No.

ジャマイカ
南部地域保健強化プロジェクト
終了時評価報告書

平成15年1月
（2003年）

国際協力事業団
医療協力部

医協二
JR
03-07

ジャマイカ
南部地域保健強化プロジェクト
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医療協力部

目　　次

序　　文

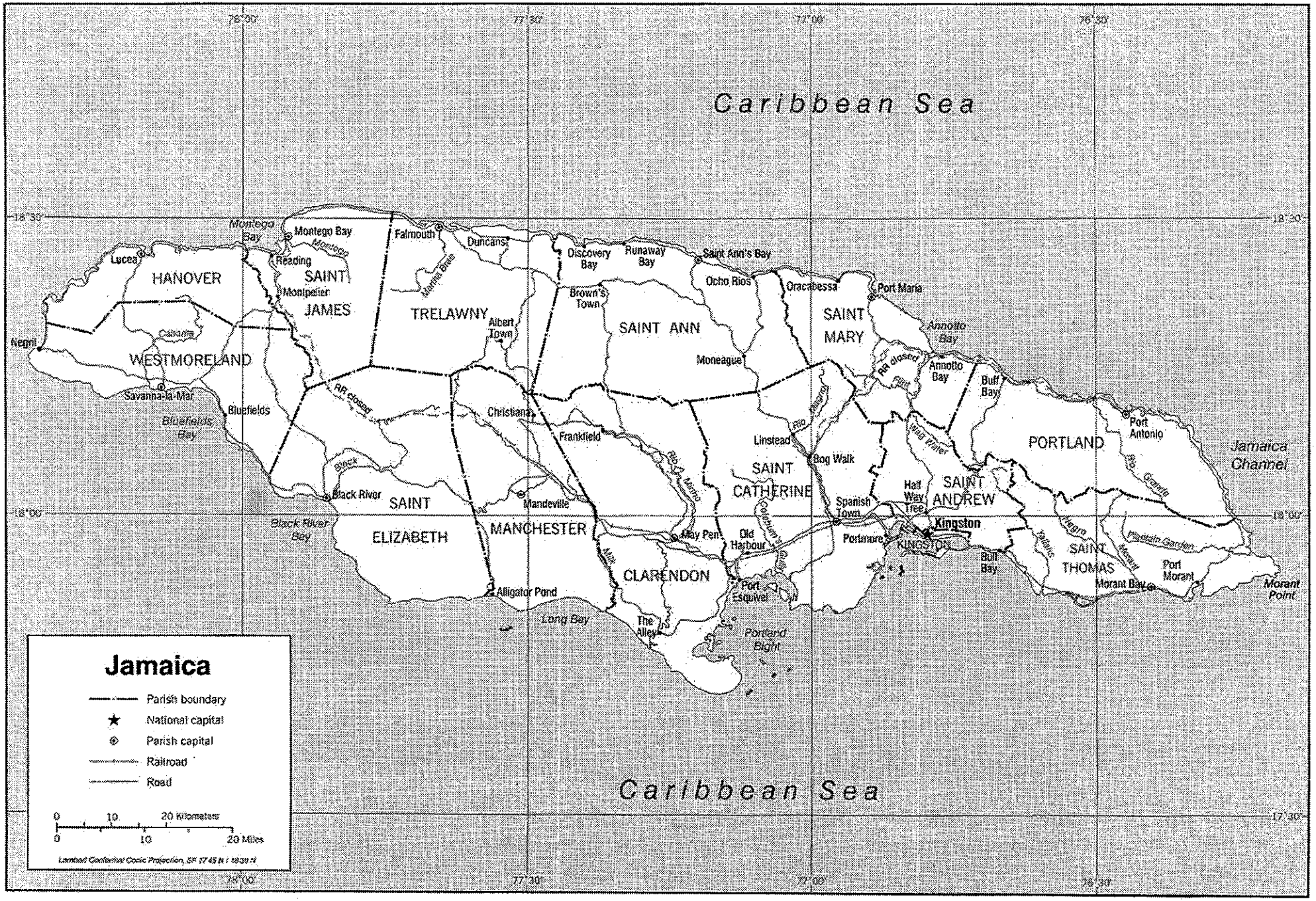
ジャマイカ南部地域保健強化プロジェクトは、平成10年６月１日から５年間の協力期間で、南部地域（マンチェスター郡、セント・エリザベス郡、クラレンドン郡）において、生活習慣病に焦点をあてた、地域医療システムの強化に関する技術移転を実施しているものです。

国際協力事業団は、本件実施に係る討議議事録（R／D）に基づく協力期間が、平成15年５月31日をもって終了するのに先立ち、これまでの協力内容などの評価をジャマイカ側と共同で行うため、平成14年11月16日～12月７日まで、弘前大学 医学部教授 佐藤 敬氏を団長とする終了時評価調査団を派遣しました。本報告書は、同調査団が実施した調査、及び協議の内容と結果を取りまとめたものです。

ここに本調査にあたり、ご協力を賜りました関係各位に対しまして、深甚なる謝意を表しますとともに、今後の本件プロジェクトの実施・運営に対しまして、一層のご協力をお願い申し上げます。

平成15年１月

国際協力事業団
医療協力部
部長　藤崎　清道



地図：ジャマイカ

Base 802854AI (C00236) 11-02

ウェルネスクリニック

ウェルネスクリニックの様子

モバイルクリニック

フリーチェック

健康教育

署名式の様子
（前席左から、Allen-Young保健省次官、佐藤国内委員、
三田チーフアドバイザー、Palmer企画庁海外協力部長、
Irving企画庁二国間協力課長）

略　語　表

BMI	：	ボディー・マス・インデックス
CHA	：	コミュニティーヘルスエイド
C／P	：	カウンターパート
GNP	：	国民総生産
HDI	：	人間開発指標
JOCV	：	青年海外協力隊
MOH	：	保健省
PAHO	：	汎アメリカ保健機関
PCM	：	プロジェクト･サイクル･マネージメント
PDM	：	プロジェクト・デザイン・マトリックス
PDMe	：	評価用 PDM
PIOJ	：	企画庁
R／D	：	討議議事録
SRHA	：	南部地域保健事務所
TSI	：	暫定実施計画
UNDP	：	国連開発計画

評価調査結果要約表

1．案件の概要		
国　名：ジャマイカ		案件名：ジャマイカ南部地域保健強化プロジェクト
分　野：保健・医療		援助形態：プロジェクト方式技術協力
所轄部署：医療協力部 医療協力第二課		協力金額：5億4,000万円
協力期間	1998年6月 1日～ 2003年5月31日	先方関係機関：保健省、南部地域保健事務所
		日本側協力機関：弘前大学、青森県
他の関連協力：		

1－1　協力の背景

ジャマイカの保健指標は、乳幼児死亡率（24.5対1,000／2001年）や出生時平均余命（72歳、2001年）にみられるように、中南米諸国のなかでは比較的良好な水準にある。しかし、高齢化及び生活様式の変化に伴う高血圧症、糖尿病をはじめとする生活習慣病の増加や、人口の40％以上が居住する首都圏と、その他地域との保健サービスの格差が問題となっている。

本プロジェクトは、保健医療面で他地域よりも遅れているジャマイカ南部地域（マンチェスター、セント・エリザベス、クラレンドンの3郡）において、地域住民の健康を改善するため、特に生活習慣病に関連する健康教育と、疾病予防に重点を置いた保健医療システムの強化を目標に開始された。

1－2協力内容

ジャマイカにおける地域保健システムの強化を目的に、同国の保健医療従事者に対して、疾病予防プログラムの作成、健康診断、カウンセリング活動、生活習慣予防のための健康教育の教材作成、啓発のためのイベントの実施に対して協力活動を行う。

(1) 上位目標

ジャマイカ住民の健康状況が、地域保健システムの強化によって向上する

(2) プロジェクト目標

生活習慣病予防に焦点をあて、南部地域における保健システムが強化される

(3) 成　果

1) 南部地域保健事務所（SRHA）の行政・組織体制が向上する
2) 郡保健センター施設の機能が向上する
3) 人的な能力・技術が向上する
4) マンチェスター郡（パイロット郡）で生活習慣病の予防モデルが開発、実施される
5) 生活習慣病の予防モデルがセント・エリザベス郡、及びクラレンドン郡に拡大する

(4) 投　入

日本側：

長期専門家派遣	13名	機材供与	8,500万円
短期専門家派遣	15名	ローカルコスト負担	2,900万円

研修員受入　　18名
相手国側：
カウンターパート（C／P）配置　22名
土地・施設提供
ローカルコスト負担

2．評価調査団の概要

調査者	総　括	：佐藤　敬	弘前大学 医学部 附属脳神経血管病態研究施設 教授
	地域保健	：柴田　ミチ	青森県 健康福祉部 副参事
	協力計画	：奥本　恵世	日本国際協力事業団 医療協力部 医療協力第二課
	プロジェクト評価	：藤田　健司	財団法人 社会経済生産性本部
調査期間	2002年11月16日～12月7日		評価種類：終了時評価

3．評価結果の概要

3－1　評価結果の要約

(1) 妥当性

生活習慣病は、ジャマイカにおける死亡、疾病の大きな要因となっており、保健省（MOH）は、保健政策における優先課題の1つとして取り上げ、健康な生活様式を住民に奨励している。また、プロジェクト対象地域となった、南部保健地域の保健5か年戦略計画（2003～2007年）においても生活習慣病が優先課題とされ、コストの面からも予防に重点がおかれており、ジャマイカ政府の政策の方向性と合致する。また、本プロジェクトでは対象3郡のうち、マンチェスター郡にてパイロットモデルを確立し、他の2郡に普及するというアプローチがとられたが集中的な投入により、他地域への早期の展開が可能となったため、本対象地域でのプロジェクト計画としては妥当であった。

(2) 有効性

住民インタビュー結果から、生活習慣が徐々に変化していることが確認されるなど、「生活習慣病に焦点をあて、南部地域の保健システムが強化される」というプロジェクト目標は、かなりの程度達成された。プロジェクト目標を達成するためには、行政・組織体制を整え、スタッフの技術力・意欲の向上を行ったのちに、モデルが構築されるという、本プロジェクトのプロセスは適切であった。特に有効性に寄与したのは、スタッフの意識の変化であり、健康的なライフスタイルの必要性を理解したスタッフが、主体的に活動を行うようになったことが重要であった。

(3) 効率性

プロジェクト・デザイン・マトリックス（PDM）（プロジェクト計画）において、あげられた3つの外部条件については、特に阻害要因となることもなかった。外部機関との協力関係については、ジャマイカ心臓病協会、ジャマイカ糖尿病協会、西インド大学等と友好な関係を築き、研修等での講師派遣等で協力を行った。ジャマイカ側のスタッフについ

ては、医師の配置のタイミングが遅れるという問題はあったものの、最終的には23名のスタッフが配置され、おおむね適切であったといえる。日本側からの投入については、開始当初の供与機材の到着に時間がかかったというタイミングの問題はあったが、量・質などは適切であった。

(4) インパクト

終了時評価時点においては、上位目標である「ジャマイカ住民の健康状況が、地域保健システムの強化によって向上する」について、対象の3郡以外で独自にウェルネスクリニック、モバイルクリニック（診療所及び診療車による健診活動）が行われている地域はない。しかし、本プロジェクトの活動に対しては、ほかの地域の保健関係者、更に民間の保険会社等からも関心が寄せられており、他の地域にもニーズがあることが確認されたことで、普及が自発的に行われることが期待される。さらに、ウェルネスクリニック、モバイルクリニックを受診することで、生活習慣病以外にも病気が早期発見された患者も確認されている。

(5) 自立発展性

現在南部で行われている活動については、プロジェクトにかかわったC／Pの意識が高く、今後も継続していくと考えられる。ただし、機材のメンテナンスに関しては、スタッフの不足、備品管理の不十分さなどから更なる改善が必要である。他の地域への普及については、具体的な予算措置等は明らかにされなかったものの、本プロジェクトの活動を高く評価しているMOHからの技術的な支援は期待できる。また、現在ウェルネスクリニック・モバイルクリニックで徴収している検診料については、受診者も適切であると感じており、これを地域保健事務所が活動資金として使っていくことができれば、財政的には問題ないものと思われる。

3－2　効果発現に貢献した要因

(1) 計画内容に関すること

中間評価の時点で、焦点を生活習慣病に絞ったため、活動が簡潔になり、定着度を高めることができた。また、日本は同分野については経験が十分にあるため、研修員受入れの効果が特に高かった。

(2) 実施プロセスに関すること

1) ウェルネスクリニック、モバイルクリニックの費用は、徐々にジャマイカ側の負担を増やすように配慮したため、ジャマイカ側の財政負担が可能となった。

2) スタッフ確保の必要性をジャマイカ側に継続して主張し続けた結果、担当の医師が任命された。

3) プロジェクト活動をモニタリング・評価する運営委員会が設置され、効果的に機能したため、ジャマイカ側（SRHA）のオーナーシップが、プロジェクト期間を通じて高まっていった。

3－3　問題点及び問題を惹起した要因

(1) 計画内容に関すること

該当なし

(2) 実施プロセスに関すること

セント・エリザベス郡、クラレンドン郡の両郡において、ウェルネスクリニック、モバイルクリニックを担当する医師がなかなか決まらなかったため、健診開始が遅れた。

3－4　結　論

本プロジェクトは、当初の目的をおおむね達成することができた。本プロジェクトにより、実施されたウェルネスクリニック、モバイルクリニックは、公的機関が実施する健康診査として、ジャマイカで初めての試みであった。プロジェクトでは、まずマンチェスター郡において生活習慣病のモデルを確立し、これを他の2郡に展開するというアプローチをとった。これにより、対象地域において生活習慣病に関する意識をもつ人々が増加し、ライフスタイルを改善した人々もみられた。

3－5　提　言（当該プロジェクトに関する具体的な措置、提案、助言）

(1) 活動が継続、拡大のため、ウェルネスクリニック、モバイルクリニックの収入を活動経費に充当するなどの予算措置が必要である。

(2) 他地域のスタッフを対象に、南部で研修を実施するなど、人材養成に努めるべきである。

(3) 生活習慣病の予防への意識をできるだけ多くの住民に植えつけるため、フリーチェック（無料で行う簡単な健康診断）を生活習慣病予防検診の優先事項として、推進するべきである。

(4) 本プロジェクトの追跡調査のため、健康診断・保健情報システムのフォローアップ専門家を派遣するべきである。

(5) 生活習慣病の予防活動は、カリブ諸国においても重要課題であり、本プロジェクトの成果を提供するため、ジャマイカにおいてカリブ諸国を対象とした第三国研修を実施するべきである。

3－6　教　訓（他の類似プロジェクトの発掘・形成、実施、運営管理に参考となる事柄）

(1) 技術モデルの対象地域全体への早期展開を可能とするため、技術移転を1郡に集中して行い、それをほかの郡に段階的に拡大するというアプローチをとると効果的である。

(2) 情報交換・方針決定を適切に行うため、実務者レベル会議を定期的に開催するとよい。

(3) 機材供与やスタッフ教育を十分に計画するため、討議議事録（R／D）署名からプロジェクト開始までの期間は、柔軟に決定すると効果的である。

(4) プロジェクトで導入された活動が、現地に根づくため、政策に合致しているだけでなく、住民のニーズに明確に応えるプロジェクト目標を設定するべきである。

3－7　フォローアップ状況

上記評価結果を受けて、2003年度より第三国研修（生活習慣病）を3年間の計画で実施している。また南部地域でつくられた生活習慣病予防の活動モデルを、同様の疾病構造をもつ周辺カリブ諸国を対象に普及することをめざし、2003年度に短期専門家を派遣予定である。

第１章　終了時評価調査の概要

１－１　調査団派遣の経緯と目的

ジャマイカの保健指標は、乳幼児死亡率（24.5対1,000、2001年）や出生時平均余命（72歳、2001年）にみられるように、中南米諸国のなかでは、比較的良好な水準にある。しかし、高齢化及び生活様式の変化に伴い、高血圧症、糖尿病をはじめとする生活習慣病の増加が問題となっている一方、人口の40％以上が居住する首都圏とその他地域との保健サービスの格差も大きい。

プロジェクト方式技術協力案件「ジャマイカ南部地域保健強化プロジェクト」は、保健医療面で他地域よりも遅れている同国南部地域（マンチェスター、セント・エリザベス、クラレンドンの３郡）において、地域住民の健康を改善すべく、特に生活習慣病に関連する健康教育と疾病予防に重点を置いて、保健医療システム強化を目標に協力を実施中である。

今般の終了時評価調査団は、2003年５月31日の協力期間終了を控え、以下を目的として派遣された。

(1) これまでの協力について活動当初計画に照らし、プロジェクトの活動実績、管理運営状況、カウンターパート（C／P）への技術移転状況等について、評価５項目に基づいて評価を行う。

(2) 評価結果から教訓、及び提言を導き出し、プロジェクト終了後の方針について相手国側と協議する。

(3) 合同評価報告書を作成し、これを添付したミニッツの署名を行う。

１－２　調査団の構成

担当分野	氏　名	所　属
団長／総括	佐藤　敬	弘前大学 医学部 附属脳神経血管病態研究施設 教授
地域保健	柴田　ミチ	青森県 健康福祉部 副参事
協力計画	奥本　恵世	国際協力事業団 医療協力部 医療協力第二課
プロジェクト評価	藤田　健司	財団法人 社会経済生産性本部

１－３　調査日程

日順	月　日	曜日	移動及び業務		備　考
1	11月16日	土	【調査団本体】	【藤田団員】 移動　JL006 成田（12：00）→ ニューヨーク（10：20）	機　中
2	11月17日	日		移動　AA645 ニューヨーク（7:00）→キングストン（10:57）	キングストン

日順	月　日	曜日	移動及び業務		備　考
3	11月 18日	月	【調査団本体】	【藤田団員】 午前：JICAジャマイカ駐在員事務所との打合せ マンデビルへ移動 午後：南部地域保健事務所（SRHA）表敬、C／Pインタビュー	マンデビル
4	11月 19日	火		C／Pインタビュー、インタビュー結果取りまとめ、受診者聞き取り調査	マンデビル
5	11月 20日	水		C／Pインタビュー、インタビュー結果取りまとめ、受診者聞き取り調査	マンデビル
6	11月 21日	木		フリーチェック視察、コミュニティーヘルスエイド（CHA）への聞き取り調査、受診者聞き取り調査	マンデビル
7	11月 22日	金	【奥本団員】 移動　AA1735 マイアミ→キングストン（15：19）	ウェルネスクリニック（あるいはモバイルクリニック）視察、受診者聞き取り調査	マンデビル／キングストン
8	11月 23日	土	【佐藤団長／柴田団員】 移動　JL006 成田（12:00）→ニューヨーク（10：20）	移動　マンデビル→キングストン 日本人専門家インタビュー　担当者との打合せ、インタビュー結果取りまとめ	キングストン
9	11月 24日	日	移動　AA645 ニューヨーク（7:00）→キングストン（10:57） 団内打合せ	午後：団内打合せ	キングストン
10	11月 25日	月	JICAジャマイカ駐在員事務所との打合せ、在ジャマイカ日本大使館表敬、企画庁（PIOJ）表敬、保健省（MOH）表敬、C／Pインタビュー（Mrs.Grace Allen-Young、Dr.Eva Lewis Fuller）		キングストン
11	11月 26日	火	午前：移動　キングストン→マンデビル 午後：SRHA 打合せ		マンデビル
12	11月 27日	水	ウェルネスクリニック訪問（セント・エリザベス）、病院・保健センター視察		マンデビル
13	11月 28日	木	プロジェクト・サイクル・マネージメント（PCM）ワークショップ		マンデビル
14	11月 29日	金	PCMワークショップ、ワークショップ結果取りまとめ		マンデビル
15	11月 30日	土	調査団内打合せ、ワークショップ結果取りまとめ等		マンデビル
16	12月　1日	日	調査団内打合せ、書類整理等		マンデビル

日順	月　日	曜日	移動及び業務	備　考
17	12月　2日	月	SRHA打合せ、保健関連施設視察（マンチェスター保健センター） キングストンへ移動	キングストン
18	12月　3日	火	PIOJ、MOHとの合同会議（合同評価報告書）	キングストン
19	12月　4日	水	ミニッツ修正・署名式準備、ミニッツ（合同評価報告書）署名	キングストン
20	12月　5日	木	在ジャマイカ日本大使館報告、JICAジャマイカ駐在員事務所報告 移動　AA656 キングストン発（16：40）→ニューヨーク着（20：29）	機　中
21	12月　6日	金	移動　JL005　ニューヨーク発（12：15）→	機　中
22	12月　7日	土	→成田着（16：25）	

1－4　主要面談者

(1) ジャマイカ側

1) 保健省（Ministry of Health：MOH）

Grace Allen-Young	Permanent Secretary
Eva Lewis Fuller	Director, Cooperation in Health/Policy Analyst

2) 企画庁（Planning Institute of Jamaica：PIOJ）

Leila Palmer	Director, External Cooperation Management Division
Denise Irving	Manager, Bilateral Unit
Sannia Laing	Senior Administrator, Bilateral Unit

3) 南部地域保健事務所（Southern Regional Health Authority：SRHA）

Fay Petgrave	Director
Michael Phillip Coombs	Regional Technical Director
H. Hamilton	Director, Management Information System
H.Ismail	Director, Operations and Maintenance Division, SRHA
Yvonne Pitter	Parish Manager, Manchester
Sandra Chambers	District Medical Officer, Manchester Health Department
D.Stephenson	Community Health Nurse, Manchester Health Department
A. Carney	Nutritionist, Manchester Health Department
N.Anderson	Medical Technologist, Manchester Health Department
A.Stephenson	Clerical Officer, Manchester Health Department
Telma Davis	Nurse Practitioner, St.Elizabeth Health Department
D.Grandison	Health Educator, St.Elizabeth Health Department
C.Taylar	Health Educator, St.Elizabeth Health Department
L.Collins	Nutritionist, St.Elizabeth Health Department

Canute Thompson	Parish Manager, Clarendon
L.Dawes	Medical Officer, Clarendon Health Department
C.Pearson	Health Educator, Clarendon Health Department
M.Lawrence	Community Health Nurse, Clarendon Health Department
W.Reeves	Laboratory Technician, Manchester Health Department

4) 汎アメリカ保健機関（PAHO）ジャマイカ事務所

Manuel Pena	Representative
Maria O.T. Rankine	Programme Officer

(2) 日本側

1) 在ジャマイカ日本大使館

大塚　功	特命全権大使
大西　英之	一等書記官

2) JICA ジャマイカ駐在員事務所

熊谷　信広	所　長
影山　洵	青年海外協力隊調整員

3) プロジェクト専門家

三田　禮造	チーフアドバイザー
宮本　則子	業務調整
吉田　智子	健康教育

1－5　対象プロジェクトの概要

1－5－1　プロジェクトの要請背景・経緯

(1) 要請背景

ジャマイカは、1994年の世界銀行推計によれば、人口約250万人、1人当たりの国民総生産（GNP）が1,380米ドルの低位中所得国であり、また国連開発計画（UNDP）の人間開発指標（HDI）においては、ミディアム（中位開発状況）HDI国と位置づけられている。

しかし、ジャマイカ全人口中、46%の112万人が地方に居住し、その地方人口の80%（約90万人）がUNDPの基準からほど遠い栄養不良、感染症等の罹患状況から脱却できない状態に置かれている。特に、医療分野では、公共地方病院における基礎的医療資機材の不足、看護体制の不備、医療従事者の海外流出等、人材不足から生じる医療サービスレベルの低下が著しく、貧困層は十分な医療サービスを満足に受けられない状況にある。

ジャマイカ政府は、医療行政の地方権限移譲をはじめ、地方保健の強化に努めているが、

財政的な制約から拠点となる保健センター等の機能拡充が困難な状況にあり、十分な進展がみられていない。

係る状況から、同国政府は保健医療面で他の地域より遅れている南部地域において、地域住民の健康を改善すべく、我が国に対し協力を要請してきた。

(2)「ジャマイカ感染症基礎調査団」派遣

1995年4月10日～5月9日の日程で、感染症基礎調査団が派遣され、ジャマイカにおける保健・医療行政の現状把握、データ収集を通じ、今後の技術協力計画の必要性と対象分野が調査された。

同調査団の報告によれば、以下のような分野で技術協力へのニーズがみられた。

・プライマリーヘルスケアプログラムの強化（栄養障害における予防と対策）
・地域保健の強化（成人病の治療と予防）
・人材開発（医療従事者の要請とそれに伴う機材供与）
・専門医療の強化〔第三次医療機関等における専門部門（救急救命センター、熱傷センター、臨床検査センター等）の機能拡充〕
・感染症対策（胃腸炎を中心とする感染症の治療と予防）
・産業保健（職場環境の改善と職業性疾病の治療と予防）

(3)「保健開発計画専門家」派遣

感染症基礎調査の結果を受け、技術協力の実施に向けてニーズの絞り込みと妥当性の検討を行うために、1996年2月12日～26日の日程で専門家の派遣を行った。専門家の調査により、プロジェクトの対象は南部3郡、分野としてはプライマリーヘルスケア（特に成人病予防に関するもの、及び母子保健、エイズ、保健教育等）の優先度が高いことが明らかとなった。

1－5－2　プロジェクトの実施目的と基本計画（プロジェクト開始当初）

プロジェクトの最終的な協力内容、協力方法、協力対象地域などの特定と協力実施計画の策定を行い、討議議事録（R／D）、及び暫定実施計画（TSI）の署名・交換を行うことを目的として、実施協議調査団を派遣した。同調査団によるジャマイカ側との協議の結果、合意されたプロジェクトの実施計画は以下のとおりである。

(1) 上位目標

地域保健システムの強化により、ジャマイカ住民の保健状況を向上する

(2) プロジェクト目標

ヘルスプロモーションと疾病予防に焦点をあて、南部地域の保健システムを強化する

(3) 成　果

1) SRHA の組織運営能力、及び人的スキルを含む郡保健施設の機能が向上する

2) パイロット郡であるマンチェスター郡において、疾病予防モデルが開発される

3) 疾病予防モデルが南部地域のほかの郡に広げられる

1－5－3　プロジェクトの活動計画

実施協議調査団派遣時に締結されたTSIによれば、活動計画は①ヘルスケアシステムの調査・評価、②疾病予防活動の計画と実施、③ヘルスケアワーカーのトレーニングに大別された。

1－5－4　プロジェクトの投入計画

実施協議調査団派遣時に締結されたTSIによれば、当初の計画は以下のとおりである。

(1) 日本側投入

1) 専門家　　：チーフアドバイザー、業務調整、健康診断、公衆衛生、健康教育、その他

2) 研修員受入れ：適　宜

3) 機材供与　　：適　宜

4) 調査団　　：2000 年に運営指導調査団、2002 年に終了時評価調査団を派遣

(2) ジャマイカ側投入

1) C／P の配置

2) プロジェクト活動費の負担

3) 土地、建物及び施設

1－5－5　プロジェクトの内容変更

2001 年 1 月に行われた運営指導調査の際に、プロジェクト後半のプロジェクト・デザイン・マトリックス（PDM）が作成された。上位目標、プロジェクト目標、成果は以下のように改訂され、より生活習慣病予防に焦点を絞った内容となった。

(1) 上位目標

ジャマイカ住民の健康状況が、地域保健システムの強化によって向上する

(2) プロジェクト目標

生活習慣病予防に焦点をあて、南部地域の保健システムが強化される

(3) 成　果

1) SRHA の行政・組織体制が向上する

2) 郡保健センター施設機能が向上する

3) 人的な能力・技術が向上する

4) マンチェスター郡で生活習慣病の予防モデルが開発・実施される

5) 生活習慣病の予防モデルがセント・エリザベス郡とクラレンドン郡に拡充する

第２章　終了時評価の方法

２－１　評価用 PDM（PDMe）

本プロジェクトにおいて、1998 年４月の実施協議調査団ではプロジェクト・デザイン・マトリックス（PDM）を作成せず、プロジェクト前半期における南部地域の保健システム、医療保健関連施設の現状、生活習慣病に関するニーズを特定したうえで、実態にあった PDM を作成することとした。前半期の現状調査を受け、2001 年１月の運営指導調査団において、PDM 作成のためのプロジェクト・サイクル・マネージメント（PCM）ワークショップが開催され、保健省（MOH）、企画庁（PIOJ）、南部地域保健事務所（SRHA）幹部、カウンターパート（C／P）、外部有識者、日本チームが討議し、PDM を作成した。

今回の終了時評価においては、2001 年１月に作成された PDM の指標、及び入手手段を見直し、必要な修正、追加を行い、PDMe を作成した。PDMe は、終了時評価調査期間中に実施した「Evaluation ワークショップ」で、ジャマイカ側からの承認を受けた。

２－２　主な調査項目と情報・データ収集方法

２－２－１　主な調査項目

今般の終了時評価では、評価５項目ごとに調査項目を設定した。

(1) 妥当性

・保健省の保健政策と合致しているか。
・ターゲットグループ「16 歳以上の成人」「南部地域」は適切であったか。
・南部地域における保健政策に合致しているか。
・プロジェクトデザインは適切であったか。

(2) 有効性

・プロジェクトにより、「コミュニティーでの生活習慣病に関連した自覚・行動の変化」がみられるか。
・プロジェクト目標達成に関して、SRHA、及び C／P は満足しているか。
・プロジェクト目標は５つの成果によって達成されたか。どの成果の貢献が大きかったか。
・外部条件は実現されたか。プロジェクト目標の達成に負の影響を与えなかったか。

(3) 効率性

・５つの成果はそれぞれ達成されたか。
・活動が成果に転換されることに対して、外部条件の影響はあったか。

・日本側、ジャマイカ側からの投入（専門家、C／P配置、機材等）の質、量、タイミングは適正であったか。

(4) インパクト

・上位目標「ジャマイカ住民の健康状況が地域保健システムの強化によって向上する」は、どの程度達成されたか。

・プロジェクトの実施により、予想外（正・負）のインパクトは生じなかったか。

(5) 自立発展性

・組織的自立発展性は確立しているか（SRHAは、プロジェクトで実施してきた生活習慣病予防活動を維持する政策意思をもっているか、MOHは、そのモデルをジャマイカ全体に展開する政策意思をもっているか、活動に必要な組織体制、機材のメンテナンス・管理体制は確立しているかなど）。

・財政的自立発展性は確立しているか〔南部地域で生活習慣病予防活動実施に必要な財源は、今後も確保されるか、現在の健康診断受診費用（600ジャマイカドル）は、住民に受け入れられているかなど〕。

・技術的自立発展性は確立しているか（育成されたC／Pは、プロジェクト活動を継続するために十分な能力をもっているか、C／Pは、今後も南部地域保健事務所に定着するとみてよいか、機材のメンテナンス・管理を行う人材は、確保されているかなど）。

2－2－2　情報・データ収集方法

評価にあたっては、以下のような情報を収集した。

1) 1998年4月の実施協議調査団における討議議事録（R／D）
2) 2001年1月の運営指導調査団におけるミニッツ、及び調査団時に作成されたPDM
3) プロジェクト活動に関する記録（ウェルネスクリニックにおける記録を含む）
4) PDMe
5) 帰国（長期）専門家へのインタビュー結果
6) 本プロジェクトに関する各調査団報告書、専門家帰国報告書、プロジェクト四半期報告書
7) 終了時評価調査時におけるMOH、SRHA幹部、その他C／P、コミュニティーヘルスエイド（CHA）へのインタビュー結果
8) 終了時評価調査時における健康診断受診者への聞き取り調査結果
9) ウェルネスクリニック、モバイルクリニックの観察

第3章　調査結果

3－1　現地調査結果

3－1－1　保健省（MOH）、南部地域保健事務所（SRHA）幹部へのインタビュー

MOH次官、保健協力調整官へのインタビューでは、現在、生活習慣病への対策が国家保健施策の重要課題であること、また、本プロジェクトが南部地域において、生活習慣病予防モデルを構築したことについて、高く評価していることが明言された。さらに、MOHにおける四半期ごとのミーティングでは、本プロジェクトの活動が他保健地域の幹部に紹介されており、MOHとしても本プロジェクトで開発されたモデルを、他保健地域に普及する意思をもっているとのコメントがあった。

SRHA幹部へのインタビューでは、他保健地域と比較して南部地域は人口に占める高齢者割合が高く、生活習慣病予防への対策は重要性を増していること、地方分権化政策のなかで保健予算の削減が強いられており、そのなかで治療より予防に重点を置いた本プロジェクトは、同地域の保健ニーズに適合するものであった旨が話された。また、南部地域のなかで、まずマンチェスター郡でモデルを開発し、それを他2郡に展開していくデザインも効果的であった旨の評価を受けた。プロジェクト目標については、指標である「コミュニティーでの生活習慣病に関連した自覚・行動の変化」は、より長期的に確認していく必要があるが、本プロジェクトによる健康診断や健康教育等の新たなサービスの実施、そのための機材の充実、コンピューターの導入、保健スタッフの教育等によって、「生活習慣病予防に焦点をあて、南部地域の保健システムが強化される」というプロジェクト目標は、十分達成されたとのコメントを受けた。プロジェクト実施の効率性については、おおむね問題がなかったが、人材確保の難しさから他2郡でのウェルネスクリニック、モバイルクリニックの開始が遅れた点が反省点としてあげられた。自立発展性については、SRHAが現在作成中の2003年からの保健5か年戦略計画でも、生活習慣病対策は最も優先順位の高い項目であり、3郡においてプロジェクトの成果を維持、発展させていくこと、そのために必要な予算措置を継続していくことについて、強い意思をもっていることが確認された。

3－1－2　カウンターパート（C／P）、コミュニティーヘルスエイド（CHA）へのインタビュー

(1) C／Pへのインタビュー

本プロジェクトでは、南部地域における生活習慣病予防にかかわる保健行政担当幹部、医師、看護婦、保健婦、栄養士、保健教育官等をC／Pとした。彼らの本プロジェクトに関する評価として共通するものが3点ある。

まず第1点は、生活習慣病を対象として健康診断と健康教育を行った本プロジェクト

が、南部地域の住民のニーズに適合し、時宜を得たものであったということである。受診者の健康に関する意識も変わってきていると感じるC／Pも多い。これは健康診断のみでなく、受診者に対して医師を中心に直接的に健康教育、カウンセリングを行っている効果だと考えられる。

第2点は、C／Pが新たなサービスであるウェルネスクリニック、モバイルクリニック等の業務にやりがいと責任感を感じていることである。特に、日本での研修で、健康を各個人が自身で管理する考え方、地方自治体やコミュニティーの役割、効率的な健康診断の運営の仕方を目のあたりにしたことが、彼らの意識向上に大きな役割を果たしたと考えられる。

第3点としては、彼らはプロジェクトの成果が持続するうえで、機材のメンテナンス、消耗品購入に必要なコストを確保することについて、強い問題意識をもっていたことである。

(2) CHAへのインタビュー

本プロジェクトでは、南部地域で活動する約450名のCHAの研修を行い、ウェルネスクリニック、モバイルクリニック、フリーチェック（無料で行う簡易健康診断）をサポートするうえで、必要な能力向上を図った。彼らとのインタビューでは、C／P同様、ウェルネスクリニック等の活動に参加できたことに満足しており、住民のニーズに合っていると感じていることが分かった。

3－1－3　健康診断受診者への聞き取り調査、及びウェルネスクリニック、モバイルクリニック現場視察

(1) 健康診断受診者への聞き取り調査

今回の終了時評価調査団では、2002年11月19日～22日の期間、クラレンドン郡で行われたウェルネスクリニック（1回）、マンチェスター郡、及びセント・エリザベス郡で行われたモバイルクリニック（各1回、計2回）の受診者のうち、同クリニックを初めて受診した14名、及びマンチェスター郡でのモバイルクリニック受診者のうち、今回の受診以前に受診経験のある人1名と、同郡で実施した糖尿病教室の既受講者9名のリピート受診者の計10名、合計24名を対象に個別対面式で聞き取り調査を行った。

初めて受診した14名の調査から分かったことは、①健康診断自体を初めて受診した人が半数おり、以前受けたことがある人も、何らかの治療を受けた際に健康診断も受けたものであった（健康診断自体が目的ではなかったこと）、②ほとんどの受診者が今回の受診の結果、栄養摂取の仕方を変えることや、より運動を行うなど、生活習慣を変える問題意識を

もったこと、③受診者全員が、家族や知人にウェルネスクリニックやモバイルクリニックに来ることを勧めると回答したこと、④ほとんどの受診者が今回の受診で受けたサービスが十分効率的であり、受診料600ジャマイカドルは高くないと感じていることの4点である。

次に、リピート受診者10名の調査から分かったことは、①以前の受診（モバイルクリニック及び糖尿病教室）以降、ほとんどの受診者がより生活習慣を変更していること（栄養価が高く、糖分や脂肪分が少ないものを摂取するようになったり、間食を減らしたり、より運動を行ったりなど)、②受診者全員が今後も受診したいと考えていること、③ほとんどの受診者が今回の受診で受けたサービスが十分効率的であり、受診料600ジャマイカドルは、高くないと感じていることの以上3点である。

インタビューの対象人数が少ないものの、この結果から、プロジェクトで実施された健康診断が受診者の意識に変化をもたらしたことがうかがわれた。

(2) ウェルネスクリニック、モバイルクリニックの現場視察

今回の終了時評価調査団では、2002年11月19日～22日の期間、クラレンドン郡、セント・エリザベス郡で行われたウェルネスクリニック（各1回、計2回)、マンチェスター郡、及びセント・エリザベス郡で行われたモバイルクリニック（各1回、計2回)、及びマンデビル保健センターに設置されたフリーチェック用機材等を視察した。その結果、分かったことは、①いずれも10名以上の受診者がいたこと（セント・エリザベス郡で行われたモバイルクリニックは40名以上が受診した)、②供与された機材は、ウェルネスクリニック、モバイルクリニックにて活用され、管理状況もよいこと、③マンデビル保健センターに設置されたフリーチェック用機材（身長計、体重計、血圧測定機）は、センター訪問者が自由に使えるようになっており、実際に使われていたこと、④クリニックの業務の効率性については、場所により差があったこと（待ち時間が長い、事前準備が不十分）などであった。

3－2　プロジェクトの実績

3－2－1　日本側投入

(1) 専門家派遣

長期13名（4分野）、短期15名（10分野）

	分　野	人　数（人）
長期専門家	チーフアドバイザー	4
	業務調整員	2
	健康診断	4
	健康教育	3
短期専門家	心電図検査法	1
	保健情報管理	2
	IEC	2
	臨床検査室運営管理	2
	生活習慣病予防のための運動指導	1
	保健教育教材開発	3
	集団検診	1
	保健行政	1
	糖尿病	1
	循環器病診断技術	1
合　計		28

(2) 機材供与

5年間で8,539万9,000円の機材が供与された。

年　度	内　容	金　額（千円）
1998	車両（4WD、マイクロバス）、心電計、体脂肪測定装置付身長体重計等	16,875
1999	車両（4WD、マイクロバス）、心電計、PC等	20,085
2000	自動血圧計、液晶プロジェクター、心電図等	19,869
2001	血液検査用自動解析装置、超音波画像診断装置、簡易血圧計等	28,570
2002	な　し	0
合　計		85,399

(3) 研修員受入れ

延べ18名を受け入れた。

分　野	人　数（人）
保健行政	7
地域保健（地域保健活動）	3
保健教育（健康教育）	2
公衆衛生	2
視聴覚メディア制作	1
循環器病診断技術及び治療法	1
健康診断	1
保健情報管理連	1
合　計	18

(4) ローカルコスト負担

5年間で総額2,653万9,000円を負担した。

3－2－2　ジャマイカ側投入

(1) 人員の配置

22人の保健省職員（SRHA含む）、及び3郡職員がC／Pとされた。各機関ごとの人員配置数は、以下のとおりである。

組　織	職員数（人）
MOH本省	3
SRHA	3
マンチェスター郡	6
クラレンドン郡	5
セント・エリザベス郡	5
合　計	22

(2) 施設の貸与

SRHA内に日本人専門家用のスペースが貸与された。

(3) 運営コストの負担

通信費、モバイルクリニック車の改装費用等が負担された。

3－2－3　成果の達成状況

(1) 成果1「SRHAの行政・組織体制が向上する」

途中で人員が欠員のある時期もあったものの、最終的にはウェルネスクリニックのスタッフ（モバイルクリニックを含む）は、23名から確保された。合同調整委員会の下に位置づけられる、実務者による委員会がほぼ毎月開かれ、中心となる行政官・保健スタッフが参加することにより、活動実績を定期的にモニタリングするよい機会となった。

(2) 成果2「郡保健センター施設の機能が向上する」

対象3郡の保健センターにおいて、フリーチェック（体重、身長、血圧等の簡易健康診断）が実施されるようになり、実施する保健センターの数も増えてきている。この背景にはCHA対象のヘルスケアワークショップがプロジェクトの活動として実施され、459人のCHAが参加したことがある。このワークショップにより、CHAは生活習慣病に関する基本的知識を得、血圧測定やボディー・マス・インデックス（BHI）の算出の仕方などを学んでいる。

(3) 成果3「人的な能力・技術が向上する」

日本でのC／P研修、中堅技術者養成研修（糖尿病対策、栄養、心臓病等）などを通じ、延べ868名のスタッフが生活習慣病に関連するトレーニングを受けた。調査で行われた主要なC／Pによるインタビューの結果においても、生活習慣病の予防のための業務の重要性を感じ、それに取り組むことに高いコミットメントを示している。

(4) 成果4「マンチェスター郡で生活習慣病の予防モデルが開発・実施される」

マンチェスター郡においては、1999年9月のウェルネスクリニック開設以来、週に2回のペースで実施され、2002年10月末までに2,397人が受診している。モバイルクリニックも週1回のペースで実施され、2,684人が受診している。延べ5,081人の受診者（うち336人が再受診者）のうち、1,061人が更なる検査、又は治療に差し向けられた。また、健康診断以外にも健康教育用の教材、ビデオ等が作成されたほか、糖尿病教室が開かれ、75人の患者が参加したり、運動の重要性を訴えるウォーカソンやヘルスフェア等が行われた。

(5) 成果5「生活習慣病の予防モデルがセント・エリザベス郡とクラレンドン郡に拡充する」

セント・エリザベス郡においては、ウェルネスクリニック、モバイルクリニック合わせて、2002年10月末までに1,447人が受診した。クラレンドン郡でもウェルネスクリニックは開始されたものの、モバイルクリニックについては車両の改造等に時間がかかっており、

開始直前という状況であった。ただし、ニーズは非常に高く、マンチェスター郡のバスを用いて健康診断を実施している。

3－2－4　プロジェクト目標の達成状況

本プロジェクトは、健康診断と健康教育の導入を通じて、「生活習慣病予防に焦点をあてた南部地域のヘルスケアシステムの強化」は、かなりの程度達成できたといえる。一連の活動を通じて、このような健康診断、健康教育に地域住民がアクセスする機会が増加し、またウェルネスクリニック、モバイルクリニックによって、人々の生活習慣が徐々に変化している様子がインタビューによって確認された。

3－2－5　上位目標の達成状況

本プロジェクトの上位目標は、「ジャマイカ住民の健康状況が地域保健システムの強化によって向上する」と設定された。現時点では対象の3郡以外で独自にウェルネスクリニック、モバイルクリニックが行われている地域はないが、MOHは、ほかの地域に本プロジェクトから得られた様々な成果を普及する意向をもっており、また他の地域保健事務所も南部の生活習慣病予防活動に関心をもっている。財政状況にやや不安は残るものの、本プロジェクトで定着した生活習慣病予防活動が、南部以外の地域に広がっていくことは、ほぼ間違いないと思われる。

3－3　プロジェクトの実施プロセス

ほぼ毎月行われた運営委員会に3郡のC／Pが集まることにより、情報交換や方針決定が行われ、活動のモニタリングがなされてきた。加えて、この委員会で他の郡の活動状況を聞くことで、活動へのモチベーションを高める効果もみられた。

C／Pの活動への取り組み状況の面では、プロジェクトが進捗するにつれて参加度も高くなり、また、特に日本での研修を受けたC／Pについては、プロジェクトが必要な背景をよく理解し、熱心に取り組んでいる様子がうかがわれた。

財政状況が厳しいなか、ウェルネスクリニック、モバイルクリニックにかかる費用は、徐々にジャマイカ側の負担を増やすよう配慮されてきた。またC／Pの配置についても、セント・エリザベス郡とクラレンドン郡の医師の配置がなかなか決定しないなどの問題はあったものの、キューバ人医師を雇用するなどジャマイカ側の努力がみられた。このことから、プロジェクトが進行するなかで、相手側のオーナーシップも高まっていったといえる。

第4章　評価結果

4－1　評価5項目の評価結果

4－1－1　妥当性

(1) 上位目標の妥当性

生活習慣病は、ジャマイカにおける死亡、疾病の大きな要因となっている。保健省（MOH）は、保健政策における優先課題の1つに生活習慣病を掲げ、ジャマイカ国民への健康な生活様式の増進、及び生活習慣病の予防に取り組んできている。またMOHは、本プロジェクト活動とその成果を高く評価しており、南部地域以外にもプロジェクトの成果を普及する方針をもっている。

(2) プロジェクト目標の妥当性

南部地域は、他地域と比較して人口に占める高齢者の割合が高く、生活習慣病に関するリスクが高いと考えられるため、対象地域として妥当性が高い。また、本プロジェクトのターゲットグループは「16歳以上の成人」とされたが、これは若年層から健康教育を実施することによって、健康的な生活様式を普及し、生活習慣病の予防につなげようというものである。

南部地域保健事務所（SRHA）は現在、2003～2007年の地域保健計画を策定中であり、生活習慣病への対策は優先課題とされる予定である。また、現在ジャマイカでは、保健サービスを含めた地方分権化推進の流れがあり、そのなかで効率的に地域保健サービスを行う必要性が高まっている。生活習慣病に関しては、治療より予防に重点を置く方がコスト面で有効性が高いことから、生活習慣病への予防に高い優先度が置かれている。

こうしたことから、生活習慣病の予防に焦点を絞った本プロジェクトは、国家保健政策と合致しており、タイムリーなものであったといえる。

(3) プロジェクトデザインの妥当性

本プロジェクトにおいては、第1段階として、マンチェスター郡において生活習慣病予防のためのモデル（ウェルネスクリニック、モバイルクリニック、健康教育）を確立し、第2段階として、そのモデルをセント・エリザベス、クラレンドン2郡に展開する形で実施された。限定した地域に集中的に投入を行うことにより、マンチェスター郡でのモデルが早期に確立し、他地域に展開することが可能になった。

4－1－2　有効性

(1) プロジェクト目標の達成度

「3－2－4　プロジェクト目標の達成状況」参照。

(2) 成果とプロジェクト目標の関連

プロジェクト目標の達成に関して、5つの成果それぞれが欠くことのできない要素であった。特にそのなかでも、「成果1．SRHAの行政・組織体制が向上する」「成果3．人的な能力・技術が向上する」「成果4．マンチェスター郡で生活習慣病の予防モデルが開発・実施される」が重要であった。成果1は、ウェルネスクリニック、モバイルクリニックを実施するための組織体制の構築（ファンデーションビルディング）であり、成果3は、それを実施するための保健実務者の技術力の向上、及び彼らのモチベーションの喚起である。成果1、2が基本になり、マンチェスター郡における生活習慣病モデルの構築という成果4を可能にし、プロジェクト目標への達成へとつながったものと考えられる。

(3) 有効性に関する貢献要因・阻害要因

有効性を促進した最も大きな要因は、本プロジェクトにかかわったジャマイカ側の保健スタッフの意識の変化である。専門家による指導、訪日研修、ウェルネスクリニック等の実践など、プロジェクトの実施に従い、生活習慣病の予防、そのための健康的なライフスタイルの必要性を理解し、主体的にプロジェクト活動を行うまでになった。

有効性に関する阻害要因は特定されなかった。

4－1－3　効率性

(1) 成果の達成度

「3－2－3　成果の達成状況」参照。

(2) 活動の成果への転換における外部条件の影響

プロジェクト・デザイン・マトリックス（PDM）においてあげられた3つの外部条件は、すべて実現した。特に、「生活習慣病予防に関する外部機関との協力関係が現状より悪くならない」については、本プロジェクトはジャマイカ糖尿病協会、ジャマイカ心臓病協会、西インド大学等医療関係機関とは、生活習慣病に関する情報交換、講師派遣等で協力した。また青年海外協力隊（JOCV）からは、ウェルネスクリニックの機材メンテナンスについて協力を受けた。

(3) 投入の活用度、及びタイミングの適正度

2002年11月20日現在、合計23人のスタッフがウェルネスクリニック、及びモバイルクリニックを実施するために配置されている。その内訳は、マンチェスター郡8名、セント・エリザベス郡8名、クラレンドン郡7名となっている。ジャマイカ側のスタッフ配置のタイミング、その質、量はおおむね適切であった。しかし、セント・エリザベス郡、クラレンドン郡の医師配置が遅れ、両郡においてウェルネスクリニック、モバイルクリニックを開始するのが遅れる原因となった。配置されたスタッフの技術的知識、専門能力は、本プロジェクトを実施するうえで適切であった。

日本人専門家の派遣のタイミング、質、量は適切であった。投入された機材の質、量は適切であり、プロジェクトの活動に大いに活用された。機材供与のタイミングについては、本プロジェクト最初の機材は、手続きの遅れから開始後1年後に供与されたが、日本人専門家が携行した機材を活用することにより、プロジェクト活動には支障を来さなかった。

4－1－4　インパクト

(1) 上位目標の達成度

「3－2－5　上位目標の達成状況」参照。

(2) 予期していなかったインパクト

本プロジェクトは、ジャマイカ南部地域のヘルスケア、住民のライフスタイルに、予想外ではあるが、下記の正のインパクトを与えた。

・SRHAは、2003年2月に「Healthy Lifestyle賞」を設置することを計画している。
・ジャマイカ国内のほかのヘルスケアサービス提供者が、プロジェクトの活動に関心をもつようになった。例えば、医療保険会社であるブルークロスがウェルネスクリニックを見学に来た。
・セント・エリザベス郡のある小学校の生徒たちが、食習慣を変えはじめた。
・ウェルネスクリニック、モバイルクリニックの健康診断で、生活習慣病以外の病気が早期に発見された患者が何名かいた。
・受診者の口コミでウェルネスクリニック、モバイルクリニックの受診者が集まるようになった。
・「英国等、先進国と同じレベルの健康診断・健康教育を受けられた」と評価した受診者が何名かいた。

4－1－5　自立発展性

(1) 組織的自立発展性

MOHは、生活習慣病への対策を国家保健政策の優先課題としている。MOHは、本プロジェクトにおける活動成果を高く評価しており、ほかの保健地域にプロジェクトの成果を展開することを検討している。こうした観点から、本プロジェクト活動、及び上位目標である本プロジェクトのジャマイカ国内への普及について、MOHから政策的な支援は、今後も継続するものと考えられる。

SRHAは、現在、2003～2007年の地域保健計画を策定中であり、そのなかで生活習慣病への対策は、優先課題と位置づけられる予定である。3郡事務所ともウェルネスクリニック、及びモバイルクリニックの実施回数を増やすことを検討しており、SRHAがプロジェクト終了後も、生活習慣病の予防に関する活動を継続することは確実といえる。しかし、3郡でウェルネスクリニック、及びモバイルクリニックのサービスを拡充するのであれば、追加人員の確保が必要になると思われる。

本プロジェクトを契機に設置された運営委員会は、プロジェクトの活動をモニタリング・評価し、計画の修正を行ううえでも、3郡で活動状況に関する情報を共有化するうえでも重要であった。SRHAは、今後も運営委員会を継続していく意思をもっている。この点は組織的な自立発展性のうえからも重要である。

現在、受診者はウェルネスクリニック、モバイルクリニックで提供されるサービスの質に満足しており、現段階での自立発展性は確保されていると考えられる。また、クリニックでの運営体制には改善の余地がみられた。今後、自立発展性を強化していくために、各クリニックは、他のクリニックでのベストプラクティスから学び、自身のクリニックに適用することにより、運営体制を改善していく必要があろう。

これまでウェルネスクリニック、モバイルクリニックの活動は、様々な形でPRされてきたが、SRHA幹部は「これまでのPR活動は十分でない」という認識をもっていた。今後の活動拡大には、更にPR活動を強化していく必要がある。

医療機器のメンテナンス等に関しては、プロジェクト・サイクル・マネージメント（PCM）ワークショップでカウンターパート（C／P）自身が、メンテナンススタッフの不足、備品・消耗品の管理の不十分な点を課題としてあげていた。メンテナンスについては、これまでMOHのヘルス・ファシリティ・メンテナンス部門が担当してきたが、今後の活動拡充を見通した自立発展を考えると十分ではない。

ウェルネスクリニック、モバイルクリニックの受診者の記録は、マンチェスター郡においてはコンピューターで管理され、受診者のフォローアップ活動を行っていくためのデータベース化が行われている。受診者のフォローアップ活動を行っていくために、同様のデー

タベースがセント・エリザベス、クラレンドン両郡で完成される必要がある。また、そのためには必要なスタッフが配置されるべきである。

上記から、本プロジェクトの組織的自立発展性は、現状の活動を維持するレベルでは高いといえるが、生活習慣病予防への社会的ニーズの高まりにあわせ、活動を拡充することを考え合わせると、上述の改善されるべき点がみられる。

(2) 財政的自立発展性

生活習慣病への予防に国家保健政策上、プライオリティーが置かれていることから、本プロジェクトの成果は、今後も財政的な支援を得て維持、発展されると考えられる。実際にSRHAは、ウェルネスクリニック、モバイルクリニックを含めた生活習慣病の管理に、継続して予算措置を講じていくことを確約している。備品や機材のメンテナンス、修理に必要なコストが適正に見積もられ、今後も年予算のなかで確保されることが期待される。

現在、ほとんどの受診者が健診料は高くないと感じていることから、ウェルネスクリニック、モバイルクリニック自体は、財政的に持続し得るものと考えられる。

(3) 技術的自立発展性

本プロジェクトのC／Pやコミュニティーヘルスエイド（CHA）等の保健スタッフは、自立的に、生活習慣病の予防に関する活動を行うために十分な知識、技術を習得している。彼らの多くが活動に積極的にかかわっており、当面現在の保健サービス業務にかかわっていくことが期待できる。

プロジェクト終了後も引き続き彼らを動機づけし、更に能力の向上を図るためには、現在行われている新任オリエンテーションに加えて、継続的に体系的な教育訓練が提供されるべきであろう。加えて、今後新たに採用される保健スタッフへの研修も、生活習慣病予防のモデルを理解するために計画、実施されていく必要がある。

C／Pや日本人専門家からのヒアリングによれば、現在の機材故障の最大の原因は、機材の不注意な取り扱いとのことである。今後の自立を考えると現状では十分でないため、すべての保健スタッフを対象にした適切な機材の使い方の指導を繰り返し行うべきであろうし、機材のマニュアルも各機材に備え付け、いつでも見られるように管理されるべきである。

4－2　結　論

終了時評価調査の結果、本プロジェクトは、「生活習慣病予防に焦点をあて、南部地域の保健システムを強化する」というプロジェクト目標をおおむね達成することができた。

本プロジェクトにより実施されたウェルネスクリニック、モバイルクリニックは、公的機関が

実施する健康診断として、ジャマイカ初めての試みであった。本プロジェクトにおいては、まずマンチェスター郡でウェルネスクリニック、モバイルクリニックといったいわゆる生活習慣病予防モデルが確立され、その後、セント・エリザベス郡、クラレンドン郡に展開されていった。こうした活動により、生活習慣病に関する意識をもつ人々が、南部地域において確実に増加しており、実際にライフスタイルを改善した人々も多くみられるようになった。

第５章　提言と教訓

５－１　提　言

本プロジェクトは、当初の予定どおり2003年５月をもって終了することとし、その成果を終了後も持続・発展させるために、以下の諸点について提言するものである。

５－１－１　プロジェクト終了までの期間に関する提言

本プロジェクト終了までの約６か月間に、考慮されるべき提言として以下の諸点があげられた。

1)　機器保守点検機能の整備が重要である。まず機器のリストを現状に照らして見直し、実態に対応したリストを完備すること、またクリニックに必要な備品・消耗品の在庫は、いつでも使えるように適度に管理される体制づくりが必要である。保守点検のためのマニュアルを確保し、機器と一緒に保管するとともに、業者に依頼する場合に備えて、機器の納入業者のリストも完備するべきである。今後の活動、拡充を見通した自立発展を考えると、メンテナンスを行う技術スタッフが各郡に１名配置されるべきであろう。

2)　本プロジェクトを成功に導いた最も重要な要因は、スタッフの真摯な取り組みであると考えられる。今後もスタッフの意欲向上を図るために、現行の表彰制度を充実させ、生活習慣病予防活動に従事するスタッフにも広く適用されるべきである。プロジェクト終了後も引き続き彼らを動機づけし、更に能力の向上を図るためには、現在行われている新任オリエンテーションに加えて、継続的に体系的な教育訓練が提供されるべきであろう。また、今後、新たに採用される保健スタッフへの研修も、生活習慣病予防のモデルを理解するために計画、実施されていく必要がある。

3)　若年者を対象とした健康増進活動が推進されるべきだと考えられる。本プロジェクトにおける健康増進活動の対象年齢は、16歳以上とされているが、若年層に対するアプローチは必ずしも十分とはいえない。この点に関しては、学校での保健教育に生活習慣病予防教育を取り入れることが考えられる。また、若年者が重要な対象となっている母子保健教育、家族計画教育などとの提携も可能だと思われる。

4)　ウェルネスクリニック、モバイルクリニックにおいて、個々のスタッフがチームとして取り組むことを強化すべきであり、それによって一層適正な健診活動が達成され、待ち時間の短縮をはじめとする受診者サービスの向上が得られるものと期待される。

５－１－２　プロジェクト終了後に関する提言

本プロジェクト終了後の自立発展性のために重要だと考えられる事項として、ジャマイカ側

に対しては以下の諸点を提言したい。

1) ジャマイカ政府は、南部地域における現行の生活習慣病予防モデルを継続し、他地域に発展させるために、適切な予算措置を講じる必要がある。特に人材の確保とスタッフ教育のための予算措置が重要である。また、ウェルネスクリニック、モバイルクリニックの徴収料金は、それらの経費に充当されるべきである。

2) 南部地域保健事務所（SRHA）において、他地域の健診スタッフ教育のためのコースを実施することが必要である。このことは、他地域にとって重要であるとともに、南部地域スタッフの能力と意識の向上にも寄与すると期待される。

3) フリーチェック（無料健診）の実施が、生活習慣病予防健診の優先事項の1つとして、維持、推進されるべきである。フリーチェックは簡単な健康診断でありながら、生活習慣病の予防に関する意識を住民に植えつけるためには、極めて有用であり、ウェルネスクリニック、モバイルクリニックが他地域に波及されるに際しても、フリーチェックも同時に導入されなければならない。

また、日本側が取り組む事項としては、以下の点が考慮されるべきである。

1) 本プロジェクトの追跡調査のために、終了後2年以内を目途に健康診断、健康情報の分野の短期専門家を派遣することは、特に重要だと思われる。

2) 生活習慣病の予防活動は、他のカリブ諸国においても重要な課題であり、本プロジェクトの成果は、それらの国に対して提供されるべきである。そのために、カリブ諸国の専門家を対象とした第三国研修をジャマイカにおいて実施することが有益である。

5－2 教 訓

今後の類似プロジェクト実施のために、本プロジェクトの経験から得られた教訓として、以下の事項があげられる。

1) 本プロジェクトでは、生活習慣病予防健診モデルがまずマンチェスター郡に導入、確立され、次いで南部地域の他郡へと敷衍された。このように、技術移転がまず集中的に行われ、段階的に広げられたことは、本プロジェクトを成功に導いた要因の1つとして重要と考えられる。技術モデルの対象地域全体への早期展開を可能とするため、技術移転を一部で集中して行い、それをほかの郡に段階的に拡大するというアプローチは効果的である。

2) ジャマイカ側カウンターパート（C／P）や、日本からの派遣専門家などで組織された実務者会議を、月1回程度開催してきたことは、プロジェクト活動の現状分析と推進を検討する場として重要であった。このような情報交換・方針決定のための実務者レベル会議を、定期的に開催することは効果的である。

3) 本プロジェクトでは、開始後約1年を経て機材が供与されたり、日本で研修を受けたス

タッフがすぐに移動した例がみられた。特に、機材供与の時期やスタッフ教育計画などに十分な準備を確保するため、討議議事録（R／D）署名からプロジェクト開始までの期間は、柔軟に決定されるべきである。

4) 本プロジェクトの目的が、ジャマイカ住民の必要性に適ったものであることは、特に重要であった。政府レベルでの妥当性とともに、住民レベルでの需要に、明確に応えるプロジェクト目標を計画することは極めて重要である。

付　属　資　料

1．ミニッツ及び合同評価報告書

2．新聞記事（The Gleaner紙　2002年12月10日付）

1．ミニッツ及び合同評価報告書

MINUTES OF MEETINGS
BETWEEN THE JAPANESE PROJECT EVALUATION TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF JAMAICA
ON
THE JAPANESE TECHNICAL COOPERATION FOR
THE PROJECT ON STRENGTHENING OF HEALTH CARE IN THE SOUTHERN REGION

The Japanese Evaluation Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr Kei SATO visited Jamaica from 17 November to 5 December, 2002 in order to evaluate the implementation and achievements of the Project on Strengthening of Health Care in the Southern Region (hereinafter referred to as "the Project") , based on the Record of Discussions signed on 17 April, 1998.

During its stay in Jamaica, the Team held a series of discussions and observations, and exchanged views with representatives of the Government of Jamaica.
As a result of the discussions, both parties agreed upon the matters referred to in the document attached hereto.

Kingston, 4 December, 2002

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JOINT EVALUATION REPORT
ON
THE JAPANESE TECHNICAL COOPERATION
FOR
THE PROJECT ON STRENGTHENING OF HEALTH CARE IN THE SOUTHERN REGION

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)
JAPAN

MINISTRY OF HEALTH, PLANNING INSTITUTE OF JAMAICA,
JAMAICA

4 DECEMBER, 2002

CONTENTS

List of Abbreviations

BMI	Body Mass Index
C/P	counterpart
CHA	Community Health Aide
CLD	chronic lifestyle disease
JICA	Japan International Cooperation Agency
M/M	Minutes of Meetings
MC	Mobile Clinic
MOH	Ministry of Health
PCM	Project Cycle Management
PDM	Project Design Matrix
PDMe	Project Design Matrix for evaluation
PIOJ	Planning Institute of Jamaica
R/D	Record of Discussions
SRHA	Southern Regional Health Authority
WC	Wellness Clinic

1. Introduction

1-1. The Evaluation Team

The Japanese Evaluation Team (hereinafter referred to as "the Japanese Team") organised by the Japan International Cooperation Agency (hereinafter referred to as "JICA") , headed by Dr. Kei SATO visited Jamaica from 17 November to 5 December, 2002 for the purpose of the joint final evaluation on the Japanese technical cooperation for the Project on Strengthening of Health Care in the Southern Region (hereinafter referred to as "the Project"), which is scheduled to terminate on 31 May, 2003, according to the Record of Discussions (hereinafter referred to as "R/D") signed on 17 April, 1998.

The Japanese Team and the Jamaican representatives jointly analysed and discussed the achievements of the Project in terms of relevance, effectiveness, efficiency, impact, sustainability and the future directions, using the Project Cycle Management method (hereinafter referred to as "PCM" method) .

Through careful studies and discussions, the Japanese Team and the Project Team summarised their findings and observations as described in this document.

1-2. Methodology of Evaluation

The Project was evaluated jointly by the Japanese and Jamaican counterparts using the PCM method.

- Both teams examined the Project Design Matrix (hereinafter referred to as "PDM") of this Project. A PDM is a summary table of the overall description of the Project, its objectives and external conditions.
- Both teams confirmed the achievements of the Project in terms of its objectives, outputs, activities and inputs stated in the PDM.
- Both teams conducted the evaluation based on the five criteria, namely relevance, effectiveness, efficiency, impact, and sustainability, the descriptions of which are stated below.

1-3. Key Criteria of Evaluation

The evaluation was conducted based on the following five criteria, which are the essential points of consideration when assessing JICA-supported development projects.

1) Relevance: Relevance is the measure for determining whether the outputs, the project purpose and the overall goal are still in keeping with the priority needs and concerns at the time of evaluation.

2) Effectiveness: Effectiveness is the extent to which the project purpose has been achieved, or is expected to be achieved, in relation to the outputs produced by a project.

3) Efficiency: Efficiency measures the productivity of the implementation process: how efficiently the various inputs are converted into outputs.

4) Impact: Impact is the intended or unintended, the direct or indirect, the positive or negative changes that occur as a result of a project.

5) Sustainability: Sustainability is the measure for determining whether or not the project benefits are likely to continue after the external aid comes to an end.

1-4. Sources of information used for Evaluation

The following sources of information were used for this evaluation study.

1) The Record of Discussions (R/D) signed by Jamaican representatives and Leader of JICA Implementation Study Team on 17 April, 1998
2) The Minutes of Meetings (M/M) of Management Consultation Team of 22 January, 2001 and The PDM
3) The record of inputs from both teams and activities of the Project
4) The PDMe (Annex 1)
5) Interviews with the former Japanese long-term experts.
6) Client interviews conducted 19-22 November, 2002
7) Jamaican Counterpart interviews conducted 18-25 November, 2002
8) Other documents

2. Background and Summary of the Project

2-1 Brief Background of the Project

Health indicators of Jamaica are at a relatively good level when compared with Central and Southern American countries. However, chronic lifestyle diseases such as hypertension and diabetes have been increasing along with negative lifestyle changes and ageing of the population. The Government of Jamaica has been making efforts to strengthen and decentralise the health system.

Under such circumstances, Japan International Cooperation Agency (JICA) started cooperation with the Southern Region in June 1998 in response to the official request of the Jamaican Government.

2-2 Duration of Technical Cooperation

Five years from 1 June, 1998 to 31 May, 2003

2-3 Overall Goal, Project Purpose and Outputs

The expected overall goal, project purpose and outputs of the Project stated in the original Master Plan of the R/D were as follows:

Overall Goal: To improve the health status of the population of Jamaica by strengthening the Regional Health Systems

Project Purpose: To strengthen health care system in the Southern Region, focusing on health promotion and prevention of diseases

Outputs: (1) The administrative/organisational capacity of the Southern Regional Health Authority and the function of parish health care facilities, including manpower skills will be improved. (2) Disease prevention model will be developed in the pilot parish - Manchester. (3) The disease prevention model will be extended to other parishes in the Southern Region.

The Master Plan was revised during the visit of a Management Consultation Team in January 2001 as follows:

Overall Goal: The health status of the population of Jamaica is improved by strengthening the function of the regional health systems.

Project Purpose: Health care system in the Southern Region is strengthened, focusing on prevention of chronic lifestyle diseases (CLDs)

Outputs: (1) The administrative/organisational capacity of the Southern Regional Health Authority is improved. (2) The functions of parish health centre facilities are improved. (3) Human resource skills are improved. (4) A CLD prevention model is developed and implemented in Manchester. (5) The CLD prevention model is extended to St. Elizabeth and Clarendon.

2-4 Implementing Agencies

Southern Regional Health Authority (SRHA) under the Ministry of Health (MOH)

3. Project Achievements

Through the evaluation workshop, both teams jointly assessed the achievements of the Project as follows;

3-1 Inputs

Refer to the detailed table of the inputs (ANNEX-2,3,4,5) .

(Japanese side)

1) Dispatch of Japanese Experts to Jamaica
Thirteen long-term experts and 15 short-term experts were dispatched to the Project for technical transfer, at various times during the project period.

2) Training of counterparts (hereinafter referred to as "C/P") in Japan
Eighteen counterparts in total were dispatched to Japan for training.

3) Technical Equipment Provision
Equipment and materials in the amount of approximately 85,339,000 Japanese yen (about28,447,000 Jamaican dollars) was provided for the Project activities.

4) Cost sharing for local operation fund.
A totalsum of 26,539,000 Japanese yen (about 8,847,000 Jamaican dollars) has been allocated for local operation cost.

(Jamaican side)

1) Appointment of C/P
The total of 22 C/P has been assigned to the Project Activities.

2) Allocation of operation cost
The Jamaican side provided the necessary allocation and contribution for Project implementation, such as the cost of communications, hiring a driver and customising Mobile Clinics.

3) Provision of facilities
The necessary office and clinical spaces for the Project have been provided.

3-2 Outputs

(1) Output 1: The administrative/organisational capacity of the Southern Regional Health Authority is improved.
Steering Committee Meetings have been held monthly and provided an important opportunity to monitor and evaluate achievements/issues with the participation of core administrative and health staff.
The necessary equipment for the improvement of parish health care delivery has been providedand utilised well.

(2) Output 2:The functions of parish health centre facilities are improved:
Free checks started in February 2001 in New Port Health Centre and have been extended to other health centres. Twelve centres in Manchester and St. Elizabeth have been providing free checks regularly and 9 centres in Clarendon are about to start. Four workshops for Community Health Aides (CHAs) were held with a total attendance of 459. They gained basic knowledge on CLDs and learned how to measure BMI and blood pressure.

The quality of health education materials has been improved through assistance from Japanese experts and C/P training in Japan, along with the equipment provided. Video materialshave been made and distributed to health centres. Posters and brochures were designedto be more colourful and illustrative.

(3) Output 3: Human resource skills are improved.

The C/Ps were trained through various lectures, C/P training in Japan and on-the-job training. In the region, 868 staff members were trained in the control/prevention of CLDs. Training in this area has improved the C/Ps capacity to implement the project activities. They have demonstrated a greater level of commitment and appreciation for lifestyle changes required in the prevention of CLDs. In turn, they have been communicating this to the general population through the established CLD prevention model.

(4) Output 4: A CLD prevention model is developed and implemented in Manchester.

Since 1999, the Wellness Clinic has been held two days per week. So far, 2,397 clients visited the Clinic. The Mobile Clinic has been held once a week since September 1999 and 2,684 clients have visited. As of 31 October, 2002, the total number of visits was 5,081, including 336 repeat visits to the Wellness Clinic/Mobile Clinic and 1,061 patients referred for further screening/secondary care.

One community group, Ingleside Wellness and Recreation Centre, has been established for the purpose of practicing the CLD prevention activities. In addition, since July 2001, the health team has held 5 special diabetes education classes, in which 75 patients have participated.

The necessary equipment (Annex 4) for free checks has been provided to 6 health centres, and free checks have been implemented with the assistance of CHAs. Approximately, 1,000 free checks have been performed. Additionally, in some health centres, equipment is available for self check of blood pressure and pulse.

Health education materials, such as Wellness Calendar, Wellness Passport, posters, brochures, manuals, and 3 different video presentations, have been developed.

Promotional materials, such as flyers, pamphlets, have been developed and distributed through community groups, churches, schools, companies, etc. In addition, the Mobile Clinic provided screening at four health fairs. And the members of the press were invited to view the Mobile Clinic in Mile Gully, and the articles on the project activities appeared in the Mandeville Weekly and the Gleaner. In February 2003, the Jamaica/Japan International Health & Lifestyle Conference will be held and the activities related to the Wellness Clinic will be presented.In order to promote physical exercise for health, Walkathons were conducted in March 2000, and April 2002. About 200 people participated in the events.

As for the PAB survey, the questionnaires and the database were prepared. The second PAB survey will be implemented in March 2003.

The database for WC/MC clients has been developed, and data on more than 5,000 visits have been inputted. The database is being used for follow-up activities.

(5) Output 5: The CLD prevention model is extended to St.Elizabeth and Clarendon.

In St. Elizabeth, the Wellness Clinic was started at Santa Cruz Health Centre in February 2002, and 332 clients visited by 31 October, 2002. The Mobile Clinic was

started in June 2001 and 1,125 clients visited. The total number screened was 1,457 by October 31, 2002. Free checks have been started at 6 health centres. Three video presentations, and health education materials, such as Wellness Calendar, flyers, pamphlets, and brochures, have been developed. The promotional materials were distributed through community groups, churches, schools, companies, etc. Walkathons were conducted in June 2001 and April 2002, and about 300 people participated in both events. In addition, the Mobile Clinic provided screening at four health fairs held during the month of June 2002.

In Clarendon, the Wellness Clinic started at Clarendon Health Department in March 2002, and 178 clients visited by 31 October, 2002. The Mobile Clinic will start by the end of 2002. The total number screened is 403 by 31 October, 2002, including those screened by the Mobile Clinic dispatched from Manchester. Free checks will start soon at 9 health centres. The health education materials, flyers, pamphlets developed have been utilized in CLD prevention activities. They were distributed through community groups, churches, schools, companies, etc. In addition, one local cable network has been advertising the Wellness Clinic free of cost. A walkathon was conducted in January 2002 about 250 people participated. In August 2002, approximately 400 free checks were conducted at Denbigh Agricultural show.

Thus, Output 5 has been almost achieved, but there is room for further development in these two parishes.

3-3 Project Purpose

Focusing on the prevention of CLDs, this project has strengthened the health care system in the Southern Region, by introducing health screening (Wellness Clinic / Mobile Clinic) and education. In doing so, the system has provided community members with greater access to these services than previously. In fact, those who visited Wellness / Mobile Clinic have been gradually changing their lifestyle, by careful food intake, regular exercise, etc. This was gleaned from random checks of clients at Wellness/Mobile Clinics. The second PAB will be conducted in March 2003, in order to further evaluate the changes in lifestyle.

In addition, the C/Ps for the prevention of CLDs have been trained, and they are capable of implementing the activities. They are satisfied with the achievement of the project.

3-4 Overall Goal

The MOH has the intention to introduce various aspects of the Project in other regions. The project activities were reported to the quarterly review meetings. There have been some inquiries about the CLD prevention model from other health regional authorities. In fact, Mobile Clinic was dispatched from St. Elizabeth to White House in the Western Health Region in July 2002. In addition, the achievements of the project will be shared with other health regions in Jamaica and Caribbean Countries at the Jamaica/Japan International Health & Lifestyle Conference, in February 2003.

Thus, the CLD prevention model developed by the project will be extended to other

regions in Jamaica. Although it may take some time, the Overall Goal is expected to be achieved.

4. Evaluation by Five Criteria

From the results of the Project, it is of great importance to thoroughly evaluate the Project from the viewpoint of present and future implications. For that purpose, relevance, effectiveness, efficiency, impact and sustainability of the Project, were assessed jointly by both sides through an evaluation workshop. In addition to the technical aspect, attention was paid to the aspect of Jamaican health policy and Jamaican people's response to the Project. The findings of the workshop and interviews are as follows.

4-1. Relevance

4-1-1 Relevance of the Overall Goal

CLDs have been major contributors to mortality and morbidity in Jamaica. The MOH has been promoting healthy lifestyle among the population and prevention of CLDs as one of national health priority goals. Moreover, the MOH viewed the achievement of the project highly, and has the intention to introduce various aspects of the Project in other regions.

4-1-2 Relevance of the Project Purpose

SRHA is preparing a 5-year strategic plan and the prevention of CLDs is one of its priorities. This is in recognition of the cost-effectiveness of preventive interventions as opposed to curative treatment of CLDs.

The selection of The Southern Region as the project target area was appropriate, because the population of the Southern Region has a comparatively higher proportion of elderly population in relation to other regions.

In addition, the target group was extended to include the age group "16 years and over", to facilitate the promotion of healthier lifestyles among youth.

The project purpose, focusing on the prevention of CLDs, is timely in the context of national policy and priorities, thus meeting the need for changes in lifestyle.

4-1-3 Relevance of the project design

The project design is in keeping with the decentralised health structure, thereby facilitating regional management. In addition, piloting disease prevention model in Manchester allowed for closer monitoring by SRHA and the Japanese Team, which is also located in Manchester. As a result, the model was firmly established in Manchester and extended to St. Elizabeth and Clarendon.

The design of having Jamaican counterparts (C/P) and Japanese experts working side by side for the duration of the project, helped significantly in the transfer of knowledge and skills.

4-2. Effectiveness

4-2-1 Achievement of the Project Purpose

Refer to 3-3.

Therefore, initial indications are that the Project Purpose is being achieved.

4-2-2 The promoting/inhibiting factor to the effectiveness

The most important promoting factor is the change in the consciousness of Jamaican health staff involved in the project. They have demonstrated a greater level of commitment and appreciation for lifestyle changes required in the prevention of CLDs.

In turn, they have been communicating this to the general population through the established CLD prevention model.

There were no significant inhibiting factors identified.

4-3. Efficiency

4-3-1 Achievement of Outputs

Refer to 3-2. The five outputs of the Project have been achieved for the most part.

4-3-2 Relation between the outputs/activities and important assumptions/other inhibiting factors

The important assumptions are realized. With reference to the important assumption, "The inter-sectoral collaboration for control CLDs remains at the same level", the project has surpassed this assumption and good relations were maintained with the outside organisations, such as Diabetes Association of Jamaica, Heart Foundation of Jamaica, University of West Indies, Japan Overseas Cooperation Volunteers, etc.

4-3-3 Utilisation of inputs, appropriateness of the timing of inputs

As of 20 November, 2002, 23 members of staff were allocated to Wellness Clinic: 8 in Manchester, 8 in St. Elizabeth, and 7 in Clarendon.

The timing of deployment, quality and quantity of the C/Ps were for the most part, appropriate, but there were some delays in allocating medical staff, especially doctors in St. Elizabeth and Clarendon. This resulted in the delay of the start of the Wellness Clinics in both parishes. The technical capability of C/Ps was adequate for the project activities.

The timing of dispatching, along with the quality and quantity of Japanese experts, were appropriate. However, the first allocation of equipment was provided more than one year after the start of the cooperation period, but health promotion activities were initiated earlier with the efforts of Jamaican and Japanese experts.

The equipment provided for the project activities have been utilised efficiently. The quantity and the quality of equipment provided were appropriate.

4-4. Impact

4-4-1 The achievement of the overall goal (as expected impact)
Refer to 3-4. Thus, Overall Goal is expected to be achieved.

4-4-2 Unexpected impact
The project had various unexpected, but positive impacts on health care and lifestyle of people in the Southern Region of Jamaica. The following are examples.

- SRHA is planning to launch the Healthy Lifestyle Award in February 2003.
- Other health care service providers have been interested in the project activities. For example, Blue Cross, a health insurance company, has visited the Wellness Clinic to observe its operation.
- Children in primary schools in St. Elizabeth have been changing eating habits.
- Some patients were found to have diseases other than CLDs through the Wellness/Mobile Clinic.
- The clients referred their family members or acquaintances to the Wellness/Mobile Clinic.
- Clients compared the services provided favourably with those received in some developed countries such as United Kingdom.

4-5. Sustainability

4-5-1 Organisational Sustainability
The MOH has set control of CLDs as one of its priorities. The policy support from the MOH would be secured continuously for the coming years. It evaluated the achievement of the project highly, and has an intention to introduce various aspects of the Project in other regions. SRHA is preparing a 5-year strategic plan and the prevention of CLDs is one of its priorities. There are plans to increase Wellness/Mobile Clinic services in all three parishes. Thus, the SRHA would certainly continue the activities for the prevention of CLDs. However, it would be necessary to allocate additional staff in order to provide more services in the future.

The Steering Committee Meetings have provided an important opportunity to monitor and evaluate project activities. It should be continued after the end of the project period.
At present, the clients are satisfied with the quality of service in Wellness/Mobile Clinic. However, there is room for improvement, especially of operational procedures. This could be achieved by applying best practices developed in other clinics.
Promotional activities have been implemented through various methods. These activities should be further enhanced to increase public awareness of Wellness/Mobile Clinic.

The Health Facilities Maintenance Unit has been responsible for technical maintenance. Considering the expansion of the activities, adequate technical maintenance staff members should be allocated to each parish. Additionally, the stock level for relevant supplies for the clinics should be adequately managed to ensure availability at all times.

The database for Wellness/Mobile Clinic clients has been developed and updated in Manchester. A similar database should be completed in St. Elizabeth and Clarendon and the necessary staff should be deployed to undertake this and other follow-up activities.

4-5-2 Financial Sustainability

Financial Sustainability is enhanced by the fact that CLDs remain a national priority with strong political commitment. As a result, the SRHA is assured of continuous budgetary allocation for the control of CLDs, including the Wellness/Mobile Clinic. The necessary cost of supplies, equipment, maintenance, repairs, etc, should be included in the annual budget.

Most of the clients of the Wellness/Mobile Clinic regard health-screening fees as affordable.

4-5-3 Technical Sustainability

The C/Ps and related health care staff have been trained and are capable of implementing the CLD prevention activities. Most of them are committed to the activities and are expected to stay within the health services for the foreseeable future. In order to motivate the present staff and to upgrade their capabilities, systematic training should be provided continuously. In addition, the training of new staff should be planned and implemented to ensure their understanding of the CLD prevention model.

The main cause of equipment breakdown was lack of care in handling. Each member of staff should be repeatedly reminded of the proper use and care of the equipment. The relevant manual should be located in close proximity to the equipment.

5. Conclusion

The result of the study indicates that the Project has been successful for the most part and achieved the objective, namely strengthening of health care system of the Southern Region, focusing on prevention of CLDs.

Wellness/Mobile Clinic launched by the Project was the first of its kind in Jamaica. The model of Wellness/Mobile Clinic was first established in Manchester, and then extended to St. Elizabeth and Clarendon. The awareness of CLDs among members of the communities has been increasing steadily, and improvement of their lifestyle has been observed.

6. Recommendation

The Project terminates at the end of May 2003 as originally planned.

To sustain the outcome of the Project after the end of the project period, it is proposed to fulfill the following:

6-1. Remaining period of the Project

(1) Strengthening of the equipment maintenance procedure

It is important to review the equipment list and to ensure availability of maintenance manuals, including information on companies which undertake equipment maintenance, especially for the equipment which is not maintained by the Health Facilities Maintenance Unit of the MOH.

(2)Recommendation for maintaining staff motivation

One of the most important factors of the success of the Project is the high consciousness among health staff in 3 targeted parishes. To maintain this motivation, staff recognition/award programmes should be strengthened and broadened to include staff in CLD prevention activities.

(3)Promotion of health education targeting the youth

Further promotion targeting youth will be needed. For example, introducing the basic knowledge of healthy lifestyle as a component of school health education will contribute to the prevention of CLDs in the future.

(4)Team operation of Wellness/Mobile Clinic

As mentioned in the previous chapter, operation of Wellness/Mobile Clinic would be further improved through more effective teamwork and application of best practices. That will lead to the services being more client-oriented and reduce waiting time.

6-2. After the end of the project period

It is proposed that the Government of Jamaica ensures adequate budgetary allocation, ongoing staff training in order to continue the CLD prevention model in the Southern Region and to replicate it in other regions. The health screening fee collected at Wellness/Mobile Clinics should be expended on the operation of these clinics.

As a specific measure, it is recommended to have a training course at SRHA for the health staff from other regions. It is meaningful not only for the other regions but for the staff of the Southern Region to enhance their ability and motivation.

In addition, free checks should be maintained as one of the priorities of CLD prevention model. The service is simple but indispensable to promote public awareness of CLDs. To introduce Wellness/Mobile clinic to other regions, it is essential that free checks are undertaken at the same time.

To follow-up project activities, it will be of great use to dispatch short-term experts in the field of health examination and health information within 2 years after the end of the project period.

The experience achieved by the Project will provide useful information for other Caribbean countries, which also have CLD-related problems.

Third-country-training inviting health staff from Caribbean countries to Jamaica should be considered.

7. Lessons Learned

(1) Phased introduction of the model
The CLD prevention model was first established in Manchester and extended to St. Elizabeth and Clarendon. Such phased introduction contributed to the success of the Project.

(2) Establishment of the Steering Committee
Under the Project, Steering Committee Meetings, which consist of Jamaican C/Ps and Japanese experts, were held nearly once per month. This provided a good forum in which to share information and to review the progress of activities.

(3) Sufficient preparation period between signing of R/D and starting cooperation
The timing of the project commencement should be carefully decided with regard to the time needed for preparation, especially on the provision of equipment and staff planning including selection of C/Ps (contract officers) for training in Japan.

(4)Appropriateness to needs of Jamaican people
The activities of the Project have been supported by strong political will and are also consistent with national and regional priorities. Moreover, they were accepted favourably by the people in the region.

8.Remarks

The acronym for the Project was considered by Jamaican counterparts, Japanese experts and team members and both sides agreed to name it JACOSH (JApan/JAmaica Cooperation in Strengthening Health/Southern Health Region).

List of Annex

Annex 1

Project Name: Strengthening of Health Care in the Southern Region

Project Area: Southern Regional of Jamaica

PDM for evaluation (PDMe)

Duration: Jan 2001-May 2003

Target Group: 16 years and over

Date: 28 November 2002

Narrative Summary	Verifiable Indicator s	2003 Target	Present Achieved	Means of Verification	Important Assumption
Overall Goal: The health status of the population of Jamaica is improved by strengthening the function of the regional health systems	Number of sustainable wellness activities in the regions			Reporting at national reviews	
Project Purpose: Health care system in the Southern Region is strengthened, focusing on prevention of chronic lifestyle diseases (CLDs)	The change in awareness and behaviour among community people related to the CLDs Level of satisfaction among staff that project objectives have been achieved			2nd PAB(People's Awareness and Behaviour) survey	The focus by MOH and other relevant Authorities remain preventive rather than curative care The level of literacy will not worsen
Output					
1.The administrative/organisational capacity of the Southern Regional Health Authorities is improved	1-1 Total number of the steering committee meetings	50	48	Record of steering committee	
	1-2 Total number of Wellness Clinic staff	15	20	Record of Wellness Clinic	
	1-3 Establishment of management system, such as planning, monitoring and evaluating the activities for the health system improvement			Record of Wellness Clinic	
	1-4 Establishment of management system of facilities and equipment			Mid-term evaluation report	
	1-5 Development of health information system, the system of updating data and maintenance			Record of Wellness Clinic	The level of personal production remains the same.
2.The functions of parish health centre facilities are *improved*	2-1 Number of free check examinees at parish health centers			Record of Wellness Clinic, Interview	
	2-2 Number of CHAs trained in the training of mid-level trainees			Record of the training for middle-level trainee	The inter-sectoral collaboration for control of CLDs remains at the same level
	2-3 Improvement of the quality of health educational *materials*			Interview, Project Record	
3. Human resource skills are improved	3-1Total number of staff trained in control/prevention of CLDs	450	868	Record of the training for middle level trainee	
	3-2 Knowledge and skill of the staff evacuated by the Steering Committee			Interview of Steering Committee Members	The stability of staff will not worsen
4. A CLD prevention model is developed and implemented in Manchester	4-1 Total number of health screened persons in Wellness/Mobile Clinic	7000 3 Pari	6941 3 Pari	Record of Wellness Clinic	
	4-2 Total number of repeated visits for Wellness/Mobile *Clinic*	100	336	Record of Wellness Clinic	
	4-3 Total number of patients referred to secondary care through Wellness Clinic/Mobile Clinic			Record of Wellness Clinic	
	4-4 Total number of community groups practicing CLDs *prevention*			Record of Wellness Clinic	
	4-5 Provision of Free Check service			Record of Wellness Clinic	
	4-6 Total number of health education materials developed			Project record	
	4-7 Total number of promotion activities			Project record	

5. The CLD prevention model is extended to St.Elizabeth and Clarendon	4-8 Establishment of implementing system of PAB 4-9 Completion of database for WC/MC Visitors 5-1 Total number of health screened persons 5-2 Total number of repeated visits for Wellness/Mobile Clinic 5-3 Total number of patients referred to secondary care through Wellness Clinic/Mobile Clinic 5-4 Total number of community groups practicing CLDs prevention 5-5 Provision of Free Check service 5-6 Total number of health education materials developed 5-7 Total number of promotion activities	Project record, interview Project record, interview Record of Wellness Clinic Record of Wellness Clinic Record of Wellness Clinic Record of Wellness Clinic Record of Wellness Clinic Project record, interview Project record, interview	
Activities: 1-1To prepare DIP and monitoring schedule 1-2 To secure annual budget (JM) 1-3 To redirect resources to support target program areas (JM) 1-4 To recruit adequate number of staff to carry out activities (JM) 1-5 To maintain the steering committee meeting (by all members) 1-6 To improve inter/intra agency networking 1-7 To improve the Data collection of CLDs in the region 1-8 To conduct periodic evaluations of referral system 1-9 To retain staff through incentives (JM) 1-10 To centralize function of clinical laboratory in the SRHA 1-11 To keep cooperation with JOCV members in the field of databases and equipment maintenance 2-1 To deploy more trained personal at parish CHAs 2-2 To evaluate strengthened linkages between hospitals and clinics 2-3 To review and monitor referral system 2-4 To improve quality of blood examination related to CLDs 2-5 To consolidate health statistics 2-6 To improve medical record system 2-7 To standardise classification of clinics (JM) 2-8 To improve the customer service mechanism at health facilities (JM) 3-1To develop standardised training manuals 3-2 To recruit more personnel (JM) 3-3 To continue training in Jamaica	**Input** **Japan (Refer to Annex)** Long term experts Chief Advisor Coordinator Health Examination (MD) Public health education Short term experts IEC ECG Health administration Health Examination(MD) Counterpart training Equipment Appropriate local cost for the project	**Jamaica** Counterparts(Implementation Project manager Provision of land and facilities for project Appropriate local cost for project Training requirement Equipment maintenance Consumable equipment	Counterpart personnel selected to work for the project

3-4 To train health professionals on importance of referral system 3-5 To utilize research findings to broader knowledge base (JM) 3-6 To train community leaders and health committee representatives about prevention/control of CLDs 4-1 To increase access the clients to "Wellness Clinic" and mobile clinic 4-2 To advertise Wellness Clinic and mobile clinic among residents 4-3 To make clinical passport available to patients 4-4 To develop a protocol for which patients get referred and where 4-5 To make long-term schedule of MC 4-6 To make database of WC 4-7 To review cost and utilization of Wellness Clinic 4-8 To develop clear and standardized of health education messages for NGO and MOH 4-9 To provide and utilize health education materials relevant to CLDs 4-10 To provide behavioural change counseling to clients at risk 4-11 To conduct survey on walking practice and food intake 4-12 To repeat PAB survey in the SR 4-13 To launch intersectional health promotion campaigns for the control and prevention of CLDs 4-14 To educate patients on lifestyle diseases in different setting 5-1 To get new medical personnel for WC (JM) 5-2 To recruit administrative personnel (JM) 5-3 Same activities as output 4		Pre-Condition

Annex 2

Japanese expart post allocation

	Field/title in the project	1998				1999				2000				2001				2002				2003		
		1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7
Long Term Experts	Project Chif Advisor			Prof. .R. Mita(7.7.98-30.9.99)						Dr. K. Seino(1.9.99-24.8.00)				Prof. S. Nakaji(1.10.00-02.2.28)				Prof.. R. Mita(17.2.02-31.5.03)						
	Health Examination			Dr. K Saito(7.7.98-30.9.9)						Dr. M. Ichinohe(1.9.99-30.11.00)				Dr.T. Endo(15.11.00-28.2.02)				Dr. M. Watanabe(17.2.02-24.11.02)						
	Health Education				Miss Y Tateda(8.10.98-23.4.00)					Mrs. T. Kawamura(3.4.00-30.9.30)							Miss T. Yoshida(8.9.01-31.5.03)							
	Coordinator					Mr. T. Omachi(15.6.98-14.6.01)											Miss N. Miyamoto81.6.01-31.5.03)							
Short Term Experts	Cardiovascular Disease					Dr. H. Ishizuka(15.6.99-20.7.99)											Dr. I. Yoshida(7.4.02-27.4.02).							
	Health Information							Mr. H. Matsutani(26.2.00-20.3.00)									Mr. H. Matsutani(12.8.02-25.8.02)							
	Informatio ,Education and communication							Prof. C. Yamada (10.3.00-2.4.00)								Prof. C. Yamada (19.1.02-9.2.02)								
	Physical Exerecise for Disease Prevention									Prof. R. Mita(1.7.00-30.7.00)														
	Laboratory Consultation									Mr. K. Kozima (1.7.00-30.7.00)								Mr. K. Kozima (30.6.02-23.7.02)						
	Health Education Media Production											Prof. A. Yoshino(31.3.01-15.4.01)						Prof. A. Yoshino(12.8.02-30.8.02)						
	Health Administration													Dr. Y. Takusari(24.7.01-8.8.02)										
	Health Examination													Dr. M. Tuge(24.7.01-8.8.02)										
	Disease Prevention														Prof. T. Nakamura(18.11.01-12.12.01)									

Annex 3

Jamaican Counterpart Post Allocation

Field/title in the project	1998				1999				2000				2001				2002			
	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10
Project Director	Mr.Geoge Briggs (Permanent Secretary)																			
													Mrs.Crace Allen-Young (Permanent Secretary)							
Project Maneger	Dr. EL Fuller (Principal Medical Officer, Primary Health Care Unit, MOH)																			
					Ms. F Petgrave (Regional Director, SRHA)															
Regional Director	Ms. F Petgrave (Regional Director, SRHA)																			
Technical Special Advisor					Dr.Eva Lewis Fuller (Directorr, Cooperation in Health/Policy Aanalyst, MOH)															
Regional Technical Director	Dr.Beverly Wright (Regional Technical Director, SRHA)																			
					Dr.Michael Coombs(Regional Technical Director, SRHA)															
Parish Manager Manchester					Mrs.Sharonn B Jones(Parish Maneger)															
													Miss Yvonne Pitter (Parish Maneger)							
Parish Manager Clarendon					Mrs.Lois Robinson(Parish Maneger)															
															Mr.canute Thompson (Parish Maneger)					
Parish Manager					Miss Yvonne Pitter (Parish Maneger)															
																	Miss Paulette Elliott (Parish Maneger)			
Medical Officer of Helth Manchester	Dr.Michael Coombs (Medical Officer of Helth, Manchester Health Department)																			
					Dr.Beverly Wright (Medical Officer of Helth, Manchester Health Department)															
Medical Officer of Helth Clarendon	Dr.Sonia Copeland (Medical Officer of Helth, Clarendon Health Department)																			
Medical Officer of Helth St.Elizabeth																				
	Dr.EA Ledford (Medical Officer of Helth, St.Elizabeth Health Department)																			

Field/title in the project	1998				1999				2000				2001				2002			
	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10	1	4	7	10
Health Examination Manchester	Dr.Sandra Chambers (District medical Officer, Manchester Health Deparetment)																			
Health Examination Clarendon	Dr.Lisa Dawes-Internist (District medical Officer, Clarendon Health Deparetment)																			
Health Examination St.Elizabeth	Dr.Tahaine (District medical Officer, St.Elizabeth Health Deparetment)																			
	Miss Telma Davis (Nurse Practioner, Clarendon Health Deparetment)																			
Public Health Nurse Manchester	Mrs. Dalcie-Esmeda Stephenson (Commuity Health Nurse, Manchester Health Department)																			
Public Health Nurse Clarendon	Mrs.Marcia Harris-lawrence (Commuity Health Nurse, Clarendon Health Department)																			
Public Health Nurse St.Elizabeth	Mrs.Valerie Wright (Commuity Health Nurse, St.Elizabeth Health Department)																			
	Mrs.Patricia Sinclare (Commuity Health Nurse, St.Elizabeth Health Department)																			
Nutrition	Miss Alice Adlica Carney (Parish Nutritionist, Manchester Health Department)																			
Health Education Manchester	Mrs. Heather Mullings (Health Educator, Manchester Health Department)																			
Health Education Clarendon	Ms. Carlisa Pearson (Health Educator, Clarendon Health Department)																			
Heajth Education St.Elizabeth	Mrs. Delphene Grandison (Health Educator, St.Elizabeth Health Department)																			
Health Information	Miss M Kenlock (Director, Management Information System, SRHA)																			
	Mr.Howard Hamilton (Director, Management Information System, SRHA)																			

Annex 4

Equipment Provided by JICA

Item	Qty.
Aneroid Sphygmomanometer	27
Automatic Blood Pressure Monitor	6
Automatic Sphygmomanometer	14
Automobile (4WD)	2
Blood Glucose Meters with accessories	105
Body Composition Analyzer	5
Brix Meter (Digital Saccharometer)	30
Centrifuge	1
Copy Machines	4
Digital Videocassette Recorder	1
Electrocardiograph	17
Electronic Balance	10
Food Model Set NASCO	6
Hand Washer	30
Health Meter / Scale	50
Height and Weight Scale with Fat Rate Measurement	8
LCD Display	1
LCD Projector	3
Magnetic Bike	3
Mini Bus (for Mobile Clinic)	3
Motorcycle	2
Note book Computer and Accessories	2
Personal Computers	7
Ramdom Access Chemistry System	1
Salt Detector	30
Spectrophotometer	1
Teaching Kit- Fat Reduction in the Diet	10
Teaching Kit- Heart Disease	10
Teaching Kit-Sugar Case / How Much Sugar Test	10
Test strips	3
Ultrasound System	1
Video Camera	1
Weight Scales with Fat Rate Measurement	45

Annex 5

C/P training in Japan

			Name	Title of Present	Training course
97-98	Feb.	Feb.	Dr. Eva Lewis Fuller	Primary Health Care Principal Medical Officer	Health Administration
98-99	Ser.	Oct.	Dr. Michael Phillip Coombs	Regional Technical Director	Health Administration
	Jan.	Feb.	Mrs. Dalcie Esmeda Stephenson	Manchester Health Department Community Nurse	Health Examination
	Jan.	Feb.	Miss. Alice Adina Carney	Manchester Health Department Acting Parish Nutritionist	Nutrition Education
1999-2000	Ser.	Oct.	Dr. Beverley Wright Wilson	Manchester Health Department, Medical Officer	Health Administration
	Jan.	Nov.	Miss. Lorraine Marcella Kenlock	Southern Regional Health Authority, Director of Management Information	Medical Information
	Oct.	Nov.	Ms. Fay laine Petegrave	Southern Regional Health Authority, Regional Director	Health Administration
2000-2001	May	June	Mrs. Lois Elena Robinson	Clarendon Health Department Parish Manager	Health Administration
	May	June	Miss Janet Yvonne Pitter	St.Elizabeth Health Department Parish Manager	Health Administration
	May	Sep.	Mrs. Healther Wood Mulling	Manchester Health Department Health Educator	Health Education
	Sep.	Nov.	Dr. Sandra Parkinson Chambers	Manchester Health Department District Medical Officer	Cardiovascular. disease
2001-2002	May	JUNE	Mrs. Sharonn Bernard-Jones	Department, Parish Manager	Health Administration
	May	Sep.	Ms. Carlisa Alginate Peason	Clarendon Health Department, Health Educator	Health Education
	Sep	Des	Mrs. Valerie Wright	St.Cruz health Centre, Community Nurse	Health Examination
	Sep.	Des.	Mrs .Delphene Grandison	St.Elizabeth Health Department, Health Educator	Health Education
2002-2003	Oct.	Nov.	Dr. Sonia Yvonne Copeland	Clarendon Health Department, Medical Officer	Health Administration
	Oct.	Nov.	Mrs. Marcia Harris-Lawrence	Clarendon Health Department, Community Nurse	Health Examination
	Oct.	Nov.	Miss Telma Davis	St. Elizabeth Health Department Nurse Practitioner	Health Examination

Annex 6

Steering Committee Members

As of 20, November 2002

1	E. Lewis-Fuller	Director, Cooperation Health/Policy Analyst	MOH
2	F. Petegrave	Regional Director	SRHA
3	M. Coombs	Regional Technical Director	SRHA
4	C. Sutherland	Director, Regional Finance Department	SRNA
5	H. Hamilton	Director, Management Information System	SRHA
6	H. Ismail	Director, Operations and Maintenance Division	SRHA
7	Y. Pitter	Parish Manager	Manchester Health Department
8	B. Wright	Medical Officer of Health	Manchester Health Department
9	S. Chambers	District Medical Officer	Manchester Health Department
10	D. Stephenson	Community Health Nurse	Manchester Health Department
11	W. Mulling	Health Educator	Manchester Health Department
12	A. Carney	Nutritionist	Manchester Health Department
13	N. Anderson	Medical Technologist	Manchester Health Department
14	A. Stephenson	Clerical Officer	Manchester Health Department
15	W. Reeves	Laboratory Technician	Manchester Health Department
16	P. Elliott	Parish Manger	St.Elizabeth Health Department
17	D. Ledford	Medical Officer of Health	St.Elizabeth Health Department
18	T. Davis	Nurse Practioner	St.Elizabeth Health Department
19	D. Grandison	Health Educator	St.Elizabeth Health Department
20	V. Wright	Community Health Nurse	St.Elizabeth Health Department
21	C. Taylar	Health Educator	St.Elizabeth Health Department
22	L. Collins	Nutritionist	St.Elizabeth Health Department
23	C. Thompson	Parish Manager	Clarendon Health Department
24	S. Copeland	Medical Officer of Health	Clarendon Health Department
25	L. Dawes	Medical Officer	Clarendon Health Department
26	C. Pearson	Health Educator	Clarendon Health Department
27	M. Lawrence	Community Health Nurse	Clarendon Health Department
28	R. Mita	Japanese Expert	
29	M. Watanabe	Japanese Expert	
30	T. Yoshida	Japanese Expert	
31	N. Miyamoto	Japanese Expert	

Annex 7

Allocation of staff for Wellness Clinic (Include Mobile Clinic)

November 20, 2002

	Manchester	St.Elizabeth	Clarendon
Doctor Nurse Practitioner	S. Chambers	T. A Jonco T. Davis	L. Dawes
Public Health Nurse Nurse	D. Stephenson B. Whyte	V. Wright	M. Harris-Lawrence
Laboratory technician	N. Anderson W. Reeves	A. Vassel	One technician from May Pen Hospital
Community health aide		J. Bromfield H. Mullings	Ms. Buchanan Ms. Martine
Nutritionist	A. Carney	L. Collins	M. Core-Brown (Nutritionist Assistant)
Health Educator	W. Mulling	D. Grandison	C. Pearson
Others Clerical Officer	A. Stephenson		
Total	8	8	7

Annex 8

Clients record of Wellness Clinic/Mobile Clinic by Parish

as of Oct. 31th, 2002

Year	Total	Manchester				St.Elizabeth			Clarendon		
		total-WM	WC	MC	Repeat	total-WM	WC	MC	total-WM	WC	MC
1999	390	390	298	92	-	0			0		
2000	1,870	1,529	621	908	-	259		259 *	82		82 *
2001	2,196	1,752	693	1,059	98	352		352 *	92		92 *
2002	2,485	1,410	785	625	238	846	332	514	229	178	51 *
Total	6,941	5,081	2,397	2,684	336	1,457	332	1,125	403		225

* The mobile bus for the Mobile Clinic was provided from Mandeville Health Center.

Annex 9

List of Diabetic Class in Manchester

Times	Date	Client
1	July 8th, 2001	11
2	October 17th, 2001	18
3	January 30th, 2002	19
4	April 17th, 2002	17
5	November 4th, 2002	10
	Total	75

Annex 10

Number of clients referred to further examination/secondary care in Manchester

As of October 31,2002

Year	Months	Total number of clients to Referred (net)	Nutrition	Pap smear	Mammogram	PSA	Other -Referrals	
2001	Jan-Sept						1 Neurologist 4 Cardiology 28 Nutritionist 5 Pap smear	
2001	Oct.	127	59	53	53	22	6	
2001	Nov.	59	39	93	71	30	3 Cardiologylogy	1 Casualty
2001	Dec.	35	6	16	16	8	1 Hospital 1 Lumpectomy	1 Ophthalmogist 1 Medical Clinic
2002	Jan.	115	26	66	52	21	2 Cardiology	2 Casualty
2002	Feb.	111	35	60	41	21	1 Cardiology	1 Ertho CTS
2002	Mar.	100	21	63	40	21	3 Cardiology	
2002	Apr.	113	37	74	47	14	1 Cardiology	1 Surgical
2002	May	106	21	51	44	13	1 Cardiology/ TFT/FBS/2hrpp	1 Casualty
2002	June	57	15	35	27	5	2 Cardiology	1 Casualty
2002	July	43	9	25	19	9	1 Cardiology	1 Ophthalmogist
2002	Aug.	23	3	11	4	8	4 Opthalmologist/ 2 Cardiology	1 Surgical
2002	Sep.	89	20	37	21	39	3 Cardiology	1 Ophthalmogist
2002	Oct.	83	6	46	44	20	1 Surgical 4 Cardiology	2 Ophthal/FBS
		1061	297	630	479	231		

Annex 11

List of health education materials developed

1 Wellness Calendar

2 Wellness Passport

3 Poster

(1) Welcome to the Wellness Clinic/Mobile Clinic

(2) Free Blood Pressure & Weight/Height Check

(3) BMI Table

4 Brochure

(1) Obesity (Overweight)

5 Textbook

(1) Textbook of Training Programme

(2) Making Health Educational Materials by PC

6 Video

(1) A Fear of Obesity

(2) Let us Exercise For Health

(3) Diabetes and Obesity (I. Lifestyle Disease, II. Exercise, III. Nutrition)

(4) Let's Enjoy Exercise (Elderly)

(5) Benefits of Exercise

(6) Health Life Style

Annex 12

For First Visitors

Japanese Evaluation Team

Result of Hearing Survey on the Visitors of Wellness Clinic

* We asked the visitors the following questions one by one, after the visitors finished the health examination.
* The survey was conducted
: at Mobile Clinic in Spring Field, St.Elizabeth, on November 19th.
at Wellness Clinic in Maypen, Clarendon, on November 20th.
at Mobile Clinic in Bombay, Manchester, on November 21st.

(P1) Age
44.1 (Ave)
76 (Max)
26 (Min)

(P2) Sample by the region

Manchester	3	21.4%
St.Elizabeth	5	35.7%
Clarendon	6	42.9%
Total	14	

(Q1) Have you ever received the health examination? (Single Answer)?

1. Yes	7	50.0%
2. No	7	50.0%

(Q2) Why did you choose this clinic today (Multiple Answer)?

1. This clinic is nearer than other medical organizations.	5	35.7%
2. The examination fee of this clinic is cheaper than other medical organizatior	7	50.0%
3. I heard that the quality of health examination/education was very good.	8	57.1%
4. My friends/acquaintances recommended I should go.	1	7.1%
5. I heard it from the health center.	3	21.4%
6. I am curious about the clinic.	1	7.1%

(Q3) How did you get to know this clinic (Single Answer)?

1. I heard it from my friends, my acquaintances.	2	14.3%
2. I heard it from other members of my family.	1	7.1%
3. I saw the poster.	2	14.3%
4. I heard it when I visited the free check.	0	0.0%
5. I heard it when I visited at the health center.	6	42.9%
6. I heard it when I visited at the church.	3	21.4%

(Q4) What do you think of the merits of visiting this clinic (Multiple Answer)?

1. To know my health condition	13	92.9%
2. To know the degree of my risk of CLDs	6	42.9%
3. To understand how dangerous the CLDs are for life	2	14.3%
4. To understand how to prevent from CLDs	0	0.0%
5. Others( )	0	0.0%
6. There is no merit of receiving them	0	0.0%

(Q5) From now on, do you think you should care your food intake ever before (Single Answer)?

1. Yes	12	85.7%
2. No	3	21.4%
3. Not sure.	0	0.0%

(Q6) From now on, do you think you should change the time or frequency of eating food (Single Answer)?

1. Yes	10	71.4%
2. No	4	28.6%
3. Not sure.		0.0%

(Q7) From now on, do you think you should change the time or frequency of eating food (Single Answer)?

1. Yes	12	85.7%
2. No	2	14.3%
3. Not sure.		0.0%

(Q8) From now on, do you think you should have less alcohol/liqueur than ever before (Single Answer)?

1. Yes	3	21.4%
2. No	0	0.0%
3. Not sure.	0	0.0%
4. Originally I don't have them.	11	78.6%

(Q9) From now on, do you think you should have less cigarette/tobacco ever before (Single Answer)?

1. Yes	2	14.3%
2. No	0	0.0%
3. Not sure.	0	0.0%
4. Originally I don't have them.	12	85.7%

(Q10) Do you like to receive the health examination regularly in the future (Single Answer)?

1. Yes	14	100.0%
2. No	0	0.0%
3. Not sure.	0	0.0%

(Q11) Do you recommend your friends/acquaintances receiving the health examination/education (Single Answer)?

1. Yes	14	100.0%
2. No	0	0.0%
3. Not sure.	0	0.0%

(Q12) Do you think the health examination fee is high in comparison with the service you took today (Single Answer)?

1. Yes	2	14.3%
2. No	12	85.7%
3. Not sure.	0	0.0%

(Q13) Do you think the process of the health examination/education today was efficient enough (Single Answer)?

1. Yes	14	100.0%
2. No	0	0.0%
3. Not sure.	0	0.0%

Thank you for the cooperation

For Repeat Visitors

Japanese Evaluation Team

Result of Hearing Survey on the Visitors of Wellness Clinic

* We asked the visitors the following questions one by one, after the visitors finished the health examination.
* The survey was conducted
: at Mobile Clinic in Bombay, Manchester, on November 21st.
at Wellness Clinic and ex-participants of Diabetes Clinic, on November 22nd.

(P1) Age	(P2) Samples by visiting reasons		
62.6 (Ave)	WC repeaters	1	10.0%
75 (Max)	Ex-Diabetes Clinic Participants	9	90.0%
49 (Min)	Total	10	

(Q1) Have you ever received the health examination at other medical organization? (Single Answer

1. Yes	10	100.0%
2. No	0	0.0%

(Q2) Why did you choose this clinic again (Multiple Answer)?

1. Because I came here before.	1	10.0%
2. Because the quality of health examination/education was good.	6	60.0%
3. Because the medical staff here was kind and reliable.	0	0.0%
4. Because this clinic is nearer than other medical organizations.	0	0.0%
5. Because the examination fee of this clinic is cheaper than other medical organizations.	1	10.0%
6. Because the health center staff recommended that I should come.	4	40.0%

(Q3) How did you get to know this clinic, when you visited at first time (Single Answer)?

1. I heard it from my friends, my acquaintances.	3	30.0%
2. I heard it from other members of my family.	1	10.0%
3. I saw the poster.	0	0.0%
4. I heard it when I visited the free check.	0	0.0%
5. The health center staff taught me about this clinic.	6	60.0%

(Q4) What do you think of the merits of visiting this clinic (Multiple Answer)?

1. To know my health condition	4	40.0%
2. To know the result of the improvement of changing lifestyle	5	50.0%
3. To know the degree of my risk of CLDs	2	20.0%
4. To understand how dangerous the CLDs are for life	0	0.0%
5. To understand how to prevent from CLDs	0	0.0%
6. Others( )	0	0.0%
7. There is no merit of receiving them	0	0.0%

(Q5) Since the first visit to this clinic, have you cared your food intake ever before (Single Answer)?

1. Yes	9	90.0%
2. No	1	10.0%
3. Not sure.	0	0.0%

(how to try to care my food intake)
- I cut the food I should not eat. I quitted having donuts.
- I cut the amount of food and am eating more vegetable.
- I am trying to eat something nutritious.
- I am trying to have less food, more energy, and less calorie food.
- I learned how to take care of my health. There is no place like this here. Since the Diabetes Clinic, I decided to have less beef, and rather to have chicken or fish with more vegetable.
- I am trying to eat less and have more vegetable. I quitted fried food. And I eat food after heat again.

(Q6) Since the first visit to this clinic, have you changed the time or frequency of eating food (Single Answer)?

1. Yes	8	80.0%
2. No	2	20.0%
3. Not sure.	0	0.0%

(how to try to change the time or frequency of eating food)
- I am trying to have the meal at the same time.
- I am not eating meals just before sleeping.
- I am trying to have meal at the right time.
- I cut the between meals.
- I cut the times of having the between meals.

(Q7) Since the first visit to this clinic, have you done more physical exercise than ever before

1. Yes	8	80.0%
2. No	2	20.0%
3. Not sure.	0	0.0%

(how to try more exercise)
- Walking.
- I walk one hour three times a week.
- I started walking. I do warming up and cool down, too.
- Since the Diabetes Clinic, I started getting up earlier and walking for an hour three days a week.
- Because I have knee injury, I am doing light weight exercise.
- I get up at 5:30 am, and do walking.

(Q8) Since the first visit to this clinic, have you had less alcohol/liqueur than ever before (Single Answer)?

1. Yes	0	0.0%
2. No	0	0.0%
3. Not sure.	0	0.0%
4. Originally I don't have them.	10	100.0%

(Q9) Since the first visit to this clinic, have you had less cigarette/tabacco ever before (Single Answ

1. Yes	0	0.0%
2. No	0	0.0%
3. Not sure.	0	0.0%
4. Originally I don't have them.	10	100.0%

(Q10) Do you like to receive the health examination regularly in the future (Single Answer)?

1. Yes	10	100.0%
2. No	0	0.0%
3. Not sure.	0	0.0%

(Q11) Did you recommend your friends/acquaintances receiving the health examination/education (Single Answer)?

1. Yes	9	90.0%
2. No	1	10.0%
3. Not sure.	0	0.0%

(Q12) Do you think the health examination fee is high in comparison with the service you took today (Single Answer)?

1. Yes	1	10.0%
2. No	9	90.0%
3. Not sure.	0	0.0%

(Q13) Do you think the process of the health examination/education today was efficient enough?

1. Yes	10	100.0%
2. No	0	0.0%
3. Not sure.	0	0.0%

Thank you for the cooperation

Annex 13 Document for Evaluation Workshop

2002/11/28

The Project on Strengthening of Health Care in the Southern Region

Agenda of Evaluation Workshop on November 28th and 29th

1. Objectives

(1) To evaluate the project in the participatory method
(2) To share the achievement of the project
(3) To share the issues hereafter for sustaining the project purpose and for achieving the overall goal
(4) To study the lessons learned from this project for implementing the similar projects

2. Methods

(1) To understand PCM/PDM and the five evaluation criteria, which is relevance, effectiveness, efficiency, impact and sustainability
(2) To review the evaluation draft in terms of relevance, effectiveness, and efficiency
(3) To discuss on the "Impact" of the project
(4) To discuss on the "Sustainability" of the project
(5) To discuss the suggestions for the similar project in the future

3. Schedule

	Time	Contents
November 28th, (Thu)	9:00-9:15	- Orientation
	9:15-9:30	- To confirm the Project Design Matrix (PDM) for evaluation of the project
	9:30-9:45	
	9:45-10:00	- To explain five evaluation criteria
	10:00-12:00	- Break
		- To review the evaluation draft in terms of relevance, effectiveness, and efficiency
	12:00-13:00	
	13:00-14:00	- Lunch Break
		- To review the evaluation draft in terms of relevance, effectiveness, and efficiency (ditto)
	14:00-14:50	
	14:50-15:00	- Group discussion-impact (4 group)
	15:00-16:00	- Break
		- *Presentation of the group discussion-impact*
November 29th, (Fri)	9:30-10:00	- To review the evaluation draft in terms of efficiency
	10:00-10:40	- Group discussion-sustainability
	10:40-11:10	- Presentation of the group discussion-sustainability Group discussion- Suggestion for new similar project (4 group)
	11:10-11:30	- Group discussion- Suggestion for new similar project
	11:30-12:00	- Presentation of the group discussion- Suggestion for new similar project
	12:00	- Closing Address

4. Participants

(Please refer to the attached list)

5. Place

The meeting room, Southern Regional Health Authority

List of Participants of Evaluation Workshop

No.	Name		Title, Organisation	Nov.28		Nov.29
				AM	PM	AM
1	E.	Lewis-Fuller	Director, Cooperation Health/Policy Analyst, MOH	x	x	x
2	S.	Laing	Senior Administrator, Bilateral Unit, PIOJ	x	x	x
3	F.	Petegrave	Regional Director, SRHA			x
4	M.	Coombs	Regional Technical Director, SRHA,	x		x
5	H.	Hamilton	Director, Management Information System, SRHA,			x
6	H.	Ismail	Director, Operations and Maintenance Division, SRHA			x
7	Y.	Pitter	Parish Manager, Manchester Health Department	x	x	x
8	S.	Chambers	District Medical Officer, Manchester Health Department		x	
9	D.	Stephenson	Community Health Nurse, Manchester Health Department		x	
10	A.	Carney	Nutritionist, Manchester Health Department			x
11	N.	Anderson	Medical Technologist, Manchester Health Department		x	
12	A.	Stephenson	Clerical Officer, Manchester Health Department		x	
13	T.	Davis	Nurse Practioner, St.Elizabeth Health Department	x	x	x
14	D.	Grandison	Health Educator, St.Elizabeth Health Department	x	x	
15	C.	Taylar	Health Educator, St.Elizabeth Health Department	x		
16	L.	Collins	Nutritionist, St.Elizabeth Health Department	x	x	
17	C.	Thompson	Parish Manager, Clarendon Health Department	x		
18	L.	Dawes	Medical Officer, Clarendon Health Department		x	
19	C.	Pearson	Health Educator, Clarendon Health Department		x	x
20	M.	Lawrence	Community Health Nurse, Clarendon Health Department	x	x	
21	W.	Reeves	Laboratory Technician, Manchester Health Department		x	
22	R.	Mita	Chief Advisor, Japanese Team	x	x	x
23	T.	Yoshida	Expert, Japanese Team	x	x	x
24	N.	Miyamoto	Project Coordinator, Japanese Expert	x	x	x
25	N.	Kumagai	Resident Representative, JICA/JOCV Jamaica Office	x	x	
26	M.	Kageyama	Coodinator, JICA/JOCV Jamaica Office			x
27	K.	Sato	Leader, JICA Evaluation Team	x	x	x
28	M.	Shibata	JICA Evaluation Team	x	x	x
29	Y.	Okumoto	JICA Evaluation Team	x	x	x
30	T.	Fujita	JICA Evaluation Team	x	x	x

What is PCM/PDM?

PCM (Project Cycle Management)

- PCM is a method for managing the lifecycle of the project more efficiently and effectively
- PCM consists of the process of planning the project, monitoring it, and evaluating it.
- PCM was structured on the basis of "Logical Frame (log frame)", which was developed in the United State in 1960s and has been widely used in a number of development assistance agencies.
- In PCM, "Logical Frame (log frame)" is called "PDM"

PDM (Project Design Matrix)

- A summary table of overall description of the project, its objectives and environment

<table>
<tr><th>Narrative Summary</th><th>Verifiable Indicators</th><th>Means of Verification</th><th>Important Assumptions</th></tr>
<tr><td>Overall Goal
Indirect/ Longer-term impact</td><td>Indicators to measure the achievement of Overall Goal</td><td>Information source of indicators</td><td>Necessary conditions for maintaining Overall Goal</td></tr>
<tr><td>Project Purpose
Target to achieve in the cooperation period</td><td>Indicators to measure the achievement of Project Purpose</td><td>Information source of indicators</td><td>Necessary, but uncertain conditions for achieving Overall Goal</td></tr>
<tr><td>Outputs
Necessary achievement to realize Project Purpose</td><td>Indicators to measure the achievement ofOutputs</td><td>Information source of indicators</td><td>Necessary, but uncertain conditions for achieving Project Purpose</td></tr>
<tr><td rowspan="2">Activities
Actual activities to achieve Outputs</td><td colspan="2" rowspan="2">Inputs
Jamaican side / Japanese side
Necessary resource for activities
(manpower, money, equipment, etc)</td><td>Necessary, but uncertain conditions for achieving Outputs</td></tr>
<tr><td>Preconditions
Conditions to be cleared before the project period</td></tr>
</table>

Five Evaluation Criteria

Relevance, Effectiveness, Efficiency, Impact, Sustainability

1. Relevance

Overall Goal
Project Purpose
Outputs
Inputs

Relevance is to question whether Project Purpose and Overall Goal are still consistent with the priority needs and concerns at the time of evaluation

- Overall goal consistence with present national health policies
- Appropriateness of the target group
- Project purpose consistence with the needs of target group
- Project purpose consistence with the policies and the needs of Southern Regional Health Authority
- Consistence with Japanese aid policy

2. Effectiveness

Overall Goal
Project Purpose
Outputs
Inputs

Effectiveness concerns the extent to which Project Purpose has been achieved, or is expected to be achieved, in relation to Outputs produced by the project

- Achievement of the project purpose
- Relation between the project purpose and the outputs
- Relation between the project purpose and the important assumptions

3. Efficiency

Overall Goal
Project Purpose
Outputs
Inputs

Efficiency is a productivity of the implementation process: how efficiently the various inputs are converted into Outputs

- Achievement of Outputs
- Relation between the conversion from the activities to the outputs and the important assumption, such as "continuity of trained C/Ps at the expected post".
- Efficient utilisation of facilities/equipment provided
- Appropriateness of the timing of allocation of C/Ps, equipment dispatching experts, etc.
- Quantity and quality of inputs, including C/Ps, Japanese experts, equipment provided

4. Impact

Overall Goal
Project Purpose
Outputs
Inputs

Impact is expected and unexpected, direct and indirect, positive and negative changes as a result of the project.

[Expected]
- The achievement of Overall Goal

[Unexpected]
- Impact on the policies and the existing health system of MOH/SRHA
- Impact on the early treatment of CLD of people in southern
- Impact on the status of traditional culture of Jamaica
- Negative impacts

5. Sustainability

Overall Goal
Project Purpose
Outputs
Inputs

Sustainability is to question whether the project benefits are likely to continue after the completion of the project

(ex)
- Whether organisational sustainability is established
- Whether financial sustainability is established
- Whether technical sustainability is established
- Whether there are constraints for sustainability

Guideline of Group Discussion

1. Rules to write in the card

- One message per a card
- Complete the sentence
- Explain your idea concretely, not abstractly
- First write a card and put on the board, then speak about it

A bad example	A good example
The consciousness of the patients has been changed very much.	A patient stopped eating donuts after the health examination.

2. Impact

(1) The achievement of the overall goal

	Expected	Unexpected
+		
-		

(2) Other expected impact caused by the project

(Example)

- Impact on the policies and the existing health system of MOH/SRHA
- Impact on the consciousness on my jobs
- Impact on the status of traditional culture of Jamaica
- Negative impacts

3. Sustainability – how to improve our activities

(1) Provided that the budget allocation and the manpower is the same as it is today, how can you improve the health services, namely Wellness Clinic, Mobile Clinic, Free Check and health education?

Topic	Present situation	Countermeasures	Target indicator
	*Complete the sentence	*Complete sentence	
	*Complete the sentence	*Complete sentence	

(2) Please consider the nickname (catchphrase) to express the project

4. Suggestion for new similar project

(1) To consider the reasons which made this project successful

(2) To consider the things which should be improved for new similar project

Reasons for Success of the Project	Things which should have been improved

Annex 14 Evaluation Grid

Relevance

No	Evaluation criteria	Data collection methods	Interviewee	Result
1	Needs of Jamaica			
	1.1 Overall goal consistence with present national health	Policy documentation, Interview	MOH	- Chronic lifestyle diseases (CLDs) including hypertension and diabetes have been major contributors to mortality and morbidity in Jamaica. The Ministry of Health (MOH) has been promoting healthy lifestyle among the population and prevention of chronic lifestyle diseases as one of national health priority goals. - According to MOH, MOH evaluated the achievement of the project highly, and will replicate into other regions. -
	1.2 Appropriateness of the target group	Interview	MOH, SRHA, CP	- According to MOH and SRHA, the selection of Southern Region as the project target area was appropriate, because the population of the southern region has a comparatively higher elderly population in relation to other regions. - The selection of Southern Region as the project target area was appropriate, because the population of the southern region has a comparatively higher elderly population in relation to other regions. (8.3% in the Southern Region, 7.4% in all Jamaica) - According to the C/Ps, the target group, "16 years and over" was appropriate, because it is necessary to educate people for healthier lifestyle in their youth. - Therefore the target group of the project was appropriate.
	1.3 Project purpose consistence with the needs of the target group	Interview	SRHA, C/P	- According to the SRHA and C/Ps, the project purpose, focusing on the prevention of CLDs, is timely and meets the needs of the target group.
	1.4 Project purpose consistence with the policies and the needs of Southern Regional Health Authority	Policy documentation, Interview	SRHA Parish Manager	- According to SRHA, it is preparing 5-year strategic plan and the prevention of CLDs is one of its priorities. Besides, it is said that the prevention of CLDs is more cost effective than curative treatment in the tight budgetary condition
2	Relevance with Japanese aid policy			
	2.1 Consistence with Japanese aid policy for Jamaica	Interview	JICA HQ JICA Jamaica Office	- According to JICA, the three important fields of technical cooperation with Jamaica are health, education and environment. Therefore, this project has been consistent with the Japanese aid policy.
	2.2 Japanese expertise in this cooperation field	Interview	Japanese experts	- Since Japan has established the effective system for providing health screening and education, it can be said that there is Japanese expertise.
3	Project design			
	3.1 Appropriateness of project design	Interview	MOH, SRHA	- In the project, the project design is in keeping with the decentralised health structure, thereby facilitating regional management. In addition, piloting disease prevention model in Manchester allowed for closer monitoring by SRHA and the Japanese Team, which is also located in Manchester. As a result, the model was firmly established in Manchester and extended to St. Elizabeth and Clarendon. - The design of having Jamaican counterparts (C/P) and Japanese experts working side by side for the duration of the project, helped significantly in the transfer of knowledge and skills.

Effectiveness

No	Evaluation criteria	Data collection methods	Interviewee	Result
1	Achievement of the project purpose			
	1.1 The change in awareness and behavior among community people related to the CLDs	PBA, Hearing Survey on Clients of Wellness Clinic	Clients of WC, MC and Diabetes Clinic	- The 1st PAB survey was conducted June- August 1999. The report was made in December 2000. - It is necessary to keep the certain period between the 1st and 2nd PAB surveys, in order to evaluate the change more precisely. Therefore, the 2nd PAB will be conducted in March 2003. - The result of Hearing Survey on the Clients of Wellness Clinic shows (random check of clients) that the repeat clients and the ex-participants of Diabetes Clinic have been changing their lifestyle, by caring food intake, doing more exercise, etc, after their visits. - The result of Hearing Survey on the Clients of Wellness Clinic shows (random check of clients) that the first clients of Wellness/Mobile Clinic are considering to change their lifestyle after receiving the health screening/health education.
	1.2 *Level of satisfaction among staff* that project objectives have been achieved	Interview	SRHA, C/Ps	- In addition, the C/Ps for the prevention of CLDs have been trained, and they are capable of implementing the activities. They are satisfied with the achievement of the project.
2	Relation between the project purpose and the outputs			
	2.1 Whether the achievement of the project purpose is led by the outputs of the project	Interview	SRHA, C/Ps, Japanese experts	- The achievement of the project purpose is led by the outputs of the project. - All the outputs are essential for the achievement of the project. But Output 1, Output 3, and Output4 mainly led to achieve the project purpose. Output 1, establishing management system, and Output 3, enhancing the capability and motivation of human resource, were the bases of Output 4
	2.2 The promoting/inhibiting factor to the effectiveness, including the achievement of the project purpose, conversion from the inputs to the achievement of the project purpose	Interview,	SRHA, Parish Manager, C/Ps, Japanese experts	- *One of the promoting factors is the change in the consciousness of related human resource,* including the counterparts and CHAs. As they were involved in the project activities, they have felt more committed and understood the necessity of the activities for prevention of CLDs. They have modified the model applicable to their environment. - The sincere effort of Japanese experts has promoted the achievement of the project. -
3	Relation between the project purpose and the important assumptions			
	3.1 Negative influence caused by the important assumptions	Interview, WS	SRHA, Parish Manager, C/Ps	- The important assumption, "The level of personal production remains the same", has been realized. - The important assumption, "The inter-sectional collaboration for control CLDs remains at the same level", has been realized. It is rather said that the project has been keeping the good relation with the outside organisations, such as Diabetes Association of Jamaica, University of West Indies, Japan Overseas Cooperation Volunteers, United Nations Peace Corps. - The important assumption, "The stability of staff will not worsen", has been realized.

Efficiency

No	Evaluation criteria	Data collection methods	Interviewee	Result
1	Achievement of the outputs			
	1.The Administrative/organisational capacity of the Southern Regional Health authorities is improved.			
	1.1 The numbers of Steering Committee meetings	Record of Steering Committee		- The Steering Committee Meeting has been held monthly and 48 times as total till November 20th. Each time, the minute is made to share the present status of the project.
	1.2 Total number of Wellness Clinic staff	Record of Wellness Clinic		- As of November 20th, 23 staff is allocated to Wellness Clinic: 8 in Manchester, 8 in St. Elizabeth, and 7in Clarendon. -
	1.3 Establishment of management system. such as planning, monitoring and evaluating the activities for the health system improvement	Record of Steering Committee	SRHA. Parish Manager. Japanese experts	- The Steering Committee has become the important opportunity to monitor and evaluate the present achievements/issues throughout the three regions with the participation of core administrative and medical staff. - According to Japanese experts, the useful information (ex. how to operate Wellness Clinic, how to promote the activities) has been exchanged in the Steering Committee Meeting. It has enhanced the sharing of the information among the regions.
	1.4 Establishment of management system of facilities and equipment	Mid-term Evaluation Report, Interview	SRHA. Parish Manager, Japanese experts	- The report on "The laboratory services in the region" has been made. - The necessary equipment for the improvement of parish health care has been provided and utilized well. - Technical maintenance and repairs of the medical equipment are supported by one engineer dispatched as Japanese Overseas Cooperation Volunteers (JOCV). After the project period, the necessary staff for the maintenance should be secured. - The equipment allocation list will be completed soon. If both the health centres and the maintenance companies share the list, the necessary maintenance and repairs can be done smoothly. The maintenance contract may be considered._
	1.5 Development of health information system, the system of updating data and maintenance	Record of Wellness Clinic, Interview		- The report on "The Health Information Management System and Its Computerisation" has been made.
	2. The functions of parish health centre facilities are improved.			
	2.1 Number of free check examinees at parish health centers	Record of Wellness Clinic, Interview	SRHA. Parish Manager. Japanese experts	Free checks started in February 2001 in New Port Health Centre and it has been extended to other health centers. Twelve centers in Manchester and St. Elizabeth have been providing free checks regularly and 9 centres in Clarendon are about to start.
	2.2 Number of CHAs trained in the training of mid-level trainees	Record of the training for middle-level trainee		Health Care Workshop for Community Health Aids was implemented twice and 459 CHAs attended. They gained the basic knowledge on CLDs and learned how to check BMI and how to measure blood pressure.
	2.3 Improvement of the quality of health educational materials	Interview. Project Record	SRHA, Parish Manager. Japanese experts	The quality of health educational materials has been improved through Japanese experts' assistance and C/P (C/P) trainings in Japan, along with the equipments provided. Video materials have been made and distributed to health centres. Posters and brochures were designed to be more colorful and illustrative..
	3. Human resource skills are improved.			
	3.1 Total number of staff trained in control/prevention	Record of the training for middle		- The counterparts were trained through various lectures and On the Job training. - Eighteen counterparts have received the training course in Japan.

	of CLDs	level trainee		- The following training courses were conducted in Jamaica. (1) Health care workshop for Community Health Aids: Feb.15-Mar.3, 2000, 158 participants. Mar. 12-Mar. 30, 2001, 129 participants. Nov. 21, Nov. 28, Dec. 5, 2001, 130 participants Oct. 31, 2002, 42 participants (2) Workshop for Medical Doctors and Nurse Practitioners: Mar. 12-30, 2001, 12 participants. Mar. 12-Mar. 30, 2001, 12 participants. Oct. 14, 2001- Feb. 13, 2002, 12 participants. (3) I.T. Training: Mar. 12-Mar. 30, 2001, 12 participants. Oct. 14, 2001- Feb. 13, 2002, 12 participants (4) Nutrition Oct. 14, 2001- Feb. 13, 2002, 12 participants. (5) Diabetes Mellitus: Dec. 7, 10 participants (6) Educational Material Development: Aug. 14, 2002, 16 participants (7) Cardiovascular Disease Jun. 21-Jul. 6, 1999, 136 participants Apr. 10, 11, 2002, 40 participants Apr. 17, 22, 23, 24, 2002, 10 participants (8) Physical Activities for Health Promotion and Prevention of Life Style Disease: Jul. 11-17, 2000, 124 participants (9) Health Information Management: Aug. 14-16, 19-21, 2002, 1 participants - Through these training courses, a total of 868 staff is trained in control/prevention of CLDs
	3.2 Knowledge and skill of the staff evaluated by the SC	Interview of members of Steering Committee	SRHA, Parish Manager, Japanese experts	- According to the interview of directors, the C/Ps have demonstrated a greater level of commitment and appreciation for lifestyle changes required in the prevention of CLDs. In turn, they have been communicating this to the general population through the established CLD prevention model.
	4. A CLD prevention model is developed and implemented in Manchester.			
	4.1 Total number of health screened persons	- Record of Wellness Clinic		- Since the opening of Wellness Clinic in September 1999, the Wellness Clinic has been held two days per a week. By October 31st 2002, 2,397 clients visited Wellness Clinic in Manchester. - Since September in 1999, Mobile Clinic has been conducted once per a week. By October 31st 2002, 2,684 clients visited Mobile Clinic in Manchester. - The total number screened is 5,081 by October 31st, 2002. The target of 7,000 was the number of total in three parishes. By the end of October, the total was 6,941 and the target will be achieved by the end of the cooperation period.
	4.2 Total number of repeat visits to Wellness Clinic	- Record of Wellness Clinic		- By October 31st 2002, there were 336 repeat visits to Wellness Clinic in Manchester. -
	4.3 Total number of patients referred to secondary care through Wellness Clinic/Mobile Clinic	- Record of Wellness Clinic		- By October 31st 2002, 1,061 patients have been referred to further examination/secondary care through Wellness Clinic/Mobile Clinic.
	4.4 Total number of community groups practicing	- Record of Wellness Clinic		- Diabetes Class has been held 5 times since July 2001; and 75 patients have participated in the clinic.

	CLDs prevention			
	4.5 Provision of free check services	- Record of Wellness Clinic		- During February and March 2001, free checks were held 8 times at the centre in Mandeville. 772 people were. - The necessary equipment for free checks has been provided to 6 health centres, and free checks has been implemented with the assistance of CHAs. Approximately, 1,000 free checks have been performed. Additionally, in some health centres, equipment is available for self check of blood pressure and pulse.
	4.6 Total number of health education materials developed	- Project record		- The health education materials, such as Wellness Calendar, Wellness Passport, posters, brochures, manuals, and 4 different video presentations, have been developed.
	4.7 Total number of promotion activities	- Project record		- In order to promote the necessity of physical exercise for health, Walkathon was conducted in March 2000, and April 2002 in Manchester Parish. About 200 people participated in the events. Besides walking, health information was delivered and the exercise materials were distributed to the participants. - The promotion materials, such as flyers, pamphlets, have been developed and distributed through community groups, churches, schools, companies, etc. - Free checks were also a good method for promoting Wellness/Mobile Clinic. - The promotion activities have been done many occasions, including Health Fares. In addition, the Mobile Clinic provided screening at four health fairs. And the members of the press were invited to view the Mobile Clinic in Mile Gully, and the articles on the project activities were appeared in Mandeville Weekly and the Gleaner. - In February 2003, the Jamaica/Japan International Health & Lifestyle Conference will be held and the activities related to Wellness Clinic will be presented.
	4.8 Establishment of implementing system of PAB	Project record, Interview	SRHA, Parish Manager, Japanese experts	- As for PAB survey, the questionnaires and the database were prepared. The 2nd PAB survey will be implemented in March 2003.
	4.9 Completion of database for WC/MC Clients	Project record, Interview	SRHA, Parish Manager, Japanese experts	- The database for WC/MC clients has been developed, and data on more than 5,000 visits have been inputted. The database is being used for follow-up activities.
	5 The CLD prevention model is extended to ST. Elizabeth and Clarendon.			
	5.1 Total number of health screened persons	Record of Wellness Clinic		[St. Elizabeth] - The Wellness Clinic was started at Santa Cruz Health Centre in February 2002. It has been conducted once a week, and 332 clients visited by October 31st 2002 - The Mobile Clinic was started in June 2001. Since October 2001, it has been conducted once a week, and 1,125 clients visited, including 611 clients screened using by the Mobile Bus of Manchester. - The total number screened is 1,447 by October 31st, 2002. [Clarendon] - The Wellness Clinic was started at May Pen Health Centre in July 2002. It has been conducted once a week, and 178 clients visited by October 31st 2002 - The Mobile Clinic has not started in Clarendon, It is because the bus was provided recently according to the late allocation of the medical staff. - The Mobile Clinic was conducted using the Mobile Clinic Bus in Manchester, and 225 clients were screened so far.

				- The total number screened is 1,447 by October 31st, 2002.
	5.2 Total number of repeat visits to Wellness Clinic	Record of Wellness Clinic		- Since Wellness Clinic has started recently and Mobile Clinic has not started yet in Clarendon, there is no repeat client to Wellness/Mobile Clinic.
	5.3 Total number of patients referred to secondary care through Wellness Clinic/Mobile Clinic	Record of Wellness Clinic		- The figure in St. Elizabeth and Clarendon was not acquired while the evaluation team stayed.
	5.4 Total number of community groups practicing CLD prevention	Record of Wellness Clinic		- Although the Mobile Clinic is provided to some community groups in both parishes, the organisation of community groups for practicing CLD prevention like "Diabetes Clinic" in Manchester is underway.
	5.5 Provision of free check service	Record of Wellness Clinic, Interview	SRHA, Parish Manager, Japanese experts	[St. Elizabeth] - The necessary equipments for checking height, weight, and blood pressure, have been provided to 6 health centres. Free checks have been implemented with the assistance of CHAs. Besides, in some health centre, the equipments are open to anyone to check own health condition. [Clarendon] - The necessary equipments for checking height, weight, and blood pressure, are ready to be used in 9 health centres. Free checks will start soon.
	5.6 Total number of health education materials developed	- Project record		- The health education materials developed have been utilized in Wellness Clinic CLDs prevention activities.
	5.7 Promotion activities	Project record . Interview	SRHA, Parish Manager, Japanese experts	[St. Elizabeth] - 3 video presentations, and health education materials, such as Wellness Calendar, flyers, pamphlets, and brochures, have been developed. - The promotional materials were distributed through community groups, churches, schools, and companies, etc. Walkathons were conducted in June 2001 and April 2002, and about 300 people participated in both events. In addition, the Mobile Clinic provided screening at four health fairs held during the month of June 2002. [Clarendon] - The health education materials, flyers, pamphlets developed have been utilized in CLD prevention activities. They were distributed through community groups, churches, schools, and companies, etc. In addition, one local cable network has been advertising the Wellness Clinic free of cost. Walkathon was conducted in January 2002 about 250 people participated. In August 2002, approximately 400 free checks were conducted at Denbigh Agricultural show.
2	Relation between the outputs/activities and important assumptions, other inhibiting factors			
	2.1 Relation with three important assumption	Interview	SRHA, Parish Manager, Japanese experts	- Important assumption, "Counterpart personnel selected to work for the project" has been realized, although there were some delays of allocation of health related staff.
	2.2 Inhibiting factors from outside of the project	Interview	SRHA, Parish Manager,	- There has been no particular inhibiting factor from outside of the project.

			Japanese experts	
3	Utilisation of inputs			
	3.1 Efficient utilisation of facilities /equipment provided	Interview	SRHA, Parish Manager,	- The equipment provided has been utilized efficiently for the project activities.
4	Appropriateness of the timing of inputs			
	4.1 Inputs from Jamaican side, including allocation of C/Ps, equipment	Interview	Japanese experts	- In general, the timing of allocation of the counterparts was appropriate. - But, there were some delays in allocating medical staffs, especially doctors in St. Elizabeth and Clarendon. It resulted in the delay of the start of Wellness Clinic in both regions.
	4.2 Inputs from Japanese side, including dispatching experts, equipment, training	Interview	SRHA, Parish Manager	- The timing of dispatching Japanese experts was appropriate. - The first part of the equipments was provided more than a year later, after the start of the cooperation period.
5	Quantity and quality of inputs			
	5.1 Quantity and quality of C/Ps	Interview	Japanese experts	- Because of the difficulty of recruiting medical staff, the quantity of the counterparts had been less than it was planned. But necessary staff was allocated at the latter stage of the project period. - The technical capability of counterparts was high enough for the project activities.
	5.2 Quantity and quality of Japanese experts	Interview	SRHA, Parish Manager	- The quantity and quality of Japanese experts were appropriate.
	5.3 Quantity and quality of equipment provided			- The quantity and the quality of equipment provided were appropriate.
6	Alternative approaches to achieve the outputs			
	6.1 Whether the alternative approaches or activities to achieve the outputs	Interview	SRHA, Parish Manager, Japanese experts	- The approach to achieve the outputs was the most appropriate.

Impact

No	Evaluation criteria	Data collection methods	Interviewee	Result
1	Expected impacts			
	1.1 The achievement of the overall goal	Interview, Hearing Survey, WS	MOH, SRHA, Parish Manager, C/P, Japanese experts, Clients of WC/MC	- MOH has an intention to replicate the CLD prevention model developed by the project in the other regions. - The project activities were reported to the periodical meetings of MOH. There have been some inquiries about the CLD prevention model from other health regional authorities. - Mobile Clinic was dispatched from St. Elizabeth to White House, Western Health Region in July 2002 at the request of community people. - The achievement of the project will be spread throughout Jamaica and Caribbean Countries at the Jamaica/Japan International Health & Lifestyle Conference, February 2003. -
	1.2 Other expected positive impacts	Interview, Hearing Survey,	MOH, SRHA, Parish	- According to the clients at Wellness/Mobile Clinics and C/Ps, the Wellness/Mobile Clinic fee, 600 Jamaican Dollar, was adequate.

		WS	Manager, C/P, Japanese experts, Clients of WC/MC	
	1.3 Negative impacts	Interview, Hearing Survey, WS	MOH, SRHA, Parish Manager, C/P, Japanese experts, Clients of WC/MC	- Not in particular
2	Unexpected impact			
	Positive impacts	Interview, Hearing Survey, WS	MOH, SRHA, Parish Manager, C/P, Japanese experts, Clients of WC/MC	- Some patients were found to have diseases other than CLDs through the Wellness/Mobile Clinic. - The clients referred their family members or acquaintances to the Wellness/Mobile Clinic. - Other health care service providers have been interested in the project activities. For example, Blue Cross, a health insurance company, has visited Wellness Clinic to observe the operation. - Children in primary schools in St. Elizabeth have been changing eating habit. - SRHA is planning to establish the Healthy Lifestyle Award in February 2003.
	Negative impacts	Interview, Hearing Survey, WS	MOH, SRHA, Parish Manager, C/P, Japanese experts, Clients of WC/MC	- Not in particular
3	3 Achieved level and the inhibiting/solving factors, influenced by important assumptions			
	3.1 Influence of important assumptions	Interview, Hearing Survey, WS	MOH, SRHA, Parish Manager, C/P, Japanese experts, Clients of WC/MC	- The important assumption, "The focus by MOH and other relevant authorities remain preventive rather than curative cares", has been realized. The preventive activities for CLDs have been more emphasized than before, because of the increase in the patients of CLDs and the necessity of utilizing limited financial resource for health activities. - The important assumption, "The level of literacy will not worsen", has been realized. According to "Economic and Social Survey Jamaica 2001", literacy rate increased from 75.4% in 1998 to 79.9% in 2001.

Sustainability

No	Evaluation criteria	Data collection methods	Interviewee	Result
1	Organisational sustainability			
	1.1 The continuity of the policy support from MOH/SRHA for the project activities	Interview, WS	MOH, SRHA, Parish Manager	- MOH has set Control of CLDs as one of its proprieties. The policy support from MOH would be secured continuously for the coming years. - SRHA is preparing 5-year strategic plan and the prevention of CLDs is one of its priorities. In all the three regions, they are considering providing more Wellness/Mobile Clinic service. Thus, SRHA would certainly continue the activities for the prevention of CLDs.
	1.2 Achieving Overall Goal- extending the CLDs prevention model to other regions		MOH	- MOH evaluated the achievement of the project highly, and has an intention to replicate the result of the project in other regions.

	1.2 The continuity of the management system, such as planning, monitoring and evaluating the activities	Interview, WS	SRHA, Parish Manager, C/Ps, Japanese experts	- The Steering Committee Meeting has provided an important opportunity to monitor and evaluate the present achievements/issues with the participation of core administrative and health staff. It should be continued after the project period. In addition, the minutes of each meeting should be shared by all the staff related to the activities.
	1.3 Manpower	Interview, WS	SRHA, Parish Manager, C/Ps, Japanese experts	- SRHA has enough health care staff to maintain the present activities. However, it would be necessary to allocate more staff, if SRHA provides more Wellness/Mobile Clinic service in the future. - At present, the clients have satisfied with the quality of service in Wellness/Mobile Clinic. There is room for the improvement, especially, the process of operation. Based on the observations at several Wellness/Mobile Clinics, there were differences in terms of the operation efficiency among the clinics. The staff should try to improve the operation practice by learning from the well operated clinics. - Promotion activities for Wellness/Mobile Clinic have been implemented through various methods. These activities should be more enhanced to increase the recognition of Wellness/Mobile Clinic.
	1.4 Equipment and supplies	Interview, WS	SRHA, Parish Manager, C/Ps, Japanese experts	- The Health Facilities Maintenance Unit, has been responsible for technical maintenance. Considering the expansion of the activities, technical maintenance staff members should be secured, one in each parish. - The stock level for relevant supplies should be established and regularly monitored.
	1.5 Information management of Wellness Clinic	Interview, WS	SRHA, Parish Manager, C/Ps, Japanese experts	- The database for WC/MC clients has been developed and updated in Manchester. The similar database should be completed and the necessary staff should be allocated in St. Elizabeth and Clarendon for follow-up activities. - The visitors' data to free checks should be inputted and monitored monthly.
2	Financial sustainability			
	2.1 The allocation of necessary staff/budget for the activities	Interview, WS	MOH, SRHA, Parish Manager	- Because of its priority, SRHA has assured continuous budgetary allocation to the Wellness/Mobile Clinic. The necessary cost of supplies, equipment, maintenance, repairs, etc, should be appropriated in the annual budget.
	2.2 Health screening fee	Interview, Hearing Survey, WS	C/Ps, Clients of WC/MC	- Most of the clients of the Wellness/Mobile Clinic were thinking its health screening fee was affordable.
3	Technical sustainability			
	3.1 The technical capability of trained C/P and related staff members	Interview, WS	SRHA, Parish Manager, C/P, CHA, Japanese experts, C/Ps, Japanese experts	- The C/Ps and related health care staff were trained and capable of implementing the CLD prevention activities. Most of them are committed to the activities and expected to stay at the present post. In order to motivate the present staff members, the systematic training should be provided to upgrade their capabilities. - The training for new staff members should be planned and continuously implemented to understand the CLDs model.
	3.2 The technical capability of maintainance, repairing and revising the equipment	Interview, WS	SRHA, Parish Manager, C/P, Japanese experts	- The main causes of the troubles of equipment were careless use. The usage of the equipment should be reminded to each member of staff repeatedly and the manual should be with the equipment. -

Result of Inputs

No	Indicator	Source of Information	Result of survey
1	Japanese side		
	Number of experts Long term experts Short term experts	Project record	28 experts, including 13 long-term experts, 15 short-term experts, have been dispatched. 2 short-term experts will be dispatched for the International seminar in February 2003.
	Provided equipment	Project record	The necessary equipments for the project activities are provided (Annex 6). Total cost of provision is 85,399 thousand Yen.
	C/P Training in Japan	Project record	18 counterparts have participated in the training course in Japan. The topics of the training course vary according to their job necessity.
	Local cost	Project record	The total amount of the local cost is 26,359 thousand Yen.
2	Jamaican side		
	Number of C/P	Project record	A total of 22 counterparts were allocated for the project. The breakdown is : 3 counterparts from Ministry of Health, 3 counterparts from Southern Regional Health Authority, 6 counterparts from Manchester Health Department, 5 counterparts from Clarendon Health Department, and 5 from St.Elizabeth Health Department.
	Land, facilities (if any)	Project record	The office space for Japanese experts was provided in Southern Regional Health Authority Office building.
	Local cost	Project record	

Process for Achievement

No	Indicator	Source of Information	Result of survey
1	Implementing monitoring		
	Monitoring system	Project record	- The Steering Committee has been held monthly, and the progress of the project has been monitored. - The Management Consultation Team was dispatched January 2001, and implemented the mid-term evaluation of the project.
	Adjustment of PDM, DIP	Interview of Japanese experts, SRHA、C/Ps	- PDM of the project was made in the Project Cycle Management workshop when the Management Consultation Team stayed in January 2001. Since the project related personnel, both Jamaican side and Japanese side, participated in the workshop, the process of making the PDM encouraged the ownership of Jamaican side. - Detailed Implementation Plan was made and used as a monitoring tool of the project.
2	Relation between experts and C/Ps		
	Communication	Interview of Japanese experts, SRHA、C/Ps	- The communication between counterparts and Japanese experts has been kept well. - The issues on the project have been discussed in the Steering Committee. It worked as the important opportunity of information sharing. -
	Change in the attitude of C/P, in planning, implementing the activities	Interview of Japanese experts, SRHA、C/Ps	- According to the progress of the project activities, the counterparts have gradually become involved positively. - In addition, C/P training in Japan has encouraged them to understand the background of the project well.
3	- Ownership of the project implementing organization		
	Participation of Project Director	Interview of Japanese experts	- The Project Director, the Permanent Secretary, Ministry of Health, has attended the important meeting of the project. - Dr. Fuller, Director, Cooperation in Health/Policy Analyst, MOH, and Special Technical Advisor of the Project, was involved in the project very much, as she participated in the PCM workshop in January 2001.
	Provision of budget	Interview of Japanese experts	- Despite of severe budgetary situation, Jamaican side has provided the necessary cost for the project activities. Jamaica side has managed to bear the increase of the direct cost for Wellness/Mobile Clinic, which was the result of the decrease of Japanese financial support.
	Appropriateness of allocation of C/Ps	Interview of Japanese experts	- Almost all the counterparts were well educated and capable of their job responsibility. But there were some delays of counterparts' allocation for several posts, which caused the delay of the project activities.

2．新聞記事（The Gleaner紙　2002年12月10日付）

Jamaica, Japan working to prevent lifestyle-related diseases

THE JAPANESE Government has been working with the Ministry of Health and Planning Institute of Jamaica (PIOJ), since 1998, to get persons in the island's southern region to adopt healthy lifestyle practises in order to prevent lifestyle-related diseases.

Some $12 million has already been invested and Japanese experts have been on the island doing the final evaluation of the project, which will end next May, to determine its viability.

So far, Ministry of Health and PIOJ officials have deemed it a godsend and hope to extend the project to other parts of the island.

The aim of the project is to provide preventative health care through public health education and health care promotion. The main target groups are people with chronic lifestyle diseases like diabetes, hypertension, heart diseases and strokes. There are free blood pressure, weight and height checks and the prevention approach is to inform all persons about maintaining a healthy lifestyle.

A clinic has already been started in Manchester and extended to the parishes of St. Elizabeth and Clarendon.

Leila Palmer, director of the external co-operation management unit of the PIOJ, said that the mobile clinics have been reaching people in very remote areas who might not have been helped otherwise.

"They are now more aware of the lifestyle changes needed to prevent the risk of diseases," she said at the signing of the final evaluation of the project. She said that the evaluation has shown that effective delivery has been attained and they will work to strengthen weak areas and target other groups like the youth.

Reports have shown that there have been thousands of visits to the mobile clinics, and return visits have also been encouraging.

Since the initial inception, the Japan International Co-operation Agency (JICA) has dispatched several experts to Jamaica, specifically to the southern region. The experts have provided two mobile clinics and an array of medical supplies and equipment. Additionally they have assisted 18 Jamaicans to receive training in health related fields in Japan.

The project 'Strengthening of Health Care in the Southern Region' addresses issues like a high trend of diabetes cases in youth, that technical director at the Southern Regional Health Authority (SERHA), Dr. Michael Coombs said last year was a cause for concern.

He said at a handing over ceremony of equipment by JICA to the SERHA last June, that while diabetes is found mostly among persons age 40-59, they have been noticing an increasing trend among youths, and that the increase in diabetic cases may very well be related to their lifestyle.

Another growing problem is obesity, especially among women, where a SERHA study showed that 50 per cent of persons found to be overweight considered themselves to be all right. Excess weight and obesity can lead to chronic lifestyle diseases, including hypertension.

The challenges are being addressed by the JICA/Jamaica wellness programme.

WINSTON SILL/*Freelance Photographer*

Professor Kei Sato, leader of the final evaluation team of the Japan International Co-operation Agency (JICA), listens to Permanent Secretary in the Ministry of Health (MOH), Grace Allen-Young (right) at the JICA/MOH/Planning Institute of Jamaica signing ceremony at the Jamaica Pegasus Hotel.