TECHNICAL COOPERATION DOCUMENT

I. Basic Information

Country:	Jamaica
TC Name:	Technical Support to Reduce Teenage Pregnancy
TC Number:	JA-T1104
Team Leader/Members:	Donna Harris (SPH/CJA), Team Leader; Janet Quarrie (CCB/CJA); Sudaney Blair (CCB/CJA); Margie-Lys Jaime (LEG/SGO); Natalie Elizabeth Wegener Carmona, (SCL/SPH); and Martha M. Guerra (SCL/SPH)
Taxonomy:	Client Support
Date of TC Abstract authorization:	July 1, 2016
Beneficiary:	Jamaica via the Ministry of Health (MOH); National Family Planning Board (NFPB); Women's Health Network; Women's Centre of Jamaica Foundation
Executing Agency:	NFPB - Sexual Health Agency
IDB Funding Requested:	US$250,000
Local counterpart funding, if any:	None
Disbursement period (includes Execution):	30 months
Required start date:	December, 2016
Types of consultants:	Individual
Prepared by Unit:	SCL/SPH
Unit of Disbursement Responsibility:	SPH/CJA
Donors Providing Funding	Special Program for Employment, Poverty Reduction and Social Development in Support of the Millennium Development Goals (SOF)
TC Included in Country Strategy:	Yes
TC included in CPD:	Yes
Institutional Strategy 2010-2020 (AB-3008):	Consistent with the Institutional Strategy Update 2010-2020 (AB-3008) and aligns with the challenge of development of social inclusion and equality

II. Objectives and Justification of the TC

2.1 **Jamaica has one of the highest adolescent/teenage pregnancy rates in the region.** The incidence of 72 per 1,000 for adolescent pregnancy among girls aged 15-19, is the third highest in the Caribbean[1], which as a region ranks among the highest in the world.[2] Up to 80% of first pregnancies among Jamaican youth aged 15-24 are mistimed, unplanned or unwanted.[3,4] Risky sexual behavior among Caribbean adolescents is influenced by a number of risk factors including exposure to sexual or physical abuse, drug and alcohol use, exposure to poverty, homelessness and hunger.[5] The Centre for Disease Control and Prevention (CDC) has identified additional factors such as living in a home with frequent family conflict, being from a single parent home, low self-esteem and insufficient information and/or improper handling about sexuality, and changes that occur in the body during adolescence.

1 World Population Report, 2013.
2 Jamaica ranks below Belize – 90 per 1,000; Guyana 97; and the Dominican Republic 98 per 1,000.
3 National Youth Survey, 2010, GOJ/IDB Youth Development Programme, Summary of Findings, p.11.
4 Preventing Adolescent Pregnancies in the Caribbean http://cms2.caricom.org/documents/13941-preventing_adolescents_pregnancies_in_the_caribbean_morella_joseph.pdf.
5 See CARICOM/UNFPA ISF, p.8-9.

Additionally, nearly half of the girls in Jamaica who have sex during adolescence will experience their sexual debut by age 12. About one in ten of these incidents are forced[6], making them the victim of a sex crime, and others occur in circumstances involving transactional, inter-generational or coerced sex.[7] There is low enforcement of legislative or social protections for violence against women and children.[8]

2.2 **Health and education impacts of adolescent pregnancy.** Adolescent pregnancy is one of the leading causes of school dropout among Jamaican girls.[9,10] Evidence suggests that adolescent pregnancy remains a major contributor to maternal and child mortality and to the cycle of ill-health and inter-generational poverty.[11] Globally, pregnancy is a leading cause of death among older adolescent girls.[12] The risks of stillbirth and newborn deaths are 50% higher among adolescent mothers, who face a wider range of additional health complications than mothers in their 20s.[13] Most teenage mothers lack private assets and human resources to cope with this new challenge, making them more vulnerable. Reducing adolescent pregnancy therefore has positive effects on the lives of girls, women, boys and men, by helping to break the cycle of inter-generational poverty and contributes to national, economic and social development.

2.3 **Progress and Remaining Challenges.** In 1967 the Government of Jamaica established the National Family Planning Board (NFPB); in 2013 the organization integrated to include the HIV/STI reduction program leading to a revised national strategy in 2014. Since its inception the NFPB has contributed to: (i) a decline from 137 per 1,000 in 1975 to 72 per 1,000 in 2008 of adolescent birth rates[14]; (ii) a decrease from 4.5 in 1975 to 2.4 in 2008 in the average number of children born to a woman (Total Fertility Rate)[15]; (iii) increased modern contraceptive use among women between 15-49 years from 70.5% in 1986 to 84.8% in 2008; (iv) the proportion of unintended pregnancies in Jamaica declined by 35% between 1989 and 2008; and (v) increased use of the condom as a prevention method to 1 in 5 women.[16]

2.4 Despite the progress achieved, Jamaica today still carries one of the highest adolescent pregnancy rates in the region. In spite of the work of the Women's Centre of Jamaica Foundation,[17] 50% to 80% of young women do not return to school after

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6 Jamaica RHS, 2008 http://ghdx.healthdata.org/record/jamaica-reproductive-health-survey-2008-2009

7 National HIV/STI KAPB study, 12% of girls in the same age range had been forced to have sex within the preceding year (p.19). RHS 2008 shows for nearly half of women in 15-24 age group, first sexual encounter was coerced (p.279). Variations may result from differing interpretations of what comprises coerced sex.

8 Children at Risk: A review of sexual abuse incidents and child protection issues in Jamaica, 2014 http://www.tandfonline.com/doi/full/10.1080/23265507.2014.972437

9 Jamaica Policy on the Reintegration of Teen Mothers in the Formal School System http://www.moe.gov.jm/sites/default/files/National%20Policy%20Reintegration%20of%20School-age%20Mothers%20-%20Ministry%20of%20Education%20Jamaica.pdf.

10 World Bank, Youth at Risk in LAC, 2008; Dropout means girls are not taught adequate skills and abilities which perpetuates inequality and lowers social mobility same also applies to youths who do not enroll, enroll late or promoted slowly through the school system.

11 CARICOM/UNFPA Integrated strategic framework for the reduction of adolescent pregnancy in the Caribbean, 2014.

12 State of the World Population: Motherhood in Childhood, Facing the Challenge of Adolescent Pregnancy, UNFPA, 2013.

13 WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries, WHO, 2011.

13 World Health Organization, Adolescent Fertility Rate, Jamaica http://data.worldbank.org/indicator/SP.ADO.TFRT?end=2008&locations=JM&start=1960.

15 Jamaica RHS, 2008

16 Jamaica RHS, 2008

17 The primary role of the Women's Centre of Jamaica is providing adolescent mothers continuing education during the course of their pregnancy and reintegrate them into the formal school system, whilst promoting mothers to get on a family planning method to delay a second pregnancy.

giving birth.[18] Adolescent fatherhood is also linked to high rates of school drop-out, as they are forced to enter the informal, low-wage workforce to support their young families.[19] The geographical distribution of adolescent pregnancy indicates high disparity across regions. The table below demonstrates that **Kingston and St Andrew (KSA), St. Catherine, St. James, Manchester, Clarendon, St. Ann and Westmoreland** parishes are most in need of intervention to lower adolescent pregnancy rates in Jamaica, as they represent over 75% of adolescent births in Jamaica.

Table 2.1. Distribution of Teen Births (Live and Still) as a % of Total Births, Per Parish (2008-2012)

Parish	Total births 2008-2012	Adolescent births <=17 yrs. (2008-2012)	Parish specific adolescent birth rates	Adolescent births as a percentage of the national total, %	Rank based on number of adolescent births
KSA	**58,365**	**3,611**	**6.19**	**25.16**	1
St. Catherine	**28,170**	**2,188**	**7.77**	**15.25**	**2**
St. James	**21,879**	**1,633**	**7.46**	**11.38**	**3**
Manchester	**22,434**	**1,467**	**6.54**	**10.22**	**4**
Clarendon	**14,050**	**1,139**	**8.11**	**7.93**	**5**
St. Ann	**15,957**	**1,043**	**6.54**	**7.27**	**6**
Westmoreland	**12,112**	**984**	**8.12**	**6.86**	**7**
St. Mary	6,915	560	8.10	3.90	
St. Elizabeth	7,241	541	7.47	3.77	
St. Thomas	5,952	500	8.40	3.48	
Portland	3,654	270	7.39	1.88	
Trelawny	3,055	238	7.79	1.66	
Hanover	2,095	176	8.40	1.22	
Jamaica	***202,934***	***14,356***		***100.0***	

Source: Registrar General's Department Vital Statistics Report 2008.

2.5 A recent consultation among key stakeholders noted gaps in Adolescent Sexual and Reproductive Health (ASRH) policy and rights in the country as follows:[20] (a) limited public awareness about ASRH issues and quality of care; (b) absence of supportive legislation recognizing adolescents as rights holders in the context of accessing Sexual Reproductive Health services; (c) limited monitoring for quality standards in service delivery targeting adolescents; (d) limited resources to provide and low monitoring of the quality or comprehensiveness of the Health and Family Life Education Curriculum; (e) inadequate screening for gender-based violence among male and female adolescents; (f) limited inclusion of adolescent males and partners in capacity building for supporting pregnancy prevention, contraceptive use, maternal and child care; and (g) limited reproductive health commodity security[21], especially for hormonal long-acting methods (for example subcutaneous implant Jadelle) that are preferred for adolescents and HIV positive mothers which remain extremely costly.

2.6 **Objective.** The objective of the TC is to contribute to the reduction in adolescent pregnancy rates in Jamaica. The specific objectives are to impact adolescent sexual and reproductive health behavior change among adolescent boys and girls, to

[18] De Bruin M. Teenagers at Risk. JARH. 2002.

[19] Gayle H. Adolescent Male Survivability in Jamaica. Kingston Youth Now. 2002.

[20] Jamaica Youth Advocacy Network (JYAN) in March 2016 in collaboration with the Ministry of Health (MOH), NFPB-SHA, UNAIDS & UNICEF hosted a National Youth Consultation on Sexual & Reproductive Health, Rights & HIV.

[21] USAID Knowledge for Health (K4H) Toolkit: Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever they need them. https://www.k4health.org/toolkits/contraceptive-security-committees/what-commodity-security

increase public awareness of ASRH issues, and to increase access to SRH services and commodities for adolescents.

2.7 **Strategic alignment.** The TC is aligned with the Update to the Institutional Strategy (UIS) 2010-2020 (AB-3008) and is strategically aligned with the development challenges of social inclusion and equality by increasing access and use of health services and diminishing inequities. It is also aligned with the cross- cutting theme(s) of gender equality by reducing vulnerability of children 0 to 18 years through improving delivery of and access to sexual reproductive health services, especially education and contraception methods. The program is aligned to the Corporate Results Framework 2016-2019 (GN-2727-6) by increasing the number of beneficiaries receiving health services. This program is also aligned with the Jamaica Country Strategy (GN-2826) of expanding access and quality of healthcare by improving institutional capacities to provide adolescent reproductive health training and services.

III. Description of activities/components and budget

3.1 **Component 1. Development, production and targeted implementation of a gender-sensitive adolescent sexual and reproductive health (ASRH) training manual to empower adolescents towards behavior change (US$120,000).** This component will engage a consultant to develop a Behavior Change Communications (BCC) Manual for ASRH. The manual will focus on behavior change strategy and implementation for health, social, economic and gender programs.[22] This component will support development of the manual and implementation in Kingston, St Andrew, St Catherine & Manchester Parishes.[23] This component will directly involve youth and adolescents in the design phase through the Youth and Adolescent Technical Working Group (YATWG) of the NFPB. Based on input from the YATWG, this component will include frameworks of services for adolescent group education, workshop programs for parents of targeted adolescents, health care worker and guidance counselor training programs, hospital staff sensitization programs focused on antenatal and postnatal care. This component will also include development of a traditional and social media campaign featuring adolescent mother and father ambassadors. Materials will be featured in the targeted Parish schools and across locations such as the Women's Centre Jamaica Foundation, Victoria Jubilee Hospital, and the adolescent friendly clinic in Manchester parish. Comprehensive sexuality education and appropriate ASRH services have been found to be effective interventions to change knowledge, attitudes, practices and behaviors of adolescents resulting in reduced teen pregnancy rates across a variety of settings.[24, 25, 26]

3.2 **Component 2. Training service providers and key civil society members (US$40,000).** This component will finance the capacity building of at least thirty (30) key stakeholders including five (5) Guidance Counsellors of the schools selected in a three-

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[22] See ASRH Manual Consultant TOR for recommended modules, these are recommendations from the EA tailored to country needs and based on best practice for comprehensive sexual education programs such as that developed by Dr. Douglas Kirby, 2009 (http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

[23] Parishes with the greatest need. See table 2.1.

[24] Behavior Change Communication Activities and Achievements: Innovations in Family Planning Services Technical Assistance Project. June 2010. http://pdf.usaid.gov/pdf_docs/pnadz653.pdf.

[25] What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. August 2015. http://www.ghspjournal.org/content/3/3/333.full.

[26] Programs to improve adolescent sexual and reproductive health in the US: a review of the evidence. April 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4396579/

day residential workshop on ASRH issues. The BCC manual developed will be utilized in conjunction with the Ministry of Health's (MOH) Standards and Criteria for Adolescent Health. The expected outcome of the training is twofold: (i) training in provision of adolescent friendly ASRH services; and (ii) training of trainers to increase the cadre of adolescent friendly service providers.

3.3 **Component 3. Strengthen contraceptive service delivery (US$60,000).** This component will strengthen and broaden service delivery in the provision and insertion of long-acting reversible contraceptives (LARC), condoms (male and female) and pregnancy testing kits through stronger experienced partnerships with relevant public and civil society agencies. The specific aim is to provide LARC implants to 1,000 adolescent girls in vulnerable communities. Dual method used for the prevention of unplanned pregnancy as well as HIV and STIs will also be promoted.

3.4 **Component 4. Monitoring and Evaluation and Audit (US$30,000).** A consultant will be hired to conduct the monitoring and evaluation and audit.

Indicative Results Matrix

Indicator	Unit of Measure	Baseline	Baseline Year	Target Y1	Target Y2	Total Target	Means of Verification
Impact Outcome: Reduced adolescent birth rate in program population							
Adolescent birth rate in program population	Births per 1,000 adolescent women ages 15-19 in program population	60.6	2014	59	58	57	Evaluation survey data published in M&E Reports to IDB from selected contractor
Outcome 1: Improved youth community knowledge of Adolescent Sexual and Reproductive Health topics including gender, sexual development, maternal/pre-natal care, contraceptives and life skills to negotiate sexual encounters							
Percentage of program adolescents who know at least two contraceptive methods	Adolescents who can identify two contraceptive methods/total adolescents trained x100	TBD	2017	65%	75%	75%	Evaluation survey data published in M&E Reports to IDB from selected contractor
Percentage of program adolescents who know at least one source of information and/or services for sexual and reproductive health	Adolescents who can identify one ASRH info source/total adolescents trained x100	TBD	2017	65%	75%	75%	Evaluation survey data published in M&E Reports to IDB from selected contractor
Percentage of adolescents who can define consent in sexual encounters	Adolescents who can define sexual consent/total adolescents trained x100	TBD	2017	65%	75%	75%	Evaluation survey data published in M&E Reports to IDB from selected contractor
Outcome 2: Improved school capacity to provide Adolescent Sexual and Reproductive Health trainings/services							
Percentage of trainees who have mastered relevant knowledge to provide Adolescent Reproductive Health specific services upon training completion	Trainees that have mastered knowledge / total trainees tested) x 100	0	2017	30	30	60	Competency test results from checklist test administered at training conclusion reported in M&E document from selected contractor
Component 1 Output: Gender Sensitive, Tailored BCC Training Manual Published							
Published BCC training manual	Training manual	0	2017	1	0	1	Training manual published from selected contractor in electronic and paper format, approved by Executing Agency and IDB

Indicator	Unit of Measure	Baseline	Baseline Year	Target Y1	Target Y2	Total Target	Means of Verification
Component 1 Output: Information Education & Communication (IEC) Materials on Adolescent Sexual & Reproductive Health distributed to target communities							
Reproductive Health IEC materials reached target communities	IEC Materials by Type	0	2017	450	450	900	Count of IEC materials distributed to target communities reported from selected contractor in M&E report to EA & IDB
Component 1 Output: Adolescent Reproductive and Sexual Health Media Campaign (social media/media strategy, timeline, media products) reach target communities							
Media Campaign Developed	Document						Media Campaign from selected contractor published and approved by EA and IDB Media campaign will include: social media/media strategy, timeline and media products (Documents/posters/ post cards, video clips, social media products such as tweets, facebook updates, blog posts)
Component 1 Output: Youth Trained on Adolescent Sexual and Reproductive Health							
Girls aged 10-19 trained on adolescent sexual & reproductive health	Girls	0	2017	450	450	900	Workshop attendance roster data published by training contractor for inclusion in M&E report, approved by IDB
Boys aged 10-19 trained on adolescent sexual & reproductive health	Boys	0	2017	450	450	900	Workshop attendance roster data published by training contractor for inclusion in M&E report, approved by IDB
Component 2 Output: Training workshops on Adolescent Sexual and Reproductive Health for service providers held							
Clinicians trained in adolescent sexual & reproductive health	Civil society persons	25	2016	10	10	20	Attendance roster data and pre-post test data published by training contractor for inclusion in M&E report, approved by EA and IDB
Community stakeholders trained in adolescent sexual & reproductive health	Sexual & reproductive health clinical service providers	300	2016	30	30	60	Attendance register data and pre-post test data published for inclusion in M&E report, approved by EA and IDB
Component 2 Output: Training for peer trainer workshops on Adolescent Sexual and Reproductive Health held							
Peer trainers of Adolescent Sexual and Reproductive Health trained to provide competent training completed	Workshop	0	2017	1	1	2	Competency test results from checklist test administered at training conclusion reported in M&E document from selected contractor

Indicator	Unit of Measure	Baseline	Baseline Year	Target Y1	Target Y2	Total Target	Means of Verification
Component 3 Output: Level of contraceptive service delivery expanded							
Long acting reversible contraception (LARC) provided to girls age 10-19	LARC unit	0	2017	1,000	1,000	2,000	Procurement plan, invoices and clinical consultation dialogue data published in M&E Reports by selected contractor, approved by EA
Condoms provided to adolescents age 10-19	Condoms	0	2017	1,500	1,500	3,000	Procurement plan, invoices and distribution report data published in M&E Reports by selected contractor, approved by EA

Indicative Budget (US$)

Activity/Component	Total Funding (USD)
1. Design and development of a comprehensive ASRH service package to empower adolescents towards behavior change	**$120,000.00**
2. Training of service providers and key members of civil society	**$40,000.00**
3. Strengthen service delivery	**$60,000.00**
4. Monitoring and Evaluation and Audit	**$30,000.00**
Total	**$250,000.00**

3.5 **Monitoring arrangements.** At the project execution level, the NFPB will monitor project execution in line with the TC Results Matrix. The Bank will monitor and evaluate project progress as part of its project supervision. As part of its execution reporting requirements, the NFPB will submit a number of key reports to the Bank, including: Semi-Annual Reports (due August 30th and February 28th respectively); Annual Operating Plan; Audited Financial Statements; and Final Audited Financial Statement (within 120 days following the date stipulated for the final disbursement of the Financing). A final evaluation report will be done within six (6) months after project completion to include: lessons learned and critical success factors. The IDB will contract independent auditors to carry out ex-post reviews of procurement processes and of supporting documentation for disbursements. Ex post reviews will include an analysis of the Financial Statements that the EA should prepare annually as part of its financial management. The costs associated with this contract will be financed with the IDB resources according to IDB procedures.

IV. EXECUTING AGENCY AND EXECUTION STRUCTURE

4.1 **Executing Agency (EA).** The NFPB will be the EA for the TC and will assume day to day responsibilities for implementing all aspects of the project. These responsibilities will include assisting with coordination and monitoring of technical and financial matters. The Director of the Health Promotion and Protection Unit within NFPB will serve as the Project Manager supported by a Project Assistant that will represent UNFPA's in-kind contribution to the project. The Project Manager, who reports to the Director of UNFPA, will be responsible for programme implementation, specifically (i) presenting annual operating plan and progress reports to the Bank; (ii) managing compliance of project outputs/activities; (iii) procurement and processing of contracts required for the implementation of agreed program interventions; and (iv) monitoring activities to ensure planned results are achieved.

A technical working group will be formed comprising representatives from NFPB, MOH and a related NGO representative to provide technical oversight.

4.2 **Procurement Policy.** The procurement of works and goods and the contracting of consulting services under the TC will be carried out according to the Bank's policies and procedures set forth in documents GN-2349-9 and GN-2350-9, respectively.

V. MAJOR ISSUES

5.1 There is need for the robust coordination among the NFPB, Ministry of Health, and NGOs- Women's Health Network and Women's Centre of Jamaica Foundation. The main risk is ensuring that the objectives and work programme of the partners are aligned towards timely execution. This risk will be mitigated by the formation of Technical Working Group that will provide oversight and inputs in the design and implementation of the TC.

VI. EXCEPTIONS TO BANK POLICY

6.1 This TC does not contain exceptions to IDB's policies.

VII. ENVIRONMENTAL AND SOCIAL STRATEGY

7.1 The safeguard policy filter categorized this TC as a 'C' project indicating that this project's net environmental and social impacts are likely to be positive for beneficiaries who will have increased access to health services (see Filters).

Annexes:

1. Letter of Request
2. Terms of Reference
3. Procurement Plan

TECHNICAL SUPPORT TO REDUCE TEENAGE PREGNANCY

JA-T1104

CERTIFICATION

I hereby certify that this operation was approved for financing under the **Special Program for Employment, Poverty Reduction and Social Development in Support of the Millennium Development Goals (SOF)** through a communication dated July 1, 2016 and signed by Su Hyun Kim (ORP/GCM). Also, I certify that resources from said fund are available for up to **US$250,000** in order to finance the activities described and budgeted in this document. This certification reserves resource for the referenced project for a period of four (4) calendar months counted from the date of eligibility from the funding source. If the project is not approved by the IDB within that period, the reserve of resources will be cancelled, except in the case a new certification is granted. The commitment and disbursement of these resources shall be made only by the Bank in US dollars. The same currency shall be used to stipulate the remuneration and payments to consultants, except in the case of local consultants working in their own borrowing member country who shall have their remuneration defined and paid in the currency of such country. No resources of the Fund shall be made available to cover amounts greater than the amount certified herein above for the implementation of this operation. Amounts greater than the certified amount may arise from commitments on contracts denominated in a currency other than the Fund currency, resulting in currency exchange rate differences, represent a risk that will not be absorbed by the Fund.

(Original signed) — 12/7/16

Sonia M. Rivera
Chief
Grants and Co-Financing Management Unit
ORP/GCM

Date

Approved: *(Original signed)* — 12/7/16

Ferdinando Regalia
Division Chief
Social Protection and Health Division
SCL/SPH

Date