Running head: EVALUTION GIPA CAPACITY BUILDING PROGRAMME

A Process Evaluation of the

Capacity Building Programme

as administered by the

GIPA Unit of the National HIV/STI Programme .

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ACRONYMS

EEHR	Enabling Environment and Human Rights
GIPA	Greater Involvement of People Living with HIV
GNP+	Global Network of Seropositives
HIV	Human Immunodeficiency Virus
HPP	Health Policy Project
JABCHA	Jamaica Business Council of HIV/AIDS
JN+	Jamaica Network of Seropositives
MOU	Memorandum of Understanding
NERHA	North East Regional Health Authority
NFPB	Natonal Family Planning Board
NHDRRS	National HIV-Related Discrimination Report and Redress System
NHP	National HIV/STI Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PLHIV	Persons Living with HIV
SERHA	South East Regional Health Authority
SRHA	Southern Regional Health Authority
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
WRHA	Western Regional Health Authority

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Background

Historically, efforts to prevent human immunodeficiency virus (HIV) infection have focused on reducing HIV infection risk among individuals with HIV negative (HIV−) or unknown serostatus (Kennedy, Medley, Sweat, & O'Reilly, 2010). Notably, there has been significant shortcomings of prevention approaches focusing on individuals living with HIV that have tended to treat them primarily as potential vectors of new infections rather than as individuals with complex and competing needs and desires (GNP+ & UNAIDS, 2011). People living with HIV (PLHIV) have always been powerful and passionate advocates for HIV prevention but relatively few policies and programmes have adequately supported people who have tested HIV-positive in their desire to prevent new HIV infections.

In April 2009, an international technical consultation on HIV prevention for people living with HIV took place in Tunisia (GNP+ & UNAIDS, 2009). Participants, more than half of whom were living with HIV, represented networks of people living with HIV, civil society, government agencies, UNAIDS Secretariat and cosponsors, international donors and development agencies.

It was agreed that the focus of current approaches was too limited and should be replaced by a broader, more holistic and interconnected human rights-based approach (GNP+ & UNAIDS, 2009). Participants agreed that policies and programmes that:

- are designed and implemented with the meaningful involvement of people living with HIV,
- treat people living with HIV humanely and with dignity,
- provide people with knowledge, skills, social and legal support, and
- focus on the holistic health and related needs of people living with HIV,

are more likely to be accepted and implemented, and will be more effective than existing programmes that narrowly focus on preventing new infections (GNP+ & UNAIDS, 2013). Such policies and programmes will also help to reduce HIV-related stigma and discrimination, resulting in numerous beneficial effects for people living with HIV, their partners, families, and communities.

Positive Health, Dignity and Prevention (PHDP) is not just a new name for the concept of HIV prevention for and by people living with HIV (GNP+ & UNAIDS, 2013). Rather, Positive Health, Dignity and Prevention is built on a broader basis that includes improving and maintaining the dignity of the individual living with HIV, to support and enhance that individual's physical, mental, emotional and sexual health, and which, in turn, among other benefits, creates an enabling environment that will reduce the likelihood of new HIV infections.

Positive Health, Dignity and Prevention encompasses the full range of health and social justice issues for people living with HIV, and espouses the fundamental principles that responsibility for HIV prevention should be shared, and that policies and programmes for people living with HIV should be designed and implemented with the meaningful involvement of people living with HIV (GNP+ & UNAIDS, 2013).

Strategy Components

Operationalizing Positive Health, Dignity and Prevention is not about creating new programmes, except where basic programmes currently do not exist. Rather, it is about using this new framework to create linkages among existing programmes and also taking them to scale, so that they are more efficient and more responsive to the needs of people living with HIV. Individual programmatic elements will inevitably differ from setting to setting according to local contexts.

Programmatic components of Positive Health, Dignity and Prevention fall under the following eight thematic areas:

- empowerment,
- gender equality,
- health promotion and access,
- human rights,
- prevention of new infections,
- sexual and reproductive health and rights,
- social and economic support, and
- measuring impact.

The Greater Involvement of People Living with HIV (GIPA)

According to the Joint United Nations Program on HIV/AIDS Deficiency Syndrome (UNAIDS, 2007) in a policy brief, GIPA is a principle that aims to realize the rights and responsibilities of people living with HIV, including their rights to self-determination and participation in decision-making processes that affect their lives. The brief further explains that people living with HIV have directly experienced the factors that make individuals and communities vulnerable to HIV infection, and their involvement in programme development and implementation and policy-making will improve the relevance, acceptability and effectiveness of programmes.

The GIPA Unit

A significant activity at the National HIV/STI Programme (NHP) was the establishment of a desk during December 2008 to support the Greater Involvement of People Living with HIV and AIDS (GIPA) and their integration into the national HIV/AIDS response (UNGASS, 2010). A Person living with HIV was hired as a GIPA Coordinator to manage the process under the Enabling Environment and Human Rights Component (See figure 1).

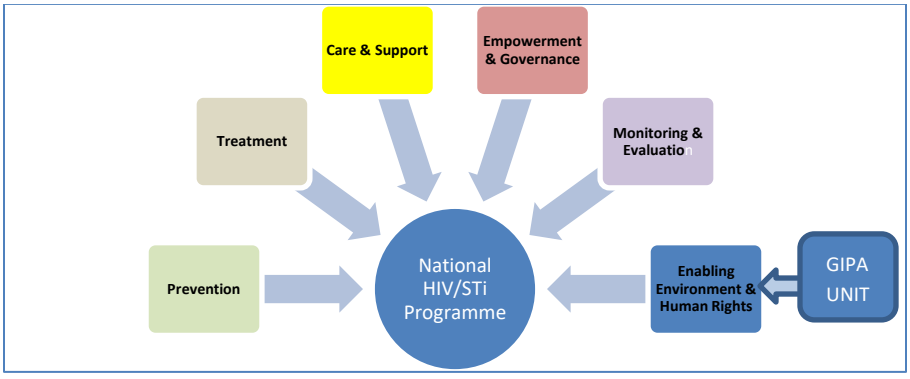


Figure 1: Depiction of GIPA Unit in relation to the NHP

The core function of the Officer includes administration, implementation and coordination of the GIPA Capacity Building Programme.

The sub-project operates on four main levels:

1. To expand the participation of PLHIV in existing interventions on request such as workshops in the workplace programme by delivering sessions on Basic HIV/AIDS Facts, GIPA and the National HIV Related Discrimination Report and Redress System (NHDRRS);
2. To participate on special committees and panels representing the people living with HIV/AIDS (PLHIV) community on request;
3. To coordinate the selection, sensitization and training of 20 PLHIV per year for their greater involvement in risk reduction and HIV-related discrimination reduction interventions (the GIPA Unit Capacity Building Programme).
4. To assist the Jamaican Network of Seropositives (JN+) and the National HIV Related Discrimination Reporting and Redress System (NHDRRS) through active participation in selected interventions.

By the end of 2009, the PLHIV community was represented on interview panels for the selection of consultants and officers; and on special committees such as the Interim Investigation Team for the National HIV-Related Discrimination Reporting and Redress System (UNGASS, 2010). The GIPA Coordinator is an active participant in numerous sensitization and training sessions for the private and public sectors and for faith-based organizations. The Coordinator also coordinates the selection of a cadre of PLHIV for a needs assessment study to be followed by sensitization and training for their greater involvement in the national HIV/AIDS response.

The PHDP Curriculum

The Jamaica Network of Seropositives (JN+) with support from the Jamaican Ministry of Health's National HIV/STI Program (NHP-GIPA Unit); the USAID; and the President's Emergency Plan for AIDS Relief (PEPFAR) funded Health Policy Project, created a capacity-building curriculum led by people living with HIV (UNGASS, 2010). The curriculum is based on the Positive Health, Dignity and Prevention (PHDP) strategy's operational guidelines as developed by the Global Network of PLWHA (See Figure 2).

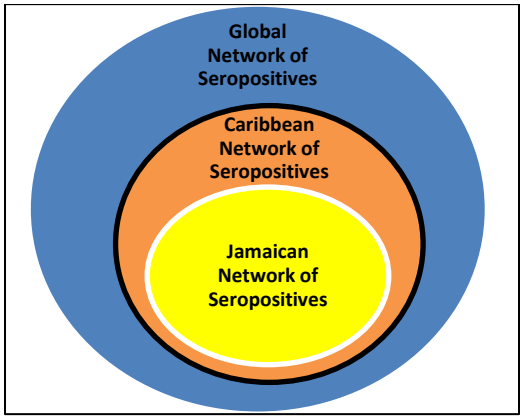


Figure 2: Regional levels of the Seropositive Network

The curriculum aims to implement and advocate for Positive Health, Dignity, and Prevention and promote community leadership at the country level, by training leaders to advocate and educate communities to reduce HIV-related stigma and discrimination, including gender-based violence. The curriculum consists of fourteen (14) modules, and topics include; HIV basics, framework for PHDP, stigma and discrimination, sexual and reproductive rights, gender, sexuality, sexual diversity, disclosure issues, positive health and health promotion, loss and grief, continuum of care, advocacy, combination prevention, and self-care. Of note, as reported by the GIPA Unit Coordinator, the PHDP curriculum has not yet been published.

The GIPA Capacity Building Programme

As explained by Mr. Ainsley Reid, Coordinator of the GIPA Unit, "the Capacity Building Programme is a mechanism to raise the level of awareness and improve the skills for effective and meaningful involvement and community leadership in the HIV response." The approach that the GIPA Capacity Building Programme has been using over the past six years is informed by the GIPA Conceptual Framework which highlights its reason for being (See figure 3).

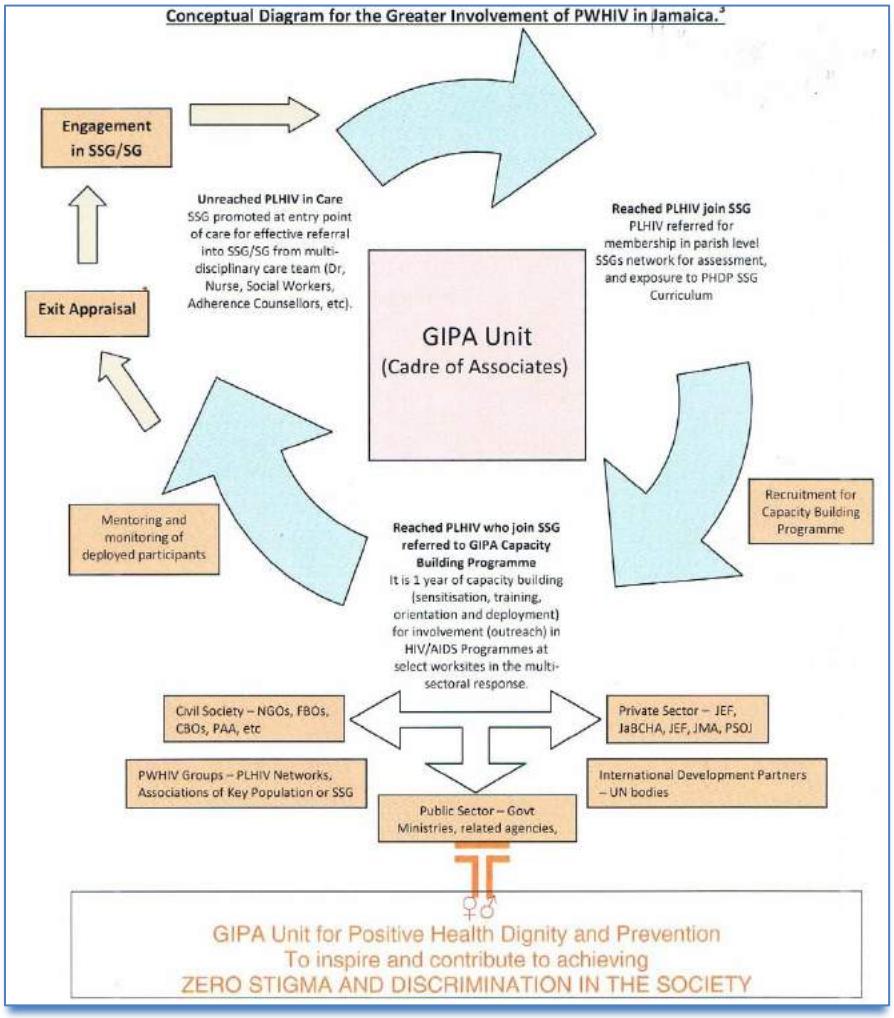


Figure 3: Conceptual Diagram for GIPA in Jamaica. (Source: Annual Report of the GIPA Unit, 2014).

The GIPA Capacity Building Programme is supported by the PHDP Curriculum and has so far completed the training of two cohorts. The programme has three phases:

- *Phase one*: an outreach to the community;

- *Phase two*: facilitation of the PHDP Curriculum; and
- *Phase three*: the Skills Transfer Workshop.

Cohort 1 was the developmental phase of the curriculum, whereas cohort 2 was the testing phase of the curriculum. Between both cohorts a total of fifty-four people have participated in the GIPA Capacity Building Programme. A module addressing "Treatment" is currently being developed to coincide with the training session for Cohort 3. Funding for the Capacity Building programme has been acquired from the Global Fund, the Health Policy Project (HPP), and PEPFAR through partnerships with JN+ and the National Family Planning Board.

The priorities relating to the GIPA Capacity Building Programme includes Officers leading the following interventions as part of the suite of initiatives of the Enabling Environment and Human Rights (EEHR) components:

- development of PHDP,
- GIPA Capacity Building Programme,
- PHDP with Key Population (MSM) Initiative, and
- representation of PLHIV community on decision making bodies (GIPA Annual Report, 2014).

Recruitment

Participants are HIV-infected adults recruited from HIV treatment sites throughout the island, and are referred by contact investigators, medical officers, nurses, social workers, or an adherence counsellor. To participate, the candidate must have a minimum of one subject at the secondary education level. During the outreach to the community, potential candidates submit a completed application form along with other particulars, such as a pass-port size photograph; Tax Return Number (TRN) and National Insurance Scheme (NIS) cards; and certificates

verifying their academic achievements. There is also an orientation where the programme objectives are explained, and the experiences of former participants of the programme are shared with the new applicants. It is also an opportunity for the programme administrators to examine and assess the attitudes and team work ability of potential programme candidates, and address concerns related to disclosure. NHP-GIPA Officers interview the potential candidates, and a maximum of twenty individuals per cohort are selected for the GIPA Capacity Building Programme.

Facilitation of the PHDP Curriculum

The Capacity Building Programme is six months to one year of sensitization and training. Each cohort in this programme participate as a leadership group to build in-depth knowledge about HIV; unpack root causes of stigma, discrimination and gender-based violence; and grow skills and confidence to be able to strengthen their leadership in the spaces where they are active (UNGASS, 2010). The modules are facilitated during a series of fourteen workshops at varying locations throughout the island. Methods of facilitation include: presentations, interactive exercises and group discussions.

Skills Transfer Workshop

After the workshops that facilitate the PHDP curriculum are completed, participants attend a four-day Skills Transfer workshop. Participants are required to give a presentation on a risk behavior of their choice, with the goal to apply the trans-theoretical model (TTM) to describe the potential for change process. Each presentation is assigned a score.

Pre-Deployment

GIPA Capacity Building Programme participants selected for deployment and their invited family members attend the pre-deployment session. During this meeting participants are

given the opportunity to reflect on aspects of behavior that reduce the risks for HIV transmission and their capacity for self-care before attending the workshops, and how their knowledge and capacity for self-management has developed at the programme's conclusion.

Deployment

There are three types of outcomes for participants in the programme:

1. Individual does not display willingness to deal with disclosure issues.
2. Individual wants to use the information within the context of PLHIV in their communities, such as support groups.
3. Individual is deployed to various sectors, such as civil society organization, private sector, and government agencies.

As funding permits, a minimum of four participants who score the highest based on their presentation are offered deployment opportunities. In addition to having at least one subject at the secondary school level, they must be available for deployment and have an appreciable comfort level with disclosure issues. These individuals are now called *Community Facilitators* and mentorship and support continues to be provided to them by the GIPA Coordinator post deployment (See figure 4). Of note, Community Facilitators function in a voluntary capacity and are compensated for personal expenses with a stipend of JA$2812.50 per session, or JA$5625 per week.

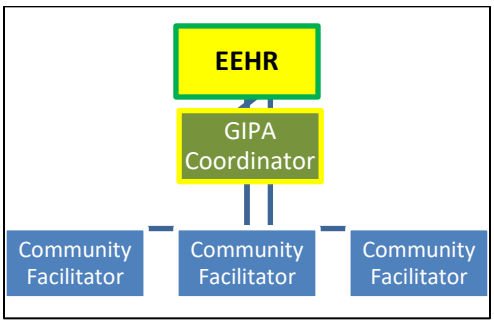


Figure 4: GIPA Capacity Building Programme Administrative Hierarchy

The Community Facilitators are required to conduct at least two sessions per week, consisting of a minimum of five participants. Reports related to their activities must be submitted fortnightly.

Focal Points for Deployment

As noted, Community Facilitators have been deployed to various public and private agencies. With respect to Cohort one, two Community Facilitators were deployed to the Jamaica Business Council on HIV/AIDS (JABCHA), a non-governmental organization; and two Community Facilitators were deployed to the Ministry of Labour. Individuals from cohort two have also been placed. Two Community Facilitators were sent to the Western Regional Health Authority (WRHA) ---Cornwall Regional Hospital and the Westmoreland Health Centre; one has been placed at the Comprehensive Health Clinic in Kingston, and one is pending placement within the North East Regional Health Authority (NERHA). According to the GIPA Annual Report (2014), Community Facilitators work alongside healthcare providers to reach PLHIV. They provide emotional support; assist with interventionists to reach key affected populations, and facilitate support groups for PLHIV using the activities from the PHDP curriculum.

Evaluation Questions

This evaluation was conducted by the Monitoring and Evaluation Unit of the National Family Planning Board, and serves to answer the following questions:

1. What aspect of operations related to the recruitment and training of participants can be improved?
2. How does the curriculum facilitate implementation of the Positive Health, Dignity and Prevention Strategy?
3. Is the current model for the Capacity Building Programme sustainable in the Jamaican context?

Method

Respondents

A total of 54 individuals have participated in the GIPA Unit Capacity Building Programme since its inception. As this is a small population, convenience versus randomization with respect to sampling was preferred. The decision was made to compile a list of at least thirty programme participants for invitation to participate in this evaluative survey, with a projection that the total number surveyed would be twenty individuals or more.

Study Design

To collect data relevant to answering key questions a cross-sectional study approach was employed. Much of the data is of a qualitative nature, consequently, proportions or frequencies will be calculated for relevant variables, and cross tabulations conducted to identify possible relationships.

Instrument #1

An Interviewer-administered questionnaire consisting of thirty-three questions relevant to collection of data (Appendix A) was developed consistent with the evaluation questions. This instrument was administered to the programme participants (respondents) by the evaluator during scheduled interviews, and aimed to answer questions related to the general characteristics of the programme participants, effectiveness of the PHDP Curriculum as an education tool, and identify potential problems or concerns related to the operations of the programme (See Table 1).

Instrument #2

A second structured questionnaire consisting of twelve questions was also developed to assist in answering the research questions (Appendix B), but most importantly to assess the effectiveness of deployed participants working in select Focal Points (deployment sites). This instrument was relayed by electronic mail to supervisors of Community Facilitators for their individual responses.

Procedure

Potential respondents for this evaluation were contacted via phone by the Deputy GIPA Coordinator. The initially planned approach was to use a speaker phone during initial contact, with the programme evaluator assisting, in order to explain the purpose of the evaluation and obtain the participants' verbal consent. Unfortunately, preceding events were not accommodating. Consequently, it was left solely to the Deputy Coordinator to contact all potential respondents, inform them an evaluation of the Capacity Building Programme was underway, and then inquire of their interest and availability to participate in the evaluation process.

Of the thirty listed individuals, the Deputy Coordinator of the GIPA Unit was unable to contact twelve as the phone service for four individuals was "out of service," and messages

delivered via voice mail to eight individuals did not elicit a response. Of the eighteen individuals contacted directly, one declined to participate in the survey; one was reportedly ill; and three were unavailable to participate in the evaluation due to employment obligations.

The process of contacting potential respondents was carried-out within forty-eight hours before the initiation of the data collection period; a possible factor contributory to the small sample size. Respondents were scheduled for interviews on specific days of the week as influenced by the region they reside. The data collection period was organized over a three-day period, beginning March 2, 2015 and concluded on March 4, 2015. The venues for interviews were as follows:

- *NFPB Conference Room (Day 1)*: participants residing in Kingston & St. Andrew, St. Thomas, Portland, and St. Catherine;
- *The St. Ann's Bay Health Department Conference Room (Day 2)*: participants residing in Westmoreland, St. James, St. Ann, and St. Mary; and
- *NFPB Conference Room (Day 3)*: all deployed Community Facilitators.

As respondents presented for the interviewer-administered surveys, the purpose of the evaluation was again reiterated in detail and their informed, verbal consent was obtained before the instrument was administered. Respondents were also advised they were under no obligation to answer any question that posed some level of discomfort for them.

Respondents were not compensated for travel expenses at the time of interviews. However, as reported by the GIPA Unit's Deputy Coordinator, funds have been identified subsequent to the interviews and respondents were informed of the intent for compensation.

In addition, the GIPA Unit provided a list of eight Focal Point supervisors. Contact was made with six of these individuals by phone and email communications, and the survey

(Instrument #2) emailed to each of them for notation of their individual responses. The email addresses for two potential focal point respondents was incorrect---one could not be reached by phone---hence there was the expectation of receiving up to six responses for this instrument.

This second set of respondents were advised to email their completed survey to the evaluator to facilitate timeliness, convenience and confidentiality in communication. For this evaluation only three completed surveys from Focal Point supervisors was received.

Data Collection and Analysis procedures

The SPSS (Statistical Package for Social Sciences) software, version 17.0, was used to analyze data collected, as pertinent to the evaluation questions.

Ethical Consideration

To protect the privacy of each participant a respondent number was assigned to each individual and affixed to the relevant copy of the survey instrument.

Table 1: Evaluation Matrix

Evaluation Question	Sub-questions	Corresponding Questionnaire Number	Respondent	Procedure
1. What aspect of operations related to the recruitment and training of participants can be improved?	• Was the application process to participate in the programme difficult?	#8	Participant	Interviewer-administered questionnaire over a three-day period.
	• Who refers participants to the programme?	#7	Participant	
	• Is the academic requirement of at least one subject a necessity?	#9	Participant	
	• What challenges may precipitate incompletion of the programme?	#11, #12, #21	Participant	
2. How does the curriculum facilitate implementation of the Positive Health, Dignity and Prevention strategy?	• What is the most effective teaching method?	#10	Participant	Interviewer-administered questionnaire over a three-day period.
	• How do participants rate their knowledge of the module topics before and after completing the programme?	#13, #14,	Participant	
	• Have participants taken a more active role in providing support to PLHIV?	#22, #23, #24, #25, #26, #27, #28, #29.	Participant	
		#7, #8	Focal Point Supervisor	Questionnaire delivered to focal point and responses received from same via email.

Table 1 (Continued.): Evaluation Matrix

Evaluation Question	Sub-questions	Corresponding Questionnaire Number	Respondent	Procedure
3. Is the current model for the GIPA Unit Capacity Building Programme sustainable in the Jamaican context?	• What role do GIPA Community Facilitators play at focal points?	#27	Participant	Interviewer-administered questionnaire over a three-day period.
		#8, #9, #10	Focal Point Supervisor	Questionnaire delivered to focal point and responses received from same via email.
	• How have focal points benefitted from the intervention of GIPA Community Facilitators?	#7, #8, #9, #10	Focal Point Supervisor	Questionnaire delivered to focal point and responses received from same via email.
	• Has the PHDP curriculum prepared participants adequately for their role as community facilitators?	#18	Participant	
		#8, #9, #10, #11	Focal Point Supervisor	Questionnaire delivered to focal point and responses received from same via email.
	• Is the stipend adequate to support the activities of Community Facilitators?	#16, #17,	Participant	Interviewer-administered questionnaire over a three-day period.
	• Would participants be motivated to take-on the role of community facilitators without a stipend?	#20	Participant	

Results

From the list of thirty individuals only thirteen people were available for interviews; six are from cohort one and seven are from cohort two. Of this number, 61.5% (8 out of 13) are female. The minimum age is 23 years old; maximum age is 67 years old, and respondents between the ages of 21 to 35 years old account for 46.1% of the sample (See Figure 5).

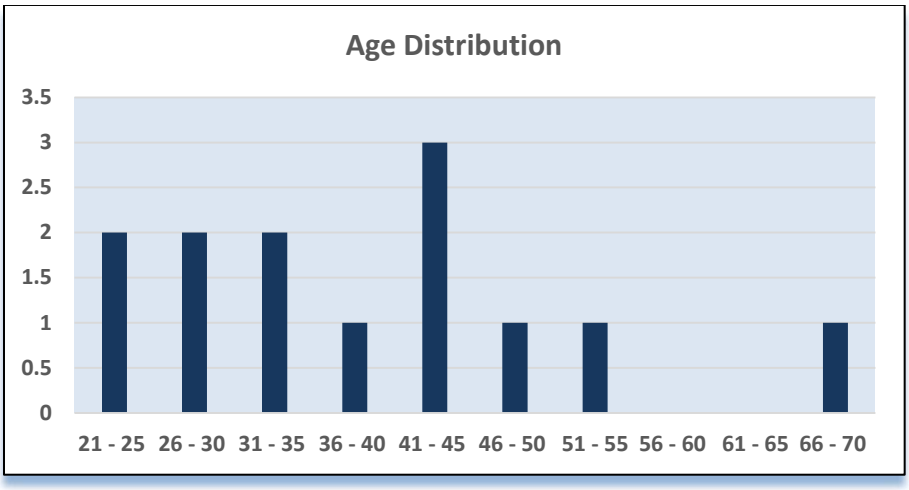


Figure 5: Age distribution of participants.

The data indicates 53.8% (7 out of 13) individuals is either single or a widower, whereas 38.4% (5 out of 13) persons are in a relationship (See figure 6). One individual reported being married, but lives separately from her husband.

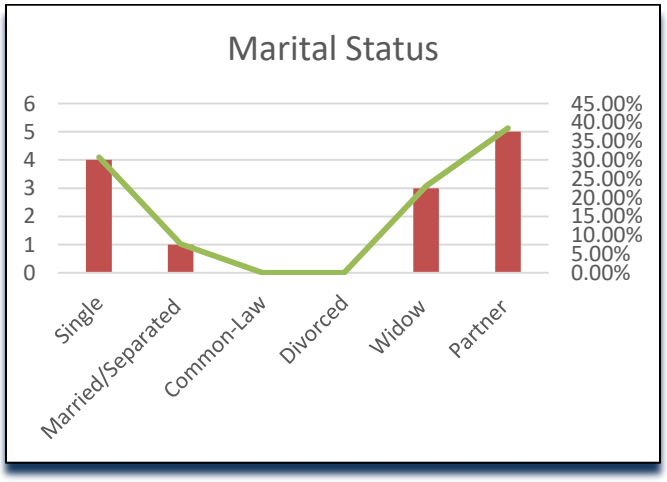


Figure 6: Marital Status

Eight respondents (61.5%) have completed their education up to the secondary level, and 30.8% respondents (4 out of 13) report attaining the tertiary level of education. Despite being a fairly educated group, unemployment was noted at a moderately high level with up to 15.4% of respondents reporting no means of making a living (See figure 7). The Employment rate is 46% consisting of both part-time and full-time employees. Though deployed respondents receive a stipend they are not considered as employed, consequently, the unemployment rate may be as high as 53.9% of the total respondents.

Analysis of the data indicated that up to 69.2% of the respondents (9 out of 13) were recruited by either The GIPA Unit Coordinator or a Contact Investigaor (See figure 8). None of the respondents surveyed reported any concerns or difficulties with the application process.

Overall, 53.8% of the respondents (7 out of 13) were of the opinion that the minimal academic requirement of one subject was necessary, but this was not significant compared to 46.2% of respondents (6 out of 13) who stated this was not necessary. For this evaluation this presented the question as to whether the proportions would be similar if the respondents were divided into two groups: deployed and non-deployed. There was a significant difference noted in this respect with 80% of deployed respondents (4 out of 5) indicating the minimal academic requirement is necessary, while 37% of non-deployed respondents also agreed it is necessary (See figure 9). The higher affirmative response rate as related to academic requirement among deployed respondents may be related to their responsibilities as Community Facilitators where peer counselling and submission of activity reports is routine. Many of the deployed respondents were in agreement that life experience is important, but as

Figure 7: Distribution of employment status.

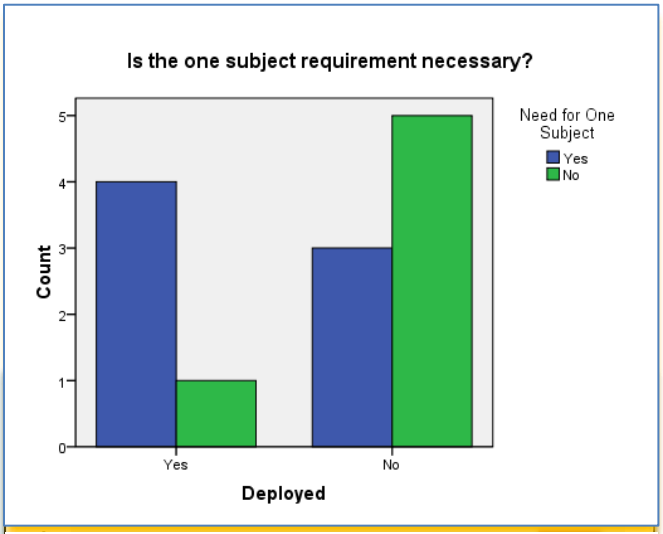
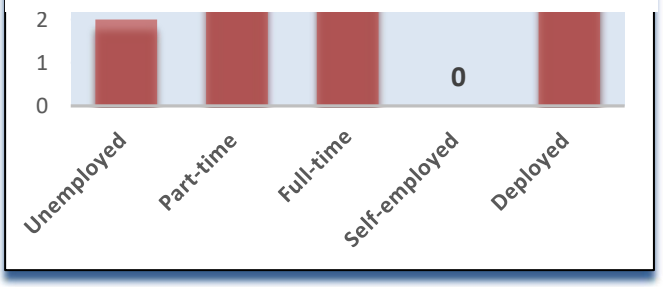
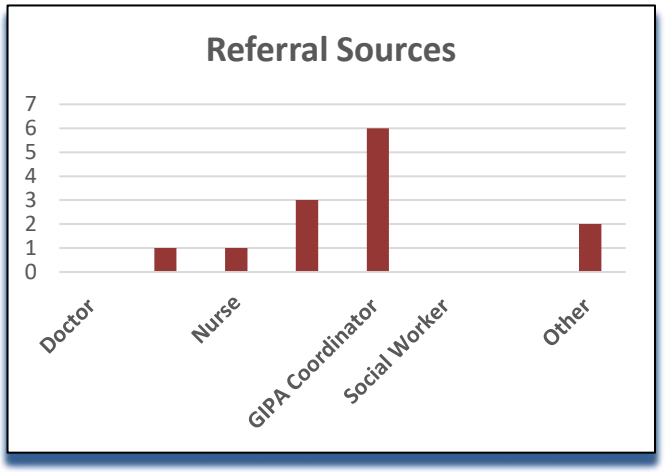


Figure 9: minimal academic requirement deployed versus non-deployed.





one explained with respect to needing one subject: “it speaks to your ability to understand the content, and disseminate to peers.” Another explained: “in deployment sites like government offices, the educational requirement is necessary.”

From the perspective of respondents who did not agree with the minimal academic requirement, one individual summarized their sentiment by stating “I have seen people with the potential to grow without the requirement of having one CXC to be part of the programme. They have the ability to read and write and comprehend well.” One suggestion for improving the programme as expressed by another respondent, “would be to omit the one CXC requirement.”

Multiple teaching methods were utilized in facilitating the PHDP curriculum. Evaluated individually, role-playing and the presentations (*Power Point*) were indicated as the most effective teaching methods, whereas interactive-combination methods, such as role-playing and discussions as well as handouts and the presentations enhanced the participants’ learning experience (See figure 10).

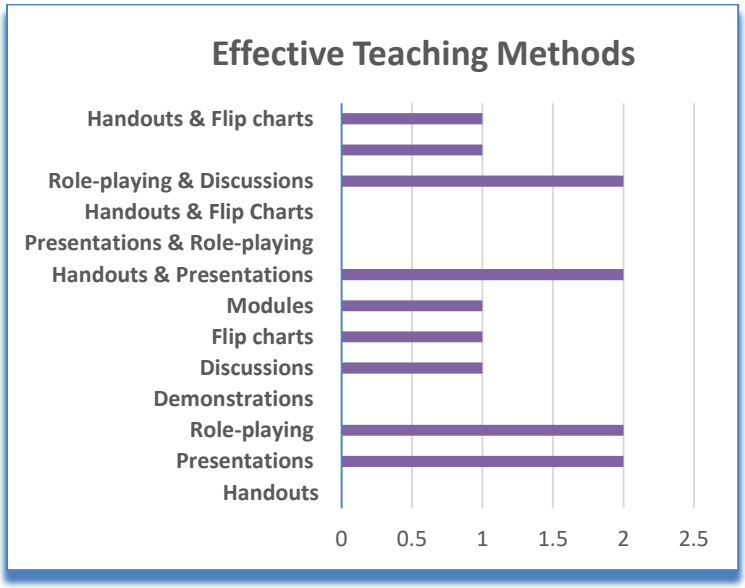


Figure 10: Effective teaching methods.

For facilitation of the PHDP curriculum, workshops are conducted throughout the year at various sites throughout the island, usually at a hotel. One respondent stated they did not complete the programme as they missed multiple workshops and could not attend the Skills Transfer Workshop due to full-time employment obligations. Her recommendation to address this issue is to "repeat the sessions for those who are unable to attend a scheduled workshop." Communication of venue sites seemed to be another concern. One respondent reported "there was no communication; (they) say they will call, but they don't."

Participants were aware that operations of the programme was influenced by funding. As one respondent suggested "It's good to have people meet in a hotel-setting, but the money could be better spent if they meet in a community-setting, and have multiple venues (like one for each region) so people will have better access to the programme." Another respondent suggested "make sure there is proper funding so when you start you don't stop in the middle." A final observation for consideration as stated by another respondent "there are more than one organizer or funder for the programme. That may cause a delay with placement---everyone would have to come together to decide on the next step forward."

The curriculum was well received by the respondents. Respondents were ask to rate their knowledge of each of the fourteen topics before and after completion of the GIPA Unit Capacity Building Programme. As the responses were nominal variables, for analysis the ratings were

Table 2: Paired Samples Statistics of perceived knowledge ratings of module topics.

MODULE	Mean Rating (Before Programme)	Mean Rating (After Programme)	*Sig. (2-tailed)
HIV Basics	1.0769	2.000	.000
PHDP	0.2308	1.9231	.000
Stigma & Discrimination	1.0000	2.000	.002

Sexual & Reproductive Health	0.3846	2.000	.000
Gender	0.3846	2.000	.000
Sexuality	0.6923	1.8462	.000
Sexual Diversity	0.3077	1.9231	.000
Disclosure Issues	0.5385	1.9231	.000
Positive Health Promotion	0.3846	2.000	.000
Loss & Grief	0.4615	1.7692	.000
Continuum of Care	0.3846	1.9231	.000
Advocacy	0.5385	1.8462	.000
Combination Prevention	0.3846	1.8462	.000
Self Care	0.7692	1.9231	.001

*95% Confidence Interval

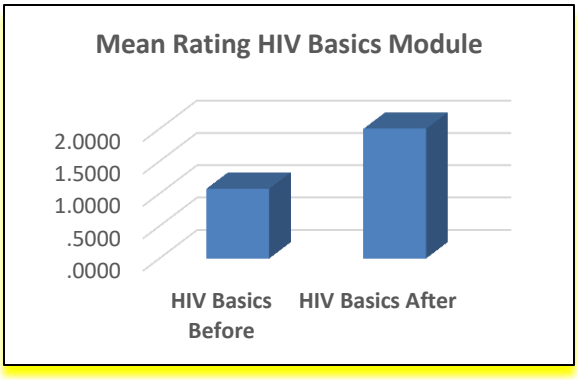
changed to ratio variables, as follows: 0.0 = unsure/knew nothing; 1.0 = knew a little; and 2.0 = knew a lot. Before the programme, participants knowledge of the topics ranged between 0.2308 and up to 1.0769, suggesting they were in general "unsure or knew very little" (See Table 2). Analysis after completion of the programme indicates an increase in the ratings participants associated with their perception of knowledge gained of the topics, ranging from 1.7692 to as high as 2.000. To illustrate, the mean rating for the module "HIV Basics" was 1.0769 (knew very little) before the respondents participated in the programme, but this rating increased to 2.000 (knew a lot) upon completion of the programme (See Figure 11). This observation is similar for the PHDP module (See figure 12), where knowledge was rated initially at 0.2308 (unsure or knew nothing), then increased to 1.9231 (knew a lot).

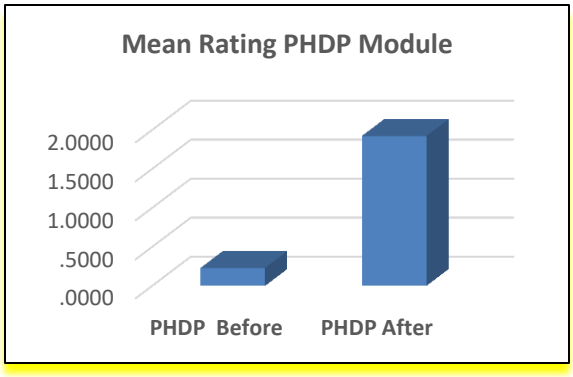
The paired sample analysis (See Table 2) suggests that these observations are significant as the results are less than 5% (p-value < 0.05). In other words, according to the respondents the PHDP curriculum was highly effective in increasing their knowledge as related to the various module topics.

Figure 11: depiction of mean knowledge rating for HIV Basics module.

In addition to increasing knowledge, many of the participants report the curriculum had a positive influence on their psycho-social environment (See figure 13).

Figure 12: depiction of mean knowledge rating for PHDP module.





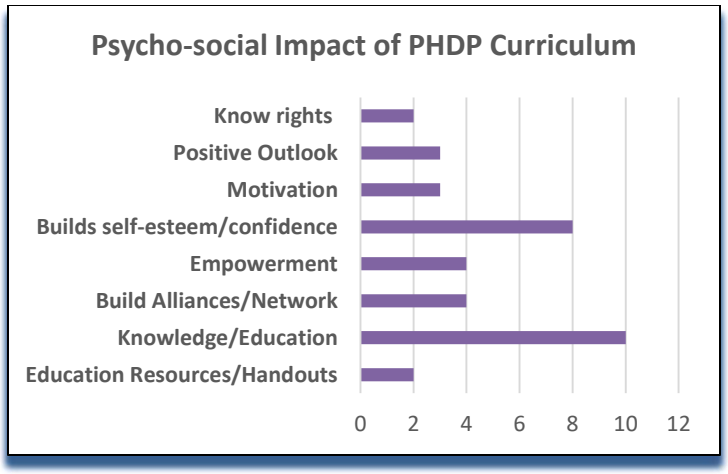


Figure 13: Psycho-social impact of PHDP Curriculum

Increased knowledge, development of self-esteem and confidence were improved factors commonly reported among the respondents. Before enrolling in the Capacity Building Programmme, 76.9% of the respondents (3 out of 13) did not belong to a network or support group for PLHIV. An appreciation for the importance of building alliances and networking with PLHIV was one positive outcome reported as a result of the PHDP curriculum, and this is reflected in 61.5% of the respondents' perception that support groups are very important (See figure 14). 23.0% of respondents did not attach any importance to support groups.

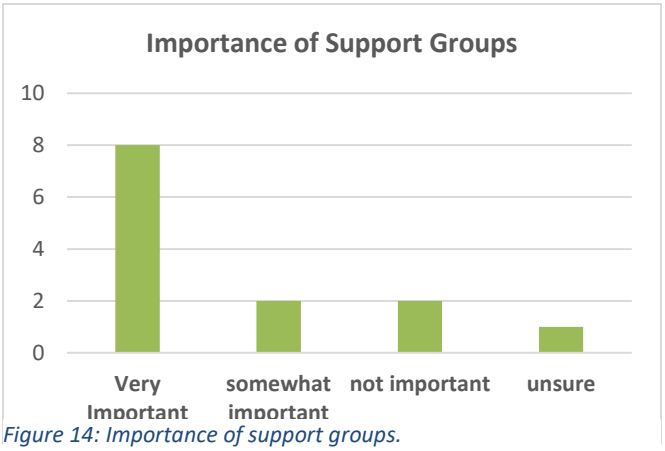


Figure 14: Importance of support groups.

In terms of networking after completion of the programme, 38.5% of the respondents (5 out of 13) have been deployed; 38.5% are involved with either a support group, attend workshops and facilitate meetings addressing needs of PLHIV, or have leadership roles in an NGO (See figure 14). However, 23% of the respondents have reported they are not involved in any activities for PLHIV. Of this proportion, one respondent; expressed a desire not to

disclose his HIV status to anyone outside of the programme, including family members, and feared association with PLHIV in support groups or other mediums for networking would threaten his privacy.

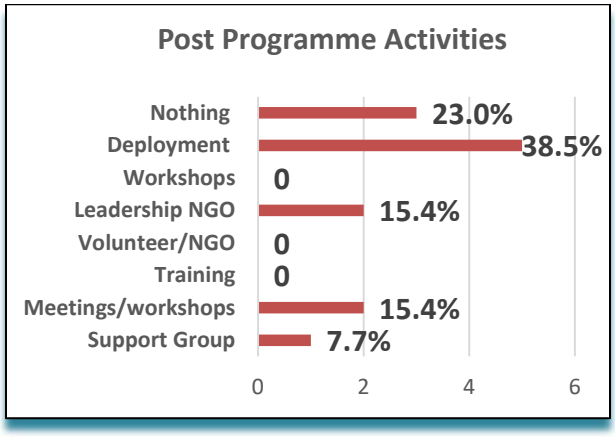


Figure 15: reported activities post completion of programme.

Outside of formal networks, 92.3% of the respondents report that they do provide support for PLHIV. The most common type of support was emotional, the provision of information, and HIV prevention support (See Figure 15). Only one individual noted they did not provide support to people living with HIV as he did not want to disclose (his) positive status.

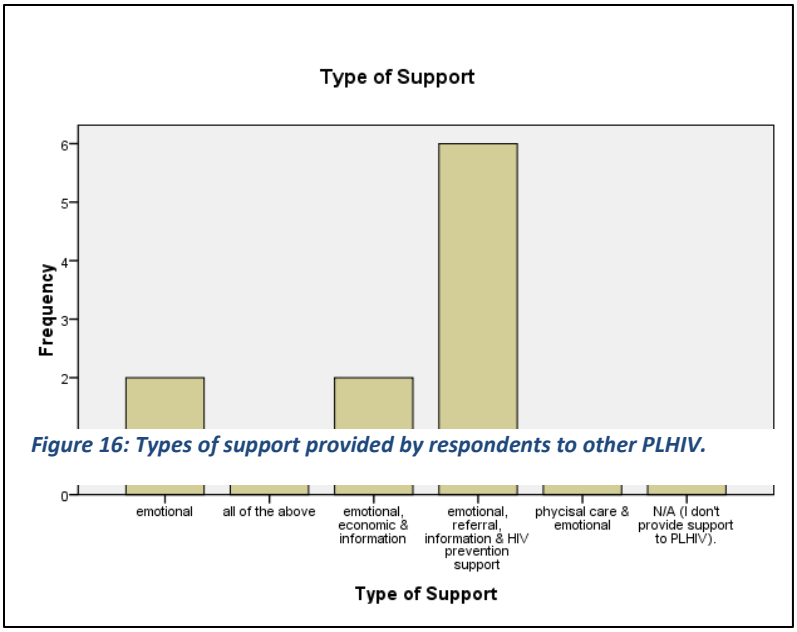


Figure 16: Types of support provided by respondents to other PLHIV.

The memorandum of understanding (MOU, SRHA) states the role of Community Facilitator is a voluntary one. They are assigned through the GIPA Unit to work closely alongside a wide range of health personnel

to improve their understanding of the continuum of care process as designed for people and used by PLHIV, and placement in the facility will contribute to the creation and maintenance of an approach for the continued engagement of persons diagnosed with HIV infection. Has the PHDP curriculum prepared deployed programme participants adequately for their role as Community Facilitators? All respondents (100%) that have been deployed are of the opinion the curriculum has met this objective (See Figure 17).

Figure 17: deployed respondents' perception regarding adequacy of training with the PHDP curriculum.

Of the six questionnaires relayed to Focal Point supervisors, three were returned for this evaluation process. Respondents consisted of two social workers from the South-East Regional Health Authority, and a Medical Epidemiologist from the Western Regional Health Authority. Prior to working with Community Facilitators, 2 out of 3 respondents reported they had never heard of the GIPA Unit Capacity Building Programme. However, from the experience of working with Community Facilitators these respondents have observed them providing the following services:

- one-to-one interaction with clients,
- participate in support groups and workshops,
- disseminate information about HIV to patients at clinic,

- participate in decision-making and policies related to PLHIV,
- share experiences with PLHIV in support groups,
- help in the disclosure process,
- eliminate myths and fears,
- visit PLHIV in their homes in terms of outreach,
- deliver medications to PLHIV, and
- ensure PLHIV keep scheduled clinic appointments.

One focal point respondent has noted the greatest value of having a Community Facilitator work in treatment sites is that "clients appreciate having someone who shares some of the same challenges as themselves to relate to." Another focal point supervisor has noted Commuinty Facilitators enhances the TCS aspect, especially at treatment sites, however "enthusiasm of GIPA Community Facilitators can lead to misunderstanding and misinterpretation between PLHIV and service provider."

It is evident in the opinions shared by the Focal Point supervisors, Community Facilitators from the Capacity Building Programme complement the treatment strategies developed for PLHIV at treatment sites. All three respondents have indicated they would recommend implementation of the programme in all organizations.

Deployed respondents exhibited enthusiasm during the evaluation interviews as they described their activities at designated Focal Points. A few noted challenges they encounter at deployment sites. One respondents notes there is inadequate space or "accommodation for privacy" at her deployment site, which negatively impacts her interactions with PLHIV. At least two lamented lack of resources such as educational tools (brochures) and inadequate condoms at her deployment site.

Only two of the deployed respondents reported the stipend they received was adequate (See Figure 18). .

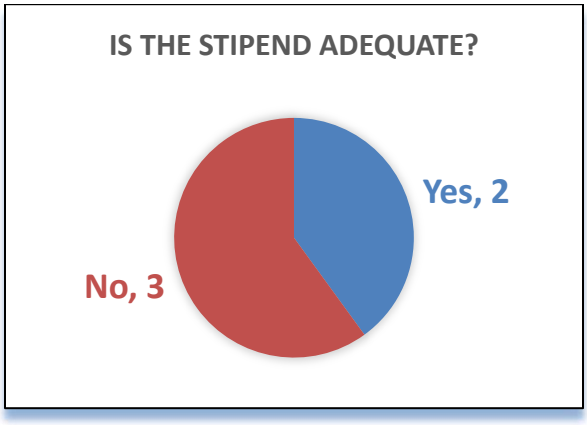


Figure 18: deployed respondents' perception regarding adequacy of the stipend.

With respect to sustainability of the programme, funding is a critical and strongly influential factor. Deployed respondents are given a stipend to assist with expenses associated with doing their voluntary work. Would they still present with an enthusiasm to engage other PLHIV in their current capacity if a stipend was not available? In response to this question, 4 out of 5 indicated they would still deploy without a stipend (See figure 19).

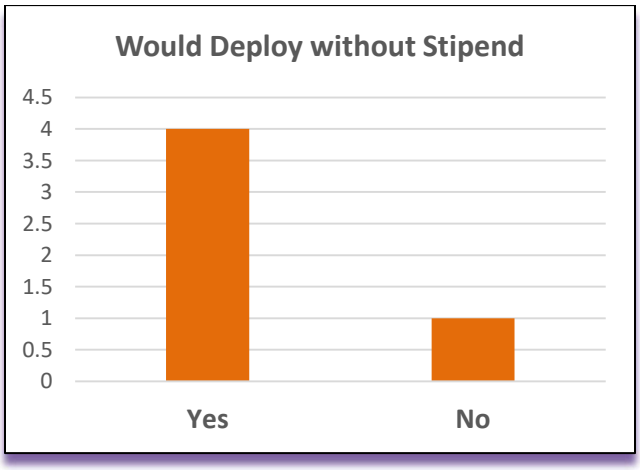


Figure 19: respondents' motivation to work with PLHIV without a stipend.

With respect to improving the programme, recall that one respondent had suggested omitting the requirement for one (CXC) subject and another respondent had suggested multiple or regional sites for facilitation of the curriculum and increased accessibility. In general, most of the respondents were satisfied with their experience and stated they could not think of ways to improve the programme. However, for a few communication between programme facilitators and participants seemed to have occasionally presented some issues.

For example, in response to the open-ended question to determine if the respondent would recommend this programme to other PLHIV, only one individual out of thirteen indicated (they) would not do so "because I don't want others to be treated like a piece of s**t. This programme is a particular issue." The individual noted that communication with the programme facilitators was poor, and suggested with respect to improving the programme, "don't use (it) for your own purposes," and discouraged "favourtism." Another respondent stated "people were told they would be placed for employment---organizers need to tell people honestly what to expect."

Participants do not receive a certificate at the conclusion of the programme. Some have indicated in consideration of the efforts to attend workshops, this document indicating completion of the programme would be a source of pride and indicative of their achievements.

Discussion

One major limitation with this evaluation process is the small pool of respondents who presented to be interviewed. Consequently, any inferences made may not be extended to the general population of fifty-four individuals who participated in this programme.

There were no difficulties noted with respect to the recruitment and training of participants. Though the majority of referrals came from Contact Investigators and the GIPA Unit Coordinator, it is expected that as Community Facilitators become more visible at deployment sites the system of referral will expand to include service providers such as Medical Officers, Social Workers and other key healthcare workers.

The minimal academic requirement is not an exclusive factor, and in general, programme participants are in agreement with this academic qualification. The PHDP curriculum has been well designed and considerate of the needs of the programme participants, and has met its main objectives with respect to implementation of the Positive Health, Dignity and Prevention strategy. This is evident in its success in relaying knowledge to participants and it has also served as a powerful tool in endowing participants with a heightened sense of confidence in self-management of their HIV-related care; empowerment with the knowledge that HIV is not an automatic death sentence and they have rights like the general populace of seronegative individuals; and participants have exhibited a strong desire to engage other PLHIV. The curriculum has also equipped Community Facilitators to successfully fulfil their roles in articulating the fundamental principles of the PHDP strategy.

With respect to sustainability, the Capacity Building Programme is relevant for PLHIV and in reducing incidents of HIV infection. The limitations of funding associated with this programme will influence the number of individuals who can participate in workshops, selection

of venues for training, and also how many individuals may be deployed. What is appreciative from this evaluation is that many of the respondents have an enthusiasm and desire to engage and interact with PLHIV based on their exposure to the PHDP curriculum. As PHDP emphasizes that at every stage of its strategy activities must be developed, implemented, and monitored by PLHIV, sustainability of this programme will be highly influenced by what participants may choose to do as related to the concerns of PLHIV.

In consideration moving forward, the purpose of the programme and expectations upon completion needs to be clearly articulated to participants, especially those who are not deployed, to dispel beliefs this is an employment programme. Discussions related to the award of a certificate to each participant upon completion of the programme should also be considered.

APPENDICES

APPENDIX A (Sample Questionnaire---Participant)

Capacity Building Programme Evaluation Questionnaire

The purpose of this survey is to determine how the GIPA Unit Capacity Building Programme facilitates the implementation of the Positive Health, Dignity and Prevention (PHDP) Strategy. Information obtained will also guide operations related to increased efficiency and coordination in the recruitment and training of programme participants and community facilitators.

*Ms. Nicole A. Simpson (MPH Candidate & Extern with the National Family Planning Board---Monitoring & Evaluation Unit) can be contacted at cellular number ***-**** to address any concerns related to this survey.*

Respondent Number: _____ **Date: _____**
Interview Location: _____

1. How old are you? _____ years.

2. Sex: ☐ Male ☐ Female

3. What is your relationship status?
   ☐ Single
   ☐ Married
   ☐ Common-law relationship
   ☐ Divorced
   ☐ Widow/widower
   ☐ partner (boy/girlfriend)

4. Who do you currently live with?
   ☐ Alone
   ☐ Partner
   ☐ Spouse
   ☐ Parents
   ☐ Friends
   ☐ Children
   ☐ Other _____

5. What is your employment status?
   ☐ Unemployed
   ☐ Full-time
   ☐ Part-time
   ☐ Informal work/Self-employed

6. What is the highest level of education you have completed?
   ☐ No schooling
   ☐ Primary
   ☐ Secondary
   ☐ Vocational/Trade school
   ☐ Tertiary (Bachelor's degree)
   ☐ Post-graduate

7. Who referred you to the programme?
   ☐ Doctor
   ☐ Nurse
   ☐ Contact investigator
   ☐ Adherence counsellor
   ☐ Social worker
   ☐ Other (specify) _____

8. In your opinion was the application process to participate in the programme difficult?
   ☐ Yes (please explain)
   _____
   _____
   _____
   _____
   ☐ No

9. To participate in the Capacity Building Programme, you need to have at least one subject. In your opinion, do you think this necessary? Please explain.
   _____
   _____
   _____
   _____
   _____

10. Which teaching methods used during the workshops did you find the most useful to understand the material presented? (check all that apply)
    a. handouts
    b. presentations
    c. role playing
    d. pre-test/post-tests
    e. demonstrations
    f. discussions
    g. other (specify) _____

11. Did you complete the programme?

    ☐ Yes (Skip to question 13)

    ☐ No

12. Why were you unable to complete the programme?

    ☐ I had to work

    ☐ I lost interest

    ☐ I could not afford bus fare

    ☐ Training venue was too far

    ☐ Topics discussed were making me uncomfortable

    ☐ Other (specify) _____

13. How would you rate your knowledge about the following PHDP curriculum topics **before** you participated in the programme?

Key---1: Unsure; 2: Did not know anything; 3: I knew very little; 4: I knew a lot.

Module Topics	1	2	3	4
HIV Basics				
PHDP				
Stigma and discrimination				
Sexual and reproductive rights				
Gender				
Sexuality				
Sexual diversity				
Disclosure issues				
Positive health and health promotion				
Loss and grief				
Continuum of care				
Advocacy				
Combination prevention				
Self care				

14. How would your rate your knowledge about the following PHDP curriculum topics **after** you participated in the programme?

Key---1: Unsure; 2: I still don't know anything; 3: I know very little; 4: I know a lot.

Module Topics	1	2	3	4
HIV Basics				
PHDP				
Stigma and discrimination				
Sexual and reproductive rights				
Gender				
Sexuality				
Sexual diversity				
Disclosure issues				
Positive health and health promotion				
Loss and grief				
Continuum of care				
Advocacy				
Combination prevention				
Self care				

15. Have you been deployed?

☐ Yes (state location): _____

☐ No (Proceed to question 21)

16. Did you receive a stipend?

☐ Yes

☐ No (Skip to question 18)

17. Do you consider the stipend amount adequate?

□ Yes

□ No

18. Has the PHDP Curriculum prepared you adequately to work with healthcare professionals and people living with HIV?

□ Yes

□ No (please explain)

_____
_____
_____
_____

19. What is/are challenges you have experienced at the deployment site?

_____
_____
_____
_____
_____

20. If you were not offered a stipend, would you still have accepted the offer for deployment?

☐ Yes

☐ No (please explain)

_____
_____
_____
_____

(Proceed to question 22)

21. If you were not deployed, can you state the reason why (check all that apply)?

    ☐ I do not want to disclose my HIV status.

    ☐ I prefer to work with a support group.

    ☐ I was not available for deployment.

    ☐ Other (specify) _____

22. Before you participated in the programme, did you belong to a network or support group for people living with HIV?

    ☐ Yes

    ☐ No

23. How important would you say it is to belong to a network of people living with HIV?

    □ very important
    □ somewhat important
    □ not important
    □ unsure

24. Do you belong to an association, network, or support group that address the concerns of people living with HIV?

    ☐ Yes

    ☐ No

25. As a person living with HIV, what activities have you been involved in since completing the Capacity Building Programme? (Check all that apply)

    ☐ Meetings

    ☐ Support group

    ☐ Training

    □ Work with an NGO

    ☐ Other (specify) _____

    ☐ Nothing

26. Since completing the Capacity Building Programme, have you supported other people living with HIV?

    ☐ Yes

    ☐ No (Proceed to question 28)

27. What type(s) of support did you provide? (Check all that apply)
    - ☐ Emotional
    - ☐ Economic
    - ☐ Referral to services
    - ☐ Physical care
    - ☐ Information
    - ☐ Legal support
    - ☐ HIV prevention support
    - ☐ Other (specify) _____

28. What have you gained as a result of your participation in this programme?
    _____
    _____
    _____
    _____
    _____

29. How do you anticipate using the knowledge that you gained as a result of your participation in this programme? Please describe.
    _____
    _____
    _____
    _____

30. What aspect of this programme did you find to be the most valuable? Least valuable?
    _____
    _____
    _____
    _____

31. What suggestion(s) do you have for improving this programme?
    _____
    _____
    _____
    _____

32. Would you recommend this programme to others? Please explain your response.

_____
_____
_____
_____

33. Is there anything you would like to add at this time?

_____
_____
_____
_____
_____

**********THANKS FOR YOUR RESPONSES**********

APPENDIX B (Sample Questionnaire---Focal Point Supervisors)

Capacity Building Programme Evaluation Questionnaire
(Community Facilitator Deployment Sites)

The purpose of this survey is to describe the benefits to various organizations within the public and private sectors in working with a GIPA (Greater Involvement of People Living with HIV/AIDS) Community Facilitator. The results will assist in developing the GIPA Capacity Building Programme as it seeks to position itself for general institutionalization.

*Ms. Nicole A. Simpson (MPH Candidate & Extern with the National Family Planning Board---Monitoring & Evaluation Unit) can be contacted at cellular number ***-**** to address any concerns related to this survey.*

Respondent's Name: _____ Date: _____
Organization: _____
Job Title: _____ Contact Phone Number: _____

1. What type of organization are you employed by?
   ☐ Regional Health Authority/MOH
   ☐ Branch of Government (not health-related)
   ☐ Private Sector Organization
   ☐ Civil Society
   ☐ Other: (please explain): _____

2. What is your profession?
   ☐ Medical Officer
   ☐ Psychologist
   ☐ Social Worker
   ☐ Behavior Change Communication (BCC) Interventionist
   ☐ Other: _____

3. Does your organization provide services for people infected with HIV? Please explain.
   _____
   _____
   _____
   _____

4. Does your organization have a HIV Workplace policy?
   ☐ Yes
   ☐ No
   ☐ don't know

5. What do you believe are the rights of people living with HIV?

   (**Check all that applies**)
   ☐ Right to equality and freedom from discrimination.
   ☐ Right to marry and plan a family.
   ☐ Right to privacy.
   ☐ Right to information and education.
   ☐ Right to political participation
   ☐ Other (specify) _____
   ☐ They have rights, except (specify):
   _____
   _____

6. Prior to this, had you ever heard of the GIPA Capacity Building Programme?
   _____
   _____
   _____
   _____
   _____

7. Does your organization currently (or on a previous occasion) have the services of a GIPA Community Facilitator?
   ☐ Yes (Please state how many) _____
   ☐ No

8. What services did/does the GIPA Community Facilitator provide for your organization? Please explain.
   _____
   _____
   _____
   _____
   _____

_____
_____

9. How has your organization benefited from working with a GIPA Community Facilitator? Please explain.

_____
_____
_____
_____
_____

10. What did you find to be the greatest and least value of having a GIPA Community Facilitator serving with your organization? Please explain.

_____
_____
_____
_____
_____
_____

11. Would you recommend implementation of the *GIPA Capacity Building Programme* in all organizations?

_____
_____
_____
_____
_____

12. Is there anything you would like to add at this time?

_____
_____
_____
_____
_____

Please return completed survey to Ms. Nicole A. Simpson via ***Email: nsimpson@jnfpb.org.***

**********YOUR PARTICIPATION IN THIS SURVEY HAS BEEN APPRECIATED**********

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Evaluation - GIPA Capacity Building Programme (PHDP) Meeting held Tuesday June 23, 2015 at NFPB

Present:

Mrs. Kerian Richards-Gray	-	HPP/Future Group
Mr. Ainsley Reid	-	GIPA
Miss Judith Fishley	-	NFPB
Miss Judy-Ann Nugent	-	JN+
Miss Sasha Martin	-	MOH

Miss Rosemarie Stone

Miss Joan Stephens

Miss Althea Cohen

Mr. Patrick Ferguson

Mr. Richard Higgins

Miss Marva McIntosh

Miss Deshon Warlock

Miss Yanique Irving

Mr. Dwayne Boreland

Mrs. Bobbet Lewis-Avis

Miss Marva McIntosh

Call to order

The meeting was called to order at 1:30pm.

Prayer

Prayer was offered by Mr. Ferguson.

Welcome and Introductions

The Chair welcomed all to the meeting and introductions were made.

Background to the Evaluation

The background of the Evaluation was read from the report by Mr. Ferguson.

Presentation of the Findings from the Evaluation

Mr. Reid presented the findings from the evaluation to the stakeholders. Questions were asked and Mr. Reid tried to answer them as best as possible despite the absence of Miss Simpson who completed the report.

Discussion (Feedback and Responses)

Miss Stephens asked if all parishes got a chance to participate in the evaluation. Mr. Reid stated that the only parish that did not participate were the Southern region parishes.

Mr. Ferguson made reference to paragraph 3, he quoted "The minimal academic requirement is not an exclusive factor, and in general, programme participants are in agreement with this academic qualification". He stated that he knew persons had concerns about the qualification requirement however, for him, after finishing the programme he thought the requirement was in keeping with the programme. Mr. Huggins pointed out that he wondered if persons with the qualification, after finishing the curriculum on PHDP were able to grasp and articulate the information.

Mr. Reid outlined the qualification requirement. He stated that participants needed to have a least one (1) CXC, GCE, SSC, and CSEC, should be able to read and write and be a graduate of a secondary school. He emphasized however, that the programme has taken on PLHIV who have not obtained the necessary requirement and they have been trained. Mr. Reid mentioned that most of the participants for the evaluation came from GIPA and CI. Mr. Reid stated that he and Mrs. Stone did the recruitment and orientation for co-hort 2 and he and Mr. Muqtadir did co-hort 3.

Mr. Reid stated that in filling out the form, persons needed to put a Next of Kin (does not have to be a family member), present a valid ID and most be 18 or older. He indicated that there are two (2) categories that are used to assess participants in the programme, they are Communication skills and Knowledge Assessment. In the communication skills participants will teach-back on the module based on what they have learnt. The knowledge assessment will show how much the participants understood the information and then given a test. With these two assessment it shows that participants are knowledgeable of the curriculum.

Mr. Gabourel asked the difference between recruiting and training PHDP facilitators and participants. He further stated that he would see deployment as a major component of the

facilitation process and also the qualification. He stated that qualification and deployment are unique to the PHDP facilitators training but when it comes to PHDP participants, he wonders whether deployment and the academics requirement is needed. Mr. Reid stated that to start the PHDP they needed persons who would be able to grasp the information. Also to get facilitators to interact with newly diagnosis persons and potential leaders.

Mr. Reid referred to the Conceptual Diagram for the GIPA in the evaluation report on how persons in the programme can be further utilized. He also stated for "Reached PLHIV join SSG", the idea is there would be another curriculum developed by JN+ and it would have be used in the context of support groups. It would not cover the elements that are in the PHDP curriculum because of the support group content and process. Mr. Reid referred to "Recruitment for Capacity Building Programme", so that persons would be recruited from the support group and oriented. Mr. Reid also referred to "Reached PLHIV who join SSG referred to GIPA Capacity Building Programme", the entity in which persons would be deployed were Private sector, International Development Partners, Public Sector, PWHIV groups and Civil Society. He stated that when persons finished the capacity building programme then mentoring and monitoring would have been provided. Mr. Reid stated that before some persons are deployed they would get further appraisal or assessed to determine the level of contribution they will make on a work site. They would further be engaged in support groups and the process would continue thereafter.

Miss Martin asked for clarity of GIPA and PHDP. Mr. Reid was able to explain the difference and she appreciated the explanation. In conclusion he suggested that she read the PHDP curriculum especially the introductory remarks.

Miss Stephens indicated that the PHDP curriculum has given her the ability to counsel PLHIV in her community. She also added that she did an interview with Susan from The Susan Show. Mr. Ferguson agreed with Miss Stephens that the PHDP curriculum has given PLHIV a more significant and effective voice and that whenever they speak there is a sense of authority on the issues affecting them. Therefore the programme is very empowering to individual lives.

Mr. Reid emphasised that we have to look at JN+ or the wider HIV response, on what is it that we need to do, to have outcomes relating to positive health, dignity and prevention for PLHIV. He indicated that PHDP present a broader framework than positive prevention, so we also need to look at health, health needs and health priorities in the PLHIV communities. For the first time many persons who have joined the programme see health as a primary issue for PLHIV. Mr. Reid mentioned that GIPA work have been conducted with Two Hundred and Ninety-four (294) MSM across the island using one (1) module from the PHDP curriculum on sexual diversity and expanded into pieces related to health. Mr. Reid stated that after the training the MSM indicated that they would like the full curriculum to be administered to their population. He

mentioned that the good thing is, we are building capacity in the PLHIV community to do adverse, self-care and peer work that needs to be done. He added that the need for a PHDP programme is great.

Miss Martin referred to the discussion section in the evaluation report about the minimal requirement, she wondered what happens when persons don't meet the requirement. Mr. Reid indicated that as long as the person can read and write they are eligible based on the referrals. He mentioned that what is lacking is additional funding support that would engage more of the persons who complete the programme. Mr. Reid stated that over sixty (60) persons have completed the programme however, only fifty-four (54) was mentioned in the evaluation. The utilization of the critical mass is important as JN+ provides an opportunity in the conceptual diagram to further utilize persons to do more work with support groups and rising awareness in community.

Mr. Reid stated that he and Mrs. Stone in the earlier stages of the programme, had developed the GIPA Tool Kit for the Education Centre. That manual has not been used however, it is hoped that this manual can train persons who completed the programme to get them to do more work in schools.

Mr. Gabourel mentioned that the agencies who recruit PHDP participants are really trying to achieve and he quoted "a powerful tool in endowing participants with a heightened sense of confidence in self-management of their HIV-related care; empowerment with the knowledge that HIV is not an automatic death sentence and they have rights like the general populace of seronegative individuals; and participants have exhibited a strong desire to engage other PLHIV" **(Taken from Evaluation Report).**

Mr. Reid stated that how participants roll out the PHDP curriculum is up to the individual because it is their personal life story. One challenge that is faced with PHDP is persons thinking it is an employment programme. Mr. Reid emphasized that this is not so although some persons are deployed.

Mr. Boreland enquired if participant's get a certificate after completion of the PHDP curriculum. Mr. Reid indicated that the curriculum doesn't provide a certificate because it was under development however, now that the curriculum is completed and published, negotiation has been entered with HPP and a copy was sent to Washington. Mr. Reid suggested that HPP look at giving participants a certificate after completion of the PHDP curriculum. Mr. Ferguson also suggested that JN+ need to play a more integral role so that the certificate can be recognized in the wider community.

Mr. Warlock suggested also that JN+ be involved with the private sector to have a broader spectrum. Mr. Reid mentioned that where persons get deployed will not be the same all the

time because the multi-sectoral is huge (to have a number of areas where persons could be deployed). He further stated that GIPA work through JABCHA so that persons could be deployed at the Ministry of Labour. Those persons contributed to the development of the HIV Workplace Policy and the life threat elements policy of various private sector entities.

Mr. Reid further elaborated that more work can be done to get into the other agencies. He is hoping at the end of co-hort 5 a documentation can be shared on what have been done in these various sectors to provide a best practice. He stated that there will be opportunities with the private sectors especially when the Occupational and Safety Act will require private sector entities to develop their policies. Mr. Reid stated that part of the development of the policy require them to engage with the communities of PLHIV. In addition there is the Voluntary Compliance Programme (VCP) which include the audit at the Ministry of Labour. He believes if persons take from co-hort 1, 2 and 3 and build on capacity audit, there can be an opportunity to be employed as Auditors because more persons are needed in this area.

He also believes that in the future persons will want PLHIV to work for them because GIPA is the international policy for PLHIV and also to ensure that GIPA is a part of their programme. Mr. Reid concluded by saying that GIPA would like to do co-hort 4 and 5 however, there needs to be a trainer of trainers. He is hoping that co-hort 5 will be done in all the regions and for persons to be a part of JN+ so the bigger movement can be supported.

Way Forward

Mr. Ferguson expressed that the meeting was necessary and GIPA for him is a very important concept, it has helped him significantly (personal and professional) and also his ability to help ours. He concluded in saying the programme is very much relevant and should continue.
Mrs. Stone stated that when she and Mr. Reid began many years ago she did not have the vision that he had, however, she supported his vision. She mentioned that so many persons are empowered, even participants in the meeting are impacting other person's life and helping PLHIV.

Miss Stephens expressed that the meeting was very progressive and productive. She stated that the intervention with the MSM should have been in the evaluation report. The programme has empowered her to do sensitization session and to disclose her status to others. This has made her now more involved in mobilizing women living with HIV and through the programme she has the strength to move forward. She hope the programme will reach co-hort 5 and beyond, because it is a very important programme for PLHIV. Mr. Reid pointed out that there is the demand to do the programme in the Caribbean. Miss Stephens added that it is good to link with other countries with PLHIV and knowledge gained is useless unless we share it we others.

Miss Cohen stated that the meeting was very informative and she is glad about the PHDP curriculum. GIPA has helped her to have more confidence and wish the PLHIV will be honest about their status. Mr. Reid pointed out that GIPA and PHDP don't teach persons to disclose their status. He stated that there is a module in the PHDP curriculum that help PLHIV to manage their situation or issue.

Mr. Huggins expressed that he really appreciated GIPA training because it has made him bold. It has made him see things differently in a critical way. He also mentioned that he has met PLHIV who are very articulate and don't have one subjects, who he hoped can be a part of the programme.

Mrs. Lewis-Avis stated that the GIPA programme has helped her greatly. She has been exposed in meeting different types of people.

Mr. Gabourel spoke on behalf of JN+, by congratulating Mr. Reid and EEHR (GIPA unit). He stated that JN+ has been supporting GIPA for many years because PLHIV need to build capacity and to be greater involve. He expressed that JN+ will work with GIPA to see how they can meet GIPA's benchmark of success, by how many persons can be reached, build their capacity to train others and the percentage of persons deployed back in to the communities they serve.

He mentioned that they got a response from the GCCM that they have accepted JN+ proposal. The proposal was to scale up persons who are trained in PHDP, to go out and promote PHDP principles, concept and all the module linked to it. One major and common goal, is the linked to care, retention in care and adherence. He stated that from JN+ perspective they are pushing the engagement of all PLHIV who have the capacity to reach out and motive, mobilize and train others. Mr. Gabourel indicated that he asked Mr. Reid for the number of person's trained in PHDP so JN+ can start to engage these persons in moving forward.

Miss Irving expressed that GIPA has empowered her to disclose her status and to encourage others.

Miss Martin expressed her thanks for the invitation to the meeting because it has helped her to get a better understanding of GIPA. She stated that she would encourage the trainers to be more active in the community because there are a number of PLHIV who still don't know what to do. Miss Martin believes if trainers are out in the community encouraging PLHIV our linkage, retention and other issues could be deal with easier.

Mr. Reid mentioned that to have persons do more outreach work they need to practice good hygiene and to see how GIPA can help them protect themselves when helping others.

Mr. Warlock expressed that after his deployment came to an end, social workers and psychologists always call him to offer counselling.

Miss Nugent expressed that if it had not been for GIPA she would not have been at the meeting. Deployment gave her the opportunity to learn more about the National HIV Policy and the HIV Workplace Policy. She stated that the programme also gave her confidence and the opportunity to facilitate a few sensitization sessions. She would also like the participation of more persons into the programme.

Mrs. Richards-Gray stated that the cycle of HPP is coming to an end and they are so proud of the work done with the PHDP curriculum and participants. There is a new project out of which a proposal has been submitted and they are hoping they will get it. Mrs. Richards-Gray mentioned that included in the proposal is to continue the work with GIPA. She concluded that since she has been involved with GIPA there has been so many human interest stories and outside of this, funding is needed for it to continue.

Any Other Business

Mr. Reid mentioned that CRN+ maybe coming to Jamaica. Mr. Reid emphasized that participants need to work together, support and build JN+, because by building JN+ all lives are being built.

Vote of Thanks

Mr. Reid thanked all for attending and for their full participation in the meeting. He reiterated what Miss Martin had said earlier, by looking at the bigger impact on the lives of the persons who are struggling. They also need to see other persons struggling but all moving towards achieving the goal of adherence and improvement in staying in care.

Mr. Reid also mentioned a follow-up meeting for M&E unit to present.

Adjournment

The meeting adjourned at 3pm.