office (to be locally recruited by UNESCO soon) and with the Regional Guidance Officers to strengthen the capacity of 288 education officers to efficiently and effectively address HIV/AIDS in the education sector and begin to work on revision of HFLE curriculum. They will enhance the IT skills of education officers and provide assistance in preparing messages and materials to be delivered in workshops targeting school principals, school board chairmen, and guidance counselors.
  - We hope to find JOCVs with a background in education or health as well as basic management and coordination skills, computer skills and communication and presentation skills. Since we have many potential specialized volunteers with expertise in specific fields, we may take full advantage of their capacity by recruiting 6 JOCVs wit h different skills and background that complement each other and the new health promotion facilitators (e.g. elementary school teacher, community nurse, community nutritionist, public health specialist, youth activities specialist, and audiovisual specialist). A good command of English is a prerequisite in the recruitment of JOCVs (preferably more than 2 years of working or studying experience in English speaking countries).

- We expect the 6 JOCVs and 1 SV to work as a team both in their region with their local counterparts and other aid workers like US Peace Corps volunteers, and in cooperation with the other JOCVs to share skills, information, materials, approaches, and best practices.

- **Primary beneficiaries**: 288 education officers in 6 Regional Education offices
- **Secondary beneficiaries in phase 1** of MOEYC's strategy: PTA Presidents, School Board chairpersons, principals, and guidance counselors in 306 primary, secondary, tertiary, and all-age schools in Jamaica (approximately 1/3 of total number of schools) in phase 1 of MOEYC's strategy
- **Secondary beneficiaries in phase 2** of MOEYC's strategy: Teachers and students in up to 1000 primary, secondary, and tertiary schools (initial focus still to be decided)

- **Monitoring and Evaluation:** Pre and post evaluations of beneficiaries will be necessary to measure how their practical knowledge, skills, and attitudes changed as a result of the activities of volunteers. Since it will be difficult to measure results of capacity development in the 1st phase, most donors are not using quantitative indicators to measure their impact, and outcome results will take a lot of time, process evaluations will be used instead, such as the number of workshops held and the number of people trained. In the second phase of the MOEYC's strategy, in which teachers and students will be the direct target, JOCVs may be able to support statistical analysis or data collection and can use the surveys conducted by the Ministry of Health to measure attitudes and behavior change.

Risks and possible solutions:

(1) The JOCVs and SV may have a health background but will require further training in HIV/AIDS

-JICA may encourage their own on the job training, ask the HIV/AIDS committee of JICA HQ to provide instruction, and/or request participation in the training course provided by the US Peace Corps to its volunteers.
- JICA may seek to use training materials already in use by organizations such as Jamaica AIDS Support and the Peace Corps

(2) The JOCVs and SV often lack sufficient English proficiency.

- JICA may hire people who have more than 2 years working or studying experience in English speaking countries
- JICA will encourage volunteers to communicate more with local people and foreign aid workers like the US Peace Corps not only in the office but through social activities
- JICA may request JOCV participation in part of in-country training or orientation course of US Peace Corps.
- JICA will consider organizing occasional forums- retreats, workshops, or other events- to bring all volunteers together to share experiences in the field and/or to bring all volunteers working in the health field and HIV/AIDS together.

(3) Need to ensure continued commitment to HIV/AIDS by MOEYC and improved coordination with the MOH

-Encourage JOCV or MOE staff to join periodic meetings of National Aids Committee education subcommittee and to share information and resources with MOH and other organizations and institutions at HQ and regional levels working on HIV/AIDS (including the UN Theme Group).

(4) Need to decrease the burden on teachers and increase the efficient use of available materials and resources for helping students better understand the risks of HIV/AIDS

- Encourage SV to build stronger links between MOE and active and experienced NGOs such as Jamaica AIDS Support, JN+, and ASHE to expand and organize a program of guest speakers from these organizations to deliver lectures to classes. (This is already done on an ad-hoc basis, although sometimes without payment for services provided by the NGOs.)
- Work with peer leaders in developing and delivering messages to encourage the participation of youth and maximize the impact of messages on behavior.
- Support teacher training initiatives and development of teaching materials.

STRATEGY (2nd Stage):

Besides sending the above-mentioned 6 JOCVs and the SV from next summer for 2 years, JICA will consider the following in the HIV/AIDS sector:

1. Summer 2006- If the JOCVs and SV work has been effective, JICA may **send successor JOCVs to MOEYC's regional offices and successor SV to HQ** in order to continue support and implementation of 2nd phase of their preventive education strategy, focused directly on school teachers and students.

2. In order **to address both in-school and out-of-school children**, JICA may **send volunteers with education/health sector expertise** (for example, nursing, primary school education, youth activities, or IT/communication) **to non-governmental organizations (NGOs) or youth information centers** of the MOEYC in order to support the HIV/AIDS education strategy from both inside and outside MOE.

Their purpose would be to improve the content and delivery of life skills and HIV/AIDS curriculum, strengthen the delivery of services, enhance the capacity of NGOs, provide health advice and information to students, and develop creative messages to youth both in school and those who have dropped out.

3. While focusing on preventive education, in order **to address care and treatment** for children and/or parents living with HIV/AIDS, JICA may send volunteers with background as social worker, education/health sector specialist, IT/communication specialist, or statistics specialist to **support the activities of NGOs** (e.g. JN +, Jamaica Aids Support, CHARES, etc). Jamaica has the 3rd largest population of people living with AIDS in the Caribbean and a 61% mortality rate. Due to stigma and lack of resources, many people do not get the care and treatment they need.

4. JICA will share experience and lessons learned here with other CARICOM countries as they develop their own approaches to HIV/AIDS in the education sector.

We can also support Jamaican's sharing of knowledge and experience with other countries in the region through our third country training or third country experts programs. (There are JOCV offices in Belize, St. Lucia, St. Vincent, and Dominica, and JICA can launch HIV/AIDS preventive education activities in these 4 countries now, and may be able to expand to other countries.)

5. In addition, JICA may consult with the Embassy of Japan regarding the possibilities of the following activities:

(a) Sending experts/consultants with education or health sector expertise to MOEYC HQ in order to strengthen and expand the MOEYC's HIV/AIDS related activities.

(b) Providing grassroots grants to NGOs (e.g. to support NGOs such as JN+ to increase capacity to provide care and support to people living with AIDS).