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Promoting sexual health and rights in a community health setting. Example of Eve for Life, a Jamaican NGO

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Acronyms

AIDS: Acquired Immune Deficiency Syndrome

ART: Antiretroviral Treatment

EFL: Eve for Life

HIV: Human Immunodeficiency Virus

JASL: Jamaica AIDS Support For Life

NGO: Non-governmental organization

OVC: Orphans and Vulnerable Children

ROAR: Restoring Order in All Relationships

STIs: Sexually Transmitted Infections

UN: United Nations

UNAIDS: Joint United Nations Programme on HIV and AIDS

UNFPA: United Nations Fund for Population Activities

USAID: United States Agency for International Development

WHO: World Health Organization

Introduction

In 1978, the Declaration of Alma-Ata at the International Conference on Primary Health Care marked a turning point in public health. It asserted the importance of primary care and communities' involvement to achieve the goal of "Health for All" (World Health Organization & United Nations Children's Fund, 1978). Nearly ten years later, the first International Conference on Health Promotion was held in Ottawa in 1986 and resulted with a "Charter for action to achieve Health for All by the year 2000 and beyond" (World Health Organization, 1986). Health promotion was defined as "the process of enabling people to increase control over, and to improve their health", "a state of complete physical, mental and social well-being" (World Health Organization, 1986). One of the strategies that comprise the Ottawa Charter is community health. In this thesis, we will explore the implications and concepts linked to community health by analyzing the community-based approach of a Jamaican NGO called Eve for Life (EFL).

1.1 Understanding the Jamaican context

1.1.1 Country profile

With a population of nearly 3 million people, Jamaica is the largest and most-populated island in the English-speaking Caribbean. Although it has been classified as an upper middle-income country[1], Jamaica faces many challenges related "to low growth, high public debt, and exposure to external shocks" (The World Bank, 2020). The economy is based on tourism, agriculture (mainly exportation of sugar, molasses and rum) and mining (Black, 2022). The economy and especially the tourism sector was hit by the COVID-19 pandemic. After a historic low of 7.2% in October 2019, the unemployment rate has risen to 9.2% in 2021. Compared to most countries in the Latin America and Caribbean region, inequality is lower but the poverty rate of 19% in 2017 is still high (The World Bank, 2020). Important social issues such as high levels of crime and violence, corruption, youth unemployment, poverty, inadequate urban planning, lack of housings, unequal regional development have yet to be addressed in a more significant way (Black, 2022; The World Bank, 2020; World Bank, 2021).

Jamaica was colonized by Spain in the early 16th century and later on by Britain in 1655. It was an important sugar production and exportation colony until the abolition of slavery in the late 1830s. A century later, Jamaica gained further control over its governance. It celebrated this year its 60th

[1] According to the World Bank, the upper middle income country group "includes 55 countries with a Gross National Income (GNI) per capita from $4,096 to $12,695 (calculated using the World Bank Atlas method)." (The World Bank, 2022)

anniversary of independence from the British. Jamaica is now a constitutional monarchy within the British Commonwealth (Black, 2022).

The population consists mainly of the descendants of African slaves, a smaller proportion of mixed European and African ancestry as well as Asian and European minorities (Black, 2022). The official language is English but the Jamaican creole, or “patois”, (a distinct language derived from a mix of English, West African languages, Spanish, French) is also widely used.

The most important health issues in Jamaica are cardiovascular diseases (stroke, diabetes, ischemic heart disease), neonatal disorders and the Human Immunodeficiency Virus (HIV) epidemic (Thelwell, 2020). Moreover, youths are particularly impacted by nutritional issues, mental health issues, unplanned pregnancies and a high prevalence of sexually transmitted infections (STIs) (UNICEF, n.d.).

A network of primary, secondary, and tertiary care facilities deliver health related services in the public sector (Goede et al., 2018). With the help of the Pan American Health Organization, efforts have been made by the Ministry of Health and Wellness over the years to adopt a more comprehensive health system to face public health burdens such as chronic diseases (Pan American Health Organization, n.d.). Jamaica counts several public hospitals including a pediatric hospital, private hospitals and clinics and hundreds of health centers (Goede et al., 2018; McCaw-Binns & Moody, 2001). Jamaica has also introduced free public health services in 2008 by eliminating user charges but still faces major public health issues and health care service access inequities. Health care demands are increasing whilst medical infrastructures are often underequipped and understaffed. Jamaica faces a lack of coordination of care between different levels of the health system, inequal health care coverage in the country and access difficulties especially for people living in rural areas. Resources of care are scarce and patients often face delays in treatment seeking and medication shortage. The Minister of Health and Wellness announced in 2019 a $200 million budget to upgrade public health facilities, build a new pediatric and adolescent hospital and invest in innovative technology (Goede et al., 2018; Thelwell, 2020).

Jamaica in numbers (World Bank, 2021):

- Life expectancy at birth: 75 years in 2020
- Gross Domestic Product per capita: 4 586.7 $ in 2021
- Gross Domestic Product: 13.64 million $ in 2021
- Personal remittances represented 22.2% of Gross Domestic Product in 2020

  Intentional homicides: 45 per 100 000 people in 2020

1.1.2 A concerning HIV epidemic prompts international and national response

The HIV epidemic started in the 1980s in Jamaica. According to the Joint United Nations Programme on HIV and AIDS (UNAIDS), 30 000 adults and children were estimated to be living with HIV in 2021. Amongst them, less than half (14 000 people representing 47%) were on antiretroviral treatment (ART) and had suppressed viral loads (14 000 people representing 47%) (UNAIDS, 2020a). In 2021, 15 000 women aged 15 and over were estimated to be living with HIV amongst which 52% were receiving ART. Less than 500 children aged 0 to 14 were living with HIV but only 33% of them were receiving ART. In 2021, the prevalence of HIV was 1.3 % of adults, 1.4% of women aged 15 to 49, and 0.6% of young women. The number of adults and children newly infected with HIV was 1400 (UNAIDS, 2020a). The rate of mother-to-child transmission was 6.72%. Approximately 11 000 children aged 0 to 17 were orphaned because of AIDS (UNAIDS, 2020a).

In Jamaica, the main social and cultural factors contributing to the HIV epidemic are related to high-risk sexual behaviors of heterosexual men, "high HIV prevalence among men who have sex with men, half of whom are bisexual, which acts as a bridge for HIV into the general population", as well as stigma and discrimination around HIV, homosexuality and marginalized groups (mainly men who have sex with men, sex workers, transgender people) that constitute a barrier to health care services (Figueroa et al., 2020). Early sexual initiation for both women and men, lack of sexual education for youths, multiple partners especially for men and low condom use are often observed (Figueroa et al., 2020). Only 39% of young people aged 15-24 have sufficient knowledge about HIV prevention[2] (UNAIDS, 2020a). The "love and trust" paradigm makes condom use between established partners less likely. Suggesting condom use with one's main partner might arouse suspicions and might be perceived as a sign of unfaithfulness (Figueroa et al., 2009). Safe sex behaviors are expected and normative with non-regular sex partners but they are not applied consistently (Figueroa et al., 2020). Stigma and discrimination related to HIV and homosexuality are still strongly felt in Jamaica. For example, in the "Knowledge, Attitude and Behaviour Study" led in 2017, 66.8 % of adults (aged 15-49) responded "No" to the question "Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?" (UNAIDS, 2020a).

Jamaica has not hit the UNAIDS "90-90-90" target[3] to be met by 2020 to end the HIV pandemic by 2030 (UNAIDS, 2020b). Although, the number of people living with HIV continues to increase, the significant HIV prevention efforts led by the government in the last twenty years through the National HIV Program have slowed the epidemy and reduced mortality and morbidity due to HIV as well as incidence of infections (Figueroa et al., 2020; UNFPA Caribbean, 2017). The National HIV

[2] Knowledge about HIV prevention is defined as being "able to correctly identify both ways of preventing transmission while rejecting major misconceptions" (Ministry of Health & Wellness, 2020)

[3] "90% of people living with HIV know their status, 90% of people who know the HIV-positive status are on antiretroviral therapy, 90% of people on antiretroviral therapy are virally suppressed" (UNAIDS, 2020b)

Program led by the Ministry of Health and Wellness is a multi-sectoral response based on health education and prevention, advocacy and human rights promotion. The program aims to develop a community-based approach and outreach communication to raise awareness, prevent infectious risk and reduce stigmatization of people living with HIV (Ministry of Health and Wellness, n.d.). Important steps of the program include a public ART access program since 2004, the development of a Pre-exposure Prophylaxis program, a rollout of HIV Self-Test Kit started in 2020 to detect and treat infections as soon as possible (Jamaican Information Service, 2021). The majority (90%) of the national response has been funded by the Global Fund but international resources are to decline with Jamaica's classification amongst middle-income countries. The government has therefore doubled efforts to ensure the program sustainability (UNFPA Caribbean, 2017).

1.1.3 Teenage pregnancies amidst a lack of specific adolescent health care

Jamaica has the third-highest adolescent pregnancy rate in Latin America and the Caribbean. The adolescent fertility rate in 2020 was at 48.4 births per 1000 women aged 15-19. It has been declining in the past few years (66.1 per 1000 in 2010) but is still fairly high compared to the average rate seen in other upper middle income countries (29.1 per 1000) (The World Bank, 2022). According to the United Nations Fund for Population Activities (UNFPA), nearly 20% of births occurred among adolescents in 2017 (UNFPA Caribbean, 2017). Over two thirds of adolescent pregnancies are estimated to be unplanned (Figueroa et al., 2020). Adolescent mothers face major challenges such as interruption in education and lack of support from the "baby-father" which undermine further economic, educational and social opportunities in adulthood (Wilson-Mitchell et al., 2014).

Gender norms and beliefs play a major role in family planning. For men in Jamaica, having multiple sex partners, fathering children with multiple women and at an early age are behaviors meant to assert manhood. Based in a largely homophobic society, it has been reported that these behaviors are also a way for men to demonstrate that they are not homosexuals. These beliefs and behaviors, especially frequent in lower socio-economic backgrounds, may also impact young girls who are pressurized into motherhood at an early age (Figueroa et al., 2009; Walcott et al., 2015). Sexual activity has also been reported to start earlier nowadays. Findings from the Knowledge, Attitudes and Behavior Survey showed that the median age of first sex for boys was 15 years and 17 years for girls in 2017, versus, 16.5 years and 18.2 years, respectively, in 1996 (Figueroa et al., 2020). The legal age of sexual consent is 16 years in Jamaica. For the most part, teenage sexual activity happen between peers but a number of adolescent girls engage in sexual activity with older men with usually a transactional and/or abusive aspect to the relationship (Baumgartner et al., 2009; Figueroa et al., 2020). There is also a high rate of sexual abuse of

children in Jamaica (UNICEF, n.d.). A study has also shown that early sexual initiation of women may also be associated with “high-risk behaviors, such as multiple partnerships and possibly transactional sex” that in turn increase the risks for unplanned pregnancies and STIs (Jarrett et al., 2018).

Around 20 percent of the Jamaican population is in adolescence. However, the lack of dedicated health services, especially in adolescent sexual and reproductive health, contributes to unsuited care for this population. Inconsistencies persist between STI and unwanted pregnancies risk reduction policies and the access difficulties to reproductive health services and contraception for adolescents. For example, health professionals may advise on contraceptives and prescribe contraception to minors without parental consent if it is in the minor’s best interest. However, conflicting messages, personal and religious beliefs of some health professionals as well as cultural barriers may inhibit adolescents from accessing voluntary family planning and sexual health services. Health professionals have also showed reluctance in doing so (Crawford et al., 2009; UNESCO, 2018). Moreover, sexual education in schools mainly focuses on abstinence and adolescents often lack safe sex skills (UNICEF, n.d.). Abortion under the Jamaican law is a felony. As a result, women seeking an abortion and people who help them are subject to prosecution. The law is rarely enforced and clandestine abortions are believed to be widely practiced (Smith & Johnson, 1976). Even so, this may also be associated with the high rate of adolescent pregnancies.

The Health Promotion program established by UNICEF “works to provide quality health services to babies, adolescents and young mothers” by enhancing “institutional capacity to deliver effective health services and to boost the access of adolescents to these health services”. Partners include institutional stakeholders such as the Ministry of Health and Wellness and non-governmental organizations (NGOs) such as EFL (UNICEF, n.d.).

1.1.4 Widespread Gender based violence sets back gender parity

Formal marriages are less common than in most other countries, children are often born out of wedlock. Women often work and provide for their families especially in households where the fathers are absent (Black, 2022). At a structural level, Jamaica works to achieve gender parity and has scored high scores in the Human Development Index and Gender Development Index of the United Nations Development Program. This suggests that the socioeconomic gap between men and women should be minimal in Jamaica(Watson Williams, 2018).

However rigid gender norms interwoven in a broader social and cultural context persist and “undermine women’s position in Jamaican society” whilst reinforcing notions of female subordination and male domination” (Davis & Graham, 2022). In this context, gender-based violence (GBV) is widespread in Jamaica. GBV is defined by “harmful acts directed at an individual

based on their gender" (United Nations High Commissioner for, n.d.). In the Jamaica Women's Health Survey 2016, the first and for now only national survey on GBV, nearly a third (27.8 %) of ever-partnered women aged 15-49 years experienced "intimate partner physical and/or sexual violence at least once in their lifetime", 23 % experienced "sexual violence perpetrated by someone other than an intimate partner at least once in their lifetime" and 25% "experienced physical violence alone at the hands of a male partner" (Watson Williams, 2018). These proportions are similar to the findings of a meta-analysis conducted in 2015 in low and middle-income countries in which "an estimated 28% of adolescent and 29% of young adult women reported lifetime physical or sexual intimate partner violence, most prevalent in the East and Southern Africa region." (Decker et al., 2015). GBV has serious consequences for women's physical and psychological health such as "increased risk of mental health issues including depression, PTSD, suicidal ideation; STIs; pregnancies, abortions". Experiences of GBV also constitute a basis for further abuse (Decker et al., 2015).

Research on GBV in Jamaica has shown that societal and macrolevel factors "including male entitlement or ownership of women, rigid gender roles, and acceptance of interpersonal violence at a social level which can be reinforced by law and practice" create a "community level tolerance of violence" (Davis & Graham, 2022). For example, marital rape is criminalized only in certain circumstances in the 2009 Sexual Offences Act. Despite the Senate approval in 2020 to review the Sexual Offences Act and better recognize marital rape as a criminal offence, changes of the law are still pending (R. Scott, 2020). The portrayal of violence against women and young girls in the media is rarely gender-sensitive and may reinforce cultural attitudes towards GBV (Davis & Graham, 2022). Some authors argue that GBV and the high rate of violence found in the Caribbean region find their roots in its colonization history. Mass slaughter of indigenous populations, oppression and slavery seem to have left deep marks that continue to impact and influence the contemporary culture of violence (Bean, 2022).

The Jamaica Women's Health Survey found that although the majority of women who experienced GBV (80%) were able to talk about it to their close circle, only a few sought help from institutions (Watson Williams, 2018). This corroborates other reports of underreported domestic and sexual violence "due to fear of shame, social stigma, disgrace, or further violence" (Watson Williams, 2018). In response to widespread GBV, the government has put in place several measures to provide protection for these women. The National Strategic Action Plan to Eliminate Gender-Based Violence in Jamaica 2017-2027 was launched "in alignment with the 2030 Vision National Development Plan, National Policy for Gender Equality, and the United Nations 2030 Agenda for Sustainable Development." (Jamaican Information Service, 2017). This plan focuses on different priority areas including prevention and protection (psychosocial and health) (Jamaican

Information Service, 2017). Nonetheless, substantial efforts still need to be made to shift gender norms and stereotypes and institutions rely on local organizations to meet these needs.

1.2 Presentation of Eve for Life

Eve for Life (EFL) is a Jamaican NGO founded in 2008 to support women, adolescents and children living with or affected by HIV and AIDS and/or gender-based violence. EFL works on the empowerment of this population through psychosocial programs enhancing information delivery, improving access to health care and social services, building key life skills and accompanying clients' needs and to their rights (Eve for Life, 2018b).

EFL's target population is adolescents and young women, aged usually from 12 to 25 years, who may be victim of sexual abuse and/or contracted HIV and/or are teen mothers and/or are leading high-risk sexual behavior. EFL also works with orphans and vulnerable children (OVC) generally of clients (Eve for Life, 2018b). In 2022, Eve for Life serves around 150 clients and 220 OVC. Offices are located in Kingston where the majority of the staff works, other team members deploy actions in Saint Catherine, Saint Ann, Trelawny, Hanover, Saint Elizabeth, Saint James and Westmoreland.

The team is mainly composed of women from different backgrounds:

- mentor moms and family liaison officers who are peer workers
- technical staff including 2 case managers, 2 regional coordinators, 3 outreach officers and an outreach coordinator, an OVC coordinator, 2 program coordinators, 2 administrative and finance personnel
- 2 psychologists
- A communications team responsible of managing social media, of EFL's branding and -
    - An executive director (Joy Crawford, registered nurse and co-founder)

Actions conducted by EFL include psychosocial support (counselling, financial aid and distribution of care packages, support groups, help with administrative matters, educational support…) training and self-development (alternative therapy, workshops…), sensitization/knowledge and sexual education sessions in health facilities, schools and communities, mentorship of clients, hospital/home visits, referrals to services, advocacy, networking and creating partnerships with public, private and international donors (Eve for Life, 2018b). EFL plans actions not only for individuals but also for communities. In 2018, the annual program report mentions that "153 interventions were conducted, 5310 people at the community and school level were reached, 20 000 male condoms were distributed". That same year, "39 community and youth leaders (were) trained around sexual exploitation, advocacy, reporting system and procedures" and Eve for Life "sponsored 5 targeted community interventions focusing on the Nuh Guh Deh messages", the communication campaign denouncing child sexual abuse (Eve for Life, 2018a). The outreach

coordinator is responsible of putting into place activities and interventions in various community settings and aimed at the general populations (distribution of condoms, health education sessions, discussions around GBV, HIV, sensitization/awareness sessions, meetings with youth, voluntary counselling and testing…).

EFL's programs are meant to be based on its motto "care, commitment, creativity, empowerment". There are currently five main programs run at EFL. Clients may be enrolled in one or several programs according to their needs:

- I am alive club: this program provides knowledge and life skills for young women and teenage mothers who are living with HIV, it also serves as a basis for these women to support and encourage each other.
- Restoring Order to All Relationships (ROAR) Club: with its client-centered approach, this program aims to address multilevel needs of young women who have been sexually abused and who may face specific challenges such as teenage pregnancy, trauma, disrupted education, ongoing abuse and high-risk sexual behaviors
- Youth Aide Club: this program under the US Funds aims to provide a safe space and empower children (boys and girls) aged 8 – 17 years old who are impacted or living with HIV. Enrollees are typically children of clients at EFL but they do not have to be. The OVC coordinator is in charge of the OVC program.
- Mentor Mom Initiative: This collaborative program with the Ministry of Health is one of EFL's key strategies for prevention. The program consists of peer-to-peer prevention and mentorship intervention. Mentor moms are former clients enrolled in the I Am Alive and ROAR clubs who undergo comprehensive training in sexual health and reproductive rights and capacity development training (life skills, policy and advocacy, mentorship, case management, public speaking…). As a result, they are qualified to provide peer support and mentorship to clients (mentees) enrolled in the I AM ALIVE and ROAR club. The main goal is to help mentees better access health care and social services, encourage HIV prevention (adherence to ART treatment, encourage safe sex behaviors, prevent vertical transmission mother-child) and follow-up with mothers especially during the post-partum period. Mentor moms may also conduct health education and sensitization sessions.
- Community change champion program: This collaborative program with the Spotlight Initiative consists of working with men who are community leaders towards changing norms and beliefs around GBV.

Notable past interventions include:

- Nuh Guh Deh, the "National Campaign to End Sex with the Girl Child" campaign launched in 2014 in an effort to increase awareness on the consequences of sexual abuse of children and adolescents, and to urge Jamaicans to recognize and report abuse.

- HOPE app: EFL developed an app with Spotlight Initiative to provide guidance to vulnerable groups in case of gender-based violence among.

EFL is a well-identified structure within the fight against HIV and GBV organization in Jamaica and has been acknowledged by several institutions for its work. For instance, EFL received several awards for its actions such as the Excellence in Civic Leadership Award from the America Chamber of Commerce or an award from the Ministry of Health and Wellness for its contribution to the National HIV and STI Programme (Eve for Life, 2018b). In 2018, EFL also sat on several committees and commissions for national representation (elimination of mother-child transmission, reduction of teenage pregnancy committee, child rights working group…) (Eve for Life, 2018a).

Partners of EFL include local and national institutions such as the Ministry of Health and Wellness and the National Family Board Planning, JASL, and international institutions such as Unicef, UN Women or the European Union with the Spotlight initiative. EFL works both with entities aimed towards HIV prevention and GBV prevention. EFL relies mainly on international donors such as UNFPA, the Global Fund to Fight AIDS, Tuberculosis and Malaria, United States Agency for International Development (USAID), Spotlight initiative.

1.3 Internship assignments

My internship assignments were based on the perceived needs identified by Joy Crawford, the executive director at EFL. On top of her management and directory functions, Joy Crawford is still very much involved in field work. She is regularly in contact with clients and her input is usually convened for difficult situations. Her extensive knowledge and insight led her to identify several issues such as lack of family planning and the occurrence of multiple close pregnancies, stigma around not breastfeeding one's child or lack of knowledge on caring for babies. Along with Patricia Watson, the other co-founder of EFL and member of the board, Joy Crawford wished for me to do a review of the situation on infants' health and new mothers' care for babies. After discussion and readjustments according to the time constraints of the internship, we sought to answer the following questions: What are the needs of the community regarding infant care? What are the gaps of information on infant care and parenting for mothers visiting EFL? What is the health literacy of mothers concerning infant care? What are the breastfeeding habits of HIV positive mothers? The study objectives were to determine the knowledge gaps of new mothers on infant care and parenting, especially on feeding habits; help determine appropriate messages to be delivered to mothers seeking EFL's intervention and messages tailored to mothers' needs; and elaborate a clear strategy on breastfeeding for women who are HIV positive, supporting and integrating this issue in advocacy to reduce the stigma around HIV.

Joy Crawford was the instigator of the study. Tajna-Lee Shields, program officer, was assigned to be my supervisor and to help me put into place this study. I mainly organized and designed the study with Tajna-Lee Shields. Preliminary results were discussed with both Joy and Tajna. Due to time constraints, organizational issues and difficulties to access a large number of clients, we decided to conduct a qualitative study focusing on clients who were living with HIV and with children aged less than 3 years-old. After the preliminary results, we also decided to interview young mothers who were HIV negative, professionals and mentor moms working at EFL and an external nurse who specializes in HIV to obtain a broader point of view.

Alongside this main project, I was able to observe and later on participate in interventions such as school interventions, group sessions and a week-long workshop on GBV with community change champions. These experiences of community-based interventions led me to question the concept of community health and how it applied to EFL's actions.

1.4 Community health

The concept of community health is difficult to define as there is a lack of consensus on its definition both in research and practice (Fadul, 2019; Goodman et al., 2014; Jourdan et al., 2012; Merzel & D'Afflitti, 2003). The implications of community health are rooted in its evolution through time. The concept of "community health" was especially popular at the end of the 1970s in the health and social welfare sectors. From the 1960s to the 1980s, community health has been influenced by various movements such as the popular education movement in South America. Therefore, the concept of "community health" implies different aspects through space and time (Jourdan et al., 2012).

Jourdan and al., approaches community health not "as a constituted discipline, based on an univocal definition and a specific body of scientific knowledge, but rather as a diverse set of intervention and research practices" (Jourdan et al., 2012). Goodman and al., defined community health as "a multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities" (Goodman et al., 2014). The World Health Organization (WHO) defines "community action for health" as "collective efforts by communities that are directed towards increasing community control over the determinants of health, and thereby improving health" (World Health Organization, 2021). This definition refers and echoes with one of the pillars of the Ottawa Charter which is to "strengthen community action" (World Health Organization, 1986). Community health is deeply embedded and strongly associated with the principles of health promotion. Indeed, the Ottawa Charter

states that “health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health” (World Health Organization, 1986). A strong emphasis is put on communities’ ability to identify health priorities and needs, address them within their own realm and means by drawing on their own resources, thus gaining “influence and control over the determinants of health in their community” (World Health Organization, 2021).

Therefore, community health “represents a conceptual framework emphasizing primary prevention and a population-based perspective” (Merzel & D’Afflitti, 2003). According to Elder and al., community-based programs are based on multiple interventions, not limited to medical care settings but also carried in other community settings. They also aim to bring change on different levels, from individual to policy and environmental changes (Elder et al., 1993). For Merzel and D’Afflitti, “the core principles of community health are built on an understanding of core functions of community health programs and science” (Merzel & D’Afflitti, 2003). Community health at its heart is “on the intersection of the community’s needs, the community’s understanding of and priorities for health, and the best methods for documenting the evidence garnered from practice in the community, as well as the evidence from the science of community health” (Merzel & D’Afflitti, 2003). It is important that community health interventions derive not only from experience but have also a scientific and theoretical basis.

Despite the multiple definitions for community health, we can see that several components form a common basis to define community-based intervention. Public Health England’s guide to community-centered approaches for health and well-being defines them as the incitive to encourage active participation and involvement of community members, rely on assets and resources within communities in order to achieve program goals related to health and wellbeing promotion and promote equity in health and healthcare. These interventions should be held in community settings rather than medical care settings. The underlying issue is to seek increased control of people over their own health and life (South, 2015). The European secretariat in community health practices formulated three categories of markers for community-based interventions in health: (Fadul, 2019)

- Markers for a health promotion approach include “having a comprehensive and positive approach to health”, “addressing the social determinants of health” and “working intersectorally for health promotion”
- Markers specific to the community-based strategy include defining the community, “encourage-ing the involvement of all stakeholders in a co-construction process”, “fostering a context of sharing power and knowledge” and “enhance and pooling the community’s resources”

- A methodological marker that consists of “having a planning process with a shared, evolving and permanent evaluation”

Community health can be put into practice by “local boards of health and health departments”. However NGOs can play a leading role in building community health, especially when effective institutional presence is scarce (Sherry et al., 2017). Indeed, community health has been considered as an economical way to improve health coverage, even more so in low and middle-income countries experiencing shortage of human resources for health (de Vries & Pool, 2017; Fadul, 2019). Jamaica faces a massive “brain drain” in the health sector that results in nationwide vacancies. Doctors and nurses migrate to higher-income English-speaking countries such as the United States of America, Canada, the United Kingdom or Australia where higher wages, safety make for general better working conditions (Lofters, 2012).

Jamaica has a long tradition of working with NGOs ever since the 19th century where NGOS were already providing services “in health, education, welfare, environmental protection and conservation, agriculture, small business enterprise, community work, and other areas of social development” (Association of Development Agencies, 2006). In the 1970s, women’s groups and youth clubs were created as a “result of the partnership between government and communities” (Association of Development Agencies, 2006). The economic crises that ensued in the 1980s increased the need for social services whereas governmental funds and grants decreased. NGOs stepped in to fill the gap and the government of Jamaica heavily rely on them to ensure community development. They are complementary to the governmental private sector initiatives in social development. Moreover, NGOs are positively perceived by the public who considers NGOs to have the population’s best interest at heart. They are deemed trustworthy, especially in contrast with the government which has a history of lack of transparency and bribery (Association of Development Agencies, 2006; McLeod et al., 2002).

1.5 Research question

> “At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.” (World Health Organization, 1986)

The different notions that encompass the concept of community health and the role of community health in Jamaica led us to question in which ways does EFL contribute to community

health. EFL's scope of intervention is rooted in public health issues (HIV, GBV) closely influenced and related to culture and societal norms. Some issues such as GBV, despite their high prevalence, have been overlooked or insufficiently addressed by governmental entities. EFL has constructed its identity and purpose on filling this gap through a community-based approach. The aim of this thesis is to describe and analyze this process. Our main research question is the following: "How does EFL fit into the concept of community health?"

We identified the following sub-questions in order to respond to the main question:

1. How does EFL identify and assess its communities' needs?
2. How are EFL's interventions community-based?
3. How relevantly will the study I'm conducting integrate with EFL's work?

We will need to explore the different meanings of community and health for EFL. We hypothesize that EFL mobilizes several meanings of these two notions. As an NGO, EFL has a close and trusting bond with the clients they provide services for. We hypothesize that EFL has a clear understanding and knowledge of the clients and applies its client-centered approach to communities. As an NGO and small entity, EFL is also quick to adapt and a pioneer in progressive and more inclusive view than the society it evolves in. Finally, we hypothesize that the conduct of a study on maternal needs and struggles and infant health could be perceived as a community health action in itself. Indeed, the results of the study could contribute to advocacy of promoting women's health and destigmatization of HIV.

Methodology

1.1 Data collection

Several sources were used for the writing of this thesis. A review of literature on the concept of "community health" was conducted to identify the various implications of this concept and how EFL's interventions could fit into these definitions. We used the PubMed, Google Scholar and Cairn search engines with the following key words "community health", "community-based interventions", "community-centered actions", adding the following key words when necessary "middle income countries", "Jamaica", "non-governmental organizations". We also referred to the different sources used in the articles or books we read to gain as much as insight as possible.

An important source of data was also collected during the internship through the assignment given during my internship, participatory observations and additional interviews. My internship assignment enabled me to interview clients at EFL, an external health professional and members of the team including peer workers. An internship journal was kept regularly during the whole duration of the internship. Observations included the general working environment, activities, participants' reactions and discussions during interventions purpose, as well as relationships between team members. I was also officially in charge of taking notes for further reporting during several formal events such as the GBV workshop and the Youth Aide Club intervention held in August 2022. Additional interviews were conducted with:

- Joy Crawford, the executive director and co-founder of EFL (44 minutes)
- Patricia Watson, co-founder of EFL, member of the board (53 minutes)
- Tajna Lee-Shields, programs and advocacy officer (35 minutes)
- Nicolene Clayton, outreach coordinator (40 minutes)
- Rushell Gray, regional coordinator in Montego Bay and family liaison officer (39 minutes)

These interviewees were selected based on their knowledge and strategic vision at EFL (especially Joy Crawford and Patricia Watson), their experience of the field work and community-based interventions. It is to be noted that Rushell Gray brought her insight and experience as a former client turned peer worker who was afterwards promoted to a managing position. She was enrolled at EFL as a client in 2012, became a mentor mom the following year. Her position at EFL has since evolved to regional coordinator and she is in charge of the Western part. We must mention that Tajna-Lee Shields and Nicolene Clayton arrived at EFL in April 2022 so are still quite new to the organization. Interview guides were elaborated beforehand and were based on the findings of literature review on community health. The purpose of the interviews was to gather

the views and understandings of community health as seen by key members of the EFL team. The guides can be found in the Annexe. The interviews were all conducted in late July 2022, either in person (Joy Crawford, Nicolene Clayton and Tajna Lee-Shields) or on the phone for those who were not working from the Kingston offices (Patricia Watson was in the United States of America where she usually lives and teaches, Rushell Gray lives and works in Montego Bay). Interviews were recorded with the permission of the interviewees and partially transcribed to include relevant verbatims in this thesis. Extensive notes were taken for the parts that were not transcribed to convey the interviewees' ideas as close as possible to what was expressed.

1.2 Data analysis

In light of the various definitions and conceptual frameworks regarding community health previously described, we chose to focus on the key domains that compose community health. We will be using the six dimensions identified by Jourdan et al., that when brought together characterize community health (Jourdan et al., 2012):

- Individual or organizational stakeholders (community leaders, policymakers, people affected by the issue…)
- Core values such as social justice, empowerment, political will
- Conceptual frameworks and concepts (ecological model, theories of social change, social determinants of health…)
- Preferred settings of interventions (vulnerable populations, access to primary care…)
- Goals around bettering health
- Methodology (participatory approach, needs assessment, evaluation…)

After analyzing how EFL defines community, identifies health priorities and designs interventions we will look into how EFL implements these interventions and their set objectives. The discussion will focus on a reflexive practice and limitations of this thesis.

Part 1: A community-based approach to design interventions tailored to community needs

1. An adaptable definition of community

1.1. The necessity to define community and health

The concept of "community" englobes several definitions and may refer to various meanings and experiences (MacQueen et al., 2001). A clarification of the concept "community" is needed to understand what EFL considers as "community".

The notion of "community" in literature may refer to these three types of community: (Hyppolite & Parent, 2020) :

- A geographical community in which people share the same setting considered as a significant place of social belonging (e.g. neighborhood, district, region…)
- A community of interest in which people share common social issues (e.g. unemployed, homeless, survivors of abuse…)
- Community of identity in which people share an acquired or desired identity (young women, cultural minorities, sexual minorities, drug users….)

In an extensive qualitative study, MacQueen and al., pointed to a "a core definition of community as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings". They found that even though people experienced community differently according to their various backgrounds, "community was defined similarly" which "suggests that people largely agree about what community is" (MacQueen et al., 2001).

As a result, when put in relation to health, the concept of "community" may focus on various aspects. Indeed, community may refer to vulnerable, marginalized and/or underserved groups, often living in underprivileged areas and that are subject to negative health outcomes. In this perspective, community health aims to reduce health inequities as a priority (Fadul, 2019). Furthermore, community may refer to a common ground and a sense of belonging which sets the goal for community health interventions to strive for a "healthy and resilient community which will be able to cope to some extent with any kind of pressure and adapt to difficult situations with coherence and cohesion" (Fadul, 2019).

The concept of "community" holds another particular meaning in Jamaica. It also evokes urban, inner-city communal setting of low-income areas where gangs may be embedded in. These communities are in a geographical location (for example, Tivoli Gardens in Kingston) and may have a parallel organization to the official one (for example, a "don" that holds power over a

certain community, gang leaders etc). Within these geographical delimitations, “there is a strong sense of communal feeling and sharing, something unknown to middle income “outer city” communities.” (Levy, 2012). Most of the clients at EFL may reside or be linked to these *“vulnerable and volatile areas”* (Patricia Watson, co-founder).

In 1948, the WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2021). Other definitions of health include a “state that allows the individual to adequately cope with all demands of daily life” and “a state of balance, an equilibrium that an individual has established within himself and between himself and his social and physical environment”. These definitions affect the type of health promotion conducted by an organization. The last definition of health implies health to “be promoted in an active way” that would “address the scales of values of individuals and communities to ensure that health is placed higher on those scales” (Sartorius, 2006). EFL’s concept of “health” adheres to the holistic vision of the WHO: “*The whole issue of community health for us is what are the policies and the activities we're putting in place to ensure that their* (the clients’) *health is fitted into the WHO definition of what complete health looks like”* (Joy Crawford). EFL does not focalize only on disease - i.e. prevention and treatment of HIV - but rather on the external factors that may impact health. McKenzie and al., identified four factors that affect the health of community: “physical (e.g., community size), social and cultural (e.g., religion), community organization, and individual behaviors (e.g., exercise and diet)” (McKenzie et al., 2011).

1.2. Community for EFL, an evolving concept

EFL conception of “community” matches the definitions described above. One part of the term “community” encompasses both identity and interest. EFL’s actions are destined for young women and girls aged 12-25 years old that share *“crosscutting development of health and psychosocial issues”* (HIV positive, sexual violence by extension family violence and GBV issues, teen pregnancies) (Joy Crawford, executive director). The other part refers to *“the environment in which our current population lives and experience their well-being”* (Joy Crawford, executive director). This may be the physical environment such as the location or living conditions. The environment also includes the social environment in which clients evolve such as the household, the family. The environment plays an important role in terms of access to health care services, to social services or other NGOs. Lack of safe and reliable public transportation constitute a barrier for clients to reach social and healthcare services. Therefore, travel stipends are issued to clients according to the distance they need to travel when accessing EFL’s services. Home visits are also organized.

As mentioned above, community in Jamaica may also refer to “inner-city” or peri-urban low-income areas characterized by environmental degradation, insufficient housing and generally higher insecurity. Various social interventions such as the Jamaica Integrated Community Development Project are regularly involved in these communities. These interventions focus on “strengthening social capital within the communities (i.e., school programs, alternative livelihood training and job placements for youth and distribution of birth certificates/other civil registration documents) to allow for increased ownership and safety within communities” (World Bank, 2021). These interventions would typically be “designed to target four levels of society—individual, family, school, and community—to prevent violence by reinforcing the effects of other interventions” (World Bank, 2021). Even though EFL’s interventions are not limited to these specific communities, they are in line with these other types of interventions.

EFL’s understanding of community encompasses individual social determinants of health such as socio-economic background, level of education as well as community social determinants of health (rural or urban setting, violence etc). In fact, EFL definition of community (place and population) has expanded throughout the years. In 2008, Joy Crawford and Patricia Watson, with the support of Peter Crawford, co-founded EFL in Kingston initially to work with girls and young women living with HIV and teen mothers. Programs then were more based on individual aspects. Patricia Watson describes “the turning point” in 2012 when EFL expanded locally to Western parishes and its client community to include women who had been victims of GBV: “it would not be only sexual violence but also the context from which these girls were coming from” (Patricia Watson, co-founder). EFL started to take more into consideration englobing issues such as parenting, poverty, lack of homes, discrimination and stigma.

This approach and findings are concordant with findings in literature. In a literature review on GBV against adolescent and young adult women in low- and middle-income countries, the authors found that “overall, young adult women demonstrated higher risk for the past-year intimate partner violence relative to adult women” (Decker et al., 2015). As a result of the expanding of the community, EFL set to identify and respond to health priorities within these new-found communities.

2. Setting priorities for health within the community

2.1. A pragmatic and informal approach to assess needs

EFL was created with the intention to fill the gaps left by governmental actions and the lack of focus on young women and girls in the HIV national policy. Patricia Watson, one of the co-founders, used to work as an editor at the Gleaner (one of the main printed news media in Jamaica) on issues of national importance like HIV. She later on worked for an international

organization. She was struck by the contrast between the weight of the burden of HIV put upon young women and the lack of interest and care for them, which prompted her interest and willingness to work with and for women affected by HIV. Apart from Eve for Life, Patricia Watson pursued her passion for promoting women's rights and health by recently earning a doctorate on sexual violence against women. Joy Crawford, the other co-founder and registered nurse, had been working in the HIV sector since the beginning of the HIV epidemics in Jamaica in the 1980s at different levels (advocacy, program…): *"we've seen the gaps that needed to be filled. Eve for Life came to fill the gaps, which is what is happening to girls and women behind closed doors. It was anecdotal as well as based on experience and facts because they are not part of the National Plan for HIV as a specific population."* (Joy Crawford). During the first six months after EFL was founded, the pair collected data to use as a baseline for EFL's policy and program making. This helped them identify another subset group with specific needs and characteristics: adolescent girls. *"From doing those interviews, interfaces with HIV women we decided to not include all women but to focus on adolescents and young mothers, for all the risks and challenges that they were having."* (Patricia Watson). To sum up, professional background, prior knowledge of the co-founders and a set methodology were essential in designing and outlining EFL's scope of work.

Their empirical evidence is corroborated by findings in literature. Research has shown that adolescents and young adult women are particularly vulnerable to GBV especially in the "strong machismo culture" that characterizes inner-city communities in Jamaica. Levy notes that "the effect of the violence and warring in communities is to incline them to an attitude of dependency on a male, to seeking protection and security rather than to standing up and challenging them." (Levy, 2012). Other factors associated with violence and abuse include women with low levels of education, economic vulnerability, who entered their first union as minors and have a controlling partner (Priestley, 2014). This has been observed amongst clients at Eve for Life that are stranded in an abusive relationship. Moreover, GBV has been linked "with contraceptive nonuse, condom nonuse, unintended pregnancy, and sexually transmitted infection symptoms" and long-lasting effects into adulthood on these women's lives (Decker et al., 2015). Even though adolescents and young women bear a significant GBV burden, less attention has been given "to the developmental and social context of adolescence and early adulthood" (Decker et al., 2015). By expanding the focus from women living with HIV to women impacted by GBV, EFL is in line with Grose et al., recommendation which is that of "addressing GBV is essential to improve SRH for girls and women in low and middle-income countries." (Grose et al., 2021)". In fact, EFL mission statement is to "improve the sexual and reproductive health and rights, and quality of life of young women and girls exposed to HIV and sexual and gender-based violence" (Eve for Life, 2018b).

Concerning the gap between the importance of GBV and the lack of appropriate response, this seems to be observed in the Latin America and the Caribbean region as a whole. Tsapalas et al.,

showed that “Latin America and the Caribbean in particular represent a gap in research on health care tools and their effectiveness in these situations” (Tsapalas et al., 2021). The “sense of distrust and stigma around GBV victims” is heightened by the inability of the health care systems to “effectively identify or halt the issues at hand” and “the lack of protocols and resources to systematically provide a framework for coping and safety” (Tsapalas et al., 2021). Moreover, violence is frequently normalized which fuels stigma for people who suffered from GBV.

EFL’s further understanding of the culture of male dominance and how it plays in the health of women also helped them identify a more subtle need to act and shift the culture norms. Indeed, upon managing the clients’ cases, it was clear that for some clients, one of the first steps of assessing their needs was to assess their physical, social, and familial environment. One of the key challenges for EFL is to accompany clients into identifying abuse as such and on a larger level to act upon communities to influence a cultural change. This was the main goal of the “Nuh Guh Deh” (Jamaican creole for “Don’t go there”). The “National Campaign to End Sex with the Girl Child” was launched in 2014 in an effort to increase awareness on the consequences of sexual abuse of children and adolescents and to urge Jamaicans to recognize and report abuse (Eve for Life, 2018a).

2.2. Designing the interventions from the needs assessment

Originally, the co-founders identified a general lack of knowledge on sexual and reproductive health, and about HIV even amongst HIV positive women. Therefore, interventions were focused on sexual health education and self-discovery, *“they had to start from scratch, learn about their body, it was a starting point to accept themselves for themselves and not just as HIV positive girls”* (Patricia Watson, co-founder).

On a daily basis, staff members, especially case managers, family liaison officers and mentor moms keep regular contacts with clients. Needs assessment for each client is typically done with case managers. Staff members have extensive knowledge of each client’s background and current needs. Case managers, outreach coordinators, family liaison officers, OVC coordinator file in technical reports on a monthly basis which can give an overall idea of clients’ needs: *“Based on the conversations with the clients, we ask them, discuss with them, discuss it with the mentors. On the monthly basis, based on the discussions and reports, we would have been able to identify what is it we need to discuss, what are the needs of the clients. As a team, we normally meet within the chapter and we discuss and plan ahead for our clients"* (Rushell Gray, family liaison officer). The discussions between the clients and the team lead to a decision concerning the choice of interventions: *“If we’re doing a group intervention, we think about what we need to talk about. If*

we decide to talk about adherence, we look at clients who need help with adherence to have them be part of the intervention" (Tajna-Lee Shields, program coordinator).

This way of proceeding echoes with reports of successful HIV community prevention programs. Research has shown that emphasis should be put into "identifying the target population and understanding how to reach it". Merzel & D'Afflitti observes that "community members, particularly peers, should be closely involved in intervention design and delivery, and messages should be tailored to target audiences through the use of real role model stories of success to help change norms and teach skills needed to reduce risk behaviors" and that "addressing social norms promoting at-risk behaviors is one of the most critical elements" (Merzel & D'Afflitti, 2003). The strong implications of the team, and particularly of the mentor moms who are peer workers, in the design and delivery of the intervention indicates that EFL takes into consideration this notion.

3. Finding resources within the community

3.1. Funding and cross-sector collaborations

The co-founders initially financed EFL with their personal money. Since a few years EFL is thoroughly financed through donors. It relies largely on international funds which in part influences the types of interventions that EFL conducts: *"95% of all the fundings that we have received since inception has been from overseas donors, which is part of the issue that a lot of our local people don't want to touch the issues, they're not going to put money in HIV, they're not going to money in sexual violence, it carries so much weight for these people. Foreign entities that don't have the same stigma, burden or cultural burden are a lot more open and attracted to what we're doing."* (Joy Crawford, executive director). This is particularly relevant to the GBV issues that EFL addresses. In the post "metoo" era, international interest in addressing GBV has soared (United Nations, 2018). The intensification of violence against girls and women during the Covid-19 pandemic has reinforced the urgency (UN Women, n.d.). GBV is a widespread and long withstanding issue in Jamaica but had not received the recognition or adequate response until now. Joy Crawford estimates that the international agenda influences the local agenda as specific budget to respond to GBV are being released.

EFL also organizes fundraising events with local partners. For instance, a dance gala with the National Dance theater company was organized in July 2022. All benefits from the ticket sales were to be donated to the organization. Always bearing the clients' well-being in mind, several seats were reserved for clients and ticket buyers had the option to freely donate or buy seats for

clients. Another fund-raising event was held at General Food, a local supermarket chain in August 2022[4]. This demonstrates EFL's desire to seek financial resources within the Jamaican context.

EFL has established partnerships with international institutions such as Global Fund, Unicef, UN Women or Spotlight initiative (partnership between the European Union and the United Nations to eliminate violence against women and girls) but also with national institutions and local organizations such as the Ministry of Health and Wellness, Jamaica AIDS Support For Life (JASL), the Women's Centre of Jamaica Foundation or health centers. Partners within the community include schools, police youth clubs and community centers. The partners mentioned above come from the health, social and education sectors. Thus, EFL strives to establish cross-sector collaborations. An important aspect of community health is applying a multi-sectoral approach to promote and develop healthy communities (Fadul, 2019). In the case of EFL, this cross-sector collaboration is not limited to the delivery of care but also taking into account social determinants of health such as access to food, financial income, education or housing.

Regarding HIV and GBV, Patricia Watson confirms that EFL tries to make these issues a "community issue": *"we want to make sexual violence and HIV a community issue, more of a local and regional issue so that we can touch people on community level. It's more than an individual issue, it's a community issue, a national issue, family, school, church… it's about moving the response from an individual level to look into how the individual rests in the society".* A lot of efforts have been put into place by EFL to raise awareness and train health care providers as well as other NGOs the necessity to address a more wholesome point of view. Patricia Watson believes that EFL has been successful into demonstrating to these stakeholders that these issues cannot be addressed only on an individual level but also on a community level. However, EFL is a small organization with limited resources and so it seems that collaborations with communities could be further reinforced to carry out this vision.

3.2. Human resources: community health workers

Peer workers

In terms of assets within the community, EFL can count on the peer workers, the mentor moms. The mentor mom program is a peer-to-peer model that sought to develop a core group of peers who could mentor others: *"We believe the peer-to-peer model of support is important because it takes someone who has been in the shoes of the person to understand what you're going*

[4] It is to be noted that this event happened as a result of serendipity. The owner of General Food who is a personal acquaintance had expressed her desire to organize a "paint and sip" event (enjoying drinks and food while painting) and was looking for an organization to donate the benefits from the ticket sales so I suggested EFL. EFL seized this opportunity to attend the event and network for potential further collaborations.

through." (Tajna-Lee Shields, program officer). Tajna-Lee Shields explains that peer workers may have greater legitimacy and reception from clients to help them by for example sharing tips for medication, leading conversations about status disclosure. They also usually have in-depth knowledge and understanding of the communities from which clients come from as they may be from the same community. The language plays also an important role as patois varies greatly between parishes. People from lower socioeconomic backgrounds may sometimes only speak patois, despite the official language being English. It is therefore important to speak, so as to say, the same language as the clients. Patricia Watson declares *"it's best for the community people to talk to their community people"*. This vision joins the "general consensus on the importance of choosing community health workers from the community itself" (Fadul, 2019). It also helps build" trust and empathy between the community and the workers" (Fadul, 2019). Indeed, mentor moms usually build strong relationships with clients. Some clients refer to them as "auntie" or even "mommy", underlining the almost familial ties between peer workers and clients.

As a result, EFL's original policy is to employ former clients, although as detailed below EFL is in the process of restructuring which puts this policy temporarily on hold. Research shows that one of the critical criteria of admission for community health workers was "belonging to the community" (de Vries & Pool, 2017). It is also the case at EFL. Potential mentor moms are clients generally who adhere to treatment (if HIV positive) or have shown signs of growth and empathy for others. After identification of potential candidates by the current mentor moms, EFL invests in them to help them acquire the requisite skills and training so that they can be competent and credible peers.

EFL identifies itself as a "*facilitator of client communities": "it is the peer relationship, the peer to community relationship that is the most impactful and sustainable and also the most empowering*" (Joy Crawford, executive director). Identifying and leaning on resources within the community characterizes the strategy used in community health (Hyppolite & Parent, 2020). Using peer workers is part of that strategy. EFL's mentor mom program follows the characteristics of community health worker programs.

Community change champions

The Community Change Champions program is a Spotlight Initiative project. The program consists of recruiting and training men who are community leaders about GBV so that they can implement actions and interventions to prevent GBV within their own communities. The Spotlight Initiative in Jamaica addresses "three key priority areas within Family Violence against women and girls (child sexual abuse, intimate partner violence and discrimination against vulnerable groups) using a life-cycle approach". Men and boys are engaged as "agents of change within community mobilization

and school interventions". The Spotlight initiative brings financial and technical support to civil society organizations working to end violence against women and girls (UNDP, 2022).

Technical staff

The technical staff is complementary to the peer workers and is composed of case managers, the programs coordinator, the programs and advocacy officer, the OVC coordinator, the outreach team (officers and coordinator) and communications team. Some of the technical staff members are also mentor moms (and former clients). The technical staff for the most part has tertiary education and specific competencies and skills. However, the structure of the EFL team has recently undergone evolution in light of the increase of clients: *"we had more of our staff that were from our client community and not technical. We weren't able to raise enough resources to pay them well enough to sustain them [...] and as our work became larger we needed larger skill sets so we decided to restructure for a while that would help us take care 150 clients versus 35, which means that they cost more and so we made the decision to hire people who were at the right professional level who could come in and help us restructure."* (Joy Crawford, executive director). Several members of the technical staff were hired recently in April 2022. The arrival of new staff and restructuring of the organization may have been a cause to miscommunications and tensions within the EFL team as a whole.

Volunteers

A larger number of volunteers has emerged recently but there is a lack of structure to optimize their willingness to participate: *"We have volunteers but not enough structure to ensure that we are utilizing them the right way"* (Rushell Gray, family liaison officer). Indeed, some of the volunteers are students or university graduates in social work or psychology. Rushell Gray suggests designing a member of the team to organize the volunteer force by ensuring for example that each parish has a valid number of volunteers, and constructing a volunteer committee. With the rising number of clients, staff can be quickly overwhelmed and volunteers could be useful in relieving some of the important but time-consuming work (checking in on the clients, following-up, making sure client attend their appointments at health centers…).

Influencers

Eve for Life also uses the services of two influencers to reach out to digital communities on social media. Both of them have artistic backgrounds and large online communities following them. One of them is also a man and might be as a consequence more likely to captivate male audiences.

This is a way for Eve for Life to promote sexual health and rights, fund-raising events and reach out to people online beyond their own social media sphere.

Part 2: Implementation and implications of community-based interventions

1. Complementary approaches to community health interventions

1.1. A client-centered approach to impact the individual

EFL's first approach is a client-centered approach that takes into account social determinants of health: "*We have to do a holistic approach to the client*" (Rushell Gray, family liaison officer). In fact, EFL provides mental health care with counselling sessions but do not provide medical care per se. For example, EFL accompanies women living with HIV in terms of treatment adherence or assisting with medical appointments but does not diagnose or treat HIV. However, EFL occasionally calls upon external health professionals to organize prevention sessions. Recently, a Covid-19 vaccination session was organized with a nurse and medical doctor from partnering health centers.

The team maintains close contact with clients through Whatsapp or phone calls for clients who do not have smartphones or in-person appointments. Flexibility is key as clients may contact team members and especially mentor moms outside of the operating hours in case of emergencies. In-person exchanges may also be done as they occur (late appointments, last-minute appointments, cancelled appointments…) as most clients have limited transportation possibilities. Incidentally, travel stipends are systematically given to clients to cover transportation costs when they come in for interventions.

A wide array of services is available for individual clients: "*Pretty much we look at everything that would help […] anything that would help them be a lot more prepared and ready to lead the life that is theirs to live*" (Joy Crawford, executive director). These services fall into the following categories:

- Social: one-on-one assessments with case managers, assistance with administrative procedures, referral to the relevant social services…
- Mental health: counselling session with psychologists
- Health: adherence to HIV treatment with mentor moms, alternative therapy (yoga, art therapy, drumming, martial arts, self-defense…), sexual health education…
- Economic: business grants, stipends, micro-grants for income generating…
- Education: school fees, grants for school supplies, referral of adolescent mothers to the Women's Centre of Jamaica[5]
- Nutrition: care packages, formula for babies…

[5] The Women's Center of Jamaica runs the "Programme of Adolescent Mothers" island wide. This program offers a continuity of education and vocational training for adolescents whose academic course was interrupted by pregnancy (Women's Centre of Jamaica Foundation, n.d.).

- Employment: assistance with job applications, preparing for job interviews (how to dress properly, etiquette), looking out for job applications…
- Housing: financial aid for rent. EFL is looking into building a shelter for women.

Example of a client-centered approach: counselling sessions.

After evaluation from mentor moms and/or case managers, counselling sessions are suggested to clients who manifest emotional and psychological distress. Clients can also request counselling sessions themselves. The psychologist at the Kingston office specializes in issues that may often affect clients such as loss and bereavement, and coping with abuse. She also used to work JASL, one of the leading and oldest NGO in the national response to HIV/AIDS (JASL, 2021). Her main responsibilities are to create "*interventions that are on a needs basis for them to help them with their psychosocial issues that they face living positively to HIV and later nurturing their role as women in today's society"* (excerpt from one of the interviews led during the maternal and infant health study). After evaluation and client's needs assessment, she implements a goal-orientated therapeutic strategy to help clients work towards their objectives. She sets up with the client three major goals that are declined into sub-goals which are in turn broken down to short-term tasks or actions, more easily achievable by the patients. Follow-up sessions are planned throughout the whole process. This strategy enables the clients to track their progression towards their goals. It also facilitates the counsellor's work to design interventions that are tailored to clients' needs. She also assesses health literacy with the Treatment Readiness Assessment Tool, a four-section tool (mental health, psychosocial background, literacy, medication) elaborated by the Ministry of Health. With clients who have low health literacy, she limits the use of written documents and recommends other supports like Youtube videos.

"If we can get them out of their vulnerable mode, psychologically, physically, financially and nurturing what they are doing to be financially free, and having a free state of mind, that makes them less vulnerable" - excerpt from one of the interviews led during the maternal and infant health study)

As explained before, common needs that could be addressed in group interventions are identified by the team. Past group interventions include:

- Group session on anxiety animated by the psychologist and case manager at the Kingston office. A small group of clients suffering from anxiety was formed to discuss signs of anxiety and practical tools to cope with anxiety.
- Group session on relationships. Discussions were held on how to choose a partner, signs of abusive relationships and signs of loving and caring relationships.

To sum up, client-centered interventions are based on the clients' needs and are conducted more on a regular basis when the needs occur. They take into consideration determinants of health, life skills and quality of life which demonstrates EFL's holistic view of health.

1.2. A community-based approach to change communities

Community-based interventions are essential components of community health (Hyppolite & Parent, 2020). In addition to individual and group care mentioned above, EFL conducts community-based interventions that touch a wider range of population than the clients, on a *"grassroot level"* (Tajna-Lee Shields, program officer).

The outreach team is responsible of deploying community-based interventions in different community settings:

- School interventions are usually sexual health education classes or awareness on child sexual abuse. EFL is often contacted directly by schools for certain needs. For example, in May, the dean of Edith Dalton James High School invited EFL to do a sexual health education class in a class where several students were already sexually active. Although this high school is not located in an inner-city community, an important portion of students come from the surrounding inner-city communities. The intervention mainly consisted of establishing a dialogue with students about sex. However, in line with the national guidelines, the talk was mainly focused on the responsibilities and potential negative outcomes that come along with sexual activity and abstinence as a way to prevent pregnancy or STIs. There is evidence that compared to abstinence-only programs, comprehensive sex education, which includes infection prevention methods and contraception, is more efficient in reducing rates of teen pregnancies and STIs (Starkman & Rajani, 2002). Moreover, this approach may not have been the best suited for since several students had already been initiated to sexual activity. Nicolene Clayton, the outreach coordinator, bears this notion in mind and is looking to shift the interventions towards a more comprehensive approach. The conditions of the intervention were also not optimal to lead talks on this sensitive subject. The session was conducted with the entire class (around 35 students) rather than in smaller groups, at a time slot close to the lunch break which made it difficult to grab the full attention of the students. Nevertheless, this session was the occasion for two girls to talk with the team members in private of the sexual abuse they had encountered. Screening and identifying children and youths who have been abused is an important aspect of the school interventions for EFL. After initial contact, they may be suggested to enroll in EFL's programs or for follow-up care.
- Interventions that would qualify as presets in terms of the National HIV program such as awareness and knowledge sessions, risk reduction sessions, fingerprint testing, distribution

of condoms… These interventions are generally led in community-settings like health fares or community centers.

- Interventions for adolescents regarding safe sexual practices and harm reduction negotiation skills are held at Police Youth Clubs. In Jamaica, the Police Youth Club movement is a community-based initiative started in the 1950s in a context of high criminality among youths and exacerbated tensions with the police force. The purpose of Police Youth Clubs was to propose meaningful activities, offer leadership skills to youths and appease tensions within the communities in which they were implemented. Nowadays more than 500 police youth clubs are registered across the island but a third of them have become inactive due to loss of interest, lack of means or dwindling memberships (Jamaican Information Service, 2015).

Part of outreach program's objective is to reach out for prospective clients and deliver first aid care for people who are in need of psychosocial attention. Outreach officers are mandated to refer these people to counselling, case managers, the OVC coordinator, mentor moms or family liaison officers. The EFL team seeks to establish first and foremost a dialogue in every community setting they are meant to work in. For Patricia Watson, it is essential to include the community in the process and come from an understanding perspective: *"it is not good for an entity to just go into community and give their own views, you have to talk with community people".* This is precisely the purpose of the Change Champions program which consists of recruiting and training men who are community leaders about GBV so that they can implement actions and interventions to prevent GBV within their own communities.

In July, EFL organized with partner JASL a one-week GBV workshop with approximately 30 men who are community leaders and influencers. The goal of the workshop was to create and encourage a dialogue with men about GBV in order to incite them to develop their own interventions and actions within their communities. The intervention program was rich and comprised of explanation of theoretical concepts, case studies, activities and practical cases. Discussions around masculinity, gender norms in Jamaican society, sexuality were held throughout the week. Even if the majority of the participants were already aware of the importance of GBV, their views on masculinity, the different roles of men and women in society were still understandably heavily influenced by the cultural context. Indeed, since "violence against women is abetted by cultural beliefs and practices, such as defining masculinity in relation to power and domination (natural head) and intergenerational violence", it was important for the participants to reflect upon their own cultural beliefs and how they may impact their own reaction to GBV (Watson Williams, 2018). A crucial point that EFL conveyed to the participants was the necessity of meeting people where they are. It is important to take into account people's conceptions, views, prejudices or bias in order to open a dialogue. EFL considers that large

informational campaigns against GBV may not touch perpetrators who may not even realize that they are perpetrators. It considers that engaging with people in a meaningful way may bear higher results. The fourth day was dedicated to putting into practice what they had learned. The participants had to lead their own awareness session with boys and adolescents that came from their communities. Feedback from the community change champions was positive and they expressed an evolution of their points of view on gender and societal norms. This workshop shows EFL's willingness to try breaking the norms, speak to and engage the community bearing in mind that the answer comes from the community. After the workshop, community leaders are expected to disseminate and spread the knowledge within the community. EFL, rather than doing instead of, positioned itself to facilitate the community leadership. This is essential as EFL is a small NGO with limited resource and outreach. This program provides the opportunity to have an impact at a community the ground through engaged community leaders. Another important aspect of the GBV workshop was the presence of the communications teams and social media influencers in order to reach digital communities. Group talks and interviews mainly on masculinity, GBV and gender norms were filmed with the participants. A communications strategy for social media was drawn up. The clips will be released during the International Day of Elimination of Violence Against Women to maximize impact.

K. Scott et al., describes the "features that enable positive CHW program outcomes" as "community embeddedness (whereby community members have a sense of ownership of the program and positive relationships with the CHW), supportive supervision, continuous education, and adequate logistical support and supplies" (K. Scott et al., 2018). This is similar to what EFL tries to achieve, particularly with the community change champions who often come to EFL for advice or support when they in turn implement interventions within their communities.

2. Community health strategies to empower communities

2.1. A nuanced take on evaluation and participation of the interventions

All the interventions are evaluated with a pre and post assessment. Clients are systematically asked for their feedback during and after interventions. EFL also organizes yearly meetings, know as "a day with the boss", during which Joy Crawford, the executive director, travels through the island to hear firsthand clients' feedback: *"they know that they can say anything without judgement"* (Joy Crawford, executive director). However, documentation and course of action on these events was not available to me for analysis. We could also raise the question as to how the clients were made to feel comfortable enough to voice criticisms in front of the "boss".

According to Joy Crawford, external evaluators have analyzed programs in the past few years (results not available to the public). Evaluation is also always included in the writing of proposals

for grants. Evaluation, as seen by EFL, seems to resemble more client satisfaction feedback than formative, process, outcome or impact evaluation and does not necessarily aim to objectify results of the interventions on the set objectives. Conducting an extensive evaluation takes, in general, a great deal of resources and competencies that EFL does not have. However, the systematic collection of clients' feedback shows EFL's willingness to adapt and tailor closely to clients' needs. On an individual level, clients' evolutions are closely monitored by the team. Even so, this still raises questions on the impacts of the interventions on a community level.

In a systematic literature review, Merzel and D'Afflitti found that community health programs, with the exception of HIV prevention programs, generally have limited effects in population risk behavior changes and community health status. Several reasons may explain the modest impact such as "methodological challenges to study design and evaluation, concurrent secular trends, smaller-than-expected effect sizes, limitations of the interventions, and limitations of theories used" (Merzel & D'Afflitti, 2003). EFL lacks the capacity to do research and clarification in design of evidence-based interventions. However, we may find comfort in the fact that community-based approach has been proven to be successful when it was used to prevent HIV transmission during the 1990s. Several studies showed that safe sex behaviors increased more in intervention communities than comparison communities, in part due to the "strong emphasis on changing social norms regarding risk behaviors and increasing the social acceptability of risk avoidance" (Merzel & D'Afflitti, 2003), which is what EFL strives to do. Merzel & D'Afflitti also note that "modification of norms and behaviors was achieved through interventions focusing on role modeling, developing a sense of mastery in the ability to engage in risk-reducing behaviors, and reinforcing educational messages" (Merzel & D'Afflitti, 2003). The use of "peer volunteers" was crucial in "influencing social norms" which is what EFL does, notably with the community change champions (Merzel & D'Afflitti, 2003). Moreover, there is substantial evidence on "the effectiveness of community-based primary health care (CBPHC) interventions in low- and middle-income countries (LMICs), especially for maternal, neonatal and child health", "in improving population-based, HIV-related health outcomes for mothers and children" (Mushamiri et al., 2021).

Community participation is one of the pillars of community health (Fadul, 2019). In a similar way to evaluation, participation in the design of interventions seems to be more considered at EFL in terms of feedback. Programs officer and coordinator collaborate with the other team members to design interventions based on clients' needs but participation of the clients in the decision-making and process seems to be limited.

At the community level, the community change champions are empowered to implement and deploy their own interventions: *"They'll usually ask for advice or help, but EFL doesn't have a say on what they're actually doing. Even if we're not doing the ones conducting the thing*

[intervention], they'll ask us for the resources. We help but we don't do instead of them" (Tajna-Lee Shields, program coordinator). This is coherent with "the assumption that community participation and coalitions create a sense of ownership and a synergy of action and outcome that could not otherwise be achieved" (Merzel & D'Afflitti, 2003).

At the team level, a member of staff sits on the board and can invoice on the internal policy level. EFL's board has 9 members, it doesn't decide on the types of interventions but overseas the statutory requirements and strategy. The program team designs interventions but the board directors may have the expertise and competencies that can help.

2.2. From individual to community empowerment: "We don't believe we should impulse what we feel like is empowerment"

Empowerment of communities, "their ownership and control of their own endeavors and destinies" is "at the heart" of community health (World Health Organization, 1986). The WHO defines "empowerment" as "a process through which people gain greater control over decisions and actions affecting their health" that "results from social, cultural, psychological or political processes through which individuals and social groups are enabled to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs including co-creating the policies and services that affect and serve their communities" (World Health Organization, 2021). Indeed, community health is about communities regaining power, decision and influence over their own health priorities (MacQueen et al., 2001). Various conceptual frameworks have been defined in literature. Overall, "community empowerment is most consistently viewed in the literature as a process in the form of a dynamic continuum, involving: (i) personal empowerment; (ii) the development of small mutual groups; (iii) community organizations; (iv) partnerships; and (v) social and political action"(Laverack & Wallerstein, 2001). There is a relationship between individual and community empowerment. Although not linear, "the potential of community empowerment is gradually maximized as people progress from individual to collective action along this continuum (Laverack & Wallerstein, 2001). According to the WHO, "individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal health decisions" while "community empowerment involves individuals acting collectively to gain greater influence and control over the factors shaping the determinants of health in their community and is an important goal in community action for health". Individual and community empowerment are interdependent as "empowered individuals create empowered communities, and vice-versa." (World Health Organization, 2021).

EFL's work is based on an empowerment model where the goal is to "improve clients' coping strategies and their ability to reintegrate in the various facets of their lives and help them grow

and develop into self-motivated and empowered individuals" and enable clients to "live and experience optimum health and well-being" (Eve for Life, 2018b). During the GBV workshop week, there was emphasis on starting with "one family at a time" and the "*snowballing and ripple effect*" (Tajna Lee Shields, program officer). EFL believes that community change starts with self, on an individual scale, then familial and close circle level to afterwards level up to a larger community scale: *"I think it begins with self, especially for outreach where we share information, whether it's referral, from which entity they can get further assistance, information about STI, GBV, HIV… it's about giving people correct information so that they can make informed decisions, maintain their autonomy and providing them with information so that they can feel and be empowered".* (Nicolene Clayton, outreach coordinator).

In Jamaica, more and more women reject and challenge many patriarchal beliefs on the appropriate roles and social norms. However, research suggests that "some groups that are potentially more disempowered (such as adolescents, women with low education attainment and women who began living with a male partner in childhood) were more likely to have patriarchal understandings and beliefs about gender roles, violence against women and intimate partner violence" (Watson Williams, 2018). In the 2016 Women's Survey, "among women who were abused, those with the lowest level of education had the highest prevalence of moderate intimate partner physical violence" (Watson Williams, 2018). Therefore, empowerment for clients at EFL is an even more important and maybe more challenging job to do. Empowerment is associated to EFL's core values: *"we are only here to facilitate the information, the skills, the honoring of rights that girls already possess so that* ***they*** *can release their divine potential within them. We are not an organization that promotes co-dependency, we don't believe that we are doing anything intrinsically for the young women but we are external forces in the environment that stimulates them so do their own work for themselves. For us, true empowerment is about releasing and motivating our clients to own their own growth and development and therefore it will look different for every girl"* (Joy Crawford, executive director).

EFL provides *"opportunities through the mentorship model, a space for young women who otherwise would not have been able to earn* (i.e. clients who did not complete secondary education, who do not have the preliminary requisites to pursue educational certifications)*, "to take up jobs that they would have been able to do if their lives hadn't been interrupted, including them into our care services, give them an income, other types of certifications to help them develop themselves as young professionals"* (Joy Crawford, executive director). The peer to peer model illustrates how empowerment is conceived at EFL: "*The peer to peer model is not unique to EFL, I think what is unique is that we spend time to ensure that the peer to peer model is an empowered peer because peers always get together, always share ideas […] we were very*

deliberate that the experts are the communities themselves and we are the facilitators." (Joy Crawford, executive director).

EFL also has the notion in mind that empowerment can look different for other people and is an ever-evolving concept: *"it's important that we meet people where they're at. We don't have all the answers, we believe they are brilliant enough to tell us what they want to work on and require to make their lives better […]. We don't believe we should impulse what we feel like is empowerment"* (Patricia Watson, co-founder). When it comes to community empowerment, EFL follows how the community change champions invest in their empowerment: *"we see what kind of interventions they are implementing in their communities, hoping to see that the people that trained will replicate what they have learnt"* (Tajna-Lee Shields, program officer).

The importance of empowerment transpires in the internal policy at EFL. As detailed before, former clients can become mentors and even ladder up to managing positions. For example, some mentor moms like Rushell Gray who was enrolled in one of the programs, quickly became a mentor mom and pushed up to management as regional coordinator for Western, EFL can be a stepping stone for career evolution. Mentor moms are selected if *"they have shown that they are knowledgeable, comfortable with themselves, we look at their comfort level with HIV and sexual violence, ability to communicate with persons about both topics, give correct information, make people feel comfortable. They are also tested on various levels, emotional intelligence, knowledge, that was done for them to move up for mentoring. Some mentors like Rushell have moved up to managing. A number of mentors now work at the ministry of Health in various position of* leadership" (Patricia Watson, co-founder).

EFL also gives importance to the empowerment of the team. Several meetings and events are dedicated to team empowerment. For example, an empowerment session, entitled "Conversations for greatness", was held for the whole staff with the JMMB Joan Duncan Foundation. The JMMB Joan Duncan Foundation is a mediation organization that supports programs in education, entrepreneurship and community development. It encourages "nation building and people empowerment" and "is guided by the core values of Love, Openness, Honesty, Integrity and Care" (JMMB Joan Duncan Foundation, 2014). The session was about reflecting upon our own core values and building a vision around them of who we are. It was a powerful and emotional session, during which team members openly shared with others their struggles and hardships. An important amount of support was shown and reinforced ties between team members. Capacity building for the team holds also an important part at EFL. Training in "advocacy and public speaking, entrepreneurship course and grant, project management for results, data security and protection, foundation in English, civil society booster initiative, Caribbean-south Africa south – South knowledge exchange" are regularly proposed to team members (Eve for Life, 2018a).

3. Research and advocacy could benefit from further structuration

3.1. The importance of capitalizing knowledge and experience

Easily accessible research on the population that constitute EFL's clients basis is scarce. Data on youths and young women are not at a one case depositary, they may be collected from different sources and are not detailed (e.g. Ministry of Health, Child Protection Agency, police records…). Identifying the needs on a larger scale than the individual level is important to drive policy changes: *"We don't have a lot of data regionally and nationally, we will have to look at numbers that are more global, it doesn't represent our population well. Not having research and someone dedicated to do research work, it sets back the work we do […] Something that policy change needs won't come out as a one-on-one conversation, you need someone with a bigger picture. Even if we have it as an anecdotal level with the clients"* (Nicolene Clayton, outreach coordinator).

Therefore, my internship assignment was seen as an opportunity for EFL to produce knowledge and evidence from field observations. Joy Crawford remarked that the antenatal process was ineffective, in particular concerning multiple pregnancies, family planning, understanding of pregnancies and their risks and parenting. The knowledge and skills should be included in the care packages but she observed that clients were not experiencing that within the public health system and at EFL. Moreover, EFL does not have the human resource and time to conduct research: *"Wanting to do better at this part of our work, we knew that we needed to have research or a proper analysis of what is happening and so for us we jumped on that opportunity when we knew you wanted to come here, looking at your background in public health and it was free. It's a big part of it because we don't have the resources to pay for another person to do this"* (Joy Crawford, executive director).

Client care remains the upmost priority and is at the heart of EFL's operations. EFL generally applies for grants for clients' care and not grants aimed towards research. The absence of a dedicated person in the team for research would also make it less likely for EFL to obtain these grants: *"We don't get the funding to do it, we need to look at expensive ways to do it and it doesn't get done"* (Nicolene Clayton, outreach coordinator). Regardless, EFL's notion of research is rooted in the fieldwork, with a pragmatic purpose of enhancing its interventions and perhaps requires less means as formal academic research would. Merzel & D'Afflitti in their systematic literature review on the outcomes of community-based programs underlines "the difference in goals and priorities frequently found between researchers and communities, given other pressing community concerns" (Merzel & D'Afflitti, 2003). They note that these differences "often lead to struggles over power and control of programs and reflect the need to build trust and mutual respect to foster true partnership" (Merzel & D'Afflitti, 2003). This was not the case for the

research I conducted for EFL. Even though I originally came from outside of the organization, I was still integrated into the team as an intern. My position as an intern and subsequently in a hierarchically lower position did not lead to power struggles with the team members. However, differing priorities between my own research work and the team's priorities over clients' care led to minor organizational conflicts (e.g. interviews interrupted by team members, criteria selection of interviewees based on clients' venues to the office...).

Apart from research per se, EFL could generate information on the interventions that it conducts. Although, team members are required to do monthly reporting on their different actions and interventions, these reports are mainly for internal use. Reporting is also necessary for the funders to justify the spending of the grants. However, these documents were not easily accessible and available for the public and even for the purpose of this thesis. EFL has a website that outlines the organization's missions, values and certain interventions but annual reports are not put online. The communications team mainly focuses for the time being on social media and the rebranding of EFL. This is a common challenge amongst NGOs for which "much of the printed information generated by NGOs is barely available to other NGOs, researchers, social and economic planners, and the general public" (McLeod et al., 2002). McLeod and al., observed that "some information that is available can only be accessed through inefficiently managed in-house records and outdated data management programs" (McLeod et al., 2002). Indeed, the experiences that EFL has in community health could be capitalized both as an occasion for the organization to reflect on its practices and for others to be informed of EFL's interventions.

Nevertheless, EFL would view research as a tool for the advocacy as *"it gives authority to what it is we're saying. It's different to say "I think" than to say "I know" […] once we know we can present our facts and we can say here is the experience, this is what we need, this is what we're asking for to shift the experiences that are not benefitting our clients"* (Joy Crawford, executive director).

3.2. Formalizing and further investing in advocacy, a prospect for EFL

Health advocacy is an important component of community health and is defined as a "strategy to raise levels of familiarity with an issue and promote health and access to quality health care and public health services at the individual and community levels" (ECDC, 2022). Advocacy implies putting into place different strategies to gain political support and commitment, social change, policy and environmental change (ECDC, 2022).

At EFL, advocacy is done at 3 levels: *"the client level - that means giving them the tools and the skills to own their voices, that could mean being able to go to a health center and to know what the standard of care should be and ask for it or insist to have it and identify stigma or discrimination, how do they address them, knowing their rights etc that is important for self-advocacy). Advocacy at the community level and at the national level takes place in various ways,*

it means publicly speaking about issues that are critical, print and social media, articles in opinion pieces, it means seeking and/or accepting opportunities to speak on issues locally, otherwise it means for us to meet policy makers, engage donors about what are the gaps" (Joy Crawford, executive director). There are several strategies for advocacy: "advocacy through media, through courts, through legislative bodies, and through regulatory processes" (Loue, 2006). It seems that EFL leans more towards media advocacy as we previously saw with the "Nuh Guh Deh" campaign and using social media as a platform for awareness.

Similarly with research, advocacy, although highly important for EFL, seems less structured than the interventions for clients and communities. The recent recruitment of a professional specifically dedicated to advocacy is rather a new take for EFL. Indeed, the recruitment of Tajna-Lee Shields as programs and advocacy officer demonstrates a wish to better structure advocacy that seemed to have been mainly led by Joy Crawford, on top of all her other functions, until now. However, since her arrival at EFL, Tajna-Lee Shields has been replacing the program coordinator, who is on maternity leave, and has not been able to set aside time for advocacy missions. Nonetheless she intends on following through her advocacy plan which would consist of *"leaning heavily on partnerships with other civil society organizations to aim towards changing policy that affect people living with HIV, and from there organize high level meetings with people from the government".* EFL is a partisan of "grass-roots" or "bottom-up" approach, which "are based on the identification of needs and goals by community members themselves" to lead policy change (Loue, 2006). It aims to put pressure on the politician by driving a demand for change from the communities themselves.

"The whole issue of CH for us is what are the policies and the activities we're putting in place to ensure that their health is fitted into the WHO definition of what complete health looks like" (Joy Crawford, executive director). Tajna-Lee Shields adds that EFL looks at the *"ways in which community might add or take away from health, all of the actions or non-actions that we do around public health, education, preventative healthcare, preventative actions all of those things"*.

Even though the work on advocacy might not yet be at its full power at EFL, it is an important dimension that the organization wants to pursue. Furthermore, it would allow EFL to widen its impact. According to McKinlay, policy and regulations changes are the most effective public health interventions as they affect entire populations (McKinlay, 1993). Moreover, EFL integrates itself in the ongoing traditional roles of NGOs in Jamaica. Indeed, "the work of NGOs contributes significantly to ensuring the social stability of the Jamaican society and NGO knowledge of "grassroots culture" makes them critical partners in any poverty reduction efforts" (McLeod et al., 2002).

Discussion

1.1 Reflexive practice

My position as an intern and perception by the rest of the team was influenced by several factors. My personal and professional background set me apart from the rest of the team. Although EFL is a local organization and intervenes in Jamaican settings, it has multiple international experiences and relations. As mentioned beforehand, almost all of the funding is internationally sourced, mainly from American, European and supranational organizations. EFL also partnered with several international organizations such as Unicef or UNWomen, for field work as well as on a more strategic aspect. EFL has also participated in practice exchanges across the American and Latin American continent. Rushell Gray, for instance, reflected on a past exchange in Brazil where she was able to compare the differences in the conduct of sexual education classes between the two countries. However, at the time of the internship, I was the only non-Jamaican person. Moreover, the majority of the team has a professional background more leaning towards social welfare while I have a medical background. This enabled me to see in practice the wider view of what health encompasses. For example, the term "client" is used to designate the person who is the beneficiary of the service provided by EFL. This was surprising to me at first as I would spontaneously evoke the word "patient" instead. The choice of word to designate beneficiaries of services may impact the way we perceive them. Indeed, the word "patient" is usually connotated with being sick or ill. It may imply "a passivity ('object of an action') that removes responsibility ('bearing, enduring'), which can be construed as stigmatizing as its usage may enhance perceived disability and impairment" (Shevell, 2009). For Shevell, the term "patient" was "an inappropriate term to refer to a healthy individual engaged in activities related to either illness prevention or health maintenance, or perhaps even rehabilitation that emphasizes function over 'normality'" (Shevell, 2009). On the other hand, the term "client" conveys "a non-medical, humanistic, less acute care model of orientation to healthcare delivery that is thought to be more empowering to the actual recipient of healthcare" (Costa et al., 2019; Shevell, 2009). Moreover, my lack of knowledge on the Jamaican culture and creole was a limiting factor to my comprehension of certain cultural subtleties or cues.

Despite these initial differences, my integration within the team was smooth, although my expectations of the role of an intern had to be adjusted along the way. For example, a certain proactive attitude was necessary in order to participate in team meetings or interventions. My internship assignment put me in a research position, which was a relatively new role for the team. Perceptions of my role as an intern by other team members was not always clear at the beginning so a clarification was needed. Although the nature of my assignment was not a realist evaluation, I found some echoes with Gilmore's experience as foreign researcher in "Realist evaluations in low-

and middle-income countries: reflections and recommendations from the experiences of a foreign researcher" (Gilmore, 2019). His four main challenges throughout the methodological process were "(1) power imbalances prevalent during realist interviews, (2) working through translation and what this means for identifying Context-Mechanism-Outcome-Configurations, (3) limited contextual familiarity and being an 'engaged researcher' and (4) the use or dependence on 'WEIRD' theories (i.e. theories based on the study of Western, Educated, Industrialized, Rich, Democratic people) within testing and refinement". The language barrier, "limited contextual familiarity" and, to a certain extent, "power imbalances" were definitely challenging to discern several interviews with clients and may have resulted in missing important data. Certain clients seemed reluctant to confide their struggles with me and I sometimes missed opportunities to pick up from what they were saying and ask better orientated questions. During the interventions that I assisted with, my contribution was mainly limited to note taking and helping for the logistics. However, my ethnicity was sometimes a subject of curiosity, especially during school interventions. An illustrative example would be during a school intervention on child sexual abuse, a student coming up to me to ask tips on getting straight hair like mine when the colleague who was animating the session asked if there were any questions in the room. This anecdote shows how I could not fully blend in even though my integration in the team was welcomed by the team.

1.2 Limitations and difficulties

Limitations of this thesis are mainly related to the difficulties to grasp the full extent of EFL's interventions. The internship duration (5 months) was too short to be able to see all of the different types of interventions that EFL does. A longer period of immersion would have allowed me to make further observations. Moreover, one-on-one sessions with the clients were confidential and I was not able to attend them. A major limitation resides with the difficulty to obtain important documents that would have been useful in this thesis such as policy and strategic documents, annual reports, programs plans… There seems to be a lack of organization for data and documentation management within the organization as my colleagues seemed to have difficulties accessing them too when I asked for their assistance. McLeod et al., pointed that NGOs in Jamaica are "constrained in meeting the increasing needs of their clientele efficiently and effectively" and some may "have inadequate institutional and organizational systems and processes; insufficient financial and program accountability; weak or non-existent personnel policies and accounting procedures; inefficient fund-raising approaches; lack of training programs for their board members and volunteers; and insufficient capacity to plan strategically" (McLeod et al., 2002). Even though EFL harbors strong personnel policies, efficient fund-raising approaches and frequent capacity-building training for the team members and a rigorous accounting

procedure, investing in Information Technology management would improve organization and structure.

Apart from these technical issues, the language barrier for patois made it difficult for me to communicate effectively with clients. This shortcoming was an important limitation for the study I had to lead. Due to lack of availability, another team member could not do the interviews with me. Instead, I recorded the interviews and listened to them afterwards with a colleague for translation. The language barrier was also a limitation for the thesis as the clients' perceptions of EFL's community-based approach could not be collected and therefore were not included.

Concerning the study I led, EFL expected me to deliver the results and was less implied in the elaboration and discussions of preliminary results. More contribution from team members and the supervisor would have increased the participation level and could have helped me better adjust the report accordingly. Israel et al., argues that community-based research focuses on determinants of health and health inequities "through active involvement of community members, organizational representatives, and researchers in all aspects of the research process" (Israel et al., 1998). Indeed, "partners contribute their expertise to enhance understanding of a given phenomenon and to integrate the knowledge gained with action to benefit the community involved" (Israel et al., 1998) which was less the case for the research I was asked to do. However, EFL is not a community-based research organization. As mentioned formerly, this assignment was an opportunity for EFL to formalize knowledge and experiences in a more methodological manner. The interviews for the thesis also sparked discussions and thoughts on the values, missions and identity of EFL and an opportunity for EFL to look at its actions in another light.

Conclusion

EFL is a local NGO that aims to address salient health and social issues rooted in Jamaican culture. Originally, EFL was created in response to needs concerning health and social welfare for young women and adolescents living with HIV. Although the Jamaican government has made efforts to curb the HIV epidemic by drawing a National HIV Program, EFL's cofounders identified gaps to fill for adolescents and young women who face specific challenges and vulnerabilities, such as teenage pregnancies, lack of skills to negotiate safe sex or higher occurrence of violence (Figueroa et al., 2020). Stigma and discrimination related to HIV are ongoing in Jamaican society. They are barriers to testing, access to care, adherence to treatment and partner disclosure of status. Stigma and discrimination bare an even higher toll on key communities affected by HIV such as youths and women (UNAIDS, 2021). Moreover, the strongly patriarchal aspect of Jamaican culture influences the power dynamics between men and women and the amount of consideration given to issues that are specific to women. Perceptions of masculinity and societal expectations for women dictate certain behaviors and normalization of violence. Jamaica knows a high rate of GBV and especially violence against women (Davis & Graham, 2022). Therefore, a double burden weighs upon women living with HIV. EFL was founded with this knowledge in mind.

Community, as defined by EFL refers to the pool of clients, adolescents and young women, usually aged 12-24 years old, living with HIV and/or affected by GBV and/or teen pregnancy. Considering the association of these issues with socioeconomic background, this community is also generally affected by low socioeconomic resources and resides in the "inner-city" or peri-urban low-income areas characterized by environmental degradation, insufficient housing and generally higher insecurity. As a result, EFL's understanding of community englobes the three types of communities as defined by Hyppolite & Parent: geographical community, community of interest and community of identity (Hyppolite & Parent, 2020).

Based on this understanding and knowledge of "community", EFL designs interventions closely tailored on needs identified by the team and community peer workers. Needs assessment for each client is done on a regular basis both by technical staff and peer workers who in turn share these needs with each other. Interventions are designed with and for a certain community (depending on the type of intervention) and are delivered to this community. Thus, participation of the community, one of the pillars of community health, is sought in the design of the intervention (MacQueen et al., 2001). EFL uses resources outside of the community by obtaining funds and making partnerships with international organizations/institutions who demonstrate sometimes more interest in the issues (especially GBV) that EFL addresses than national institutions. Most importantly, EFL also relies on resources within the community with its mentor

mom program, community change champions or partnerships with local NGOs and organizations. The close proximity with the communities they serve facilitates trust and empathy with these communities. This grassroots approach is a specific characteristics of community health. In turn, the government and international institutions can lean onto the grassroots knowledge (Mercer et al., 1991).

Interventions are designed on the clients' needs and feedback that are collected on a regular basis. The needs assessment is done in a pragmatic and time-fitting way. The proximity of the team with the clients and the communities they evolve in enables EFL to design interventions tailored to these needs and that aim to impact the determinants of health and life skills in a holistic approach to health. Capitalization of knowledge and experience could be improved in order to encourage and spark practice reflections and exchanges as well as set the ground for more advocacy. The conduct of a study on young mothers' struggles and infant care contributes to this process and may guide further development.

With a "one family at a time" philosophy, EFL strives to empower individuals who will regain power over their lives, develop to their full potential and who may in turn empower others and ultimately communities. Perhaps, what is most striking at EFL is the passion and engagement that animate the team members and especially Joy Crawford who has marked significantly EFL's identity. Similarly to other NGOs that operate in Jamaica, EFL's strengths include commitment, accountability, "grass-roots" knowledge of the communities they serve, networking, partnerships with different levels of organizations including the government of Jamaica and a media strategy (McLeod et al., 2002; Sanadgol et al., 2021). Challenges include funding challenges (notably the amount of energy and time spent on finding grants, negotiating with umbrella NGOs to unlock funds, the administrative burden to justify expenses), data management, increase of clients and lack of capitalization of knowledge and experience.

McLeroy et al., stated that "many of the problems around which community-based interventions have been developed—HIV, adolescent pregnancy, diet, tobacco use, other drug use, alcohol consumption, physical activity, access to health services, firearms—have profound personal and cultural meaning. These problems do not just result from personal choices; rather, they say something about social structure and who we are as individuals and as a society, and about our place in society" (McLeroy et al., 2003). This resonates as particularly true with what EFL tries to achieve. EFL uses a community-health approach to change and build community capacity. As an NGO and small entity, EFL is also quick to adapt and a pioneer in progressive and more inclusive view than the general society. EFL's strong ideals are directly linked to how it perceives a "good society" which is an accepting and non-judgmental society that stands up against GBV, accompanies women living with HIV and overall protects and promotes women's sexual health and rights (McLeroy et al., 2003).

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Annexes

INTERVIEW GUIDE

Study

What was the reason of doing this study?

How are clients' needs usually identified?

How will the study be used for further actions? How will this study further EFL's actions on the field?

As a community health worker, what use is this study for you?

Research and advocacy

What type of advocacy is done at Eve for Life?

How do you implement community health actions?

How do you evaluate community health actions? How are plans/actions decided?

Why is it interesting for EFL to have research work?

Why is research important for EFL?

What are the core values of EFL? How were they chosen?

How does the team participate in advocacy for EFL?

Community health work

What is your definition of community health?

What does community mean?

How do you recruit volunteers and assign them work? On which criteria/basis? How do you decide the projects on which interns work?

What does empowerment mean? How does EFL empower women? (clients and workers)

How do you determine the type of actions that EFL does?

What is the role of a community health worker?

Why is it important to have peer workers working at EFL?

How do you monitor the work that EFL does?

Participation/team

How do you make decisions? As a team?

How do the clients participate in the community health actions? Do clients participate in decision-making?

Could the study be used by the team?

Teamwork? How do you build a sense of team?

GUYONVARCH	Ophélie	14/10/2022

Master 2 Promotion de la santé et prévention

Promotion 2020/2021

Promoting sexual health and rights in a community health setting. Example of Eve for Life, a Jamaican NGO

PARTNERING UNIVERSITY: Université Rennes 2

***Summary*:**

Community health is deeply embedded and strongly associated with the principles of health promotion. It encourages active participation and involvement of community members, relies on assets and resources within communities in order to set health priorities by the communities themselves, achieve program goals related to health and wellbeing promotion and promote equity in health and healthcare. Eve for Life, a Jamaican non-governmental organization, sets itself as a facilitator for girls and young women impacted by gender-based violence and/or living with the Human Immunodeficiency virus and strives to promote their sexual health and rights. The ultimate goal is to empower girls and women so that they can achieve for themselves what they consider optimal health and well-being. With extensive grass roots level knowledge and experience, EFL is an important asset for national and international institutions to rely on. However, a more structured and methodological approach to needs assessment and research could further advocacy.

***Key words*:**

Community health, health promotion, gender-based violence, low and middle-income countries, Human Immunodeficiency Virus, empowerment