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**UNCLASSIFIED**

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D. C. 20523

CARIBBEAN REGIONAL

PROJECT PAPER

POPULATION AND DEVELOPMENT

LAC/DR:82-3

Project Number:538-0039

**UNCLASSIFIED**

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT DATA SHEET**

1. TRANSACTION CODE  
 A = Add  
 C = Change  
 D = Delete  
 Amendment Number \_\_\_\_\_  
 DOCUMENT CODE  
 3

2. COUNTRY/ENTITY  
 CARIBBEAN REGIONAL

3. PROJECT NUMBER  
 538-0039

4. BUREAU/OFFICE  
 LAC [05]

5. PROJECT TITLE (maximum 40 characters)  
 POPULATION AND DEVELOPMENT

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)  
 MM DD YY  
 1 | 2 | 3 | 1 | 8 | 6

7. ESTIMATED DATE OF OBLIGATION  
 (Under 'B.' below, enter 1, 2, 3, or 4)  
 A. Initial FY 8 | 2 | B. Quarter 4 C. Final FY

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	( 500 )	( )	( 500 )	( 500 )	( )	( 3,500 )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.						
1.						
2.						
Host Country						884
Other Donor(s)						
<b>TOTALS</b>						<b>4,384</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO. PRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)	PN	400	400			500		3,500	
(2)									
(3)									
(4)									
<b>TOTALS</b>						500		3,500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)  
 A. Code  
 B. Amount

13. PROJECT PURPOSE (maximum 480 character.)

To reduce the number of unwanted pregnancies in the Eastern Caribbean.

14. SCHEDULED EVALUATIONS  
 Interim MM YY MM YY Final MM YY  
 0 | 7 | 84 | | | 1 | 2 | 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES  
 000  941  Local  Other (Specify) 935 for vehicles

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment)

17. APPROVED BY  
 Signature: *William B. Wheeler*  
 Mr. WILLIAM B. WHEELER  
 MISSION DIRECTOR, RDO/C

Date Signed  
 MM DD YY  
 1 | 7 | 28 | 92

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION  
 MM DD YY

## INSTRUCTIONS

The approved Project Data Sheet summarizes basic data on the project and must provide reliable data for entry into the Country Program Data Bank (CPDB). As a general rule blocks 1 thru 16 are to be completed by the originating office or bureau. It is the responsibility of the reviewing bureau to assume that whenever the original Project Data Sheet is revised, the Project Data Sheet conforms to the revision.

Block 1 - Enter the appropriate letter code in the box, if a change, indicate the Amendment Number.

Block 2 - Enter the name of the Country, Regional or other Entity.

Block 3 - Enter the Project Number assigned by the field mission or an AID/W bureau.

Block 4 - Enter the sponsoring Bureau/Office Symbol and Code. *(See Handbook 3, Appendix 5A, Table 1, Page 1 for guidance.)*

Block 5 - Enter the Project Title *(stay within brackets; limit to 40 characters).*

Block 6 - Enter the Estimated Project Assistance Completion Date. *(See AIDTO Circular A-24 dated 1/26/78, paragraph C, Page 2.)*

Block 7A. - Enter the FY for the first obligation of AID funds for the project.

Block 7B. - Enter the quarter of FY for the first AID funds obligation.

Block 7C. - Enter the FY for the last AID funds obligations.

Block 8 - Enter the amounts from the 'Summary Cost Estimates' and 'Financial Table' of the Project Data Sheet.

**NOTE: The L/C column must show the estimated U.S. dollars to be used for the financing of local costs by AID on the lines corresponding to AID.**

Block 9 - Enter the amounts and details from the Project Data Sheet section reflecting the estimated rate of use of AID funds.

Block 9A. - Use the Alpha Code. *(See Handbook 3, Appendix 5A, Table 2, Page 2 for guidance.)*

Blocks 9B., C1. & C2. - See Handbook 3, Appendix 5B for guidance. The total of columns 1 and 2 of F must equal the AID appropriated funds total of 8G.

Blocks 10 and 11 - See Handbook 3, Appendix 5B for guidance.

Block 12 - Enter the codes and amounts attributable to each concern for Life of Project. *(See Handbook 3, Appendix 5B, Attachment C for coding.)*

Block 13 - Enter the Project Purpose as it appears in the approved PID Facesheet, or as modified during the project development and reflected in the Project Data Sheet.

Block 14 - Enter the evaluation(s) scheduled in this section.

Block 15 - Enter the information related to the procurement taken from the appropriate section of the Project Data Sheet.

Block 16 - This block is to be used with requests for the amendment of a project.

Block 17 - This block is to be signed and dated by the Authorizing Official of the originating office. The Project Data Sheet will not be reviewed if this Data Sheet is not signed and dated. Do not initial.

Block 18 - This date is to be provided by the office or bureau responsible for the processing of the document covered by this Data Sheet.

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

NAME OF ENTITY : The Caribbean Community Secretariat (CARICOM  
and  
The International Planned Parenthood Federation (IPPF)  
NAME OF PROJECT : Population and Development  
PROJECT NUMBER : 538-0039

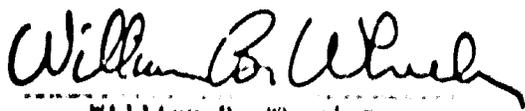
Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Caribbean Community Secretariat (CARICOM) of not to exceed One Hundred Thousand Dollars (\$100,000) and to the International Planned Parenthood Federation (IPPF) of not to exceed Four Hundred Thousand Dollars (\$400,000). The total amount granted to the two organizations is Five Hundred Thousand Dollars (\$500,000), (The "Authorized Amount"), to assist in financing certain foreign exchange and local currency costs of goods and services required for the Project as described in the following paragraph.

The Project will be implemented by CARICOM, IPPF and AID. CARICOM will implement a regional campaign among its member countries to raise the awareness of key leaders of the consequences of the present demographic trends on the socioeconomic development of their countries, in addition to outmoded procedures concerning family planning practices among the medical profession. Concurrent with the activities to be implemented by CARICOM, IPPF will assist selected Eastern Caribbean countries to improve the delivery of family planning services in four major areas: 1) Training of family planning delivery personnel; 2) Contraceptive supply and distribution systems; 3) Increasing the capacity of existing public health systems to provide family planning services; and 4) Programs targeted specifically at adolescents. AID, through appropriate contracts, will provide contraceptives and funds for the implementation of Commercial Retail Sales Programs in selected countries.

I approve the total level of AID appropriated funding planned for the Project of not to exceed Three Million Five Hundred Thousand Dollars (\$3,500,000) of grant funding, including the authorized amount during the period June, 1982 to December, 1985. I approve up to Three Million Dollars (\$3,000,000), subject to the availability of funds in accordance with AID allotment procedures.

Based on a waiver signed by AA (Acting) LAC on June 28, 1982, I authorize up to \$100,000 for the purchase of up to thirteen right hand drive vehicles and spare parts. The source and origin of such vehicles may be from countries included in AID Geographic Code 035.

I hereby authorize the initiation of negotiation and execution of Project Agreements by the officer to whom such authority has been delegated in accordance with AID regulations and Delegations of Authority.

  
William B. Wheeler  
Director

28 July 1982  
Date

PROJECT PAPER

POPULATION AND DEVELOPMENT PROJECT

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LIST OF ACRONYMS  
AND ABBREVIATIONS

AVS	Association for Voluntary Sterilization
CARICOM	Caribbean Community Secretariat
CFPA	Caribbean Family Planning Affiliation
CRS/CSM	Commercial Retail Sales/Commercial Social Marketing
CRESALC	Committee for Sex Education in Latin America and the Caribbean
CBD	Community Based Distribution of Contraceptives
DA	Development Associates
EC	Eastern Caribbean
FP	Family Planning
FPA	Family Planning Association
IEC	Information-Education and Communication in Family Planning
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD/IUCD	Intra-Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCC	Management Coordinating Committee
MCH	Maternal Child Health
HOH	Ministry of Health
NPTF	National Population Task Forces
OB/GYN	Obstetrics/Gynecology
OC'S	Oral Contraceptives
PAHO	Pan American Health Organization
RDO/C	Regional Development Office/Caribbean
RSSA	Reciprocal Support Service Agreement
ST/POP	Science and Technology Bureau/Office of Population
UNFPA	United Nations Fund for Population Activities

List of Acronyms and Abbreviations (continued)

UWI	University of the West Indies
VSC	Voluntary Surgical Contraception

POPULATION AND DEVELOPMENT PROJECT

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I. SUMMARY AND RECOMMENDATIONS

A. Recommendations

The Agency for International Development Regional Development Office, Caribbean (RDO/C) recommends the authorization of \$3,965,000 in grant funds to assist the states of the Eastern Caribbean in effectively reducing population growth. RDO/C will contribute \$3,500,000 to the project while AID/Washington will contribute \$465,000. The grant will be funded over a four year period as follows:-

	<u>FY 82</u>	<u>FY 83</u>	<u>FY 84</u>	<u>FY 85</u>	<u>Total</u>
RDO/C	500,000	1,800,000	1,000,000	200,000	3,500,000
AID/W	100,000	365,000			465,000

B. Grantees

The grantees and implementing agencies will be the Caribbean Community Secretariat (CARICOM) and the International Planned Parenthood Federation (IPPF).

Grant funds totalling \$729,000 will assist CARICOM in implementing a three and a-half year program to increase the awareness of regional leaders on major population issues facing the region. CARICOM will implement the program in member states that wish to participate.

\$3,236,000 in grant funds will assist IPPF in implementing a four and one half year program designed to improve the delivery of family planning services in selected countries. Eligible countries involve: Antigua, Barbados, Dominica, St. Lucia, St. Vincent, Montserrat and St. Kitts/Nevis.

C. Summary

The goal of the Population and Development Project is to bring the populace of the Eastern Caribbean into better balance with available resources, by limiting birth rates. The purpose of the project is to reduce the number of unwanted pregnancies in the region.

The project is to systematically address the two major constraints to limiting population growth in the region.

1. The lack of awareness, among key leaders of the consequences of the present demographic trends on the socio-economic development of their countries, in addition to outmoded procedures concerning family planning practices among the medical profession.

2. The current inability of countries to deliver adequate and timely family planning services.

The project will fund a multi-faceted inter-related program to overcome these constraints. CARICOM will implement a comprehensive campaign to raise awareness and promote commitment and action to support family planning services, among leaders in the public and private sectors. Through this national and regional campaign leaders will be better equipped to formally and informally take into account demographic processes in overall policy planning. Furthermore the medical profession will be better able to introduce modern family planning methods into existing medical procedures. Concurrent with the policy initiatives, IPPF will assist selected countries to improve the delivery of family planning services in four major areas:-

1. Training of family planning delivery personnel;
2. Contraceptive supply and distribution systems
3. Increasing the capacity of existing public health systems to provide family planning services.
4. Programs targeted specifically at adolescents.

#### END OF PROJECT STATUS

By the end of the project medical and public sector leadership will have formulated appropriate and effective policies and protocols to adequately address demographic and family planning issues.

Government family planning delivery services will have advanced from their current restricted and partial coverage to a position where they can provide a comprehensive range of services, catering for the needs of the diverse groups of contraceptive users. Access to family planning services will be open to all the fertile age groups regardless of income or area of residence. The governments will have the clinics and equipment needed to provide these services; they will be generating adequate numbers of trained staff to operate these services; they will have developed efficient and economical systems to order, purchase, store and distribute the appropriate contraceptive commodities and they will have established programs that are specifically tackling the adolescent fertility problem.

Outside of the government sector there will be a self-financing commercial contraceptive sales program established in at least three islands. All the islands will also have community based distribution programs distributing contraceptives on a non-clinic basis.

These major extensions and improvements to the region's family planning programs can realistically be expected to increase contraceptive prevalence by 25% by the end of the project. The reduction on the number of births and the consequent reduction in population growth rates will make a significant contribution to the region's overall development process.

D. FINANCIAL SUMMARY

(Thousand Dollars)

	RDO/C	AID/W	TOTAL AID	COUNTERPART	TOTAL
<u>Demographic Policy</u>	250	125	375	27	402
<u>Medical Policy</u>	70	-	70	23	93
<u>Training</u>	234	114	348	54	402
<u>Commodity Supply and Distribution</u>	510	222	732	300	1,032
<u>Improvement of Clinical Services</u>	425	-	425	-	425
<u>Adolescent Extension</u>	474	-	474	390	864
<u>Program Support</u>	610	4	614	-	593
<u>Administration</u>	927	-	927	90	1,038
<b>TOTAL</b>	<u>3,500</u>	<u>465</u>	<u>3,965</u>	<u>884</u>	<u>4,849</u>

## II. BACKGROUND AND PROBLEM STATEMENT

Excessive population growth has exacerbated the Eastern Caribbean countries' deep-rooted structural problems by having its dependent effect on high unemployment, low GDP per capita, and natural resource deterioration. While reducing population growth immediately to a more appropriate level will obviously not eliminate the above problems, in the warnings of Rep. William Lehman (D-Florida), "any new initiative seeking to ensure peace in the Caribbean Region will be overly ambitious and unrealistic unless it includes effective programs to reduce fertility rates". (POPLINE, Volume 4, No. 2, February, 1982) See Annex A. This has been recognized and reiterated by the Caribbean Health Ministers who at their last meeting, empowered the CARICOM Secretariat to actively seek external resources to combat this increasingly important impediment to economic and social growth. (See Annex B). Undoubtedly, excessive population growth undermines all development efforts and AID at present is technically best suited to provide the needed leadership in the population area. Additional population activities can significantly reduce fertility rates, bring population and resources into better balance and ultimately ensure greater peace and economic prosperity in the Region.

### A. The Demographic Situation

Looking ahead to the Year 2000 in the Caribbean, serious demographic constraints stand in the way of economic development. This harsh reality will strike hardest at those living in the so-called "Less Developed Countries (LDC)" where population growth rates are unacceptably high and the infrastructure capable of helping to reduce fertility is weak or ineffectual.

#### 1. Fertility

The demographic constraints on Caribbean development goals are real and rigid. Fertility is declining but it is still considerably above replacement levels. Even with further fertility decline, the populations of the LDCs will continue growing well into the next century because of their present youthful age-structure. The present pace of fertility decline to replacement fertility levels means that the populations will double in size before equilibrium can be reached. At present fertility levels, this doubling will occur sometime during the first decade of the next century. Given the small size and at best, fragile economic situation of many of the LDCs, a doubling of a small island's population could result

in considerable social unrest as islands are unable to meet the demands for additional jobs and social programs that the population has become accustomed to.

## 2. Migration

Historically, the Caribbean islands have been "migrant societies". Between 1950 and 1972 it is estimated that 10 percent of the total population of the Caribbean left the area permanently for North America and Western Europe.

Socioeconomic and demographic realities argue that at least a similar volume will need to leave during the next twenty years, 1980 - 2000.

In the past, high levels of fertility have been held at bay by out-migration. The LDCs will not even be able to maintain current population density without increasing rates of out-migration. During the next twenty years most Caribbean nations will most probably need to legally or illegally export people permanently or else face further deterioration in standards of living, as well as serious ecological pressures.

Meanwhile, many of the receiving nations which have traditionally welcomed migrants are becoming more restrictive and sensitive to immigration, as they themselves attempt to bring population, jobs and resources into balance. Besides migration to the metropolitan countries, intra-regional migration is also affecting population growth rates, particularly as higher standards of living and economic opportunities draw immigrants from the LDCs to the Region's MDCs.

## 3. Unmet Need for Contraceptives

Actual fertility of Caribbean women has declined but remains considerably higher than desired fertility given the limited resources available to most islands in the Region. Recent surveys in Barbados, Antigua, St. Vincent, St. Lucia and Dominica indicate that a very large number of women do not wish to become pregnant, yet are not currently using any form of contraception. According to the same surveys half of the last pregnancies were unwanted. A significant portion of clients were unable to use their preferred method because of unavailability or difficult access to services. One of the major reasons for discontinuation was the unmet need to allay fears about potential side effects. In summary, prevalent desire for smaller families exceeds actual use of contraceptives. This scenario leads unfortunately to a large number of unwanted pregnancies and/or the illegal use of abortion as a major birth control method within the Region.

## 4. Adolescent Pregnancies

Adolescent fertility in the EC nations is extremely high with the overwhelming majority (up to 80 percent) of first births occurring before the age of 20. The adolescent fertility

rate has not declined as have the rates among older women. Family planning services are not reaching this group adequately. High adolescent fertility rates, besides being a serious public health problem, indicate a tremendous growth potential because of the large number of teenagers and the shorter span between generations.

The number of teenagers in the population will continue to grow for at least the next 15 years because of past high rates of fertility. Unless something is done soon, the problem could become significantly worse, placing tremendous demands on already over-burdened maternal and child health services.

The related health issues of abortion and the alarmingly high prevalence of sexually transmitted diseases among adolescents present further burdens on health care systems. In addition to these demographic and medical considerations arguing for a reduction in adolescent fertility, there are also urgent social reasons. The infant of a teenage mother is typically born into the already overcrowded household of its grandmother. Very limited support is usually available from the child's father. Early motherhood restricts a girl's opportunities and compromises her future relationship with men, increasing the risk of further unwanted fertility.

#### 5. Multisectoral Implications

Even small increases in fertility and limitations on inter-country migration can have a devastating impact on small, already densely populated countries. The ability of the economic, social, and ecological systems of the Caribbean to support these eventual numbers of inhabitants is unknown, but to date this Region has had to cope with weak and fragile economic and ecological systems pressured by some of the highest human population densities in the Western Hemisphere. (See Table 1).

TABLE I

POPULATION DENSITY\*

(PERSONS PER SQ. KM.)

<u>CARIBBEAN</u>		<u>CENTRAL AMERICA</u>		<u>SOUTH AMERICA</u>	
Antigua	161	El Salvador	206	Argentina	10
Barbados	585	Guatemala	63	Bolivia	6
Dominica	101	Honduras	28	Brazil	14
Grenada	279	Panama	26	Chile	15
Jamaica	198	Mexico	34	Columbia	23
Montserrat	133	Costa Rica	44	Ecuador	29
St. Kitts	185	Nicaragua	20	Guyana	4
St. Lucia	179	Belize	6	Paraguay	8
St. Vincent	234			Peru	13
Trinidad & Tobago	210			Suriname	3
				Uruguay	17

\* IPEF Office of Evaluation - September 1979

Especially hard hit by rapid population growth will be social services. In almost all the states of the Eastern Caribbean, governments have traditionally provided a wide array of services such as schools, hospitals and housing. These large expenditures have a substantial impact on economic activity and welfare. This is illustrated in the following Table which indicates that central government expenditures per capita are quite high in comparison to GDP per capita.

TABLE II

	<u>CENTRAL GOVERNMENT PER CAPITA EXPENDI- TURE - 1979 - US\$</u>	<u>GDP PER CAPITA 1979 - US\$</u>
<u>MDC</u>		
Barbados	805.1	2,632
<u>LDC</u>		
Antigua	375.5	1,132
Belize	189.1	970
Dominica	320.6	549
Grenada	327.3	722
Montserrat	401.0	1,348
St. Kitts/Nevis	375.0	794
St. Lucia	276.2	793
St. Vincent	225.8	476

If population continues to grow at the current rate, governments in the near future will have to reduce services, resulting in serious adverse impact on both overall economic activity and the quality of life in these states. Rapid population growth means that the dependency ratio (the proportion of the populace that is not working) will rise, a development that places stress on employment options, social services, food availability, housing and so on. Unable to finance expenditures for social services, governments will have little recourse but to reduce the provision of services. Hence, with rapid population growth, central government expenditure per capita would decline over time, leading to frustration, anger, and a climate ripe for political change.

B. Other Regional Population Activity

While numerous international, bilateral and private organizations have provided assistance in population/family planning to the countries of the Region, the major donors have been the International Planned Parenthood Federation (IPPF) and the United Nations Fund for Population Activities (UNFPA).

1. International Planned Parenthood Federation/  
Western Hemisphere Region

IPPF support has for many years worked to develop strong private Family Planning Associations (FPAs) in each of the

project countries except Belize. It is these FPAs that have until recently been the major provider of family planning services in the region. To support the FPAs IPPF has, with primarily AID funding, opened a regional office, the Caribbean Family Planning Affiliation (CFPA). The CFPA serves an Information, Education and Communication (IE & C) role within the Region, producing educational materials and doing media work on a regional basis. CFPA also provides technical assistance on a country specific basis, (e.g. training and media experts for the FPAs), and upon request for government programs. Nevertheless, assistance from IPPF resources for the Western Hemisphere have been declining in real purchasing power for years, as other regions increase their demand for assistance in family planning. It is unrealistic to believe they will be able to significantly expand their Caribbean program.

## 2. United Nations Fund for Population Activities (UNFPA)

The Pan American Health Organization (PAHO) has been the implementing agent for the bulk of UNFPA supported activities. Major elements of the UNFPA program have been the Family Nurse Practitioner Training Project in St. Vincent, Family Health Care Research based at the University of the West Indies in Jamaica, and numerous small projects in individual countries. These country specific projects have dealt with training, commodity supply and family life education.

Governments, recognizing that UNFPA would support government family planning programs, began to take the first steps towards an increased role in the delivery of family planning services a few years ago. Now, for numerous reasons, the most significant being a shift of emphasis to the largest and poorest countries of the world, UNFPA has decided to phase out assistance to the Region. This will cause problems for many ongoing projects, the most immediate being the commodity needs of government programs that are supplied by UNFPA. Recognizing that an abrupt termination of commodities to programs that are dependent on them would cause very serious problems, UNFPA is searching for ways to extend provision of supplies through 1982 and possibly into 1983. The final outcome though is at the time of writing in doubt.

## 3. AID/Washington Collaboration

In addition to RDO/C resources provided under this project, substantial amounts of assistance will be provided by the AID/Washington Office of Population in collaboration with the RDO/C project. These activities are viewed as crucial to the project design and have been developed through consultations between AID/Washington - ST/Population and RDO/C. (See Annex C, State 068050).

In addition to the specific contributions by ST/Population outlined in the detailed project description (Section III), ST/Population Research Division will undertake a substantial operations research program in the English-speaking

countries of the Caribbean. The project is being undertaken in the EC because population density is the highest in the Western Hemisphere, adolescent pregnancy is endemic, and emigration from the Region is not a long term viable means of relieving population pressure.

The objectives of the OR project are: (1) to improve the innovative delivery of family planning (FP) services and identify effective approaches to increasing contraceptive use; (2) to sensitize administrators and decision makers as to the benefits of operations research for improving program effectiveness; and (3) to strengthen the research capabilities of local institutions through on-the-job training and experience.

The plan of action will consist of contacting FP administrators (governmental or private) in the different Caribbean nations; assessing current obstacles to contraceptive use and more effective service delivery; developing an operations research project designed to address these problems by testing alternative approaches to information-education-communication, training service delivery, and other aspects of FP programs; awarding sub-contracts for implementation to a local institution(s) in the Caribbean.

The OR project will be funded by ST/POP research but will be jointly managed by RDO/C and AID/W. The Research Coordinator stationed in Barbados will work out of the newly established IPPF Project Office and collaborate with the CFFA office in Antigua as well.

In sum, the operations research activity will allocate ST/POP resources for relatively high risk/high cost research that would be inappropriate for regional or bilateral population DA funds. Once the results of the research are known however, government, Mission or other donor funds could be utilized to expand the successful demonstration efforts to a region-wide focus.

#### 4. Other Organizations

Two FP organizations have been active in the region utilizing funds from AID/W. These are the Association for Voluntary Sterilization (AVS) and Development Associates (DA). AVS has given assistance to sterilization clinics in Barbados and St. Lucia. DA is primarily a training organization. They have recently held a regional workshop on Adolescent Fertility. PAHO is another organization which is interested in family planning but does not have resources, other than UNFPA funded projects for any major level of support. In sum, other than AID, there are no other organizations in a position to provide the levels and types of assistance required to meet this serious problem. Other bilateral organizations (EEC, BDD, CIDA, IDRC, SIDA, etc.) do not typically carry out major population efforts. Thus the introduction of AID funding into the population field is needed and can be seen to be not in conflict or competition with what other donors are doing. AID inputs will in fact build and expand on the initiatives that have been made by other donors. In the case of UNFPA, this project will further strengthen family planning service delivery, commodity support, and training that UNFPA has begun with governments.

### C. Constraints

Four constraints limit programs attempting to effectively deal with population problems in the Eastern Caribbean. First, leaders in the Region are not fully aware of the negative development impacts of the current rapid population growth on overall economic and social development. Second, access to FP services is restricted by outmoded medical protocol. Third, the technical and implementation capacity of the organizations involved in the delivery of family planning are generally deficient to the task of delivering quality family planning services. Fourth, there is a reluctance amongst men in the Caribbean to accept contraception.

#### 1. Lack of Leadership Awareness

Generally, policy makers are not familiar with demographic issues. Many leaders in the Caribbean feel that the population problem has been solved because the population growth rate has declined significantly in the past decade. Few prominent leaders, or population technicians, for that matter, understand the potential impact of sudden restrictions in out-migration. Furthermore, fewer understand population momentum. Even if fertility were to immediately drop to replacement levels, an achievement impossible to obtain unless truly mammoth family planning programs were implemented, current population size would double. These gaps in information and awareness to leaders' understanding hide the true implications of non-action and retard plans to tackle these problems. If made more aware, leaders could devote more time and resources to understanding and solving population problems.

## 2. Inappropriate and Out-dated Medical Protocols

In many countries medical protocols and policies are both out-dated and inappropriate. First the medical institution has failed to keep up-to-date with recent research and changes in recommended family planning procedures. The gap between new knowledge and its implementation must be shortened. This should be first accomplished at the level of the Region's medical leadership and then diffused through to the national and local level.

Caribbean family planning protocols are not only out-dated but also inappropriately conservative. In the false hope of providing risk-free care, the medical establishment exposes its population to higher risk problems. For example, the distribution of the pill is quite restricted, while the risk of pill use is clearly lower than childbirth for all women. Similarly, the risk of surgical sterilization is extremely low compared to complications of pregnancy.

The Caribbean medical system which requires excessive medical supervision and patient follow-up fails to delegate responsibility to the appropriate health worker and often ignores the client in planning its services. Many patients are forced to wait for long periods of time, to submit themselves to inappropriate examinations by over qualified physicians and then to return for unnecessary follow-up examinations. These obstacles limit efficiency and increase costs. Many of these problems could be significantly reduced in a short period of time with a few simple realignments in medical policies and appropriate short-term follow-up training. Ultimately, curriculum in formal training programs should be changed as well.

## 3. Shortcomings in Delivery System

In their attempt to meet the unmet need for family planning services, existing programs are often over-burdened by several major problems: inadequately trained personnel, insufficient supply systems under equipped and poorly managed clinics, a lack of assistance from the commercial sector, and inadequate projects to address the special needs of adolescents.

### a) Training

Several different constraints exist in the training areas. First formal curricula require revisions. Currently, formal training for nurses, allied health workers and pharmacists fails to even include family planning. Second all personnel lack critical refresher and on-the-job training to update skills vis-a-vis advances in contraceptive technology. This need is critical for staff knowledge and motivation. Third, potentially new suppliers of family planning services such as shopkeepers, educators, and community volunteers, need an introduction to family planning adequate to their respective role if they are to be effective. Fourth, too few doctors are trained in surgical contraception to meet current demand.

b) Insufficient Contraceptive Supply Systems

An insufficient contraceptive supply system limits the number of active contraceptive users. Because the supply system effectively regulates the number of active users, this critical problem limits the effectiveness of all other elements in the program, i.e. it is the limiting constraint.

While the government's distribution system must be improved to attract more users, relying exclusively upon it would be a major constraint to reducing the birth rate. It could not, even with tremendous resources, be expanded sufficiently. Other existing distribution systems must be used to reach targets that the government system could, for a variety of good reasons, never reach. These alternative systems are the commercial and community-based distribution systems. These systems penetrate the local community using existing commercial and social networks. They bring contraceptives to the users making it genuinely accessible. They are also potentially financially self-sufficient. The commercial retailer and volunteers are also financially rewarded for distributing contraceptives, thereby enhancing reliability and motivation to maintaining a continuous flow. Simply stated, establishing these alternative distribution systems could remove several current limitations: inconvenience for users of the government distribution system, continuous expense of maintaining publically-financed supply system, and inability of public sector to establish far reaching and self-sufficient network of distribution points located in nearly every convenient place.

c) Poorly Managed and Ill-Equipped Public Health Systems

Public health clinics are vital support for commercial and community-based programs insofar as they provide specialized referral service, e.g. surgical contraception, IUD -insertions, and side effects management. Because it is necessary that commercial and community-based system be expanded, the clinical back-up must concomitantly enhance its capacity. The public health system is, however, currently unprepared for expansion. Management ills constrain expansion potential at a reasonable price. On the other hand, proper management changes could enhance capacity at low cost. With proper technical support, clinics could expand their delivery of medical services. Management perfection will not, however, eliminate resource scarcity as a constraint to service expansion. A lack of basic equipment and adequate space certainly limit capacity. Even if the public health system had the resources to maintain current levels of equipment, it is not in a position to expand equipment stock necessary for program expansion.

c) Ineffective Adolescent Programs

Fear, ignorance and social disapproval constrain adolescents from using clinics/<sup>present</sup> commercial outlets ~~are~~ usually too costly. Nevertheless, adolescents continue to be sexually active despite obvious risks. Too few attempts have been made to provide family planning services which adolescents would use. Experimental efforts have provided sufficient insight into the problem and avenues of solution to warrant expansion beyond the pilot stage.

If successful on a larger scale, these initial efforts could begin to ameliorate the problem in a major way. However, these intensive projects are somewhat expensive requiring a tremendous financial commitment from administrators who are not totally convinced. If shown to be effective at a somewhat lower price, specialized adolescent programs may gain greater acceptance. Administrators would then be more enthusiastic and confident.

#### 4. Male Attitudes to Contraception

Some women who wish to limit their fertility are prevented from doing so by their partner's negative attitudes towards family planning. The magnitude of this problem in the region has not been measured but informed opinion amongst FP workers suggests that it is sufficiently serious to merit further investigation.

The origins of this male resistance to FP use are not clearly understood; there are three separate strands discernible. Some men hold strong pro-natalist views. Some of this group regard the number of children they father as a statement of their own virility. These form a minority group. Others in the pro-natalist group, particularly Rastafarians, adhere to Old Testament notions of "increase and multiply", and oppose the use of contraception accordingly.

A second strand of male resistance to FP is formed by those who more specifically object to contraceptive use by men because they see it as unmasculine and a restriction on sexual satisfaction. These objections are specific to particular contraceptive methods and are not based on a rejection of fertility limitation per se. They can be overcome by the promotion of alternative images of contraceptive users.

The third strand of resistance to FP is more complex. It appears that some men oppose female contraceptive use, believing that it encourages their girlfriends to be unfaithful. The removal of the risk of pregnancy is perceived as an increase in a girl's autonomy - an increase that some men resent. Some girls are accordingly forced to be secretive about their contraceptive behaviour.

Male resistance to FP is a secondary constraint to this project when compared to the three constraints discussed above. It does, however, warrant careful consideration so that the maximum effectiveness of project activities is not undermined.

#### D. Proposed AID Response

This project proposes to reduce to the smallest possible extent the major factors constraining the expansion and acceptance of family planning services. To repeat these major constraints are: (1) a lack of awareness concerning population problems among Caribbean leaders and their concomitant inaction; (2) outmoded medical policies that restrict access to FP services; (3) a deficient capacity to deliver FP services on the part of (a) several organizations already mandated to do so and (b) new organizations which could play a critical role; (4) negative male attitudes to FP.

The project will work towards eliminating these constraints by:

1. Heightening the awareness of population problems among Caribbean leaders so that they will establish more realistic population policies and will implement broader and more ambitious population programs, and:
2. Informing and assisting medical leaders in devising new medical protocols.
3. Assisting public, private not-for-profit, and commercial agencies to better deliver family planning services to the currently underserved population.
4. Focusing closely on the male through the new services to be launched under this project.

This project will accomplish these objectives by providing training, technical assistance, contraceptives, and financial support for a series of inextricably linked policy and service activities. To simply state these linkages a more knowledgeable and favorable policy environment enhances program implementation and, in reverse, a well implemented program allows policy makers to set more ambitious targets at reduced costs. The policy and service activities are therefore mutually reinforcing.

With regard to policy development, the Mission's strategy is to work in collaboration with other regional institutions, such as CARICOM, UWI, CFPA and IPPF/WHR to educate the uninformed political, commercial and civic leadership about the negative developmental consequences of rapid population growth and unbridled migration. Written and visual materials will be disseminated through the mail and media, and face-to-face dialogues will be planned to inform leadership of the development problems related to fertility and migration. The project will then assist several countries to integrate these population variables into their current development plans by helping to establish population task forces to spearhead the design and implementation of population policies.

As the project works to persuade the socio-political leadership of the overall demographic problems, the project's strategy is to simultaneously inform the medical leadership of the most up-to-date medical policies and protocols. If adopted, such changes are expected to improve the quality of services delivered and reduce costs. This project will provide funds to bring together internationally known medical experts and the Caribbean medical community for face-to-face dialogues on key medical policy and service delivery issues. These dialogues will be supported and followed up with persuasive written materials to reinforce the most important messages and reduce confusion and mis-information. The key issues appear to be the non-clinical delivery of FP services, the expanded role of voluntary sterilization in family planning programs, and the greater use of nurses and community workers in the delivery of family planning.

To summarize, by making leaders more aware and more committed to overcoming demographic problems and by bringing the medical community up-to-date with scientifically acceptable medical policies and protocols, the project will establish a more favorable policy environment in which to move towards its second major objective of improving the delivery of family planning services to currently underserved populations.

This project will provide three major inputs to address these delivery problems. First, through training, management assistance, and commodities support, this project will improve ongoing family planning programs, mainly in the public sector. Complementary information and education support to the public sector service program is already provided by an OPG to Caribbean Family Planning Affiliation (CFPA). Second, to enhance access to non-prescription contraceptives on an expanded and more self-financing basis, this project will launch commercial and community-based projects in several islands. Third, this project will initiate several potentially high impact projects aimed at adolescents.

Males will be major targets of the commercial and community based projects and of the adolescent programs. The detailed design and implementation of these projects will benefit from the results of a male attitude survey to be carried out during the first months of the project.

RDO/C feels that this proposed response to the major constraints limiting the expansion of family planning services will be adequate and is cost-effective. In its design, each element of the project addresses at least one major problem limiting expanded coverage. Tackling the policy and service areas simultaneously produces a more balanced reinforcing approach. In this way, one element will not limit the other. In other words, a magnificent policy will not stand alone without the capacity to implement and a great service delivery machine will not face high-level intransigent policy opposition. The situation requires a comprehensive approach to solving several major problems simultaneously.

III. Project Description

A. Summary Description

To address the critical population issues confronting the islands of the Eastern Caribbean, AID/W and RDO/C will provide \$3.965 million in grant funds to finance a two pronged inter-related project.

1. In an attempt to foster the development of sound planning, regarding population issues, and medical policy, AID grant funds will assist CARICOM to implement programs designed to increase the awareness of regional leaders about present demographic issues confronting the Region and present to medical practitioners, the latest medical protocols regarding family planning services.

2. To limit unwanted pregnancies, particularly among adolescents, the project will assist IPPF to improve the capacity of participating countries to deliver family planning services to satisfy unmet demand and initiate programs aimed specifically at adolescents.

The Population and Development project will provide the basis for participating countries to effectively limit future population growth as they see fit. Other resources, provided by AID and the international donor community, will assist countries in their quest for economic and social development. Thus, the project seen in the context of a total development approach, is crucial to the ultimate success of other on-going and planned development activities.

1. Policy

RDO/C and AID/W will provide \$729,000 in grant funds over a three year period to the Caribbean Community Secretariat (CARICOM) to implement a comprehensive campaign to raise awareness and generate commitment and action to support family planning services. All CARICOM member states will be requested to participate. Activities supported under this project will address two key pieces of the population policy puzzle: macro-demographic planning and medical protocol.

a) Demographic Policy

With regard to macro-demographic policy and planning, this project will work at both the regional and national levels. At the regional level, an awareness-raising seminar, followed by a RAPID presentations, several publications and a publicity campaign will be carried out to educate policy makers about regional population issues. These region-wide efforts will be reinforced, at the national level, by the formation of National Population Task Forces composed of leaders from both the public and private sector. These National Population Task Forces will set out to review existing national population policies - both implicit and explicit - with the goal of taking the initiative in designing

and implementing national population policies in their respective countries. CARICOM will assist the National Population Task Forces by providing access to macro-demographic data, by supplying technical assistance to analyze key issues as identified by national leadership, and by training population analysts to provide needed data and analysis in the future.

b) Medical Policy

To hurdle barriers imposed by inadequate and out-dated medical protocols, this project will inform the various segments of the medical community about new directions in the field of family planning and contraceptive delivery, as well as the developmental problems related to rapid population growth and migration. First, the medical community will be invited to actively participate in all macro-demographic activities carried out to harmonize national and regional population policy objectives with medical protocols. This will increase the awareness within the medical community - doctors, nurses, administrators. A Steering Committee will review medical policies, practices and protocols on a comparative country basis. Because existing medical practices vary considerably from island to island, CARICOM will collaborate with the University of the West Indies in carrying out regional medical conferences to review national and regional medical policies. These regional conferences will be followed up by a series of national seminars, in addition to short-term training to insure application of "updated" medical policies at the local level. The design of this project assumes that face-to-face discussion and direct observations are the best ways to get physicians who control the medical institutions to change antiquated practices.

The policy activity financed under the project will lay the essential groundwork in terms of public and medical awareness of the existing population dynamics in the region, in addition to informing the medical profession of up-to-date family planning practices and protocols. RDO/C feels that by undertaking these policy initiatives, the implementation of the activities under the Service Delivery component will be facilitated as countries become aware of the population problems confronting them and seek support to carry-out programs to address these problems.

2. Improvement in Service Delivery

Concurrent with the policy activities, through CARICOM, \$3,236,000 in grant funds will be made available to the International Planned Parenthood Federation (IPPF) to assist selected countries in the Eastern Caribbean to improve the delivery of family planning services. \$2,900,000 of these funds will be from RDO/C, \$336,000 from AID/W. The project will focus on four major elements of the overall delivery system.

1. Training of health professionals and family planning administrators in the latest accepted family planning techniques. Regional educators will also be trained in family life education.

2. Improving existing contraceptive supply and distribution systems, in addition to initiating Community Based Distribution Programs and Commercial Retail Sales Programs in selected countries.

3. Increasing the capacity of the existing public health system to provide family planning services; and

4. Providing programs targeted specifically at adolescents.

The activities under the Service Delivery component of the project have been designed to take into account the absorptive capacity of Caribbean countries, and have resulted from indepth analysis and discussions between RDO/C, CARICOM, IPPF and health and family planning officials throughout the region. Because family planning is still a sensitive area in some countries officials were not willing or capable of participating in all aspects of the Service Delivery component. Therefore, not all activities will be implemented in every country. A geographical summary of each project activity is described in Table III, and in detail below.

TABLE III

Geographic distribution of Project Activities.

	Antigua	Barbados	Dominica	Grenada	Montserrat	St. Kitts/Nevis	St. Lucia	St. Vincent	Belize	Regional
<u>POLICY ACTIVITIES (CARIOOM)</u>										
1. <u>DEMOGRAPHIC POLICY</u>										
National Population Task Force	x	xx	x	x	x	x	x	x	x	x
Country Population Reports	x	x	xx	x	x	x	x	x	x	x
Regional Conference	x	xx	x	x	x	x	x	x	x	x
RAPID			x				x			
Demographic Training	x	x	x	x	x	x	x	x	x	x
2. <u>MEDICAL POLICY</u>										
Steering Committee	x	xx	x	x	x	x	x	x	x	x
Regional Seminars	x	x	xx	x	x	x	x	x	x	x
National Seminars	x	x	xx	x	x	x	x	x	x	x
Observational Training	x	x	xx	x	x	x	x	x	x	x
3. <u>PROGRAM SUPPORT</u>										
Technical Assistance	x	x	xx	x	x	x	x	x	x	x
Publicity Program	x	x	xx	x	x	x	x	x	x	x
Evaluation	x	x	xx	x	x	x	x	x	x	x
<u>IMPROVEMENT IN SERVICE DELIVERY (IPPF)</u>										
1. <u>TRAINING</u>										
Physicians	x	xx	x	x	x	x	x			
Nurses	x	xx	x	x	x	x	x			
Allied Health Workers	x	xx	x	x	x	x	x			
Administrators	x	xx	x	x	x	x	x			
Pharmacists	x	xx	x	x	x	x	x			
Educators	x	xx	x	x	x	x	x			
2. <u>COMMODITY SUPPLY AND DISTRIBUTION</u>										
Supply System	x	xx	x	x	x	x	x			
CRS	x	xx	x		x	x	x			
CBD	x	xx	x	x	x	x	x			
3. <u>IMPROVEMENT OF CLINIC SERVICES</u>										
Clinic Upgrading	x	xx	x	x	x	x	x			
Clinic Equipment	x	xx	x	x	x	x	x			
4. <u>EXTENSION OF ADOLESCENT SERVICES</u>										
Adolescent Clinics	x	xx			x	x	x			
Youth Outreach	x	xx	x		x	x	x			
5. <u>PROGRAM SUPPORT</u>										
Technical Assistance	x	xx	x	x	x	x	x			
Evaluation	x	xx	x	x	x	x	x			
Contraceptive Prevalence Survey	x	xx	x	x	x	x	x			
Male Attitude Survey	x	xx	x	x	x	x	x			

B. Detailed Description : 1. Policy

a. Demographic Policy

i. National Population Task Forces (\$53,000)

With the use of grant funds CARICOM will help to establish National Population Task Forces (NPTF) in up to eight participating countries. The NPTF will be responsible for spearheading the formation and implementation of a national population policy. Leading individuals in each country will launch this multisectoral group which will include members from both the public and private sectors, for example, government officials, businessmen, lawyers, doctors, religious leaders, educators, and agriculturalists. Initial impetus for the NPTF's will come from the newly organized National Health Councils presently being assisted in their formative stages by CARICOM. The appropriate legal status and bureaucratic locus of each NPTF will be decided on a country-by-country basis. The NPTF will generally consist of five to seven members who will meet periodically to design a national policy, guide its implementation, and monitor changing attitudes towards population issues among the leadership of its country. Leadership for the NPTF will in many cases be drawn from the Board of local family planning associations (FPAs). At the regular meetings of the NPTF, members will also be updated on ongoing activities under this project, review project materials for distribution to government and private sector leaders, recommend candidates for special training and nominate participants for regional conferences which are outlined below.

Because the NPTFs are so important for the implementation of the entire policy program, CARICOM will begin organizing them immediately after the Project Agreement is signed. Grant funds will allow CARICOM to provide technical assistance and a small amount of logistic support to each task force, amounting to approximately \$5,000 per year per country.

Representatives of the NPTF will also be given the opportunity to exchange ideas and information on the design and implementation of a national population plan. These exchanges can be very important at the onset of the project to build motivation among the leaders to take action in their respective countries. Guest experts will present ideas about successful policy activities in the Caribbean, for example, in Jamaica where a new policy has recently been drafted. Potential problems and issues will also be discussed.

To enable regional leadership to discuss all these matters, CARICOM will convene a two-day regional conference,

tentatively scheduled for St. Lucia in April, 1983. CARICOM will select up to thirty participants for the Conference. These will include members of the NPTFs. AID grant funds will finance travel and per diem expenses for participants and speakers. Proceedings of the conference will be published and distributed to participants and the media to enhance dissemination and further discussion.

ii. Country Population Reports (\$61,000)

As each NPTF begins its program to educate national leadership and formulate national population policy, it must have available appropriate demographic information in a readily understandable form for policy makers. CARICOM through RDO/C will, therefore, subcontract a series of eight country population reports presented in a magazine format, complete with color charts and graphs highlighting the major demographic situation of each country.

It is envisioned that each report will consist of three major sections: (1) a summary of major population changes since 1930; (2) a summary of findings from the 1980 census; and (3) a series of alternative population projections to the Year 2030.

The first section will place the current demographic realities into historical perspective by comparing current to past birth rates, death rates, migration rates and growth rates. These data will help to measure past successes and failures in health, economic, and migration programs and policies.

The second section will present the latest 1980 census information to the NPTF thereby giving them the most up-to-date demographic information for planning purposes. Typically the 1980 census data would take some time before even its basic tabulations were formally printed. For the most part, policy makers would generally not read through the long detailed tables prepared by the Census Office. The Country Population Report in overcoming these problems will in a timely manner highlight only the most relevant information.

The third section will include population projections. These projections will be based on reasonable assumptions regarding future fertility and migration to demonstrate the impact of high fertility, the built-in momentum for excessive population growth and the implications of a sudden closure of emigration. Ultimate population size will be emphasized.

iii Regional Awareness Conference (\$38,000)

The NPTFs and the Country Reports are seen as the organizational and informational starting points in an effort to inform and educate policymakers about population dynamics. From this basis will flow a regional conference to increase overall awareness of regional population problems and to promote an exchange of experience about the design and implementation of a national population program.

CARICOM will contract with the Population Reference Bureau (PRB) to prepare fact sheets, bulletins and pamphlets highlighting regional population issues. Most of the information needed to complete this material is completed in the form of studies on adolescent fertility, immigration, population projections and contraceptive prevalence surveys which were funded by RDO/C. These publications will serve as background support materials for the conference and will help the participants to share the issues and answers with other leaders in their home countries. Estimated cost of preparing and printing these materials is \$10,000. This is included in the cost of the conference.

This regional conference will spend a significant amount of time discussing the multi-dimensional impacts of rapid population growth on socio-economic development. This theme is generic to all the island nations in so far as each must align its population growth to its abilities to provide basic human needs such as water, housing, jobs, education etc. But excessive population growth is also a regional problem to the extent that some islands "export" their excess population to other islands through emigration. Therefore, to a large degree, the region has a "shared" demographic future.

iv The RAPID Presentations (\$13,000)

After the April 1983 regional conference, CARICOM will contract the National Population Task Forces (NPTF) to assess the level of population awareness among the top policymakers in each country. Where appropriate, arrangements will be made to offer a RAPID presentation for the Prime Minister and other pertinent Ministers to dramatize the multi-sectoral impact of excessive population growth. Such presentations have had tremendous impact in convincing the highest level leaders in many developing nations of the impact of population trends. (for example President Sadat and King Hussein).

Briefly, a RAPID presentation involves the use of an Apple or similar computer and a television screen. High quality visual materials are presented on the television screen showing the impact of population on jobs, land, GNP, food, housing, etc. Upon completion of the presentation, the Apple mini-computer is left in the country together with suitable software and instructions as to its use for future presentations by local

statisticians and demographers. In many countries these computers have also become an important tool used by national planners in statistical data collection projections and analysis. The full unit of the RAPID presentations, including technical assistance, equipment and cost of the presentation will be provided by AID/W. Funds will be made available for two RAPID presentations scheduled to be held in the fall of 1983.

#### V. Demographic Training (\$100,000)

Throughout the course of the project development, it has become increasingly clear that two major problems were inhibiting leadership's ability to formulate and implement a national population program. These are a lack of adequately trained personnel and the paucity of quality demographic data. To a significant degree these problems are inter-related in so far as population technicians need to improve their skills in data collection. Beyond that, personnel also lack the skills necessary for adequate data analysis. Therefore, through the project, CARICOM will fund training in data collection and analysis to individuals recommended by the NPTF. More specifically three two-week training courses for up to 20 mid to upper level statisticians will be carried out in the region by the International Statistical Program Center of the U.S. Bureau of the Census (ISPC). The core curriculum will include:- (1) statistical techniques; (2) techniques in demographic analysis; (3) analysis of quantitative data; (4) sampling design; (5) survey planning and; (6) data processing (including the use of calculators and mini-computers). Throughout the course, ISPC will train an upper level statistician in the Barbados Central Statistical Office to assist in conducting project funded courses, as well as instilling a capability to conduct similar training courses after this project is over.

AID grant funds will be provided for travel and per diem for participants, as well as salary, travel and per diem for ISPC consultants. Funds for ISPC participants will be provided through the Central ST/Population RSSA with the U.S. Bureau of the Census.

#### b) Medical Policy

##### i. Steering Committee and Regional Seminar (\$24,000)

A Medical Steering Committee consisting of up to five prominent medical practitioners will be named by CARICOM soon after approval of the project. The Committee will meet, initially, for two days in Barbados to review existing policies and practices and to organize the first regional seminar on FP policies, which will be held during the first year of the project. This seminar will include up to twenty doctors, nurses and FP administrators. The focus of the seminar will be to identify and discuss issues related to FP policy and protocol, with internationally-known obstetrician/gynecologists and experts in the field of contraceptive technology. The results of the regional seminar will be used to plan for the follow-on national seminars.

ii National Seminars (\$36,000)

During the first year of the project a national seminar will be held in Barbados for thirty participants, including a mix of prominent doctors, nurses, educators, and community leaders. The national seminar in Barbados will serve as a "model" for organizing up to twenty two-day national seminars to be held during subsequent years.

Each national seminar will be attended by medical practitioners from prominent medical institutions within the region, such as CARICOM and UWI, who will have participated in the regional seminar and the "model" national seminar in Barbados. These regional experts will help to guide the discussions and present new techniques to the participants.

iii. Observational Training (\$10,000)

As training needs are identified during the course of these seminars, short-term observational training will be made available to a limited number of individuals over the course of the project. Training in modern contraceptive techniques will be held at UWI in Jamaica, where trainees will be able to observe first hand the operations of more up to date medical practices and protocols.

c) Program Support (\$144,000)

i. Technical and Promotional Assistance (\$104,000)

In order to implement the demographic and medical policy programs under this project, it is envisioned that CARICOM will be required to provide a broad range of specialized technical advice in both the medical and demographic areas. Therefore, grant funds have been provided for CARICOM to contract up to 12 months of short term technical advice in such areas as : demographic policy formation, population projections, computer simulation, demographic training, FP surgery, contraceptive research, and others. Estimated costs of technical assistance is \$94,000.

The process of policy change will require broader dissemination and consensus than the seminars and training could possibly provide. Therefore, a small amount of grant funds has been reserved for CARICOM to carry out a promotional campaign planned to support the demographic and medical policy activities through the regional mass media.

ii. Evaluation and Audit (\$40,000)

To assess the impact of the various task forces, seminars, conferences, publications and publicity will require an outside evaluation. The project will provide funds to conduct a mid-term and final evaluation at the approximate cost of \$30,000. Funds are also provided for periodic audits of project expenses.

d) Administration (\$140,000)

To effectively implement the project activities over the many islands of the Eastern Caribbean, CARICOM will require support for additional staff, travel and operating costs. Therefore, grant funds are provided to CARICOM for a half time administrator to the project, in addition to adequate administrative support staff, operating expenses and travel funds. CARICOM using its own resources will provide one-quarter time the service of a project manager, in addition to office space, and administrative and support assistance.

SUMMARY AID BUDGET FOR POLICY ACTIVITIES

(Thousand U.S. Dollars)

	<u>Total</u>	<u>RDO/C</u>	<u>AID/W</u>
I. Demographic Policy	375	250	125
II. Medical Policy	70	70	-
III. Program Support	144	140	4..
IV. Administration	<u>140</u>	<u>140</u>	<u>-</u>
Total	729	600	129

2. Improvement of Service Delivery

a) TRAINING (348,000)

Throughout the region there is a lack of qualified health professionals qualified in family planning techniques. To increase the human resources available to effectively extend family planning services this project will fund appropriate short-term training for health professionals and family planning administrators, in addition to training in family life education to regional educators.

i. Physicians

The project will support the following training activities for physicians.

a) Voluntary Surgical Contraceptives Techniques (VSC) (\$40,000)

Voluntary sterilization of women is currently the second most popular method of contraception in the Region. VSC techniques are however, generally restricted to a few doctors in each country.

To increase the utilization of this important method, AID/S&T/POP has agreed to continue its Eastern Caribbean VSC training program under the direction of The John Hopkins Program for International Education in Obstetrics and Gynecology (JHPIEGO). S&T/POP will sponsor tuition cost and expenses for eight government doctors from the Eastern Caribbean to attend the two week VSC courses at UWI, Jamaica and UWI Trinidad. Upon completion of training it is expected that all trainees will perform VSCs for their respective government program. It is estimated that each physician trained under this program should be able to perform an average of 100 sterilizations per year or more, each representing approximately 15 couple years of protection.

b. On-Site Training (\$59,000)

On-site training courses to improve the skills of government physicians to deliver the entire range of reversible contraceptive methods will be necessary to stimulate activities in the existing public health systems. This need was repeatedly identified during project development as one of the highest priorities. This training will also encourage and reinforce rationalization of the physician's role in FP delivery as discussed at the regional medical seminars. It is anticipated that as a result of this physician training, nurses will be able to perform the majority of routine FP delivery so that highly trained physicians can concentrate on the more specialized procedures.

To implement the in-country training program IPPF will contract with two prominent obstetricians/gynecologists from UWI to carry out the in-country training courses for the Eastern Caribbean. In-country training courses will be available for all physicians who operate wholly or partly in the government health system. Seven, one-week courses will be funded during the first two years of the project. It is expected that ten physicians will attend each course.

Each one-week seminar will be followed by a one-day refresher seminar to be held at appropriate times during the life of the project. The purpose of the refresher seminar is to bring previously trained physicians up to date on the most recent developments in contraceptive technology. These seminars will be for doctors in both public and private sectors who already have had basic training in family planning delivery, but need to sharpen particular skills. It is currently anticipated that the refresher courses will be held in Year III and IV of the project, after the medical policy seminars and initial on-site training has been completed. This training will help to reinforce the recommended changes in medical protocols.

Refresher seminars will generally be coordinated by local obstetricians/gynecologists, but will draw upon the resources available from the UWI in Barbados, Jamaica and Trinidad. These seminars for approximately 15 physicians each will reach a total of some 100 doctors. An honorarium for one obstetrician/gynecologist will be provided in addition to travel costs for those islands without local expertise.

ii. Nurses

Nurses are the primary providers of family planning services, yet their skills are surprisingly weak. To upgrade family planning skills, thus making these skills the part of every qualified nurse, the project will fund two types of training activities.

a) On-Site Nurses Training (\$49,000)

At present family planning training is for the most part only provided by the Advanced Fertility Management course at the Department of Obstetrics and Gynecology at UWI, Mona. It is a highly successful course, with about fifteen nurses per year attending. While highly successful, the cost of the course is high, therefore limiting the numbers that government can afford to send for training. In addition, the Advanced Fertility Management course does not produce any local capability for on-going training in family planning. The project will therefore provide resources to expand the training of nurses in family planning and instill the local capability of countries to continue with family planning training.

The project will create the local capability by:-

a) providing funds (see below) to send two family planning trained nurses from each country to Jamaica to develop training skills and to add to their existing family planning knowledge. This four-week course will provide a core of local staff from each island who can develop an in-country training program. These 14 nurses will go to Jamaica in the first two years of the project.

b) IPPF will contract with UWI to assist local medical personnel (for example obstetrician/gynecologists, graduates of the Advanced Fertility course, and others, to develop an in-country training course that coordinates best with each country's on-going in service training program. After the training course is developed UWI will assist local resource staff in conducting and reviewing the first course.

The project will fund travel, per diem, and salary costs of a UWI consultant, in addition to incidental on-island training costs. After the project terminates this training mechanism will be funded with local resources, thus establishing an on-going capacity and increasing the impact of training funds.

b) Advanced Course in Fertility Management UWI (\$50,000)

To further enhance the capability for in-country family planning training, the project makes provisions for fourteen additional scholarships for nurses in the region for advanced level courses in Year III and IV of the project. These graduates will further strengthen and add to the number of trainers, thus establishing a cadre of well qualified personnel to administer in-country training programs.

c) Training of Trainers (\$47,000)

The 14 nurses required as trainers for the on-site training courses will themselves be trained at Mona in years one and two of the project. The special course lasting four weeks will enhance the technical skills of the chosen individuals as well as giving them basic training as Teachers so they can pass on their skills during the on-site training activities.

**iii. Other Family Planning Personnel (\$41,000)**

**(a) Allied Health Workers and Community Development Workers**

The importance of para-medical and CDW staff in public health has long been recognized. Their potential for delivering FP has, however, been largely overlooked in the region, unlike in many developing countries where para-medical staff play key roles in FP delivery. Their day-to-day contact with the community outside the clinic enables these workers to gain the confidence of the FP users. Such personnel can provide FP information to potential new users, they can provide commodities to existing users, and they can counsel and reassure these users to reduce the number of drop outs. In sum, they can potentially play a critical role in bringing the service to the clients.

The medical policy developed under this project will create a recognition and acceptance of the expanded role of the allied health workers and community development workers. Only with support for training can these individuals realize their potential as FP workers.

On-site training for allied health workers, community health aides, community health nurses, community development workers, and public health inspectors will be arranged in Year II and III of this project as follow on activities to the regional medical seminars. These courses, typically two per island for approximately thirty people, will be aimed at both new recruits and at in-service personnel. The project will fund honoraria for local experts to design and deliver the course in addition to incidental expenses for local transport and implementation costs of one week courses. It is anticipated that over 400 FP workers will be trained at the community level as a result of these courses.

**(b) Pharmacists**

As new commercial channels of contraceptive distribution are opened up under this project, pharmacists in government and the private sector will play an increased FP role. Even new pharmacy workers are often consulted informally about FP to guide and reassure FP clients, but unfortunately, their capabilities at present are quite limited. Training pharmacists can have a high potential impact at very low cost. Pharmacists will be motivated, (especially if increased sales are expected) as a result of advertising funded by this project as anticipated under the Commercial Retail Sales Program.

Training for pharmacists will be comprised of seven one-day seminars to be held in each participating country. The training will be conducted by local experts contracted by IPPF. Twenty participants are expected per seminar. The project will fund the cost of seminar honoraria, incidental expenses, and literature for distribution.

(c) Family Planning Administrators

New administrative demands will arise from the expanding FP services envisaged under this project. Government FP programs will be playing larger and more diverse roles to minimize the potential administrative problems these changes imply, this project will provide training for family planning administrators who need their skills upgrading to manage the expanded FP programs.

This project will fund the tuition, travel and support costs for one administrator from each of five islands to attend the specialized six week course in FP administration held at UWI, Mona, Jamaica. Follow-up and general technical assistance to these administrators will be provided by IPPF to facilitate the administrative changes and increasing roles anticipated for them under this project.

All the training envisaged for paramedical personnel, pharmacists and FP administrators will be coordinated by the IPPF office and funded under our AID/W office of Population central contract for training.

iv. Family Life Education (\$68,000)

High adolescent fertility is not solely a consequence of inadequate access to contraception. There is also an urgent need to address the problem from an educational and motivational perspective. Sex education and family planning counselling are nominally included in general Family Life Education curricula currently being introduced into the Region's schools. These key elements are being largely ignored at the classroom level because teachers do not have adequate training, motivation, courage, resources material, or official approval to teach these sensitive yet crucial areas. This project will provide assistance to address this need in three ways:-

a) Two Week Course for Lecturers

This project will support the training of lecturers from teacher training colleges so that new recruits to the teaching profession can receive training in family planning and sex education within a Family Life Education curriculum. The multiplier effect of this project activity will be vast, as potentially all newly qualified teachers will be going into their schools with a background in FP/sex education as a consequence of the training of trainers carried out under this project. To accomplish this the project will fund a lecturer from each of up to seven teacher training colleges. Each lecturer will attend a two week family life education course with a strong sex education/FP component. The course will be held in Antigua and developed by the staff of the CFPA under the AID funded Caribbean Family Planning project.

b) In-Country Seminars for In-Service Teachers

A seminar will be held in each participating country lasting 3 days, each for approximately 40 teachers who are already qualified and working in government secondary, post-primary and all-age schools. It is anticipated that at least one in-service

teacher from every school will be attending these seminars. The seminars will be given by C'PA's education office with support from local expertise in each country.

c) Materials

The impact of classroom education in this project will be greatly enhanced by the provision of teaching materials. Teachers will be more confident in teaching the delicate and potentially embarrassing topics involved and the pupils will learn and retain more accurate information. Suitable materials on Family Life Education subjects have been developed by the Regional Committee in Sex Education for Latin America and the Caribbean (CRESALC). Suitable CRESALC textbooks, posters, flip-charts, pamphlets, and other teaching aids will be reproduced and distributed with assistance from an S&T/POP funded project to all schools in the region with teenage students.

Training Activities: Summary

This project will support training for a wide range of family planning personnel to enforce the delivery of family planning services. At the end of the project the region will have sufficient trained doctors to meet an increased demand for sterilization, nearly all doctors will have benefited from updating in their general FP knowledge. All public health nurses will be qualified in family planning and there will be a capacity to continue this training on an in-country basis. Allied Health Workers will have the capacity to fill the new FP roles created for them by policy change. The region's administrators will have the capacity to manage enlarged and improved family services and the region's school students will benefit from the wide teaching assistance to family planning education in schools.

b) COMMODITY SUPPLY AND DISTRIBUTION (\$732,000)

This project will undertake an innovative, mutually reinforcing three level approach to insuring the ready supply of contraceptives in the Eastern Caribbean. 1) The project will provide commodities and, through technical assistance, enhance the capacity of the public health systems to forecast requirements, procure, receive, store and distribute contraceptives (both those supplied by the project and those provided to government by other sources. 2) The project will stimulate the development and expansion of

localized commercial distribution by supporting advertising and subsidizing the price under a sound contraceptive marketing scheme in three to five islands. (3) The project will bolster the formulation of a network of community-based distributions readily accessible to the clients in an effort to bring the service to the client rather than attract the client to the service. Each of these three systems serve a different "hole" in the market, and their efforts are mutually reinforcing. Only with such a comprehensive approach, can the project expect to significantly lower the numbers of unwanted pregnancies

i. Improvement in Government Supply Systems

The availability of supplies is especially important for family planning programs because breaks in supply easily discourage clients that family planning programs have often gone to considerable lengths to recruit. More important, breaks in supply undermine the creditability of program personnel and will ultimately result in unwanted pregnancies. One of the objectives of the project is to assure the continuous availability of contraceptive commodities throughout the region.

Within the context of agreed upon "work plans" for individual countries, AID will provide many of the inputs needed to ensure continuous availability of contraceptives at all program levels. The two primary areas of assistance are the provision of supplies and technical assistance.

a) Commodity Support (\$298,000)

Over the years, governments have developed various ways to obtain family planning supplies. In some instances private FPAs, who in turn are supplied by IPPF, have provided government programs with limited supplies. Relatively recently UNFPA began supplying some of the government programs within the region. In most instances these have been the direct supply routes of contraceptives to governments.

The UNFPA is reluctantly withdrawing commodity support either at the end of 1982 or early in 1983. With UNFPA's withdrawal, many governments will be hard pressed to even sustain current levels of services while all will have difficulty in implementing new programs. The provision of AID financed commodities will ensure no interruptions of service in existing programs and will make possible the implementation of new programs and projects. Continuing UNFPA support is being sought for selected contraceptives that AID cannot supply.

Annex F contains detailed estimates of AID commodity supply requirements over the four years of the project, as well as the assumptions that were made in arriving at these estimates. Increases in prevalence of use of contraceptives will depend a great deal on the effectiveness of the other project activities. While most contraceptives present no problem, acceptance of AID supplied Noridiet and Norminest oral contraceptives by physicians, as well as current and potential users of orals will be a factor.

Acceptance of these contraceptives varies from one island to another. For example, acceptance of these brands had been low in both the private program of the Barbados Family Planning Association and the public programs of the Ministries of Health in other islands. However, in St. Vincent, clients and providers readily accept these products. The subject of brand preference and medical consequences of changing brands of orals will be intensively addressed in the medical policy seminars and the training for physicians and nurses that will both be conducted under this project. The design team believes these problems are manageable.

It is anticipated that AID's supply requirements will begin in the first quarter of FY 83. Initially, all AID commodities, for example, condoms, orals, vaginal methods, IUD's will be centrally procured and shipped to Barbados consigned to the IPPF Project Office. The Project Office and Government of Barbados will provide adequate storage space for these commodities (an air conditioned room that is 25ft X 25ft has been determined to be adequate). Based on supply reports and requisitions from the participating country programs, commodities will be trans-shipped to the individual countries on a periodic basis. The individual programs will be responsible for receiving, storing, and distributing the commodities they receive. Based on periodic reports the IPPF project office will be responsible for forecasting future contraceptive requirements.

It is the intent of the project to transfer the responsibility of inventory control and forecasting to the individual country programs. This capacity will be developed by means of technical assistance. By the end of the project the individual country programs will be forecasting, procuring, receiving, storing and distributing contraceptives.

b) Technical Assistance for System Improvement (\$53,000)

Technical assistance in contraceptive supply management will be one of the most important components of the project. Technical assistance will be provided through an S&T/POP funded RSSA with the Centers for Disease Control U.S. Public Health Services in information and records, supply management, and evaluation. In all instances emphasis will be placed on developing efficient supply systems that will keep operating costs down and assure a continuous supply of contraceptives. This will include the establishment of maximum and minimum supply levels, delivery schedules, and the development of supervisory systems.

During the first year of the project technical assistance will focus on assuring basic operational standards for existing systems and establishing systems for contraceptive supply in those countries where they do not currently exist (Antigua, Montserrat, St. Lucia). Another area to be addressed early on will be the development of a uniform supply information and inventory control system in the region. Every system must be supported by an information and inventory control system to monitor the flow of supplies.

The development of these systems is particularly critical to this project since estimates of contraceptive requirements for the region are tentative at best. The system that will be developed will be based on IPPF's supply information system a method effectively used by the FPA's in the region.

In developing a uniform supply information and inventory control system, assistance will also be provided to the programs and to the IPPF Project Office in the preparation and analyses of supply reports. These reports will be used to monitor use rates by method, evaluate the supply status at each program level, and forecast future contraceptive requirements. In addition, these reports can also be used to estimate the number of active users served by the programs and to measure the impact of other project activities on contraceptive use.

Most Ministries of Health in the region have been dependent on external donors for their family planning supplies. The accountability required by these donors have dictated that the supplies be ordered, stored and distributed through a vertical system that is separate from the regular system for medical supplies. In the long run the maintenance of these vertical systems given the small sizes of the countries and the additional manpower needed to maintain such a system, may be inefficient. Thus in those countries where vertical systems do exist, emphasis may be placed on integrating family planning supply into the Ministries' overall supply system.

ii. Commercial Retail Sales Program (\$215,000)

To achieve an increased availability of contraceptives throughout the Eastern Caribbean, a Social Marketing/Commercial Retail Sales (CRS) program will be implemented under the project with support in the first two years under the S&T/POP centrally funded social marketing project (\$170,000). The remaining two years will be funded by this project (\$45,000). (For details, see Annex E).

The CRS program will distribute oral contraceptives and condoms to commercial outlets (pharmacies, stores, rum shops, etc.) where they will be sold at a low cost. These commodities will be supported by an intensive advertizing campaign using the media and point-of-sale promotional material. The pills and condoms will be specially packaged in distinctive cartons and marketed with specific brand names. The highly successful Jamaican CRS program will be used as a model to reduce start-up and design costs. The same brand names (Panther condoms and Perle Orals) will be used; the contraceptive will be packaged in Jamaica to reduce costs and similar advertizing and educational material will be used. AID/W's experience of the Jamaican CRS program will enable the Eastern Caribbean program to be launched swiftly and at a substantially reduced cost.

The Jamaican program suggests that the CRS program will have a high success rate in attracting more participants. The educational material will be disseminated widely to men as well as women and the media educational campaign will reach a wide male audience. CRS programs raise levels of knowledge amongst men about all family planning methods, they promote a more favourable attitude towards family planning amongst men and they increase male access to

contraceptives. The clinic based distribution of contraceptives make contraceptives a female reserve - CRS activities allow men to purchase condoms at an affordable price without having to enter the female dominated clinic to obtain a subsidized product.

The CRS program will be launched in Barbados, Antigua, and St. Kitts/Nevis. In Year Three of the project the CRS program will be expanded to two other countries, probably St. Vincent and St. Lucia. The projections for the CRS market size are given in Annex F. The CRS program aims to be providing over 10,000 couple years of protection across the region by the end of the project.

#### CRS Program Management and Implementation

AID/W's International Social Marketing Project will contract directly with IPPF/WHR for CRS project management. IPPF/WHR/CRS resident staff will consist of a full-time project manager and necessary support staff at the level of a half-time secretary and maximum half-time financial analyst.

Product distribution and project advertising/promotion will be done through subcontracts with commercial agencies established in the Caribbean and familiar with the CRS approach.

The WHR/CRS project manager will be responsible for ordering commodities; preparing the annual marketing plan; selecting, contracting with, and monitoring the distribution and advertising agencies; and interfacing with the larger family planning project for the purpose of planning and conducting pharmacist training. AID/W will provide the necessary technical assistance required by the WHR/CRS project manager.

#### iii. Community-Based Distribution Program (\$167,000)

Two major factors affecting the adoption and continuation of family planning practice are accessibility and price. Furthermore, no single service delivery system can meet the varied contraceptive needs of an island's population, regardless of the relatively small numbers of people in question. Clinics serve one sector of the "market" - the highly motivated 25-44 year old women within reasonable distance to the clinic. Private physicians serve yet another market segment, the middle to upper income group generally in the urban areas. The commercial system caters to still another segment, those already motivated with some purchasing power and a nearby commercial retailer.

Community-based programs, however, offer a wide range of contraceptives to a variety of individuals not served by the other systems: the poorer working women and/or housewives as well as men who need community support and individual motivation. To reach their target, CBD programs take many forms as they reach out to bring the service to the client rather than forcing the client to come to the service point: an active outreach program from the family planning clinics; the use of youth educators within rural development programs; the effective allocation of clinical personnel to work in factories and schools; or the distribution of contraceptives through depot sites in communities such as grocery stores, pharmacies, gas stations, homes, etc.

The market served is broad: teenagers without disposable income, too inhibited to attend public health centers; rural agricultural workers for whom travel to a health center or physician or pharmacy is cumbersome and expensive and for whom a commercial product is not available in the rural village or is just beyond his/her financial means; the industrial worker for whom ready access within the work place would make family planning practice so much easier; the marginally motivated man or woman for whom the immediate offer of contraceptives provides the trigger for trial action, the first step to continued practice.

CBD programs lie in that middle ground between clinics and commercial sales. CBD provides considerable flexibility in points of distribution and in pricing. As a consequence, such programs have the potential for reaching many individuals who otherwise would not be served. Even in a situation, therefore, of both clinic and commercial programs, efforts are needed.

#### Program Description

CBD programs will be implemented in five countries: St. Lucia, St. Vincent, Dominica, Montserrat and Barbados. In all of these, family planning services are currently provided by clinics and private physicians. However, contraceptives have been successfully distributed, at least on a small scale, through outreach, commercial and industrial programs carried out by the local Family Planning Associations (FPA's). The project will build on these initial efforts. This CBD project will expand distribution points to include small grocery stores, rum shops, beauty parlors, youth clubs, selected homes, job sites and community volunteers. These distributors will be trained in the basics of contraception, client motivation, and program record keeping. Antigua and St. Kitts already have such programs.

These CBD programs will require their own communication support. It is not enough to simply provide an outlet: people need to know of them and be motivated to use them. The project will fund brand advertising and educational material in the media and at the distribution points.

Contraceptives will be sold at a subsidized price to attract the poorer market. Approximate prices will be EC\$0.50 for three condoms and EC\$1.00 for a cycle of pills. The distributors will retain part of the sales price and return the rest to the program. Incomes generated from sales will be used to offset program costs such as publicity and management salaries.

#### CBD Implementation

The CBD program will distribute orals, condoms, and foaming tablets supplied by AID and warehoused in Barbados by IPPF/WHR. IPPF will conduct negotiations in each island with the proper authorities, to obtain approval for distribution of orals without a prescription. In the absence of such approval a standardized ID card will be issued to users which will establish that they have been examined by a physician and orals are prescribed. Condoms and foaming tablets can be freely distributed without prescription on all islands.

Implementation agencies have been identified in each country as follows:-

St. Lucia	:	St. Lucia Family Planning Association
St. Vincent	:	National Family Planning Board
Dominica	:	Dominica Planned Parenthood Association
Montserrat	:	Montserrat Family Planning Association
Barbados	:	Barbados Family Planning Association

It is expected that these agencies will establish the following number of distribution points:-

	<u>Total</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
St. Lucia	80	30	30	20
St. Vincent	80	30	30	20
Dominica	80	30	30	20
Montserrat	30	15	15	-
Barbados	150	50	80	20

The distributors will attract approximately the following number of new acceptors each year: 1,200 in St. Lucia; 1,200 in St. Vincent; 1,000 in Dominica; 1,500 in Barbados and 100 in Montserrat. With careful attention to obtaining a high degree of continuation of use, it is anticipated that by the end of the project, the CBD system will have the following number of active users; 2,500 in St. Lucia and St. Vincent; 2,000 in Dominica; 2,000 in Barbados and 300 in Montserrat.

In achieving these objectives the CBD program will be delivering services to approximately 10,000 women of fertile age who would go unserved by the existing systems. Total annual costs will be approximately \$65,000 or \$6.50 per active user which is well in line with international standards and superior for smaller sized nations where economies of scale are difficult to achieve.

IPPF/WHR will first negotiate necessary approvals with local authorities, usually the Ministry of Health, then prepare detailed first-year work plan for IDO/C approval; next negotiate a sub-contract with the local implementing agency; and lastly monitor and evaluate programs. Funds have been provided for IPPF to supply up to eight person months of technical assistance to assist in implementing the CBD program.

c) IMPROVEMENT OF CLINIC SERVICES \$385,000

While the majority of contraceptive users in the Eastern Caribbean currently obtain family planning services from government run health clinics, many clinics do not provide family planning services and others are generally over-burdened due to lack of proper facilities and equipment. The training, commodity support and policy development portions of the project will create the potential for the clinic system to recruit new-users and provide them with contraceptives. Furthermore, the commercial distribution of contraceptives will increase the need for clinical referrals and for specialized services. Government health clinics will therefore be playing a much more expanded role. At present, most clinics are not even able to cope with their current workload. The increased workload anticipated by this project will over-burden clinic facilities if no improvement in facilities are made available.

To overcome these problems the project will make available grant funds to purchase appropriate, and relatively inexpensive equipment, such as examination couches, lights, sterilizers and speculums. (Additional list of equipment is found in Annex E p 14). In addition, the project will provide funds for simple renovations for existing clinics. The cost for renovations per clinic are relatively small, averaging about \$3,000 per clinic, and include partitioning to screen a private area for examination and counselling or simple repairs and renovations to existing rooms to upgrade the clinics into areas appropriate for medical examinations. Detailed work to be done on each clinic and cost estimates are included in Annex E p 13. Countries participating in the expansion of clinical services include: Antigua, Montserrat, St. Vincent, St. Lucia, Dominica and St. Kitts/Nevis. To do requested improvements governments, in most cases, will contract with local firms to do the required renovations. To monitor clinic renovations funds have been provided for IPPF to contract with a local consultant to assure that required work is done to appropriate specifications.

To further improve clinic services, funds are also made available for IPPF to provide technical assistance to governments in establishing more effective clinic utilization. This assistance will ensure that facilities are used to the maximum extent possible to provide a comprehensive, easily accessible and acceptable service to PP clients.

d) ADOLESCENT EXTENSION PROGRAM (474,000)

There is widespread concern in the region over the large number of births occurring to girls under the age of twenty. To obtain a realistic picture of the problem, RDO/C funded a major study entitled "Adolescent Fertility in the English-speaking Caribbean" (Clipson P.T., 1981). The study focuses on three major areas:- 1) describes the situation as regards adolescent fertility, (2) presents how adolescents view pregnancy and fertility, and (3) describes present population activities aimed at young people and suggests programs that will impact an adolescent fertility levels. The study's major findings and recommendations conclude that:

1. Adolescent fertility in the region is high, being in the region of 100-150 births per 1,000 teenage girls per year. Nearly one third of all births across the region are to teenage mothers.
2. Three quarters of these teenage births are to girls aged 17-19. Girls who become mothers before the age of 17 have a very high risk of having another child before they are 20. One third of teenage deliveries are of birth order two or above. Concentrating programs on the easily identifiable, high-risk group of young mothers could reduce adolescent fertility levels by one third by delaying second births until they are past their teenage years.
3. Adolescent fertility is a major factor contributing to the current high rates of population growth in the region. Teenage mothers and their infants also represent a sizeable demand on maternal and child health services, a demand added to by the specific medical problems of the very young mother. The related health issues of abortion and of sexually transmitted disease have a significant adolescent component.
4. Most teenage pregnancies are accidental. The infant is often born into the already overcrowded household of its grandmother. Very limited support is available from the child's father. Early motherhood restricts a girl's opportunities and compromises her future relationships with men, increasing the risk of further unwanted fertility.
5. There is rarely much discussion between a teenager and her boyfriend about sexual activity, about contraception or about having children. Pregnancy is frequently the unsought consequence. The boyfriend is, on average, five years older than the girl. The girl's mother typically warns her daughter through threats rather than advice. She then gets angry when the pregnancy is discovered, but the infant itself never receives any of this resentment. It is welcomed into the family.

6. Teenage contraceptive usage is low. There is wide-spread fear of the current methods available. The fears are based on misinformation spread by negative rumors. There is also a great reluctance on the part of the teenage girl to attend a clinic for family planning services. Such a visit is a public statement that she is sexually active. She expects and looks for a hostile reception from clinic staff because of her age and she is embarrassed and afraid to undergo an internal examination. There are massive psychological barriers that prevent teenagers having real access to contraception. Teenagers are also poor users of contraception and require skilled and sympathetic counselling.

7. The general family planning services do not meet the needs of adolescents. Those programs that are aimed specifically at adolescents also vary in their potential for reducing adolescent fertility. The schools are increasingly being recognized as important agents for change. Family Life Education is being introduced in different ways across the Region, but there seems to be a reluctance to concentrate this subject on information that would lower fertility. Many teenagers are sexually active within a year or two of leaving school, yet contraception is not a central theme of Family Life Education. Teachers need more training to increase their confidence in teaching a difficult topic. At present, contraception is ignored or treated on an ad hoc basis by visiting nurses. Trained teachers are potentially more useful as they represent a constantly available source of information and advice both within and outside the classroom.

8. Community programs addressing the adolescent fertility problem could substantially reduce pregnancies, particularly in reducing second pregnancies.

To specifically address the problem of adolescent pregnancies, RDO/C will provide funds to establish two programs in the Eastern Caribbean that have proven successful on a pilot basis, in extending family planning services to adolescents. These programs entail establishing clinics and outreach programs aimed specifically at adolescents:-

1. Adolescent Clinics (\$205,000)

Properly run adolescent clinics allow teenagers to learn about contraception and receive non-judgemental service from sympathetic medical personnel. The adolescent clinic setting, is usually within a youth club, and provides an effective facade so that the teenager has easy access to a confidential service. This innovative approach to increasing contraceptive use among sexually active teenagers has been successful in Jamaica. The cost of these clinics has remained reasonable, although somewhat higher than providing family planning through the regular health service.

Adolescent clinics in the Eastern Caribbean will provide an opportunity for specially trained staff to work more directly and efficiently with teenagers. A pilot project in St. Kitts has demonstrated the potential for adolescent clinics to recruit new family planning users who otherwise would not have obtained services. Access to sympathetic personnel helps reduce dropouts among teenager users by helping them manage side-effects and providing them with constant encouragement to continue to use contraception. This encouragement and support is a vital element in starting and maintaining contraceptive use among the sexually active adolescents.

Funds are provided for the establishment of up to eight adolescent clinics. The number of clinics to be included in this project is based on indepth discussions with officials in Dominica, St. Kitts, St. Lucia and Barbados who have given firm support to this concept. Each clinic will provide family planning and other health services to young people. In Jamaica, where youth clinics have proven successful, figures indicate that approximately 50 teenagers per week, will utilize a single clinic. Family planning services to this traditionally hard-to-reach group will be made more available by locating the clinics in youth clubs or youth centers. Teenagers attending the center for recreational purposes will have access to clinical services at the same time, within the same building. Not all clients will actively register as FP acceptors. Some young people will benefit from the information gained and become recruits to non-clinic FP programs such as a CRS or a CDB program. Others will attend pre clinic for non FP purposes. However, each clinic will expect to be serving over 1,000 teenage FP uses by the end of the project.

The clinics will be staffed by two nurses with training in counselling and family planning education. The clinics will operate a flexible schedule to coincide with the main activities in the building in which it is housed.

Each youth clinic will provide:-

- a) clinical services in Family planning for males and females. The clinic will also perform pregnancy testing;
- b) contraceptives;
- c) counselling in contraceptive use on a one-to-one basis or to couples;
- d) other clinical services such as counselling on sexually transmitted diseases;
- e) referral to regular sessions at the clinics by an obstetrician/gynecologist;
- f) an informal information and education program.

Group discussions will be run by the nurses for the dissemination of family planning information. These discussions will be supplemented by the use of audio visual equipment. The small waiting room/meeting area will also be used to display information and educational materials including films, posters, and literature.

Young people will be encouraged to participate in group activities whether or not they are seeking one-to-one counselling or service delivery. The clinics will thus increase family planning knowledge among the whole youth center clientele, in addition to providing counselling and service delivery to individuals and couples.

It is anticipated that each youth clinic will serve between 2,000 and 3,000 sexually active young people. Most of these would not have been recruited by the regular family planning services. In addition to new family planning users the clinics will also raise the levels of knowledge and promote additional changes through its information and education programs. The benefits of these activities will be indirect but powerful. Knowledge will diffuse to a far larger audience than the immediate participants. Teenage usage of other distribution systems will be increased, particularly CDB programs are prevailing negative attitudes towards contraception among teenagers eroded.

The project will fund the equipment costs of each clinic, provide medical supplies and educational materials. In addition, grant funds will pay salary costs for nurses during the first year of each clinic. Additional funds will be available for salaries, on a decreasing basis for AID and increasing government contribution over a four year period.

Funds are also provided for technical assistance in establishing each clinic program, arranging its administration, organizing services and monitoring progress.

ii. Youth Outreach (\$269,000)

Experience in Jamaica and Antigua has shown that youth outreach programs, targeted at specific, high fertility sub-groups within the teenage population are a highly cost-effective mechanism for reducing fertility. This project provides funds to establish up to 10 similar programs in other islands. These programs will

focus on the teenage mother and the post-school age, unemployed teenager. Officials in Barbados, St. Lucia, St. Vincent, St. Kitts, Dominica and Montserrat have given firm support for establishing outreach programs.

Social and economic pressures force many young teenage mothers to have a second unwanted child within eighteen months of arrival of their first born. Youth outreach workers working in conjunction with the maternal and child health services, will provide intensive counselling, monitoring and service delivery to this easily identified group to delay second pregnancies.

In addition, each youth outreach program will provide intensive services and monitoring to all teenage mothers for two years after the delivery of their first child. It is anticipated that a total of 3,000 girls per year will come into the program.

The second element of the youth outreach activities will reach its audience via an information and education program. These group activities will thus increase the knowledge, break-down resistance and enhance the usage of adolescent clinics, CBD programs and other contraceptive distribution systems by young males and females. Additionally, these youth outreach programs will directly increase teenage contraceptive prevalence through their distribution activities.

Each youth outreach project will employ two family planning nurses, trained in the delivery of services to adolescents. They will operate an integrated program to reach the two identified target groups of teenage mothers and out-of-school, unemployed teenagers.

Selecting specific communities (areas covered by one health clinic) and working as a team, the nurses will make weekly visits, on a pre-arranged day over a period of two months. They will perform a range of functions, including:

- 1) Holding group discussions with young people about family planning. These discussions will be preceded by a film about family planning or related issues. A film serves several purposes. It attracts the audience to the meeting; it provides a focus for the discussion and it educates the young people. The meetings will be held in the evenings in an appropriate building, school, community center or hall. The meetings will be announced by radio and posters before hand. This system of informal education has been shown to be more successful than formal lecturing when it comes to educating out-of-school youths about family planning.

- 2) Assist the district nurse at the local health clinics in the delivery of family planning services by counselling on a one-to-one basis all teenagers attending antenatal, post-natal or infant clinics. The regular nurse rarely has the time for this and potential contraceptors are thus not recruited.

3) Visit selected teenage mothers in the community who are not registered as family planning users and not attending the clinics. These individuals will be identified by the district nurse.

4) Upon request distribute contraceptives directly to the young people that receive counselling.

The outreach team will visit each community every week for two months and repeat the program after a six month hiatus. The schedule (two months in the community, six months away) enables the team to contact all pregnant teenagers using the clinic and to follow-up fairly soon after a baby is born.

Visiting five communities a week in four two-month blocks allows the team to cover 20 communities under the program. The schedule will vary according to distribution of clinics on each island.

Project components consist of providing suitable vehicle support for each team, in addition to equipment and supplies. AID grant funds will pay salaries and operational costs of vehicles on a declining basis with increasing government contributions during the implementation of each program. Technical assistance will be provided for the actual design, implementation and monitoring of each program.

e) PROGRAM SUPPORT \$470,000

i. Technical Assistance (\$102,000): The range of activities to be supported under the project will demand a tremendous diversity of professional skills for their successful execution. In addition to the technical assistance to be provided to successfully implement certain elements of the service delivery component (CBD, CRS, and Youth Extension) the provision has been made to supply up to 17 person months of assistance to IPPF to meet demands that will inevitably arise once implementation has begun. Technical assistance will be coordinated by the IPPF project manager and will be based on identified need, government requests, and problems encountered in actual implementation. Funding this mechanism will provide the project with the maximum flexibility in implementing a broad scope of activities.

ii. Two Technicians (\$73,000)

Two one-year contracts for full time technical staff will be funded under this project. These individuals will be responsible for the design and start-up phases of project activities. These technical staff will not be required for the full life of the project. They will be based in the Barbados project office. Funds are reserved for their salaries, benefits, travel, and per diem costs. The administrative and support costs per the two technicians are included under the Barbados project office costs.

iii. Contraceptive Prevalence Surveys (\$215,000)

Adequate baseline data in which to measure progress exist for most countries participating in the project. However, provision is made to conduct two contraceptive prevalence surveys (CPS) in order to establish adequate baseline data for St. Kitts and Montserrat. These will be similar to the five already completed. CPS will be undertaken in all participating islands in year four to measure increases in the use of contraceptives.

iv. Male Attitude Survey (\$30,000)

This project will fund a small-scale research project into male attitudes towards fertility and family planning and levels of male knowledge and use of contraceptives. The research will be carried out in the early months of the project. The results will be used to guide the detailed design and implementation of other project activities as they relate to men. In particular the survey will indicate appropriate subjects for educational and promotional materials to be disseminated by the Commercial Retail Sales Program, the Community based distribution programs and the adolescent extension activities. The research findings will also be of general use to planners and those involved in the delivery of family planning services.

The project will fund one social scientist to work in up to three of the project countries for four months. The research will be questionnaire based involving a cross section of the Caribbean male population. The social scientist will prepare a detailed report of his findings. Funds are also available for the distribution of these findings to all interested parties in the region. The project will fund travel, per diem and salary costs of the social scientist and meet incidental research expenses.

v. Evaluation & Audit (\$50,000)

Funds are reserved for adequate evaluation of project components. A more detailed description of evaluation activity is given in the Evaluation Section of the Project Paper. The provision is made for periodic audit of project funds.

f) ADMINISTRATION (\$787,000)

\$357,000 of project funds will be reserved to enable IPPF/WHR to provide home office support for the effective administration of the project. This includes salary of a quarter-time program assistant in addition to travel director and per diem, overheads on salaries, and benefits of home office staff and overheads on technical assistance salaries.

The project director will have overall responsibility for the project. He will supervise the overall progress of the project and be available to the Barbados Project officer to assist in problem-solving and major decision making. He will travel to Barbados at least six times yearly. The project director will be IPPF's Caribbean Program officer. He will work one quarter time on this project.

The program assistant in New York will backstop the Barbados Office in the areas of procurement, technical assistance, consultant recruitment, and contraceptive supplies, and be the main administrative link between IPPF/WHR out of the Barbados Office.

To effectively implement the broad range of project activities AID will fully fund the costs of an IPPF Caribbean Office to be maintained in Barbados over the life of the project. A total of \$430,000 is provided to fund the salaries of a full time project manager, a Caribbean representative (quarter time), a financial advisor (half time), administrative and clerical staff, operating expenses and travel and per diem.

The Barbados Office staff will perform the following duties:-

i. Project Officer

This key individual will be in charge of the project office in Barbados. He will administer the various sub-contracts required by the project; he will organize the contraceptive supply system to each country; he will be responsible for orientation and liaison with short-term technical assistance personnel and he will be responsible for monitoring project activities and ensuring their smooth operation.

ii. Caribbean Representative

This individual will be a family planning technician familiar with existing Caribbean family planning delivery systems who will be funded under the project on a quarter-time basis. He will be a resource person available to the project officer to design and monitor project activities and travel to each island as needed. He will also be a key figure in coordinating new project activities and travel to each island as needed. He will also be a key figure in coordinating new project activities with ongoing government and FPA activities.

iii. Financial Advisor

This individual will be responsible for monitoring the budgets for each activity under the project, including the project office costs. He will be responsible to the project officer. He will work on a half-time basis. He will supervise the administrative assistant/book-keeper to ensure accurate records of expenses are maintained. He will be able to seek assistance from financial staff at IPPF/WHR. An experienced Barbados-based accountant will be required to fill this position.

**SUMMARY AID BUDGET FOR IMPROVEMENT  
IN SERVICE DELIVERY ACTIVITIES  
(THOUSAND U.S. DOLLARS)**

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	<u>TOTAL</u>	<u>RDO/C</u>	<u>AID/W</u>
Training	294	227	67
Commodity Supply & Distribution	811	591	220
Improvement of Clinical Services	385	385	
Adolescent Extension	639	639	
Program Support	335	335	
Administration	640	640	
Inflation & Contingency	496	496	
	<u>3,600</u>	<u>3,313</u>	<u>286</u>

V. PROJECT ANALYSES

A. Financial Analysis

1. Summary of Cost Estimates

The total cost of the Caribbean Population and Development Project is \$4,849,000. AID will contribute \$3,965,000 in grant funds, of which RDO/C will provide \$3,500,000 and AID/Washington \$465,000. The participating countries and CARICOM will contribute at least \$884,000. Detailed budget estimates can be found in Annex E. Inflation is calculated in these figures at 10% compounded per year after the first year.

BUDGET SUMMARY

(Thousand U.S. Dollars)

	<u>TOTAL AID</u>	<u>RDO/C</u>	<u>AID/W</u>	<u>COUNTER- PART</u>	<u>TOTAL</u>
Policy	729	600	129	140	869
Improvement in Service Delivery	<u>3,236</u>	<u>2,900</u>	<u>336</u>	<u>744</u>	<u>3,980</u>
<b>TOTAL</b>	<b><u>3,965</u></b>	<b><u>3,500</u></b>	<b><u>465</u></b>	<b><u>884</u></b>	<b><u>4,849</u></b>

a) Policy

The total cost of the activities under the policy component of the project amount to \$869,000. AID will provide \$729,000 in grant funds as follows:

i. Demographic Policy (\$375,000) RDO/C will contribute a total of \$250,000 for programs funded under this activity of the project. Grant funds provided by RDO/C will finance the cost of travel, maintenance and consultants for meetings of the National Population Task Forces as well as the Regional Population Awareness Seminar. In addition the project will fund development and printing costs of the Country Population Reports. RDO/C will fund the cost of salaries, travel and per diem for the U.S. Bureau of the Census to run the demographic training workshops in addition to all travel and support costs for participants.

AID/Washington has agreed to provide a total of \$123,000. AID/Washington, through a centrally funded contract with the Futures Group will provide \$123,000 to present two country RAPID presentations and supply one Apple II computer, along with software. In addition to providing funds for computer-time to analyze the data for the Country Population Reports as well as funding the salary of a consultant for the Regional Population Awareness Seminar.

ii. Medical Policy (\$70,000). RDO/C will provide funds to finance travel and support costs, consultants and training costs for all activities under the Medical Policy component of the project.

iii. Program Support (\$144,000). RDO/C will provide \$140,000 for program support. This includes funding \$90,000 for specific technical assistance requirements identified by CARICOM to implement the project. RDO/C will also fund the costs of two independent evaluators, as well as semi-annual audits. Finally, a small sum has been budgeted to assist CARICOM in promotional activities.

AID/W will provide \$4,000 for the short-term technical assistance requirements of CAIRCOM.

iv. Administration (\$140,000). RDO/C will fund the full salary of a CARICOM project administrator and up to \$33,000 for CARICOM administrative staff associated with the project. RDO/C will fund all project related operating expenses and travel.

CARICOM and participating countries will contribute at least \$140,000 to implement activities under the project.

CARICOM (\$90,000). CARICOM will fund the salary of a project manager assigned to quarter time to the project. CARICOM will also provide all funds needed for administrative staff, in addition to those provided by AID. Finally, CARICOM will provide all support staff-legal, financial, technical - to carry out project activities.

Participating Countries (\$50,000). Countries benefitting from this project will pay salaries of all participants to seminars and training programs, as well as, in-kind costs associated with national seminars.

b) Improvement In Service Delivery

The total cost of activities to improve the delivery of family planning services amount to \$3,980,000 of which AID will provide up to \$3,236,000. \$2,900,000 being through RDO/C and \$336,000 via AID/W.

1. Training (\$348,000). RDO/C will provide \$344,000 in grant funds for training activities under the project. This includes all travel and support, and training costs for the seminars in family planning techniques for physicians. In addition to all nurses training RDO/C will also provide up to \$35,000 to fund family life education activities. AID/W will fund training for family planning administrators, pharmacists, and allied health workers under a central contract for training.

AID/Washington will provide up to \$40,000 for physicians training in voluntary sterilization under a central JHPIEGO contract, as well as \$33,000 for activities under family life education.

ii. Commodity Supply and Distribution (\$732,000). RDO/C will provide \$510,000 to improve the supply and effective distribution of contraceptives under the project as follows:

(1) Commodities - A total of \$298,000 has been budgeted for providing contraceptives to participating countries over the life of the project.

(2) Community-Based Distribution Program - A total of \$167,000 has been budgeted to implement CBD programs in five countries. Under the CBD program grant funds have been provided for the purchase of five vehicles (\$50,000); in addition to financing the operation and maintenance of these vehicles on a declining basis over the life of the project (\$42,000); promotional material (\$17,500); and training costs (\$7,500). Finally, (\$50,000) has been allocated for up to 12 person-months of short-term technical assistance to assist countries in the implementation of CBD programs.

(3) Commercial Retail Sales Program (CRS) - Up to \$45,000 will be provided to finance calculated deficits of the CRS over the life of the project.

AID/Washington will provide \$220,000 under the Commodity Supply and Distribution component as follows:

(1) System Improvement - A total of \$52,000 has been budgeted to provide technical assistance through the Center for Disease Control, to assist countries in improving their overall supply systems.

(2) Commercial Retail Sales - Up to \$170,000 has been budgeted for funding the major portion of the calculated deficit for the CRS program.

iii. Improvement of Clinical Services (425,000) RDO/C will fund the full cost of providing suitable equipment for family planning clinics (\$115,000). RDO/C will also provide funds for basic renovations of existing clinics to make them suitable for family planning purposes (\$298,000). Five percent of the total cost of renovations (\$15,000) has been added to allow for the cost of monitoring island specific renovations. Funds for up to two person-months of technical assistance have been provided to assist islands in establishing effective clinical systems for family planning programs (\$13,000). A detailed list of equipment and the country allocations, found in Annex E.

iv. Adolescent Extension (474,000)

(1) Clinic Program - A total of \$205,000 has been budgeted to carry out seven adolescent clinic activities

in six countries. Grant funds will provide for the purchase of clinic equipment, furniture and expendable supplies and promotional material (\$55,000). Grant funds are also provided for basic clinic program for the first year, in addition to fifty percent of salary costs the second year (\$100,000). Finally, up to 12 person months of technical assistance will be provided to assist in the design, implementation and evaluation of the clinic program (\$50,000).

(2) Youth Outreach - RDO/C will provide \$269,000 for up to eight programs. Funds will be provided for the purchase of up to 8 vehicles (\$80,000); in addition to the full cost of vehicle operation for the first year and 50 percent of operations the second year (\$25,000); and necessary equipment (\$20,000). Funds are also provided to finance the full salaries of nurses attached to the program for the first year of the program and fifty percent the second year (\$86,000). Finally, technical assistance will be provided to assist countries in the design and evaluation of the program (\$58,000).

v. Program Support (\$470,000). Grant funds will be provided for up to seventeen months of short-term technical assistance (\$102,000) in addition to carrying out seven contraceptive prevalence surveys (\$215,000), and a male attitude study (\$30,000). The project provides for two independent evaluations during the life of the project (\$25,000) as well as semi-annual audits (\$25,000). Two technicians to assist in project design and implementation will be hired each for one year and based in the Barbados project office (\$73,000).

vi. Administration (\$787,000). IPPF home office support is calculated at \$357,000. This includes salaries and benefits of a quarter-time project advisor and a quarter-time program advisor; \$45,000 of travel and per diem of home office project staff, and \$201,000 for overhead at 78.5% of home office and technical assistance salaries.

Grant funds totalling \$291,000 will provide for the salaries and benefits of a quarter-time Caribbean Representative, in addition to a full-time project officer and financial advisor in addition to administrative and clerical staff. A total of \$139,000 has been budgetted for the operations of the Caribbean office.

Participating countries will contribute at least \$774,000 to the service delivery activities. This includes \$54,000 for the in-kind contributions, for salaries for participants in training programs and for expenses associated with island specific training programs. The five countries participating in the CBD program will contribute a total of \$300,000 for the salaries of managers and promoters and the operation and maintenance of project vehicles. Countries participating in the adolescent extension programs will contribute a total of \$390,000 for salaries of nurses, and the operation and maintenance of vehicles, clinics programs and the ongoing maintenance of clinic and youth facilities.

TABLE I  
POPULATION AND DEVELOPMENT  
COSTING OF PROJECT INPUTS  
(U.S. Thousands Dollars)

	<u>TOTAL AID</u>	<u>RDO/C</u>	<u>AID/W</u>
<u>POLICY - AID</u>			
I. <u>Demographic Policy</u>	<u>375</u>	<u>250</u>	<u>125</u>
National Population Task Force	53	53	-
Country Population Reports	61	60	1
Regional Awareness Seminars	38	37	1
RAPID Presentations	123	-	123
Demographic Training	100	100	-
II. <u>Medical Policy</u>	<u>70</u>	<u>70</u>	-
Steering Committee Meetings	3	3	-
Regional Seminars	21	21	-
National Seminars	36	36	-
Observational Training	10	10	-
III. <u>Program Support</u>	<u>144</u>	<u>140</u>	<u>4</u>
Technical Assistance	94	90	4
Promotional Assistance	10	10	-
Evaluation	30	30	-
Audit	10	10	-
IV. <u>Administration</u>	<u>140</u>	<u>140</u>	-
Project Administrator	52	52	-
Administrative Staff	33	33	-
Operating Expenses	27	27	-
Travel	28	28	-
<b>TOTAL AID POLICY</b>	<b><u>729</u></b>	<b><u>600</u></b>	<b><u>129</u></b>

IMPROVEMENT OF SERVICE DELIVERY - AID

	<u>TOTAL AID</u>	<u>RDO/C</u>	<u>AID/W</u>
<b>I. <u>TRAINING</u></b>	<u>348</u>	<u>234</u>	<u>114</u>
a. <u>Physicians</u>	<u>99</u>	<u>59</u>	<u>40</u>
1. On-site training in Family Planning Techniques	59	59	-
2. JHIEPGO	40	-	40
b. <u>Nurses</u>	<u>140</u>	<u>140</u>	-
1. Advanced Courses in Fertility UWI	50	50	-
2. On-site Training	49	49	-
3. Training of Trainers	41	41	-
c. <u>Support Personnel</u>	<u>41</u>	-	<u>41</u>
1. Allied Health Workers	22	-	22
2. Family Planning Administrators	19	-	19
d. <u>Family Life Education</u>	<u>68</u>	<u>35</u>	<u>33</u>
<b>II. <u>COMMODITY SUPPLY AND DISTRIBUTION</u></b>	<u>732</u>	<u>510</u>	<u>222</u>
a. <u>System Improvement</u>	<u>52</u>	-	<u>52</u>
b. <u>Supply and Distribution Systems</u>	<u>680</u>	<u>510</u>	<u>170</u>
1. Commodities	298	298	-
2. Community Based Distribution Programs	167	167	-
3. Commercial Retail-Sales Programs	215	45	170
<b>III. <u>IMPROVEMENT OF CLINICAL SERVICES</u></b>	<u>425</u>	<u>425</u>	-
1. Equipment	115	115	-
2. Clinic Renovations	298	298	-
3. Service Improvement	12	12	-
<b>IV. <u>ADOLESCENT EXTENSION</u></b>	<u>474</u>	<u>474</u>	-
1. Clinics	205	205	-
2. Outreach Programs	269	269	-
<b>V. <u>PROGRAM SUPPORT</u></b>	<u>470</u>	<u>470</u>	-
1. Technical Assistance	102	102	-
2. Two technicians person-years (salary benefits, travel, per diem)	73	73	-
3. Contraceptive Prevalence Surveys	215	215	-
4. Male Attitude Study	30	30	-
5. Evaluation	25	25	-
6. Audit	25	25	-

	<u>TOTAL AID</u>	<u>RDO/C</u>	<u>AID/W</u>
VI. <u>PROJECT IMPLEMENTATION</u>	<u>787</u>	<u>787</u>	-
a. <u>Home Office Support</u>	357	357	-
1. Project Director (25%)	53	53	-
2. Program Assistant (25%)	26	26	-
3. Benefits (40% of salaries)	32	32	-
4. Overheads (78.5% of salaries & benefits)	87	87	-
5. Technical Assistance Overhead	114	114	-
6. Travel/Per Diem	45	45	-
b. <u>Caribbean Office</u>	<u>430</u>	<u>430</u>	-
1. <u>Personnel</u>	<u>291</u>	<u>291</u>	-
Project Officer	121	121	-
Project Representative (25%)	30	30	-
Financial Advisor (50%)	26	26	-
Administrative Assistant/Book-keeper	44	44	-
Secretary	35	35	-
Benefits (13% of salaries)	35	35	-
2. <u>Operations</u>	<u>139</u>	<u>139</u>	-
Office space	37	37	-
Equipment	15	15	-
Supplies	13	13	-
Operating Expenses	16	16	-
Other Costs	12	12	-
Travel/Per Diem	46	46	-
Total Improvement of Service Delivery	<u>3,236</u>	<u>2,900</u>	<u>336</u>

2. Expenditure and Obligations Schedule

Expenditures for the project have been calculated as follows:

(Thousand U.S. Dollars)

	<u>Yr.1</u>	<u>Yr.2</u>	<u>Yr.3</u>	<u>Yr.4</u>	<u>Total</u>
Policy	243	337	149		729
Improvement of Service					
Delivery	1,200	893	499	644	3,236
	<u>1,443</u>	<u>1,230</u>	<u>648</u>	<u>644</u>	<u>3,965</u>

This schedule of expenditures suggests the following obligation of:

	<u>FY82</u>	<u>FY83</u>	<u>FY84</u>	<u>FY85</u>	<u>Total</u>
RDO/C	500	1,800	1,000	200	3,500
AID/Washington	100	365	-	-	465
	<u>600</u>	<u>2,165</u>	<u>1,000</u>	<u>200</u>	<u>3,965</u>

### 3. Actual and Recurring Costs to Participating Countries

#### 1. Actual Costs

Because of the difficult economic situation being experienced by many countries of the Eastern Caribbean, consideration has been given in the design of the project to minimizing any additional burden to, in some cases, already over-strained national budgets.

The total commitment required of participating countries during the life of the project is expected to amount to \$794,000, approximately sixteen percent of the total cost of the project. Approximately \$105,000 of this amount is estimated to be in the form of in-kind contributions for salaries of participants and country expenses associated with on-site training programs. The average in-kind expense for each island is approximately \$13,000 over the life of the project.

Governments and organizations participating in the Community-Based Distribution Program and the Adolescent Extension Activities will be expected to contribute approximately \$690,000 for an increasing share of the costs of salaries and the operation and maintenance of vehicles. In addition to maintenance costs of clinics and youth facilities, the costs associated with the CBD to be borne by the respective counterparts in the program amount to approximately \$60,000 per island over the life of the project. Similarly, average cost associated with Adolescent Extension Activities amount to approximately \$49,000 per island. Since RDO/C will assume seventy-five percent of these costs during the first two years of the project, the bulk of the commitments needs not be realized until year three and four of the project.

#### 2. Recurring Costs

Since most of the activities to be financed under the project will serve to augment an awareness of the consequences of population growth in the Eastern Caribbean, in addition to upgrading the capabilities of existing staff and facilities, no recurring costs to the island states are anticipated after the life of the project. The CBD program and the Adolescent Extension Activities will have real costs associated with the future implementation of these programs. Depending upon how successful the CBD programs are in generating revenue the recurring costs to the implementing agencies should be minimal. Governments will however have to pay the full costs of Adolescent Extension Activities if they wish to continue supporting them. An estimate of average island specific variable costs for each program is detailed in the following summary:-

<u>POLICY - COUNTERPART</u>	<u>TOTAL COUNTERPART</u>	<u>CARICOM</u>	<u>COUNTRIES</u>
<b>I. <u>Demographic Policy</u></b>	<u>27</u>	-	<u>27</u>
National Population Task Force	3	-	3
Regional Awareness Seminars	4	-	4
Demographic Training	20	-	20
<b>II. <u>Medical Policy</u></b>	<u>23</u>	-	<u>23</u>
Regional Seminar	1	-	1
National Seminars	20	-	20
Observational Training	2	-	2
<b>III. <u>Administration</u></b>	<u>90</u>	<u>90</u>	-
Project Manager	30	30	-
Administrative Staff	12	12	-
Office Space	20	20	-
Operational Support	18	18	-
<b>TOTAL - Counterpart Policy</b>	<u>140</u>	<u>90</u>	<u>50</u>

<u>IMPROVEMENT OF SERVICE DELIVERY - COUNTERPART</u>	<u>Countries</u>
I. <u>Training</u>	<u>54</u>
a. <u>Physicians</u>	<u>20</u>
1. Seminars on Family Planning Techniques	18
2. JHIEPCO	2
b. <u>Nurses</u>	<u>16</u>
1. Advances/Course in Fertility	1
2. On-site Training	15
c. <u>Support Personnel</u>	<u>9</u>
d. <u>Family Life Education</u>	<u>9</u>
II. <u>Commodity Supply and Distribution</u>	<u>300</u>
1. Community Based Distribution Program	300
III. <u>Adolescent Extension Activities</u>	<u>390</u>
1. Clinics	126
2. Youth Outreach	264
<b>TOTAL - Counterpart-Improvement of Service Delivery</b>	<b>744</b>
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TABLE II  
POPULATION AND DEVELOPMENT  
SCHEDULE OF AID EXPENDITURES:  
POLICY  
(U.S. Thousand Dollars)

	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>TOTAL</u>
I. Demographic Policy	145	174	56	375
II. Medical Policy	18	52	-	70
III. Program Support	72	58	54	144
IV. Administration	48	53	39	140
<b>TOTAL</b>	<b>243</b>	<b>337</b>	<b>149</b>	<b>729</b>
	<hr/>	<hr/>	<hr/>	<hr/>

TABLE III  
POPULATION AND DEVELOPMENT  
SCHEDULE OF AID EXPENDITURES:  
IMPROVEMENT OF SERVICE DELIVERY  
(U.S. Thousand Dollars)

	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>YEAR 4</u>	<u>TOTAL</u>
I. Training	101	122	73	52	348
II. Commodity Supply and Distribution	250	205	149	128	732
III. Improvement of Clinical Services	200	225	-	-	425
IV. Adolescent Extension Activities	329	90	30	25	474
V. Program Support	138	68	45	216	467
VI. Administration	182	183	202	223	790
<b>TOTAL</b>	<b>1,200</b>	<b>893</b>	<b>499</b>	<b>644</b>	<b>3,236</b>
	<u>          </u>				



ESTIMATED ANNUAL VARIABLE COST  
PER ISLAND OF PROJECT ACTIVITIES

	ACTUAL COST 1982			ESTIMATED COSTS 1986*			ESTIMATED ANNUAL VARIABLE COSTS		
	CBD	ADOLESCENT CLINICS	ADOLESCENT OUT-REACH	CBD	ADOLESCENT CLINICS	ADOLESCENT OUT-REACH	CBD	ADOLESCENT CLINICS	ADOLESCENT OUT-REACH
Salaries	11.0	4.8	7.0	76.1	7.0	10.2	16.1	7.0	10.2
Promotion	1.8	2.4	-	2.6	3.5	-	2.6	3.5	-
Training	0.5	-	-	0.7	-	-	-	-	-
Vehicles	10.0	-	10.0	14.6	-	14.6	-	-	-
Vehicle Operation/ Maintenance	2.0	-	2.0	2.9	-	2.9	2.9	-	2.9
Equipment	-	6.4	2.5	-	9.4	3.7	-	-	-
Supplies	-	0.5	-	-	0.7	-	-	0.7	-
Facility Alterations	-	1.5	-	-	2.2	-	-	-	-
Facility Maintenance	-	0.3	-	-	0.4	-	-	0.4	-
<b>TOTAL</b>	<b>25.3</b>	<b>15.9</b>	<b>21.5</b>	<b>36.9</b>	<b>23.2</b>	<b>31.4</b>	<b>21.6</b>	<b>11.6</b>	<b>13.1</b>

\* 10% Compounded for four years.

## B. Economic Analysis

### 1. Population Resources and Fertility Reduction in the Eastern Caribbean - Macro-Analysis

The Caribbean, plagued by high unemployment is one of the most densely populated regions of the world. If present standards of living are to be maintained in each state, a certain minimum requirement of food, clothing, housing, health-care and other social services must be provided on a per capita basis. However, if birth rates are allowed to remain at current levels, additional strain would be placed on the Region's already scarce economic resources. Therefore to the extent that the current rate of growth of the population can be lowered substantial resources could be released to be channelled into developmental projects which would improve overall living standards in the long-run. On the other hand, each new member of society is a potential producer of national output. Whether or not the member contributes to national output depends on his eventual employment status. However, given the current high regional unemployment rates, the possibility that one out of every four additional births could eventually be either unemployed or underemployed is very real. This means that in order to maintain current living standards the three individuals who obtain employment would together be required to produce at least enough output to sustain four persons.

Curbing population growth would help eliminate unemployment. In general, the problem of unemployment is very critical in the Caribbean and is exacerbated by small size, large populations, and generally agro-based economies with very limited absorptive capacities. More recent figures estimate unemployment rates ranging from below 10 percent in Belize and Montserrat to 23 percent in Dominica.

Reducing births would permit a reduction of consumption. Traditionally Eastern Caribbean states have been guilty of over-consumption, especially their governments. In 1980 total consumption ranged from 80 percent of GDP in Barbados to 147 percent in St. Vincent. Spending by governments, an important component of the consumption, has been excessive. Government expenditures as a proportion of GDP range from 31 percent in St. Vincent to 59 percent in Dominica. Apart from high expenditures on wages and salaries, significant portions of these government expenditures provide social and welfare services for the respective populations. Using data for fiscal year 1977/78 -- the latest period for which data are available for all states, the provision of social services, including education, health, housing, welfare, etc., accounted for between 18 percent of the national budget in St. Kitts/Nevis to 48 percent in both Barbados and St. Vincent. For instance in St. Lucia whose population growth rate is among the highest in the East Caribbean, public sector expenditure on social services were as follows: education and health 38 percent of the national budget; housing, community development and social services 6 percent; and labor, communications and works 17 percent.

The magnitude of the social and economic demands of the population problem in the Eastern Caribbean can be seen using the illustrative example of St. Vincent, whose estimated 18 percent unemployment rate already is alarmingly high. If we assume the fertility rate remains at the level reached in 1980, the number of children aged 5 - 14, the majority of whom attend school, will increase from 30,655 in 1980 to 37,496 in 2000 - an increase of 22 percent; an additional 21,222 jobs will be required to provide employment for a labor force of 108,747; housing and essential services will be required for an additional 60,000 people; and the number of societal dependents\* will grow from 73,583 in 1980 and 100,211 in 2000. Based on these estimates, which assumes a continuation of the fertility level of 2.9 reached in 1980, an investment of \$11.7 million to construct and equip schools will be required.

Should the fertility rate in St. Vincent fall gradually nearing a replacement level of 2.1 by 2000--assuming this project is successfully implemented--then social and economic demands will be reduced. With only 33,557 children aged 5 - 14 in the year 2000 rather than 37,496 at the higher fertility rate, \$2.8 million in primary school construction and equipment alone could be saved. With a total population of only 164,841 rather than 173,046 in the year 2000, 2,050 fewer housing units will be needed. A reduction to 56,882 societal dependents rather than 100,211 in the year 2000 will result in savings available for investment in other sectors. Finally, the decline in dependents suggests that increases in per capita income should be in evidence by the turn of the century.

## 2. Micro Analysis

Under the project, benefits are the equivalent to the net stream of consumption (i.e. the stream of future consumption less the stream of future production) available as a result of the averted of an additional birth, as well as the favorable impact on worker productivity arising from sharing the same economic "pie" with less people, while the costs of an averted birth include actual project costs of USAID and the recipient country as well as a valuation of time spent by receptors who use the contraceptive services (see Annex I for methodology). Therefore, if the benefits to be accrued from the averted of a birth are greater than the costs incurred in its averted, the project is considered economically viable.

The net present value of the benefits from averting a birth range from \$2,541 in St. Vincent to \$5,364 in Barbados. On the other hand, for the project as whole, the net present value of the costs of averting a birth is \$43. According to these data, the project is economically viable. In calculating costs per birth averted, we include all project costs, i.e. administrative costs and procurement costs with the exception of the opportunity cost of the time spent by users of the contraceptive services. However, we would expect the opportunity cost to be negligible since the users would be predominantly drawn from the ranks of the unemployed.

\*Dependents are defined as those members of the population under 15 years old, those 65

### 3. Analysis of Project Cost Effectiveness

The efficacy of a population project as a development strategy has been discussed above: support for population activities is an economically sound and feasible use of development resources. Attention must now be given to the details of this particular population project. Each of the many activities to be supported under this project has been designed with least cost criteria closely in mind. This section of the economic analysis examines the costs of each activity in relation to its expected contribution to the major project objectives, namely the reduction in population growth rates. To some extent this is an artificial exercise as emphasis has been placed throughout on the synergistic nature of the project activities; in isolation the single activity may have minimal fertility - reducing impact, in the context of other project activities its impact become significant.

This inter-active and mutually reinforcing aspect of the project is particularly apparent when assessing the policy section of the project.

The policy activities on their own will reach a narrow audience and will not avert a single birth. The effect of the policy changes that will accrue from these activities is potentially massive. The recognition of family planning as an essential development tool by leaders and planners in all sectors will have a fertility reducing effect, long after the life of this project. The increased access to family planning services arising from the medical policy changes generated by this project will lend substantial support to the service delivery activities supported by this project, which in turn will lead to fertility reduction through the elimination of unwanted pregnancies. The resources to be spent on demographic and medical policy development will have a profound effect on population growth rates over the next decade. Although the births averted, couple-years of contraceptive protection or other numerical indicators used in evaluation, will be attributed to a specific service delivery activity, the policy development will have made the fertility reduction possible. Thus expenditure on policy cannot be narrowly assessed; these activities will have long lasting effects on population growth rates in the Region; even though their fertility reducing impact remains unquantifiable.

The service delivery activities lend themselves more readily to quantitative assessment. Each of the activities will be taken in turn.

#### 1. Training

##### A. Physicians

Training in voluntary surgical contraceptive techniques for eight doctors will cost approximately \$4,000 per doctor. Assuming each doctor performs an average of 300 sterilizations during the project life and representing 15 years of protection, then each couple year of protection is costing less than a dollar to achieve. This unit cost will be reduced still further, as the trained physician continues to perform sterilization after the end of the project.

The on-site training of 70 physicians for one week with refresher seminars to follow, is a highly cost-effective training exercise. At a minimal cost of \$750 per participant, the direct and indirect family planning gains are large, medical teams supervised by physicians will all benefit from the training; the network of FP services will be widened and contraceptives become more accessible.

#### B. Nurses

These are the key FP workers within the Maternal and Child Health Services. This project will train 300 nurses in FP and at the end of the project have established a capacity for on-site training of future recruits to the nursing profession. The overall cost of the nurses' training component is \$140,000 of which approximately \$50,000 will go into the training of the first 300 nurses, at a cost of \$170 per nurse. One nurse would expect in a typical week to come into direct contact with 20 FP users in need of support to encourage continued usage and at least as many potential new recruits. In the space of a year, the cost of training has dissipated into a few cents per FP user. Whilst training is only one cost of the overall service, the economic rationality of on-site training is apparent.

#### C. Other Training Activities

The costs of training other medical and para-medical staff in basic FP are minimal. The supporting and distribution role of community health aides can play in a FP program far outweighs the additional \$25 it costs to train each individual in basic FP. The smaller number of participants at the pharmacists' training course makes the unit cost higher, but again the importance of the pharmacists' role in regular and commercial contraceptive distribution systems warrants the \$40 it costs to give him this training.

#### D. Family Life Education

The multiplier effect of these training activities will be registered long after the life of this project as the school pupils who learn from the recipients of this training, move into the fertile age groups. The unit cost of training in-service teachers is \$35. Each of these will be able to outline the fundamentals of family planning to several hundred students each year.

Providing a high quality, detailed course for lecturers from teacher training college is expensive (\$2,500 per participant). The project recognizes the importance of activities to train-the-trainers. The benefits of providing each teacher training college in the Region with a qualified lecturer in FP and related topics will be long-term. All new recruits to the teaching profession will benefit from this resource and such an individual will also be invaluable in the in-service training of teachers. The ultimate recipients of the knowledge

imparted to these lecturers will be the over 100,000 school pupils in the Region's secondary schools. The economic rationality of spending a total of \$17,500 on this course is apparent when viewed in this context.

## 2. Commodity Supply

The economic feasibility of providing contraceptives as part of a FP program is self-evident. Some points need to be made on the details of the commodity supply section of this project.

### A. Source of Supply

As a long-term goal, this project is encouraging each country in the Region to overcome the economic disadvantage of buying contraceptives for a small market through promoting access to bulk purchase of contraceptives. In the short-term, AID procured commodities will be supplied to the project countries. The cost to AID of these commodities is a fraction of the cost the countries would have to pay, were they to buy the commodities through commercial channels.

### B. Range of Methods

Successful FP programs recognize that different people have different contraceptive needs and thus promote a range of contraceptive methods. Economic considerations alone may argue for the cheapest method being promoted, but such an approach would undermine program success. For commodities alone (separate to their distribution systems) costs range from less than \$2.00 per Couple Year of Protection (CYP) for sterilizations to nearly \$4.00 per CYP for some vaginal methods. This project is supporting a broad method mix of reversible and non-reversible techniques. Restrictions on methods based on financial considerations will restrict the number of recruits to the FP programs this project supports.

### C. Range of Distribution Systems

Commodity costs are only one part of the overall costs of FP programs. Distribution systems vary greatly in their costs from \$5.00 per CYP to \$20.00 per CYP. Similar arguments to those for commodities apply in the choice of distribution systems. Supporting only the cheapest system will only capture part of the market.

Commercial and community-based distribution programs are significantly cheaper than clinic based programs, so when all other considerations are equal, the economics argue for an enlargement of the non-clinic sectors. Eastern Caribbean FP programs will receive a massive impetus in both clinic and non-clinic distribution systems. It is an unavoidable fact that some FP users are cheaper to recruit and provide services for than others. CBD and CRS activities will never fully replace clinic services. Indeed to some extent they are dependent on the exis-

tence of a back-up clinical service. Launching these programs does make economic sense, as once the programs are established, they can provide a cheaper service. The economics must remain a secondary consideration as clinical and non-clinical programs are complimentary rather than competitive, each serving the needs of a separate market.

### iii. Clinic Improvements

Improvements to Government health clinics in the less developed countries (LDC's) that will lead specifically to the introduction or improvement of FP delivery through these outlets are being funded under this project. Some 60 clinics will be upgraded and equipped to provide comprehensive FP services at a total cost of \$381,000. The benefit of this expenditure will be widespread reaching as it does almost 50% of the clinics in the Region. The expenditure has been directed specifically at FP equipment and facilities. Small amounts of money for each clinic will enable the FP clinic needs of currently unserved communities to be met. Five thousand dollars (\$5,000) per clinic will purchase all necessary equipment such as examination couches, sterilizers and speculums and allow improvements and alterations to be made to the building to provide a private examination area.

This expenditure is a highly efficient use of funds as it allows the already widespread network of small government clinics to add family planning to their activities without significant recurring costs. It is a move that will make FP services widely available, particularly in the most needy rural areas of the LDC's.

### iv. Extension of Adolescent Services

About one quarter of the funds that are to be spent on improving service delivery are to support activities specifically for adolescents. The unit costs of this part of the project are high: to start-up and operate a youth clinic for four years will cost nearly \$40,000; to start-up and operate a youth outreach program for four years will cost nearly \$45,000. Commodities and training costs are additional to this.

This substantial expenditure is a necessary feature of starting new programs aimed at the most hard-to-reach family planning group. During the first phase of FP programs the emphasis is on the provision of basic services to the highest motivated group. The Eastern Caribbean is coming to the end of this phase and is ready to extend in new directions - particularly towards the adolescent age groups. This requires new start-up costs as effectively new services have to be created.

The gravity of the adolescent fertility problem has been referred to throughout this paper. The project has selected the two most cost efficient mechanisms to have a strong impact on a large number of adolescents. Youth clinics will provide services at a cost of approximately \$15 per couple years of protection, a high but reasonable figure for this difficult sub-group. This figure will decline as the clinic

become more widely known and accepted through the associated education activities. The recurring costs of a youth clinic after the end of project will be only slightly higher than costs of running a regular clinic, although the counselling makes FP delivery more labor-intensive.

Youth outreach projects focused on teenage mothers to delay second pregnancies are similarly expensive in their start-up costs. A vehicle is essential to reach the client (the rationale of these projects being that the client will not come to the service, so the service must go to the client). Selecting this target group is economically sound: it aims to provide intensive services to a high risk, easily identifiable sub-group. The cost of this service is high at nearly \$20 per teenage mother per year, excluding the actual delivery of family planning arising from the counselling.

The cost of the wider educational role of the youth outreach projects is difficult to quantify. Group discussions and other informal educational activities play a supportive role to youth clinics, CBD and other programs.

The major role is to generate FP use; reaching approximately 6,000 young people in this informal way costs in the region of \$22,000 over four years. Recognizing that these young people are out of school and unemployed and are very inaccessible, a cost of \$4 per participant for a largely educational program is not excessive.

### Conclusion

The design of this project is based on sound economic considerations. The Eastern Caribbean's development process will be greatly enhanced by the successful execution of this project to reduce fertility. The activities the project incorporates vary in their immediate objectives so a neat comparison of costs per FP user for each activity is not feasible. The project recognizes also that the costs of method and distribution systems vary but that a range of alternatives for the client to choose from is an essential feature of a comprehensive FP program. Some groups are more expensive to serve than others. This project has selected the most cost-efficient mechanisms to attract the diverse groups of FP users.

## C. Social Soundness Analysis

### 1. Introduction

In summarizing the results of extensive sociological analysis the Mission judges the project to be socially sound, based on the three AID required criteria. First, RDO/C analysis reveals that family planning as a concept and a practice is quite compatible with the sociocultural environment in the Eastern Caribbean. Numerous quantitative surveys and qualitative assessment reinforce this conclusion and have helped in the design of this project. Second, the practice of family planning has already successfully shown its ability to diffuse itself among a variety of Caribbean cultural sub-groups. Today, there remains only two major groups where acceptance of FP has been stalemated: adolescents and hard-core intransigent non-users who we accept may never change. Third, the broad distribution of project benefits is insured by the variety of mechanisms that will be used to deliver services. Free or very inexpensive services will be provided by community-based and health care delivery programs to ensure that the potential contraceptive can utilize services and special motivational and delivery activities are planned for adolescents.

The Eastern Caribbean has a critical mass of knowledgeable leaders and institutions in family planning to help the Mission interpret the available quantitative and qualitative data necessary for detailed project design. This project as perceived by the Mission and local counterparts clearly plays a key role in the Mission's overall strategy to deliver basic human services to the needy by helping to slow down the numbers in need while simultaneously enhancing productive capacities to provide several basic goods, e.g. housing, health care, education and food.

### 2. Sociocultural Acceptability of the Project

The proposed Population and Development Project for the Eastern Caribbean encompasses activities of wide diversity. At the one extreme leading individuals including heads of state are to be presented with "demographic displays" exhorting the importance of the population variable in national and regional planning. At the other extreme, gas station proprietors are to be encouraged to sell condoms. A plethora of activities falls in between. Training is one key element: training of statisticians in demographic analysis, training of medical personnel in family planning delivery and training of teachers and others in family life education. Policy development is another important theme in the project. This includes the development of population policies to respond to the current demographic status of the Region and medical policies to improve the current contraceptive delivery system. Service delivery and commodity supply also occupy important positions in the project design. This report aims to unite the various threads of the project through an analysis from a social science perspective. The AID guidelines for social soundness analysis referred to throughout the report, read as follows:

The Social Soundness Analysis has three distinct but related aspects: (1) the compatibility of the project with the sociocultural environment in which it is to be introduced (its sociocultural feasibility); (2) the likelihood that the new practices or institutions introduced among the initial project target population will be diffused among other groups (i.e., the spread effect); and (3) the social impact or distribution of benefits and burdens among different groups, both within the initial project population and beyond.

The major question needing to be answered for a project of this nature: "Is a family planning project socially acceptable in the Eastern Caribbean?" For this project, the spread effects and the distribution of benefits and burdens are secondary to a need to analyse the sociocultural acceptability. Accordingly the emphasis in this summary analysis is placed on this particular question.

A population project funded by an external donor is not new to the English-speaking Caribbean. First efforts at family planning programs in the Region began over 20 years ago in the larger nations. The idea of restricting fertility has received official and social approval as demonstrated by government support for family planning and the general fertility decline observed in recent decades. In general, the high fertility norms of earlier generations have been eroded though not totally overturned. Fertility levels are still considerably above replacement and the ultimate goal of this project is to change people's behavior so that they have fewer children. The Region is not able to support prolonged population growth even at moderate rates.

#### A. Fertility Desires

This project does not have to overcome the social resistance often faced by "first stage" population programs in countries where the whole idea of restricting fertility has yet to take root. This project is not trying to change fertility desires, it is seeking to help people achieve the fertility desires they already have. Women in the Caribbean are still having a large number of unwanted children because they lack access to services.

The Contraceptive Prevalence Surveys (CPS) recently carried out asked a number of questions about fertility desires. Approximately six percent of all women wanted to become pregnant at the time of the survey. The bulk of these women were in the age groups 20 - 29. A further eight percent of the women were actually pregnant at the time of the survey. The remaining 86 percent of the women did not currently want to become pregnant.

One third of the women in the age group 25 - 29 did not want any more children. Two thirds of the women aged 30 - 34 did not want any more children and only a small amount of women 35 or over desired another child.

Fertility desires among younger women are also low from figures obtained in the Contraceptive Prevalence Surveys. The

desired family size for girls in their teens who had not yet had any children fell below three children in all islands and was nearer two children in three of the surveys. The fertility intentions of women who already had one child were similarly low.

The questionnaire used for the CPS did not ask all women with children whether their last pregnancy had been deliberate or not. It restricted the question to those women who had earlier stated that they wanted no further children at the time of the survey. Half of the women had not wanted anymore children before their last pregnancy.

Two smaller research projects solely among adolescents in the Region have indicated that the vast majority of adolescent pregnancies (which comprise nearly one third of the total number of pregnancies) are unplanned and unwanted. (Clipson: P.T., 1981 Jagdeo: T. 1981). The picture sometimes drawn of young girls deliberately getting pregnant to prove their fertility or as a rite de passage into womanhood gained no support from either of these separate research projects covering five islands.

The project seeks to bring population growth into line with resources by reducing the levels of unwanted fertility. It is therefore operating in a far more favorable social climate than those projects in countries where even the idea of lower fertility is novel.

#### B. Contraceptive Use

There is potential for increasing contraceptive use among sexually active women who do not want to become pregnant. The prevalence surveys indicated that over 60% of all women in the fertile age groups are sexually active. The number of potential contraceptive users is lower as women that currently want to become pregnant, women that are pregnant and women that know they are unable to become pregnant must be excluded. This leaves the following figures.

Potential Contraceptors As a % Age of All Women		Actual Contraceptors As a % Age of All Women	
Antigua	57		31
Dominica	53		37
St. Lucia	53		34
St. Vincent	53		37

So although over half of the women at risk of becoming pregnant are contracepting there is still a substantial minority that is risking unwanted pregnancy. It is this group that is crucial in reducing unwanted fertility. Younger women are over represented in this group.

The contraceptive methods currently used vary to some extent between islands but in all cases the pill is the single most popular method and female sterilization is the second most popular method. On average 20% of exposed women are using the pill and 14% have been sterilized. The injectable contraceptive is used by a significant number of exposed women in Dominica (11.2%), elsewhere it is a lot less popular, probably reflecting program bias as much as personal preferences of users.

The levels of knowledge about contraception are generally high in the Region. Most women interviewed knew a range of available methods. Knowledge of the existence of a method is not always likely to encourage a woman to use that method. There is a real resistance to contraceptive use generated through widespread misinformation about the risks involved. Negative rumors about contraceptives deter many women from using them. So while fertility control is acceptable behavior, using contraception is not always an easy step for a woman to take, given high levels of popular mistrust of contraceptive technology. It should be noted that the multi-faceted approach to service delivery is essential - getting contraceptives into the country will, by itself, solve few of these problems.

### C. Male Attitudes

Male attitudes towards contraception is an under-researched subject in the Region. Frequent reference however is made by those who work in family planning to the negative attitude of men towards family planning. This resistance takes three forms:

#### i. Disapproval of Fertility Control

Strongly pro-natalist views are apparently still held by some men. This cannot be accurately described as "a desire for children". Apparently, some men regard siring many children as a statement of their own virility.

While this "irresponsible impregnating" was referred to by many family planning workers, it is not seen as normal male social behavior, but rather a minority of men who behave in this manner.

#### ii. Resistance to Male Contraceptive Use

The condom does not enjoy wide popularity among Caribbean men. In addition to the usual aesthetic objections surrounding condom use (which seem particularly strong in this Region) there appears to be an additional connotation that using a condom is not masculine and does not impress girls. Specialized product advertising under the project will seek to emphasize the "macho" nature of condom use and seek to overcome this problem.

#### iii. Resistance Among Men to Female Contraceptive Use

Stories are frequently told of domestic rows occurring when a man discovers his girlfriends's supply of contraceptive pills. Male resistance to their partners using contraception has other origins than simply a high fertility desire on the part of men.

One explanation that is often cited is that men believe their women will be unfaithful if the risk of pregnancy is removed. Male attitude to fertility and contraception are seen as a constraint which will have to be resolved during the project. Is it best to recognize male resistance and encourage girls to be independent in their contraceptive decision-making, or is it best to tackle the problem directly and try to change male attitudes? The whole male role in decision-making about fertility and contraception is poorly understood.

The Male Attitude Survey to be funded under this project will clarify some of these issues and assist in the implementation of those project activities aimed at males. These include family life education training and materials and extension of adolescent services.

The CRS program will attack male resistance to condom use by promoting the "macho" image of the "panther" - the man who uses condoms and attracts the girls. The CRS advertising will also have a more serious educational component in promoting the concept of male responsibility.

The educational program in schools will be equally targetted at girls and boys. Teenage boys will be motivated to adopt attitudes of responsibility and recognize contraceptive use as a necessary male behavior.

The adolescent extension services will have strong male components both in the clinic and in the outreach activities to educate and motivate young men to adopt the values of responsible parenthood.

### Cultural Variation Within the Region

The primary countries to be covered by this project are Antigua, Barbados, Dominica, Montserrat, St. Kitts/Nevis, St. Lucia, and St. Vincent. Other countries will be drawn into regional activities when appropriate but it is at these seven islands that the bulk of the activities will be targetted. Whilst a fair degree of cultural homogeneity exists between these islands there are some important variations which the project recognizes.

#### i. Religion

The seven countries that are the primary target of this project display a startling degree of religious heterogeneity. Christianity is the major theologh in all cases but within that an array of established and informal religious sects operate. Dominica and St. Lucia are predominantly Roman Catholic; the other islands have populations that are mainly Protestant with the major affiliation being the Anglican Church. The Catholic islands are considered first.

In St. Lucia over 95% of the population is Roman Catholic. While in many Latin American countries this may become a major form of resistance for family planning projects, (given the Church's pronounced attitude to artificial contraception), the reality is quite different. St. Lucia has had a long exposure to both the concept of "Planned Parenthood" and the details of contraceptive technology through the promotional and service delivery

activities of the IPPF affiliate. The St. Lucia Planned Parenthood Association has fought for and has been successful in winning the acceptance of the people, the government and the Church. Differences over choice of contraceptive method still exist. The Church employs two trained family planning nurses to promote the Billings (natural family planning) method, which is endorsed by the Vatican. Tolerance and mutual respect for artificial contraceptive users however are still very much the order of the day.

In Dominica the service delivery of family planning is the sole responsibility of a Roman Catholic government. The promotion of family planning is cautious and conservative but the full range of contraceptive techniques are available free of charge through Ministry of Health clinics.

At the popular level too the religious element does not impede the acceptance of contraception. The Contraceptive Prevalence Surveys showed as high acceptance and usage rates in the Catholic as the non-Catholic countries.

Education in these two countries was hitherto dominated by the Church. In recent years the State has taken over control of most schools. It is now up to government to control curricula and in both countries there are positive steps being taken towards a full scale Family Life Sex Education Program to be introduced.

The religious picture in the other five islands is more diverse. A nominal majority commitment to the Church of England disguises a proliferation of non-established low church sects of a predominantly revivalist nature. Formal policy statements on contraception are rarely made. Public debates between Church groups and Family Planning Associations take place but few groups directly oppose the idea of family planning or of the use of contraceptive technology. The major exception to this is probably the Rastafarian movement which is still a small group in the Eastern Caribbean.

In general the religious dimension will need to be considered in the implementation of this project, particularly when it comes to mass media advertising of contraceptives, but it has not been a major obstacle over the past twenty years of family planning nor is there any reason to expect this project will encounter resistance.

## ii. Socioeconomic Variation

The different socioeconomic levels across the Region and within each country are recognized in the design of the project. Differential access to services are compensated for by the provision of a range of alternative systems of distribution. Commercial Retail Sales (CRS) of contraceptives pre-supposes a market capable of supporting such a venture. Disposable income to purchase commodities is available to a large enough group in the targeted countries. A CRS activity will appeal to hitherto

unreached populations for whom the financial cost of purchasing contraceptives is lower than the time costs and the psychological costs of visiting a family planning clinic.

The CRS activity cannot however be all-embracing. The very poor in the Region would be barred from utilizing the CRS on financial grounds alone, all other things being equal. The community-based distribution projects are designed to cater for this group specifically among others.

Cost is only one variable in people's decisions on contraceptive use. This project acknowledges that for some people paying for an advertised product increases the appeal of the product while for others it is a deterrent. The range of distribution mechanisms to be supported allow for socioeconomic variations by providing choices in the sources available.

### iii. Variations in Government Involvement in Family Planning Programs

The history of family planning across the Region displays some variation. In particular only some governments have openly espoused the family planning "cause". Antigua and Montserrat have hitherto been satisfied to leave the provision of family planning services to the private IPPF affiliates. This project, targeted as it is largely at governments, represents a new direction for those two governments. Accordingly the range of activities channelled through the government sector are designed to allow for a smooth transition to family planning service delivery.

In Barbados and St. Lucia the main family planning delivery system rests with the private associations, but with close government involvement and cooperation. The expansion of family planning activities does not represent a policy change for these governments. Accordingly no political disfavor is likely to arise from implementing this project.

In St. Vincent, Dominica and St. Kitts/Nevis the government Ministries of Health are the primary family planning providers. This project does not significantly change the government role in service delivery; that role is already significant and highly visible.

In all seven primary project countries the expansion of family planning services is coming at a time when family planning has ceased to be a novel or controversial issue likely to be used for political advantage by government opponents.

The other CARICOM countries, Guyana and Belize are involved in the policy development sections of this project, but will not be receiving direct support to deliver family planning because family planning remains politically contentious. This project will seek only to introduce discussions on population and medical issues at a policy-making level.

### 3. General Conclusions

This project is creating new directions for population activities in the Region, particularly in the policy development area. The major impact at the popular level will be increased access to family planning services. The policy activities aimed at the leadership level are indirect in their impact - the social acceptability of the policy work is not an issue. The social acceptability of the ensuing changes in family planning services is the important area addressed in this analysis.

The spread effect of many particular elements of the project will continue long after the end of the project life. For some activities (policy development, training) the benefits of these indirect activities are enormous as the resulting expansion and improvement of family planning services develop to reach the entire sexually active population. For other activities the impact is more specific; youth outreach activities, for example, which provide information and services directly to a distinct target group.

Sociocultural acceptability and the diffusion of benefits are the first two elements of the social soundness analysis. The third is the distribution of benefits and burdens to these within and outside the project area. The project encompasses entire countries so the benefits of reduced fertility should not be isolated to specific areas within countries. The benefits of reduced fertility and the consequences of failing to reduce fertility are starkly outlined in the background and problem statement.

D. Institutional Analysis

The following analysis examines the current activities of the regional and local agencies who will be involved in the execution of this project.

1. Caribbean Community Secretariat

The Caribbean Community Secretariat (CARICOM), created in 1973, is one of the principal administrative organs of the Caribbean Community in the field of functional cooperation. The Health Secretariat of CARICOM, one of the implementing units of this project, is a regional body with considerable experience in implementing complex regional programs as demonstrated in its programs and actions. The Secretariat is composed of numerous multisectoral technical divisions (agriculture, women in development, economic, etc.) whose primary task is the promotion of functional cooperation in a multisectoral framework.

In this role the Secretariat and particularly the Health Section has demonstrated success in providing the kinds of assistance envisioned to be undertaken under this project: namely bringing together key multisectoral individuals for the development of policy and the implementation of policy-related activities. The CARICOM Health Section itself annually brings together the Ministers responsible for Health within the region to discuss and prioritize required actions and review accomplishments. Under CARICOM's guidance the Ministers jointly passed a key resolution on Population and Health (See Annex B). In addition CARICOM convenes numerous regional and subregional meetings on policy issues.

Population concerns are not the problem of any single country within the region. The problems of migration, unemployment, lack of housing, social and other essential services cross all borders. It is essential that a regional organization be involved in matters of policy relating to the current future demographic trends within the region. On the basis of the project design team's assessment, it is believed that CARICOM is capable of carrying out the proposed activities with a demonstrated competence to be able to award and administer contracts, attract competent professional staff, and with current leadership committed to undertaking a substantial effort in population. CARICOM has been determined to be the single institution with unique capability in this area and a demonstrated competence to undertake this effort.

2. International Planned Parenthood Federation/Western Hemisphere Region, Inc. (IPPF/WHR)

IPPF/WHR, Inc. is incorporated in the state of New York pursuant to the Not-For-Profit Corporation Law and is a Private Voluntary Organization registered with AID. The membership of the corporation consists of affiliated Family Planning Associations (FPAs) in the Western Hemisphere Region which embraces North, South, and Central America, and the Caribbean.

The central purpose of the Corporation is "to advance the acceptance of family planning and responsible parenthood in the interest of family welfare, community well-being and international goodwill."

IPPF/WHR, Inc. functions as one of the six regional offices of the International Planned Parenthood Federation (whose headquarters is in London) and receives its primary support through an allocation from IPPF London which AID provides general support. Partial funding is also received for support services as executing agency for specific support earmarked grants, as in the case of the USAID grant for the CFP program. (538-0050). Staff operations in the corporation (WHR) are performed through the Regional Office headquartered in New York. Their management and staff are highly committed to expanding FP services throughout the Eastern Caribbean region.

IPPF/WHR monitors approximately \$12 million of grants to its member associations. In addition it manages the implementation of three USAID grants totalling approximately \$5 million, one for the Caribbean Family Planning Affiliation, another for family planning activities in Ecuador, and a third for leadership education on population in selected Latin American countries. Its familiarity with USAID project implementation requirements is therefore substantial.

The range of programs implemented by WHR affiliates show considerable variation and reflect the diversity of IPPF/WHR's 27 years of experience in family planning. Some associations maintain networks of family planning clinics or supervise distribution posts that deliver community services. Some direct themselves primarily toward improving the national policy atmosphere vis-a-vis family planning. Others concentrate on information and education in support of government programs of service delivery

Programmatic approaches such as community based distribution that are now being elaborated on a global basis were developed originally by associations in this region. Many recent developments in the family planning movement have been tested and improved by associations during the past two decades in the Western Hemisphere. These include the use of mass media to deliver family planning messages, systems of commercial distribution, the development of networks of cooperating doctors, the use of paramedical personnel where medical doctors are in short supply, delivery systems that bring family planning to homes and working places, the promotion of sex education in and out of schools, and the integration of family planning activities with other developmental activities such as agricultural extension, community development and programs encouraging adult literacy. It can be seen that there already exists within IPPF/WHR substantial technical expertise in policy, commodity supply, financial management, medical policy and other areas.

Due to the size of most Eastern Caribbean islands, work in family planning conducted by the private family planning associations and WHR has been both visible and coordinated with government efforts. Many associations have been the primary source both of commodities and technical services for the delivery of family planning. Thus little difficulty is foreseen in moving WHR into a more substantial role of assistance to governments in the delivery of FP services. The general trend desired by most governments within the region has been to become more actively involved in actual service delivery placing emphasis for the FPA's in roles of promotion, information and education. The role of WHR in developing this collaborative effort is crucial.

IPPF is considered both willing and capable of undertaking the substantial role of leadership for government involvement in the delivery of FP services throughout the Eastern Caribbean, with a demonstrated ability to select and administer contracts, attract competent professional staff and undertake overall responsibility for a complex program in seven countries.

For these reasons the use of WHR as a primary implementing agent for a substantial portion of this project is considered both feasible and desirable.

### 3. Country-by-Country Institutional Analysis

Antigua The main service delivery and I-E-C activities in Antigua were initiated and remain the responsibility of the Antigua Planned Parenthood Association. The APPA has a clinic/office in St. John's which provides clinical services twice weekly. The rest of the island is served by their CBD program which uses a limited number of outlets. These do not reach to all communities on the island.

The Government's involvement in FP has been restricted to granting permission for their Public Health Nurses to participate in the CBD program. Some nurses with links to the APPA do distribute commodities out of their clinics. This operates on a haphazard basis in about one third of the clinics. Commodities are free.

The APPA is currently running a sex education program in selected government schools. The Ministry of Health's own educational program is run through the Health Education Unit. Contraception is not a major focus of their activities. The Ministry of Education is planning to introduce Family Life Education into the school curriculum shortly.

31% of all women in Antigua are currently using a contraceptive. This is the lowest of the countries surveyed in CPS.

Barbados: The Barbados Family Planning Association's (BFPA) Headquarters in Bridgetown is the major provider of family planning services in Barbados. Their clinic provides a daily service, commodities are sold at a subsidized rate. The BFPA also runs a series of I-E-C activities in the community and with a range of institutions: Parent Teacher Associations; youth clubs; factories, etc.

The Ministry of Health is developing plans to provide family planning services within their polyclinic system. Currently the BFPA and Ministry of Health cooperate so that the association provides post-partum services to mothers who deliver at the major hospital. The BFPA also provides limited services through the polyclinics. The Ministry of Health assists the BFPA with their running costs.

Sex education in schools is done on an ad hoc basis, the Ministry of Education is committed to expanding Family Life Education as a formal part of the curriculum.

Thirty-eight per cent of women in the fertile age group in Barbados are currently using contraceptives, the highest in the region.

Dominica: Family planning services in Dominica are primarily the responsibility of the Ministry of Health. Family planning is an integral part of the Maternal and Child Health program. Clinics across the island distribute commodities free of charge. These commodities have up to now been supplied by UNFPA. There are seven comprehensive clinics where full family planning services are provided. Women who wish to start on a method have to travel to these comprehensive clinics.

The Dominican Planned Parenthood Association distributes some commodities but does not operate a clinic. Its major role is in I-E-C activities. Thirty-seven per cent of all women in the fertile age groups are using a contraceptive method.

Montserrat: Family planning in Montserrat has to date been the responsibility of the IPPF affiliate, the Montserrat Planned Parenthood Association. They operate a clinic in Plymouth where subsidized commodities and free services are provided. The government has a network of clinics across the island which have not previously been used for family planning distribution or services. No prevalence data for Montserrat are available.

St. Kitts/Nevis: Family planning services in St. Kitts/Nevis are provided by the Ministry of Health through its Maternal and Child Health program.

Twelve clinics provide family planning services typically on a twice monthly schedule. There are insufficient trained nurses to operate a more flexible schedule. Commodities are available free of charge from all clinics.

The St. Kitts/Nevis Planned Parenthood Association has an office in Basseterre and runs a clinic in Sandy Point. Its activities include a CBD program and I-E-C. No prevalence data for St. Kitts/Nevis are available.

St. Lucia: The St. Lucia Planned Parenthood Association is the primary provider of family planning services in a combined program with the Ministry of Health. The Planned Parenthood Association has a clinic in Castries and channels commodities to government health clinics throughout the island.

There are cooperative arrangements over staff between Ministry of Health and the Planned Parenthood Association.

Thirty-four percent of St. Lucia women in the fertile age groups are currently using contraceptives.

St. Vincent: The National Family Planning program in St. Vincent is the major provider of family planning services. This program is run under the Ministry of Health's overall clinic activities but is separately administered. There is a daily clinic at the hospital in Kingstown and family planning is available on certain days at the other clinics. Commodities are free.

The St. Vincent Planned Parenthood Association has no service delivery role; its activities are restricted to I-E-C.

The Family Life Education in schools is already established by the family planning/sex education component is very restricted.

Contraceptive prevalence in St. Vincent is currently thirty-three percent of all women in the fertile age group.

## V. PROJECT ADMINISTRATION

### A. PROJECT IMPLEMENTATION ARRANGEMENTS

#### 1. CARICOM

To enable CARICOM to implement the policy related activities for which that organization will be responsible, a half time project administrator will be funded under the project at CARICOM for three years in Guyana who will:-

- a) assist in organizing National Family Planning Task Forces and provide contracted technical assistance in the development of national population policies.
- b) organize the regional conference on Effects of Population Growth on Socio Economic Development.
- c) provide coordination for AID/W contracted RAPID presentations, country population reports and demographic training for statistical officers.
- d) convene medical policy steering committee and develop sub-contract with University of the West Indies School of Medicine (Department of Obstetrics and Gynecology) for regional and national medical policy seminars.
- d) coordinate observational travel for medical participants.

In addition to the half-time project administrator an administrative assistant and secretary/stenographer will be provided under this project. Approximately 10% of the time of the Chief of the CARICOM Health Section will be provided by CARICOM, office equipment, materials and resources provided under the Basic Health Management Training Project to CARICOM will be utilized to the extent possible to maximize the usefulness of that investment.

## 2. IPPF/WHR

IPPF/WHR will implement its activities under the general supervision of its New York Office but specifically through a project office to be established in Barbados. The Ministry of Health and the Ministry of Finance and Planning have already offered limited office space and storage facilities for contraceptives for one year of the project.

A Project Officer will be designated at the New York Office and will be assisted by a quarter-time Program Assistant. The Project Officer will be responsible for coordinating the work of the Barbados Project Office which will be staffed by a Project Manager and Support Personnel (Administrative Assistant/Bookkeeper, Secretary, and a half-time financial advisor. The IPPF Project Office Manager will be responsible for the following:

- (1) coordinating IPPF conducted activities with those being undertaken by CARICOM, the CRS Program, Tulane University and CFFA.
- (2) negotiate and administer sub-contracts for training of physicians, nurses, and others.

- (3) establish and manage transshipment of commodities to government programs.
- (4) coordinate TA provided by CDC logistic experts.
- (5) contract technical assistance and other inputs for youth outreach, adolescent clinics and community based distribution programs.
- (6) undertake equipment procurement and monitor systems for clinic improvements.
- (7) contract for contraceptive prevalence surveys with local institution and U.S. based consultants.
- (8) coordinate required technical assistance for in-country program support.
- (9) coordinate other program support activities as required.

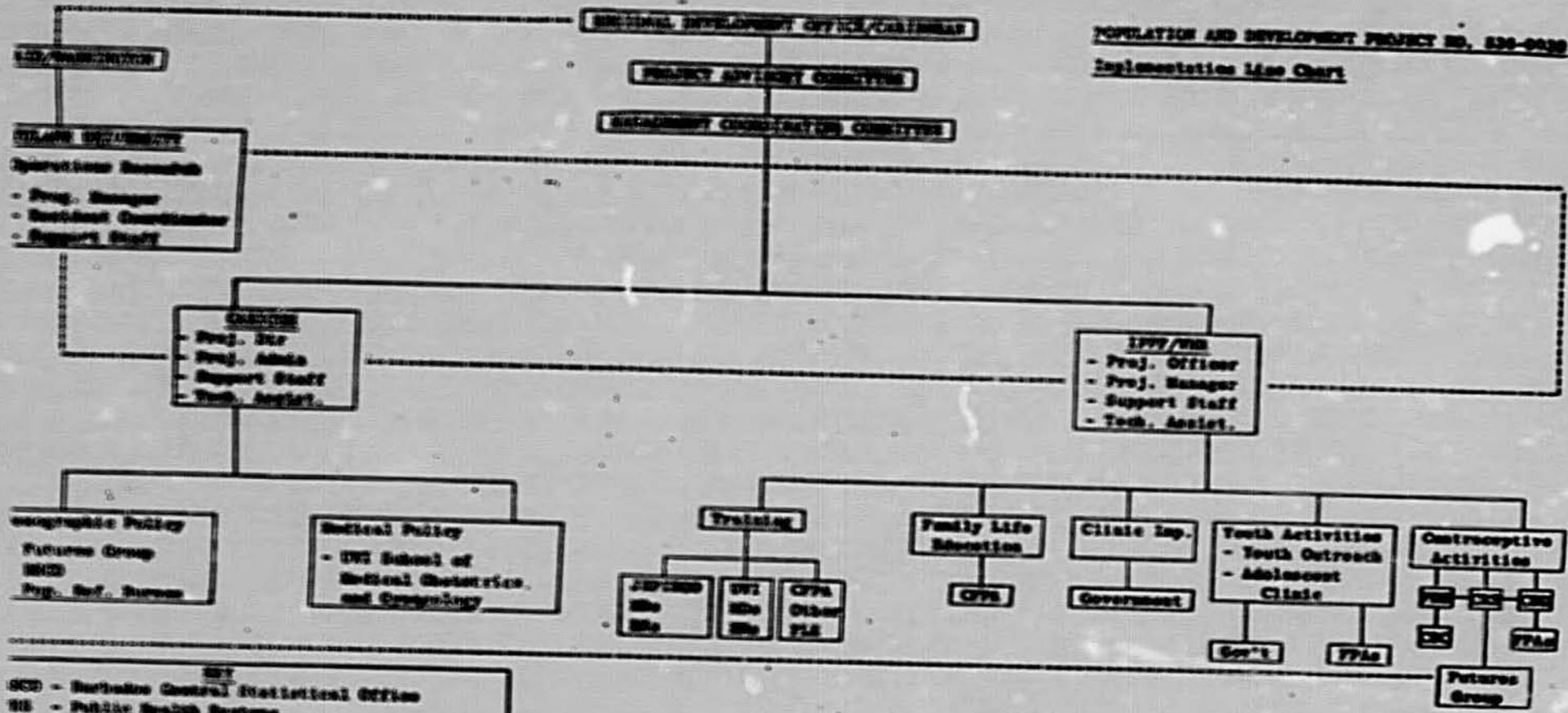
In order to assist the Project Office Manager undertake the above activities, technical assistance will be provided under the project in specific categories (i.e. youth outreach, community based distribution, etc.) as well as an additional 17 person-months of unspecified TA over the life of the project to provide project office and host government required implementation capability. Additionally, two technicians will be hired for one year each to assist in the design and implementation of project activities.

### 3. Implementing Mechanism

#### a) Project Coordination

The implementation of this project is complex. The implementation design has been carefully constructed to minimize the individual requirements on any one group or individual. An oversight coordinating committee mechanism has been established to coordinate the activities of the various groups involved in project implementation.

In summary, one grant will be made to CARICOM to undertake demographic and medical policy activities. It is expected that a contract or sub-grant will be negotiated between the University of the West Indies, (School of Medicine, Department of Obstetrics and Gyrecology) and CARICOM for implementation of many of the medical policy elements. A cooperative agreement will be negotiated between AID and the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) to undertake specific service delivery activities (including training, family life education, contraceptive commodity supply and distribution, adolescent clinics, youth outreach, improvement of clinic services, non-clinic distribution of contraceptives and contraceptive prevalence surveys). IPPF/WHR will undertake a commercial retail sales program within the region under the AID/Washington cooperative agreement with the Futures Group. AID/Washington will also be sponsoring a



- KEY**
- SCD - Bureau Central Statistical Office
  - SB - Public Health Systems
  - SC - Centers for Disease Control
  - SB - Commercial Retail Sales
  - SD - Community Based Distribution
  - FPA - Family Planning Association
  - FPA - Caribbean Family Planning Affiliation
  - LE - Family Life Education
  - SD - Johns Hopkins Program for International Education in Community & Countries

FIGURE 1

simultaneous 3 year operations research project to be undertaken by Tulane University in conjunction with the RDO/C project. (See Section III B.3.)

The key implementing agencies then are CARICOM, IPPF/WHR, Tulane University, and the University of the West Indies and the International Commercial Social Marketing Project (Futures Group). In order to coordinate these various activities, two committees will be formed with the primary purpose of advising on project implementation and coordination. The operations research activity will also have an oversight committee to guide its actions during the course of the project. The following committees will be responsible for coordinating project implementation:

(a) Project Advisory Committee (PAC): The PAC will be composed of CARICOM Health Section Chief (Boyd), IPPF/WHR Project Officer (N.Y) (Hosein), Tulane University Project Director (Bertrand), University of the West Indies OB/GYN Chairman (Wynter) and AID RPHA (Laskin). An AID/Washington representative will also be invited to attend. The primary function of the PAC will be: (1) to provide overall guidance to project implementation, (2) review and approve annual agency work plans, (3) resolve inter-agency implementation difficulties, (4) address other coordination problems as required. The PAC will meet twice yearly at project expense during the course of the project in locations to be determined by the PAC.

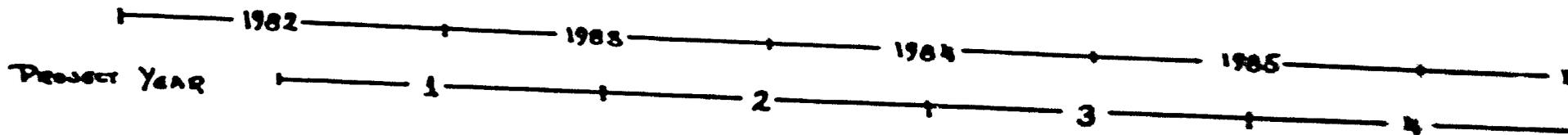
(b) Management Coordinating Committee (MCC): The MCC will be composed of the CARICOM Project Administrator; the IPPF/WHR Project Manager, the Tulane University Research Coordinator; the Commercial Retail Sales Project Coordinator; and other representatives as required. This group (MCC) will meet semi-annually one month prior to the PAC so that issues can be referred to the PAC for resolution.

The RDO/C Health/Population Advisor will be the primary focus for routine management coordination, referring issues for resolution to the appropriate agency or individual. It is expected that 30-35% of the RPHA's time will be utilized in project monitoring and implementation. (See Figure 1 .)

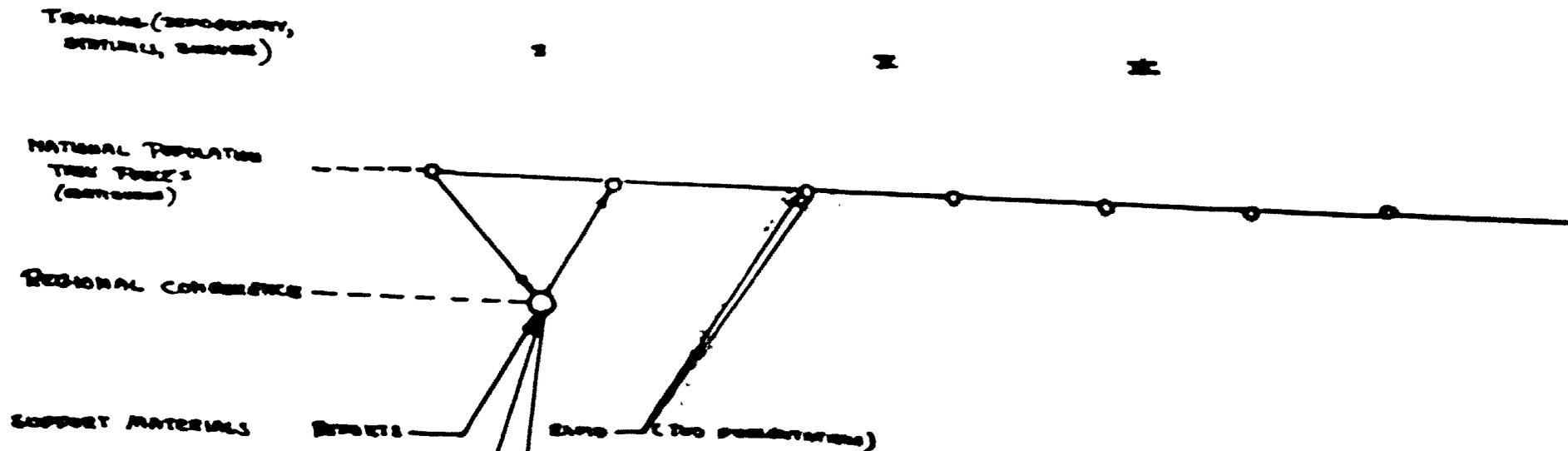
b) Schedule of Major Events

The attached schedule of major events indicates the types of activities to be undertaken during the course of the project the implementors and their inter-relationship to other project implementors.

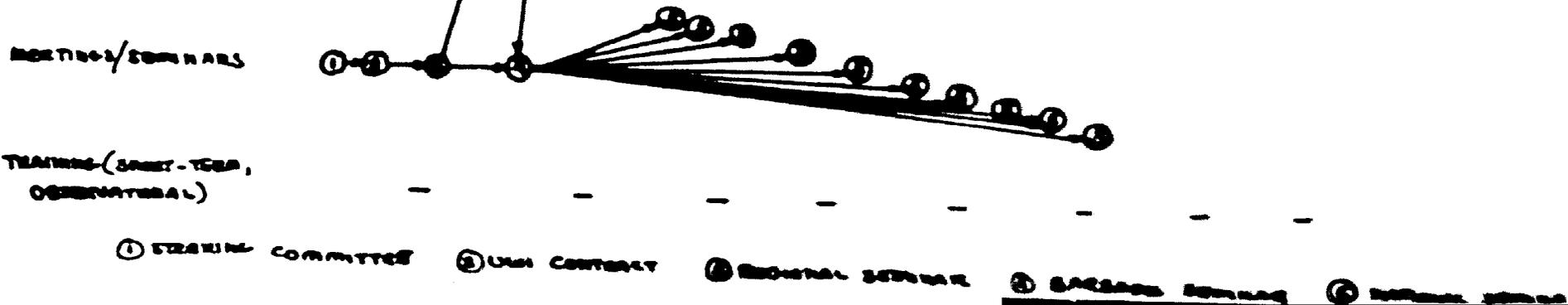
# POLICY



## Population Policy

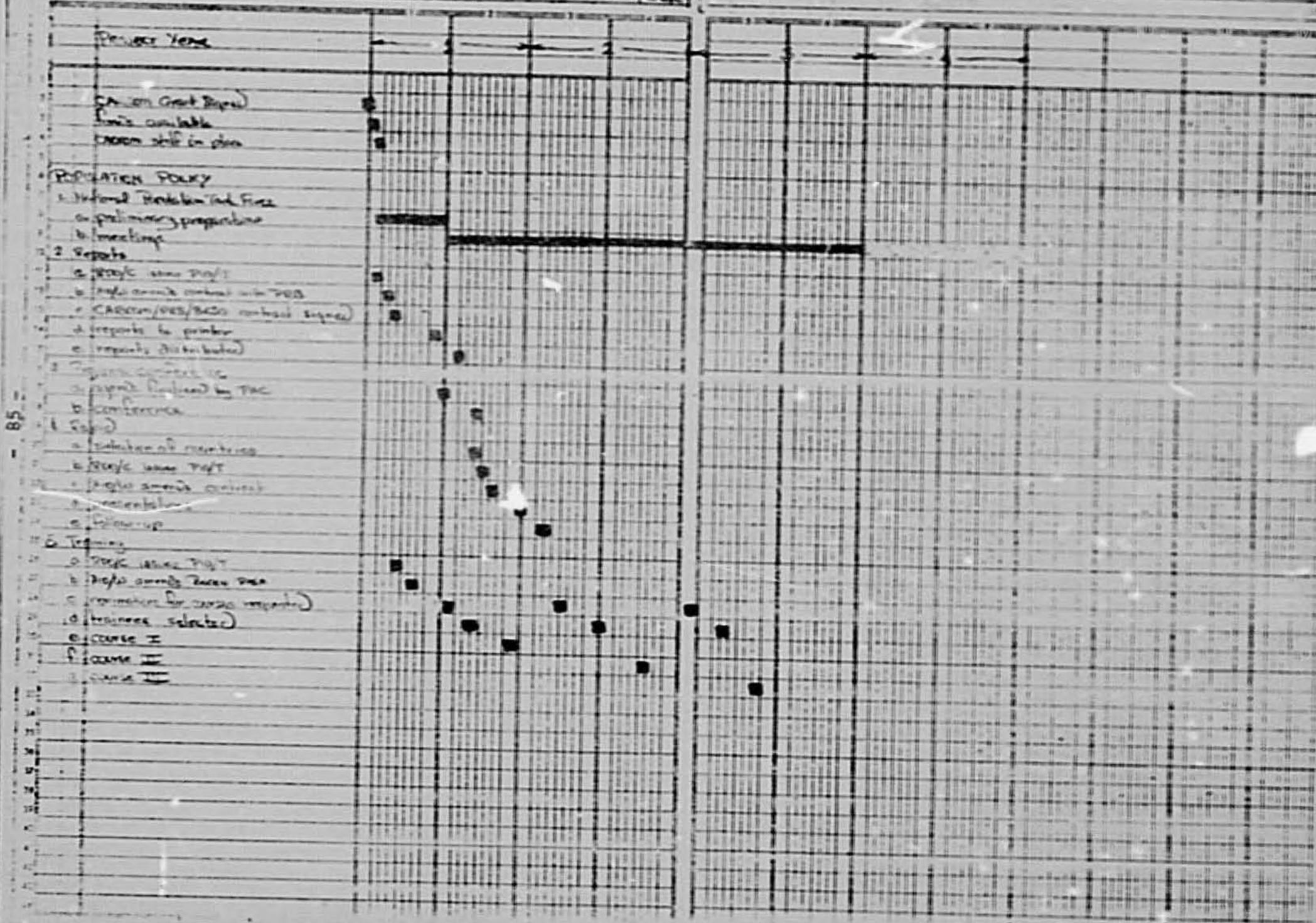


## Medical Policy



# TASK EVENTS

## POLICY



# MAJOR EVENTS

## POLICY (cont.)

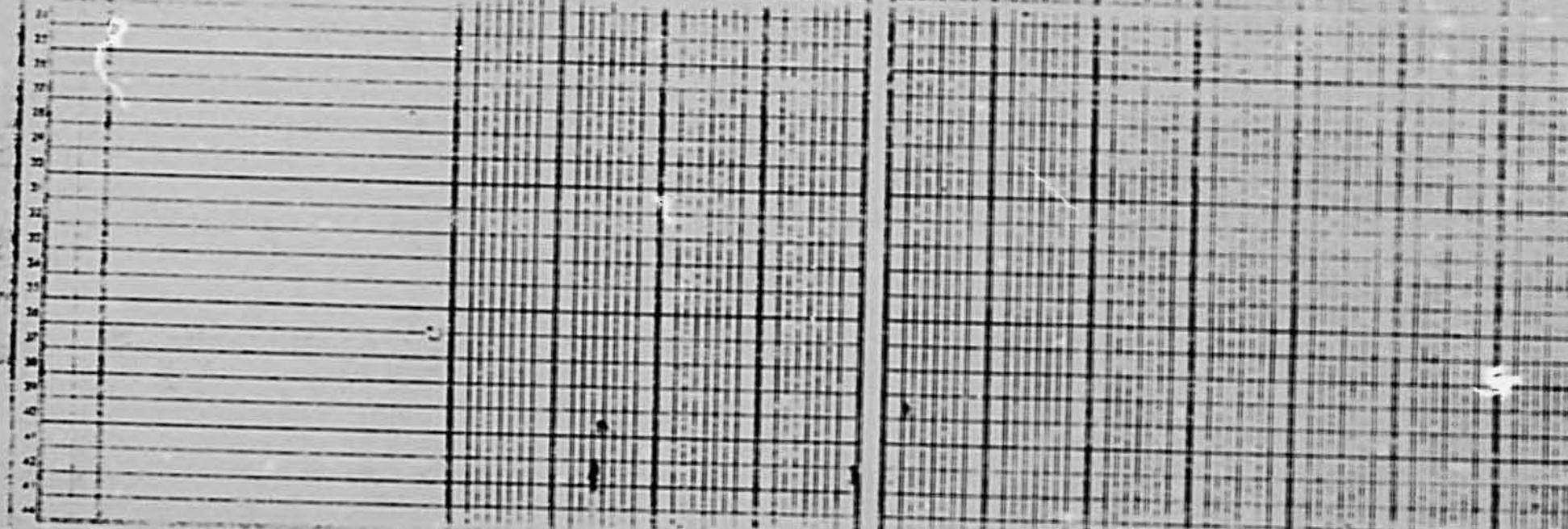
PROJECT YEAR



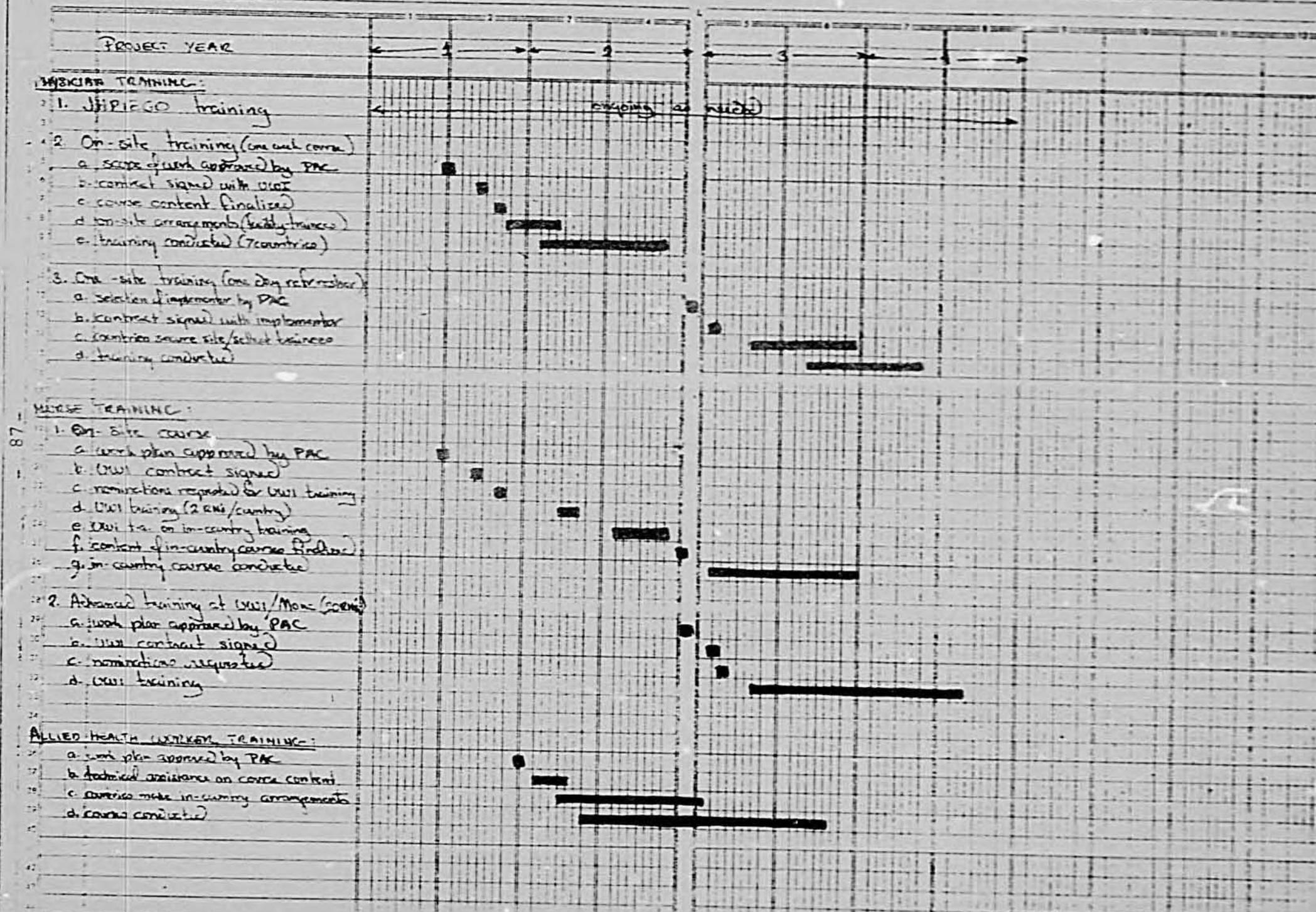
### MEDICAL POLICY

- 1. Steering Committee
  - a. members named
  - b. meetings
- 2. Regional Seminar
  - a. planning
  - b. seminar
- 3. National Seminars
  - a. Barbados
    - i) planning
    - e) seminar
  - b. others
    - i) planning
    - e) seminars
- 4. Training (short-term)

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# MAJOR EVENTS TRAINING



# MAJOR EVENTS

## TRAINING (CONT.)

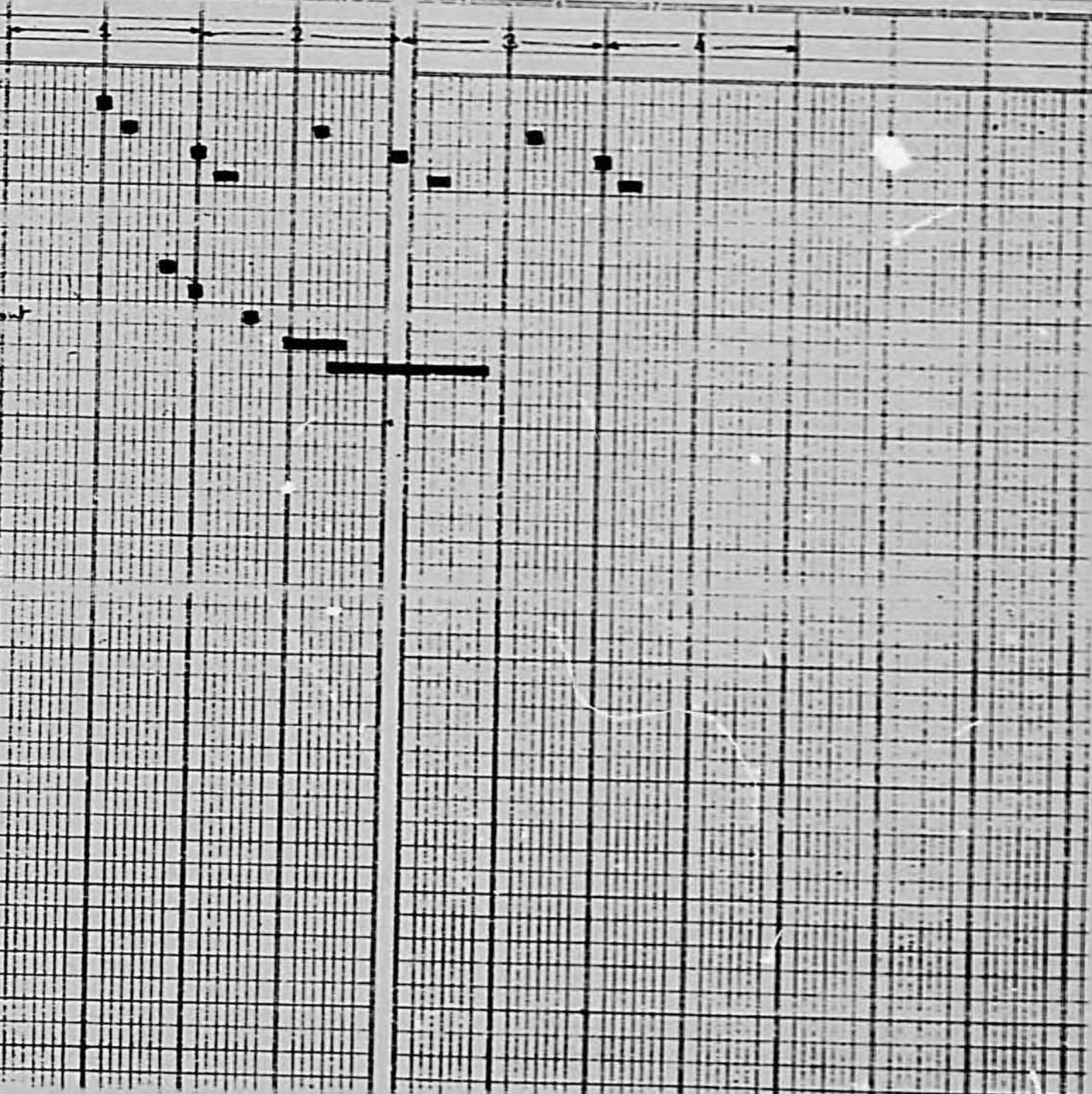
PROJECT YEAR

- FAIRY TRAINING - MINIDAPA (C)
- a. work plan approved by PAC
  - b. nominations received for OVI training
  - c. candidates selected & approved by PAC
  - d. OVI training

- TRAINING IN
- a. consultations with pharmacy clinic
  - b. work plan approved by PAC
  - c. in-country training, needs assessment
  - d. labors selected & arrangements made
  - e. training conducted

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MAJOR EVENTS  
FAMILY LIFE EDUCATION

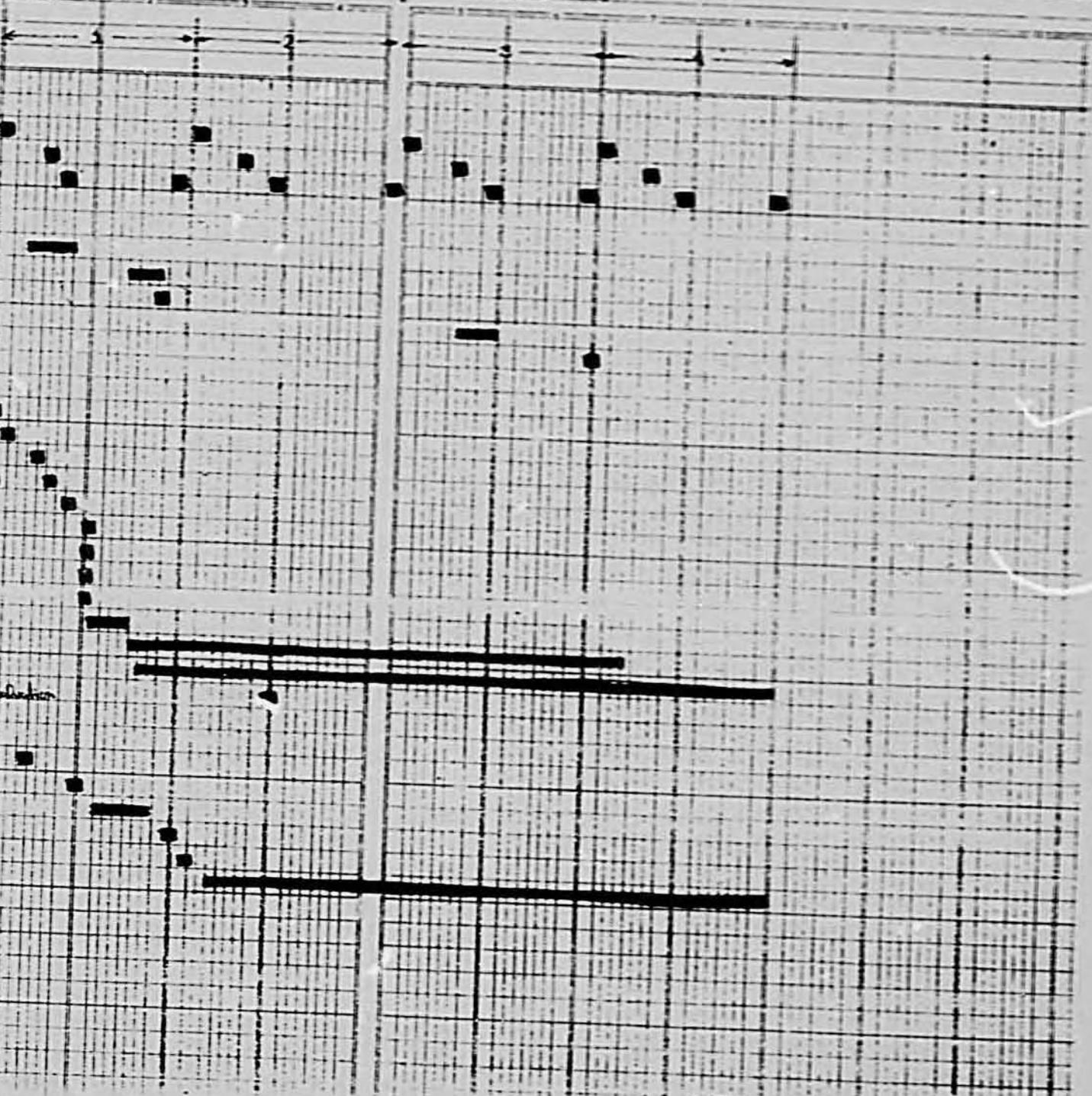
PROJECT YEAR	1	2	3	4	5	6	7	8	9	10	11	12
1. Two week course for lecturers												
a. agreement CFPA/ on content												
b. nominations requested												
c. candidates selected												
d. course												
2. Materials												
a. consultation with CRESALC												
b. materials selected												
c. contract with printer												
d. distribution of materials												
3. In-country seminars for lecturers (7)												
a. CFPA requests proposals												
b. proposal evaluation / approval												
c. training site selected / lecturers selected												
d. seminars												

MAJOR EVENTS

COMMODITY SUPPLY & DISTRIBUTION

PROJECT YEAR

1. Commodity support
  - a. RDC/C issues PIC/C
  - b. contraceptive items in cartridges
  - c. shipments made to government health
2. Technical assistance, supply distribution
  - a. general evaluation of existing system
  - b. follow-up on recommended change
  - c. data on forecasting contraceptive needs
  - d. data on sources of supply after end AD grant
  - e. finalization of new source of supply
3. Commercial retail sales
  - a. PAC contracts completion
  - b. future size contract with IDPF
  - c. project manager hired
  - d. determination on how orders to be handled
  - e. Future approval of draft contracts
  - f. commodities ordered by IDPF
  - g. contract signed for advertising
  - h. contract signed for distribution
  - i. PA approval of contracts, work plan
  - j. advertising campaign planning
  - k. advertising campaign conducted
  - l. commodities available in retail outlets
  - m. Report issues PIC/C for year 21.4 funding draft application
4. Community based distribution
  - a. IDPF obtains country approval
  - b. PAC contracts completion
  - c. detailed planning in each country
  - d. PAC approves draft contracts with implementors
  - e. commodities shipped & available in country
  - f. commodities available in outlets



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MAJOR EVENTS

CLINIC IMPROVEMENTS

PROJECT YEAR

1997 contracts with engineer  
monitor key equipment, budget finished  
PAC approves clinic improvement plan  
1997 signs agreement with contractor  
equipment ordered  
1997 transfers advance of funds to contractor  
contractor make arrangements for remodeling  
construction activities initiated proceed on site  
equipment received by 1998  
equipment distributed

# MAJOR EVENTS

## ADOLESCENT PROGRAMS

PROJECT YEAR

### YOUTH CLINICS

1. Discussions with government (prop + contract)
2. Detailed proposal presented to PAC
3. Clinics established
4. Evaluation

### YOUTH OUTREACH

1. Discussions with government (prop + contract)
2. Detailed proposal presented to PAC
3. Programs operational
4. Evaluation

## B EVALUATION PLAN

In order to evaluate progress under the project, several evaluation mechanisms will be employed. These include the following:

### A. Contraceptive Prevalence

The major indicator of program success will be the overall rate of contraceptive prevalence. There is currently available base line data from which to measure project impact in Barbados, Antigua, Dominica, St. Vincent and St. Lucia. Two Contraceptive Prevalence Surveys (CPS) will be implemented in St. Kitts/Nevis and Montserrat as soon as the project begins to provide similar base line information. Early in year four of the project, a complete series of seven second-round CPS will be conducted to measure change in contraceptive use for each of the family planning methods. Although it will be difficult to establish direct causality between project activity and overall usage, it is felt that the project is of sufficient magnitude to raise contraceptive prevalence 20 - 25 percent above its current level.

### B. Service Delivery Activities

To measure the success of service delivery activities, adequate information systems will be maintained for activities funded under the project to measure the approximate number of users in each of the major service systems, i.e. public health, commercial, CBD, non-profit clinics and private physicians. These service statistics can be verified by the CPS to insure the proper order of magnitude. By carefully watching the changing usage of contraception by age, method and provider, this project evaluation will be able to pinpoint in greater detail the more specific impacts of the project's sub-components. For example, it is anticipated that use of the commercial system will increase significantly in countries where CPS programs are launched. Also, teenager usage should increase in a measurable amount in those countries with important youth activities. And, where significant, training in VSC and in management of the side effects of orals has been carried out, these methods should take over a greater share of the overall volume of delivery.

To supplement the overall evaluation of the project using CPS and service statistics, each individual element of the project will have built in an appropriate evaluation plan to periodically assess efficiency, effectiveness and significance. Briefly, the evaluation of each element will be conducted jointly with the implementing agency's collaboration as follows:

#### 1. Demographic Policy

The evaluators will judge the composition and effectiveness of the NPIFs by gauging changes country-by-country in population policies -- both explicit and implicit. Visits to each of the islands and interviews with key leaders, including those outside the NPIF, will be necessary. The same evaluators will also assess the quality and local impact of the individual country reports, RAPID presentations, the regional seminar and training of population analysts by interviewing appropriate individuals and by reviewing available reports, documents, and media clippings. Such qualitative judgement will require

a senior evaluation expert. It will be important that CARICOM report in writing on the state of population policy in each project country at the beginning of the project, to provide an adequate base line from which to measure change.

## 2. Medical Policy

An international medical/evaluation expert will accompany the population policy evaluation on his/her visits to the individual islands. This medical/evaluation expert will interview key members of the medical profession -- doctors, nurses, administrators, auxiliaries, etc. -- to pinpoint specific changes in medical policies and/or practices since the beginning of the project. Again, CARICOM/UWI will have prepared a base line assessment of medical policies in preparation for their steering committee meeting to plan the first regional seminar. The evaluator will ask questions specifically related to the impact of the regional and national medical seminars, observation training, and media publicity on medical practices and protocols. It may be feasible to inexpensively sample the medical professions in each island before and after project activities, to have a more quantitative look at change.

## 3. Training

As part of each training program, each institution and trainee will be asked to formally evaluate the course, using a short interview schedule designed by IPPF/WHR. Such information will be useful to measure the short-term impact of the course. To measure longer-term impact, however, will require additional effort. IPPF/WHR will, therefore, prepare a questionnaire for mailing to each trainee at least one year after training to measure more quantitatively the longer-term utility of the course. The Mission will review IPPF/WHR's reports, highlighting the findings of the short- and long-term assessment. Additional evaluation activities will probably not be warranted for reasons of excessive costs.

## 4. Commodity Supply and Distribution

The three activities included under this heading will be evaluated separately. First, the Mission will rely on the Center for Disease Control to establish the base line logistical capacity of the public health systems. Near the end of project, an independent evaluation will be contracted by APHA to estimate improvement in logistical capacities to forecast, procure, handle and distribute contraceptives, since the beginning of the project. The Mission, with the help of CDC, will keep ongoing watch on the public health systems' abilities to assure the continuous flow of contraceptives to clients.

Second, the commercial retail sales project will be evaluated in great part by reviewing sales figures for each product in each country. Of course, it will be necessary to carefully assess the advertising, pricing, distribution and training approximately once a year to monitor the program. In large part, however, the failure of any of these elements will be reflected in deficient sales. In the evaluation plan, attention will also be given to assure lowest cost per unit output.

Third, the community-based program will maintain an information system capable of tracking distribution by method and distributor, as well as cost per unit output. Periodically, program management will review these and other

figures to track progress. IPPF/WHR will submit annual progress report and, if the Mission feels it necessary, an outside assessment will be contracted for by APHA at the appropriate time(s).

#### 5. Improvement of Health Delivery Clinics

With host government collaboration, IPPF/WHR has preplanned to collect base line service data in those clinics where improvements are to be made. After a sufficient period of time, IPPF/WHR will again collect information on services delivered in the same clinics, to measure approximately the impact of improvements. Similar information will be collected near the end of the project to gauge longer-term impact. It is not anticipated that the clinic staff will need to collect information which it isn't already gathering, in order to implement this evaluation strategy. IPPF/WHR will include results of this evaluation in its periodic reporting to AID.

#### 6. Adolescent Programs

The age-specific contraceptive prevalence rates and source of supply data from the base line contraceptive prevalence surveys and from the CPS to be held in year four will provide the major evaluation of the adolescent programs.

Evaluation on an ongoing basis will be part of the scope of work for consultants assisting the adolescent programs once they are in operation. These evaluations will be facilitated by a simple record-keeping system maintained by program staff. Data will list clients, acceptors, requests for counselling and numbers attending I-E-C sessions. Only if it is identified that achievements are significantly below targets will an outside evaluation be arranged by the Project Office.

#### 7. CARICOM and IPPF/WHR Evaluation Roles

CARICOM and IPPF/WHR have agreed to collaborate with host institutions and outside experts in carrying out the above evaluation strategy. Each of their sub-contracts with host institutions will formalize this agreement. For each activity, CARICOM and IPPF/WHR has agreed to help establish base line data, when necessary, with outside assistance. Both CARICOM and IPPF/WHR have agreed to quarterly financial and program accounting for all elements in their cooperative agreements.

CARICOM, IPPF/WHR, RDO/C and the involved host country institutions will collaborate in an ex post facto evaluation to judge the overall success of the project. RDO/C will secure evaluation expert(s) through central resources to carry out its responsibilities for this final evaluation. CARICOM and IPPF/WHR will have sufficient funds from this project to carry out this final assessment.

PROJECT PAPER 0039

LIST OF ANNEXES

- A. "Excessive Population Growth Ignites Explosive Instability" ( 1 page)  
Popline vol. 4 no. 2 February 1982
- B. Seventh meeting of the Conference of Ministers Responsible for Health ( 7 pages)  
July 14 - 16, 1981: Final Report
- C. Cables concerning Project ( 9 pages)
- i. PID Approval (state 278324)
  - ii. Operations Research Project approval AID/Washington (state 074364)
  - iii. Operations Research Project Mission Concurrence (Bridgetown 1664)
  - iv. AID/Washington Contributions to project (state 068050)
  - v. IPPF Overhead Costs (state 137648)
- D. Letters from Host Country Governments ( 6 pages)
- i. Antigua, Barbados, Dominica, St. Kitts/Nevis St. Vincent, St. Lucia
  - ii. CARICOM Secretary General
- E. Project Activities: Financial Annex (22 pages)
- F. Contraceptive Requirements for the Eastern Caribbean. Projections prepared by Richard Monteith (Centers for Disease Control) for USAID January 1982. ( 5 pages)
- G. Project Checklist ( 8 pages)
- H. Logical Framework ( 3 pages)
- I. Economic Analysis - Methodology ( 4 pages)

# 'Excessive Population Growth Ignites Explosive Instability'



**AWARD PRESENTATION**—Rep. William Lehman (D-Florida), center, is presented with the Population Action Council's Legislator of the Month award by Mary Dent Crisp, PAC governing committee chairperson, and Stephen Keese, a member of the governing committee. The presentation was made at The Bankers Club in Miami before a wide cross section of community leaders in the Congressman's 13th District.

People working together for solutions in 134 countries.

World Population News Service

# POPLINE

VOL. 4, NO. 2

FEBRUARY, 1982

## U.S. Family Planning Services Called 'Productive Investment'

U.S. family planning services are "cost-effective, efficient, and a sound and productive investment of our foreign economic assistance," according to a report prepared by the Agency for International Development.

Entitled "Rationale for AID Support of Population Program," the document warns that rapid population growth, in addition to being detrimental to developing countries, will "impact on the quality of life in all nations for generations to come."

Failure to act now to slow population growth will make the task in the future more difficult, the report stresses.

Without continuing and increased population assistance, improvements in economic and social well being leading to an expansion in world markets and to

conditions likely to promote political stability will be "more difficult, more costly, and more time-consuming."

Population assistance and family planning programs have proven effective in contributing to decreased fertility and are increasingly acceptable to and requested by developing countries.

Observing that a substantial share of family planning funds, commodities and technical assistance must come from developed countries for at least the coming decade, the report claims that the U.S. is "the best situated to provide needed leadership, research and technical assistance."

The report maintains that a development assistance program which fails to stress population concerns

Any new initiative seeking to ensure peace in the Caribbean region will be "overly ambitious and unrealistic" unless it includes effective programs to reduce fertility rates, warns Rep. William Lehman (D-Florida).

"Excessive population growth ignites explosive instability within countries," the congressman emphasized.

Rep. Lehman's remarks were made at a Miami ceremony where he was presented with the Population Action Council's Legislator of the Month award by Mary Dent Crisp, who chairs the PAC governing committee.

The award recognizes the congressman for "fostering support to solve the world population crisis through a commitment to share ideas, knowledge, and experience towards the ultimate objective of reducing population growth and creating a better life for all the world's people."

Rep. Lehman told an audience including a wide cross-section of community leaders that while "eruptions of turmoil and violence" in the Caribbean and Central American basin are alarming, "the worst may be yet to come."

He noted that 40 percent of the population of Latin America and the Caribbean is now under 15 years of age and the labor force is expected to grow from 92 million to 192 million by the end of the century.

"Large numbers of unemployed youth searching for jobs will almost inevitably lead to radical political activism as an expression of frustration and rage," Rep. Lehman said. "Such an atmosphere will threaten the very stability of these countries."

Massive unemployment in the region, he said, would "almost certainly lead to illegal migration, and the United States would bear the brunt of this significant increase in migratory pressures."

Rapid population growth would strain food and water supplies in the Caribbean, Rep. Lehman warned, and "there is absolutely no way that education and health services will be able to keep pace with the numbers of people."

He pointed out that, unless there is an acceleration of future fertility declines, the population of the Latin American and Caribbean region is expected to double in only 28 years—from 350 million to 700 million.

"Thirty million couples of reproductive age in this region do not have access to family planning services," Lehman observed. "And, unless significantly more effective programs are implemented immediately, the unmet demand for family planning services is expected to exceed 40 million by 1990."

Noting that the U.S. is currently spending \$21 million for bilateral and interagency population assistance in Central America and the Caribbean, he

Continued on P. 4

## White House Seeking Cut In Population

WASHINGTON — The Reagan Administration has recommended that Congress cut \$10 million from international population assistance in the fiscal 1983 foreign aid budget.

The Administration has proposed a \$201 million expenditure for population aid, which is funded in the current budget at \$211 million.

Meanwhile, the Agency for International Development reports that there is a backlog of about \$200 million worth of U.S. projects for developing countries that cannot be funded with available resources.

AID relates the current large funding shortfalls to increased willingness of developing country governments to support population projects, increased requests from these countries, inflationary factors, and an increase in the number of couples of childbearing age. The number of childbearing age couples in the developing world is expected to double between 1975-2000.

Of the \$1 billion currently spent on international population assistance, about 40 percent is provided by the outside sources. About half of the donor funds is provided by the United States, through AID.

Continued on P. 4

# FINAL REPORT

## SEVENTH MEETING OF THE CONFERENCE OF MINISTERS RESPONSIBLE FOR HEALTH

BELIZE

JULY, 14 - 16, 1981

RESOLUTION NO. 20

ANNEX B

Page 2 of 7.

POPULATION AND HEALTH

THE CONFERENCE,

Having studied the Report of the Committee of Officials and the Secretariat's Paper entitled "Family Planning: A Health Issue of Concern to the Caribbean Community" (CMH 01/7/37);

Convinced that family planning is closely linked with human development and the quality of life;

Aware of the fact that family spacing and family size are major factors underlying the problems of malnutrition and maternal and child health care in the Caribbean Community, since pregnancies that are too closely spaced expose both mothers and children to high rates of sickness and death;

Recalling the fact that in its Resolution on Health and Youth (1978) it had identified adolescent pregnancy and its social and economic consequences as major Caribbean issues;

Appreciating the close relationship between illegal abortion and its complications, on the one hand, and family planning on the other;

Aware of the strain that rapid population growth places on health, education and other services in communities living on islands with limited space and limited resources;

Noting the Secretariat's commencing cooperation with the Caribbean Family Planning Affiliation;

Recalling the concern that it had expressed at its Meeting in 1980 about the sudden withdrawal of the resources of the United Nations Fund for Population Activities (UNFPA),

1. REQUESTS the Secretary-General -

- (a) to seek the cooperation of UNFPA to develop appropriate population policies;
- (b) to seek resources to enable Member States to expand their family planning activities within their maternal and child health programmes;
- (c) to develop close cooperation with the Caribbean Family Planning Affiliation.

2. REAFFIRMS in the strongest terms its concern about the diminution of UNFPA activity in the Caribbean Community and the implications of this reduction for the important issues raised in this Resolution ; and requests the Secretary-General to convey its concern at once to the appropriate organs of the United Nations.

FAMILY PLANNING: A HEALTH ISSUE OF CONCERN  
TO THE CARIBBEAN COMMUNITY

(Note prepared by Chief, Health Section)

When the Secretary General addressed the Opening Session of the Caribbean Workshop on Food and Nutrition Strategy, convened by the Secretariat in Jamaica in November 1980, he mentioned lack of family planning as one of the major factors underlying the problem of malnutrition in the Caribbean Community.

In its Declaration on Health Policy in 1977, the Health Ministers Conference identified Family Planning as an essential component of its Maternal and Child Health Strategy. The rationale is as follows:-

Women having too many or too closely spaced pregnancies are at greater risk of having obstetric complications. Pregnancies that are too closely spaced leave little time for a woman to replenish her nutritional reserves. The effects are manifested not only in maternal mortality and morbidity, but also in higher neonatal and post-neonatal mortality rates. The age (too young or too old) of the mother is also a significant determinant, some studies showing that women over 35 years of age are two to three times more likely to develop complications of pregnancy and childbirth.

Too close spacing of the family is also serious for the health of the child, because lactation ceases as soon as a woman becomes pregnant. Indeed the African name "kwashiorkor" for the resulting malnutrition denotes an infant that arrives too close to its predecessor.

The problems of Health and Youth have also been engaging the attention of the Health Ministers Conference, and they have been particularly concerned about adolescent pregnancy. Pregnancy among teen-agers is now a

major health and social issue causing great concern to all the Caribbean Governments. Adolescent pregnancy has serious consequences for a woman's options in later life and may result in limited educational, employment and social opportunities. Moreover, there are serious medical risks: a greater risk of complications of pregnancy and childbirth and of death or poor health of the infant. Many of these girls take refuge in abortion. In these circumstances, adolescents often have less access to health care and family planning.

The problem of abortion is closely related to family planning, because it is in many respects the neglect of family planning that has made illegal abortion and the resulting deaths and disability major health issues in the Caribbean Community. Deaths from illegal abortion are numerous, although the number is difficult to estimate because of the secrecy surrounding those cases. It is generally estimated that about one-half of all pregnancies are not completed.

In the Caribbean countries, the abortion laws are greatly in need of liberalisation. The evidence clearly shows that illegal abortions carried out by unqualified persons, under unhygienic conditions and late in pregnancy, contribute considerably to death rates of women. Morbidity resulting from the excessive blood loss, pelvic infection and shock, frequently occurring in such situations, may be even greater. The effects are immediate and long-term, affecting subsequent pregnancies.

One very important aspect of induced abortion - whether legal or not - is when it is performed; abortions early in pregnancy (within the first three months) being much safer. However, due to many legal and procedural constraints, it is difficult for many women (especially those with inadequate information, little access to the "system" and little or no financial resources) to obtain an abortion at a sufficiently early stage. This is especially serious for adolescents, who are seeking abortion in increasing numbers. Furthermore, abortion has to be seen in relation to the availability of contraceptive methods, for which it can never substitute.

- 3 -

Thus, there are a number of specific health-related indications for the practice of family planning by a woman:-

- (1) Not to become pregnant until her body is mature enough to manage the physical burden of pregnancy; that is, not before the age of 18;
- (2) To have enough time between pregnancies for her body to recuperate; that is, not less than 12 months between the ending of one pregnancy and the beginning of the next;
- (3) Not to become pregnant when she suffers from a condition that would threaten her life; for example, severe malnutrition, tuberculosis, heart disease, uncontrolled diabetes;
- (4) Not to become pregnant when her previous health predicts that a new pregnancy would threaten her life or health; for example, if she has had seven children or more, or two caesarians, or repeated miscarriages;
- (5) Not to become pregnant after she has reached the limit of the number of children the family can adequately feed and support.

In his Study Paper No. 4 prepared for the Caribbean Ecumenical Consultation for Development, held in Port-of-Spain in 1971, Mr. William Damas drew attention to the growth of population as one of the factors contributing to the high level of unemployment in the towns, which he identifies as the greatest single social and economic problem in the area. For communities living on islands with limited space and limited resources, rapid population growth is a serious problem. The pressure on health services, hospitals, school places, housing, and general well-being are all too evident. It contributes to high rates of infant and maternal sickness and death. Over-sized families trying to survive on a limited income contribute to juvenile delinquency and to a new cycle of young pregnant teen-agers with high rates of still birth, and complications of pregnancy.

- 4 -

These problems are compounded by the sudden withdrawal from the Caribbean countries of the resources of the United Nations Fund for Population Activities (UNFPA) who, up to now, have been assisting family planning projects in Dominica, St. Kitts/Nevis, Saint Lucia and St. Vincent and the Grenadines. Even in these programmes coverage has been lamentably low.

The International Planned Parenthood Federation (IPPF) helps only the voluntary family planning associations; we have been told they would welcome some initiatives that would enable the Governments and the Secretariat to become more actively involved.

Family planning and family life education are not synonymous with contraception. They are concerned with the quality of life of individuals, families, nations and the Caribbean Community as a whole. Thus they lie at the root of human development in the broadest sense and are issues of considerable importance to the people of the Caribbean.

Recalling the special interest of USAID in matters to do with population and health and the possible interest of other agencies, it is now proposed to begin explorations about possible cooperation in this programme area.

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3. IN VIEW OF THE UNCERTAINTY REGARDING THE IMPLEMENTATION ARRANGEMENTS FOR THE PROJECT, THE BUREAU SHOULD PROVIDE THE BUREAU WITH AN INTERIM REPORT. THE REPORT CAN BE PROVIDED IN THE FORM OF AN ABBREVIATED ADDITIONAL ANALYSIS SECTION FOR THE PP WHICH SHOULD COVER, IN THE ALIA, THE CONCERNS RAISED IN PARAGRAPH 20 AND ABOVE. ONCE RECEIVED AND APPROVED, THE MISSION SHOULD BE AUTHORIZED TO COMPLETE THE PP AND APPROVE AND AUTHORIZE THE PROJECT IN THE FIELD.

4. SHOULD THERE BE A CHANGE IN THE POLICY FRAMEWORK WHICH AFFECTS THE GUIDANCE PROVIDED HEREIN, THE BUREAU WILL ADVISE. HAIG  
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TAGS:

SUBJECT: POPULATION: S & T/POPULATION COLLABORATION IN  
REGIONAL POPULATION AND DEVELOPMENT PROJECT (538-0039)

REFERENCE: (A) LASKIN/S & T/POPULATION MTGS. 2/22-2/25

1. ON BASIS OF REF. MTGS. S & T/POPULATION HAVE AGREED TO  
PROVIDE ASSISTANCE TO CARIBBEAN REGION IN COLLABORATION  
WITH REGIONAL POPULATION AND DEVELOPMENT PROJECT AS  
FOLLOWS:

(A) COMMODITIES - RDO/C WILL BUDGET 290,000 (DOLS.) TO  
PROVIDE CONTRACEPTIVES IN 031 PROJECT. BASED ON PROJECT  
MANAGERS ESTIMATES AID/W WILL PROVIDE COMMODITIES DIRECTLY  
TO PROJECT OFFICE IN BARBADOS FOR TRANSSHIPMENT IN PROJECT  
YEARS ONE AND TWO. DURING YEARS THREE AND FOUR, AID/W WILL  
IF APPROPRIATE, SHIP DIRECTLY TO CARIBBEAN GOVERNMENTS.  
TECHNICAL ASSISTANCE DURING LIFE OF PROJECT WILL BE PROVID-  
ED AS NEEDED BY S & T/POPULATION UNDER RSSA WITH CDC TO  
ASSIST GOVERNMENTS TO DEVELOP AND MAINTAIN CONTRACEPTIVE  
LOGISTICS SYSTEMS.

(B) COMMERCIAL SOCIAL MARKETING - BASED ON  
REFTEL DISCUSSIONS S & T/POPULATION CONCURS WITH  
ESTABLISHMENT OF CARIBBEAN REGIONAL CSM ACTIVITY FUNDED  
THROUGH AID/W CENTRAL CONTRACT WITH FUTURES GROUP  
PROVIDED ADEQUATE FINAL ARRANGEMENTS APPROVED BY RDO/C  
AND ST/POP. IMPLEMENTATION ARRANGEMENTS TO BEGIN  
ACTIVITY WILL BE FINALIZED DURING PLANNED TOY OF FUTURES  
CONSULTANT ASAP. MISSION SHOULD INCLUDE FUNDING  
TOTALING 45,000 (DOLS.) FOR PROPOSED COSTS IN YEARS  
THREE AND FOUR OF CSM IMPLEMENTATION. ARRANGEMENTS  
COULD BE MADE TO ADD THIS AMOUNT TO CENTRAL CONTRACT, IF  
INDICATED.

(C) TRAINING - BASED ON JHPTEGO/LASKIN AND AARNES

DISCUSSION, S & T/POPULATION WILL UNDERTAKE PHYSICIAN  
TRAINING ACTIVITY UNDER CENTRAL JHPTEGO CONTRACT TO  
TRAIN PHYSICIANS IN FAMILY PLANNING IN CONJUNCTION WITH  
REGIONAL POPULATION AND DEVELOPMENT PROJECT. JHPTEGO  
WILL REVIEW DETAILED WORK PLAN OF ABOVE TRAINING FOR  
REGION AS DEVELOPED IN ARMSTRONG/LASKIN MEETING 2/23 FOR  
WILEY REVIEW AND WILL ADVISE.

(D) POLICY - PER REF DISCUSSIONS S & T/POPULATION  
WILL COLLABORATE WITH RDO/C IN FOLLOWING ACTIVITIES:

(i) RAPID PRESENTATIONS: THROUGH CENTRAL  
FUTURES CONTRACT S & T/POPULATION WILL PREPARE AND  
PRESENT TWO COUNTRY RAPID PRESENTATIONS AND SUPPLY ONE  
APPLE II COMPUTER, ONE DISC DRIVE, ONE SILENT TYPE  
PRINTER AND APPROPRIATE SOFTWARE, TO BE INSTALLED IN  
BARBADOS MANAGEMENT OFFICE. PLANS FOR TWO ADDITIONAL  
RAPID PRESENTATIONS WILL BE FUNDED BY RDO/C PROJECT  
039. PIO/T FOR ADDITIONAL TWO COUNTRIES SHOULD BE  
PREPARED BY MISSION OUTLINING SCOPE OF WORK, FUNDINGS  
CITATIONS, PROPOSED TIMING AND COUNTRIES TO BE INCLUDED.  
ESTIMATED RDO/C COSTS FOR ADDITIONAL TWO RAPID  
PRESENTATIONS WILL NOT EXCEED 125,000 (DOLS.).

(ii) COUNTRY POPULATION REPORTS: USING RDO/C  
FUNDS, S & T/POPULATION THROUGH CONTRACT WITH POPULATION  
REFERENCE BUREAU WILL PRODUCE SUBJECT REPORTS. MISSION  
SHOULD FORWARD PIO/T INFORMATION WITH FUNDING CITATIONS,  
SCOPES OF WORK REQUESTED FOR COUNTRY AND ESTIMATED  
COMPLETION DATE. AID/W UNDERSTANDS PRODUCTION OF  
REPORTS WILL PROCEED ASAP FOLLOWING AVAILABILITY OF 1980  
CENSUS DATA. ESTIMATED BUDGET FOR REPORTS IS 61,000  
(DOLS.).

PROVIDE AID/W WITH PIO/T INFORMATION TO AMEND RSSA WITH  
CEN/ISPC, TO PROVIDE THREE TWO-WEEK TRAINING PROGRAMS  
AS DISCUSSED. ESTIMATED COST FOR BUCEN PARTICIPATION IS  
22,000 (DOLS.).

(E) INFORMATION EDUCATION AND COMMUNICATION -  
UNDER S & T/POPULATION PROPOSED IEC FIELD SUPPORT  
PROJECT AID/W WILL TRY TO PROVIDE TRAINING WORKSHOPS AND  
MATERIAL PRODUCTION PER DISCUSSIONS. SUBJECT PROJECT IS  
PLANNED FOR AID/W REVIEW O/A APRIL 1982. WILL ADVISE.

(F) OPERATIONS RESEARCH - FOLLOWING DISCUSSIONS  
WITH RDO/C REPRESENTATIVE, IPPF AND TULANE UNIVERSITY,  
ST/POP RESEARCH DIVISION WILL NEGOTIATE (CONTRACT) WITH  
TULANE UNIVERSITY TO UNDERTAKE OPERATIONS  
RESEARCH/DEMONSTRATION PROJECTS IN EASTERN CARIBBEAN.  
COORDINATION OF SUBJECT ACTIVITIES WILL BE UNDERTAKEN BY  
A STEERING COMMITTEE COMPOSED OF RDO/C, IPPF/WHR, CFPA,  
CARICOM, UMI (ISER & DEPT OF DR/GYN) AND TULANE  
REPRESENTATIVES THAT WILL MEET QUARTERLY IN YEAR ONE,  
SEMI-ANNUALLY IN YEAR TWO AND ONCE IN YEAR THREE, TO  
ENSURE APPROPRIATE SELECTION OF PROPOSED OR PROJECTS.  
ALL PROJECTS WILL BE APPROVED IN ADVANCE BY RDO/C,  
LAC/DR AND ST/POP RESEARCH DIVISION. PROPOSAL MAY NEED  
TO BE MODIFIED DEPENDING ON MISSION AND/OR AID/W  
RESEARCH REVIEW COMMITTEE DECISIONS. ST/POP WILL CABLE  
PROPOSED SCOPE OF WORK UNDER OR COMPONENT FOR MISSION  
CONCURRENCE. STOESEL

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4. THE CONTRACTOR SHALL COORDINATE WITH THE COGNIZANT MISSION POPULATION OFFICE TO OBTAIN APPROVAL FROM THE AID MISSION TO SUPPORT EACH FAMILY PLANNING OPERATIONS RESEARCH PROJECT.

5. WHEN A SUBCONTRACT HAS BEEN APPROVED BY THE CONTRACTOR, COPIES OF THE PROPOSAL WILL BE SENT SIMULTANEOUSLY TO THE APPROPRIATE AID MISSION AND

AID/WASHINGTON COGNIZANT TECHNICAL OFFICER FOR REVIEW AND APPROVAL. APPROVAL BY THE AID/W CONTRACTING OFFICER MUST BE RECEIVED BY THE CONTRACTOR PRIOR TO AWARDING THE SUBCONTRACT.

6. AS PER GENERAL PROVISION NO. 30, ENTITLED, QUOTE RIGHTS IN DATA, UNQUOTE THE CONTRACTOR SHALL DISSEMINATE, IN COORDINATION WITH THE AID/W CTO AND THE APPROPRIATE MISSION POPULATION OFFICER, THE OPERATIONS RESEARCH RESULTS THROUGH WORKSHOPS SPONSORED BY OTHERS, SEMINARS, ORAL COMMUNICATIONS AND PUBLICATIONS IN NATIONAL OR INTERNATIONAL JOURNALS. RECORDS OF THESE ACTIVITIES SHALL BE MAINTAINED BY THE CONTRACTOR.

7. AFTER EIGHTEEN (18) MONTHS OF PROJECT ACTIVITIES, AND EVALUATION AND ANALYSIS SHALL BE UNDERTAKEN MUTUALLY BY THE CONTRACTOR AND AID TO DETERMINE PROJECT EFFECTIVENESS AND THE FUTURE OF PROJECT ACTIVITIES. THE ANALYSIS WILL INCLUDE THE NUMBER OF QUALITY OF SUBCONTRACTS MADE AND THE TECHNICAL ASSISTANCE PROVIDED TO PROMOTE, DESIGN AND EXECUTE OPERATIONS RESEARCH PROJECTS IN ADDITION TO THE SUCCESSFUL COMPLIANCE WITH THE OUTLINED POINTS ABOVE.

8. REPORTS AS REQUIRED IN GENERAL PROVISION NO. 16 ENTITLED QUOTE REPORTS, UNQUOTE THE CONTRACTOR SHALL SUBMITT THREE (3) COPIES OF THE FOLLOWING REPORTS TO AID/W AND TWO (2) COPIES TO THE A.I.D. MISSION WITH 45 DAYS OF COMPLETION OF EACH SPECIFIED PERIOD.

1. SIX (6) MONTH PROGRESS REPORT;

2. TWELVE (12) MONTH PROGRESS REPORT;

3. SIXTEEN (16) MONTH PROGRESS REPORT (THIS WILL BE THE BASIS FOR THE EVALUATION REFERRED TO IN PARAGRAPH 7 ABOVE);

4. TWENTY-FOUR (24) MONTH PROGRESS REPORT;

5. A FINAL REPORT FOR THE THIRTY-SIX (36) MONTH REPORT

6. A FINAL FISCAL AND RESEARCH PROGRAM REPORT FOR EACH SUBCONTRACT WITHIN THREE (3) MONTHS OF THE COMPLETION OF EACH SUBCONTRACT.

#### TECHNICAL DIRECTIONS:

PERFORMANCE OF THE WORK HEREUNDER SHALL BE SUBJECT TO THE TECHNICAL DIRECTIONS OF THE CTO, AID TECHNICAL OFFICE (N/P/R). AS USED HEREIN, QUOTE TECHNICAL DIRECTIONS UNQUOTE ARE DIRECTIONS TO THE CONTRACTOR WHICH FILL IN DETAILS, SUGGEST POSSIBLE LINES OF INQUIRY, OR, OTHERWISE COMPLETE THE GENERAL SCOPE OF THE WORK.

#### KEY PERSONNEL:

THE KEY PERSONNEL WHICH THE CONTRACTOR SHALL FURNISH FOR THE PERFORMANCE OF THIS CONTRACT ARE AS FOLLOWS. PROJECT MANAGER (20 PERCENT), PROFESSOR JANE BERTHARD, TULANE UNIVERSITY. A RESEARCH COORDINATION (100 PERCENT), TO BE NAMED LATER, WILL RESIDE IN BARBADOS.

THE PERSONNEL SPECIFIED ABOVE ARE CONSIDERED TO BE ESSENTIAL TO THE WORK BEING PERFORMED HEREUNDER. PRIOR TO DIVERTING THE SPECIFIED INDIVIDUALS TO OTHER PROGRAMS, THE CONTRACTOR SHALL NOTIFY THE CONTRACTING OFFICER REASONABLY IN ADVANCE AND SHALL SUBMIT JUSTIFICATION (INCLUDING PROPOSED SUBSTITUTIONS) IN SUFFICIENT DETAIL TO PERMIT EVALUATION OF THE IMPACT ON THE PROGRAM. KEY PERSONNEL MAY, WITH THE CONSENT OF THE CONTRACTING PARTIES, BE AMENDED FROM TIME TO TIME DURING THE COURSE OF THE CONTRACT TO ADD OR DELETE PERSONNEL, AS APPROPRIATE.

PERIOD OF CONTRACT:

THE EFFECTIVE DATE OF THIS CONTRACT SHALL BE APRIL 1, 1982. THE ESTIMATED COMPLETION DATE IS MARCH 31, 1985.

ESTIMATED CONTRACT COST:

THE TOTAL COST OF THE 3 YEAR PROJECT WILL BE APPROXIMATELY DOLLARS 994,356. DURING THE FIRST YEAR DOLLARS 360,000 WILL BE ALLOCATED.

	1982	1983	1984	TOTAL
OPERATIONS RESEARCH				
SUBCONTRACTS	200,000	200,000	-	400,000
SALARIES OF PROJECT PERSONNEL	59,250	68,269	78,604	206,123
PER DIEM TRAVEL	28,420	22,440	24,684	67,524
CONSULTANTS FEES	5,400	5,940	6,554	17,874
TRAVEL & PER DIEM	7,200	7,920	8,712	23,832
MEETINGS	8,300	14,400	2,420	14,820
COMPUTER TIME	1,000	3,300	4,000	8,300
ADMINISTRATIVE COSTS				
AT TULANE	19,750	21,750	23,875	65,326
AT BARBADOS	8,800	2,360	9,755	27,683
INDIRECT COSTS				
ON CAMPUS	14,300	17,884	21,482	53,672
OFF CAMPUS	23,161	24,270	26,065	73,522
FOR SUBCONTRACTS	18,000	18,000	-	36,000
TOTAL	385,347	422,920	206,109	994,356

THE CONTRACTOR SHALL ESTABLISH AN OFFICE IN BARBADOS. THE RESEARCH COORDINATOR AND RESEARCH ASSISTANT WILL WORK IN THIS OFFICE. IT IS ANTICIPATED THAT OFFICE SPACE WILL BE RENTED FROM THE BARBADOS FAMILY PLANNING ASSOCIATION.

THE ACTIVITIES CONTEMPLATED IN THIS CONTRACT ARE COMPLIMENTARY TO THE USAID MISSION FUNDED PROJECT AND SHALL BE COORDINATED WITH THE MISSION SUPPORTED EFFORTS. STOFSEL

ANNEX C

# TELEGRAM

BRIDGETOWN  
 CATE  
 COLLECT  
 CHARGE TO PROGRAM

12065  
 E.O. 12812  
 TAGS  
 SUBJECT:  
 ACTION:  
 AID  
 AMB  
 DCM  
 POL/ECOM  
 CHRON  
 RF

FROM: AMEMBASSY, BRIDGETOWN  
 CLASSIFICATION: UNCLASSIFIED

N/A  
 POPULATION: OPERATIONS RESEARCH PROJECT  
 SECSTATE WASHDC IMMEDIATE  
 UNCLASSIFIED BRIDGETOWN 1664  
 AIDAC  
 REF: A. STATE 074364 (B) LASKIN/BAILEY MEETINGS (C) BRIDGETOWN 1483

1. PER REFS RDO/C CONCURS IN SUBSTANCE WITH PROPOSED SET/POPULATION OPERATIONS RESEARCH ACTIVITY TO BE CARRIED OUT IN EASTERN CARIBBEAN AS A COMPLEMENTARY ACTIVITY TO PLANNED POPULATION AND DEVELOPMENT PROJECT. (538-0039).
2. WHILE MISSION BELIEVES PROPOSED PROJECT HAS CONSIDERABLE MERIT, MISSION REMAINS CONCERNED THAT PROPOSED RATIO OF PROJECT ADMINISTRATION COST IS QUITE HIGH IN COMPARISON TO ACTUAL PROJECT ACTIVITIES. REQUEST CONTRACTS OFFICE MAKE EVERY EFFORT TO REVIEW REASONABleness OF THESE COSTS DURING FINAL NEGOTIATION.
3. FOLLOWING ARE MINOR MODIFICATIONS TO PROPOSED WORK SCOPE SUGGESTED BY MISSION:-
  - A. IN ORDER TO FACILITATE MISSION COORDINATION OF ALL AID SPONSORED POPULATION EFFORTS IN EC REQUEST UP AID REP. SERVE

RDO/C: RPHAM  
 DCM: E. FLORES  
 POL/ECOM: J. BERRY  
 LAC/DI: R. GARDNER  
 RE: BRIDGETOWN  
 CPD: L. HIGGINS

DATE: 04/02/82  
 TIME: 202  
 DIR: WILLIAM B. WHEELER

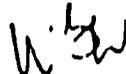
CONFIDENTIAL IN DRAFT  
 A/PROG: JAMES L. IN DRAFT

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IN EX OFFICIO CAPACITY ON ADVISORY COMMITTEE CITED  
PARA. 3 REF A. SIMULTANEOUSLY, REQUEST TULANE/BERTRAND  
PARTICIPATE IN EXECUTIVE COMMITTEE OF 538-0039 PROJECT  
ALONG WITH CARICOM, IPPF, UWI AND AID.

ANNEX C  
Page 8 of 9

- B. TO EXTENT POSSIBLE CARICOM HAS INDICATED USEFULNESS OF  
INVOLVING UWI IN OR ACTIVITIES TO ASSIST IN REF A. STATED  
OBJECTIVE 3 AS WELL AS TO FACILITATE FURTHER CARIBBEAN NATIONAL  
PARTICIPATION.
- C. SUGGEST ADDITIONAL FUNDING BE INCLUDED FOR PROJECT  
EVALUATION COMPONENT CITED PARA. 7 REF A.
3. FYI, MOH/GOB HAVE AGREED TO SEEK DONATED OFFICE SPACE  
FOR IPPF PROJECT OFFICE, CRS, AND TULANE RESEARCH COORDINATOR.  
END FYI.
4. APPRECIATE AID/W ADVISE ASAP AFTER CONTRACT NEGOTIATED  
WITH TULANE.

  
BISH

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Classification





GOVERNMENT OF ANTIGUA AND BARBUDA

Ministry of Health

ST. JOHN'S, ANTIGUA, W.I.

Telephone: 809-46-21014

Mr. Mark Laskin  
Regional Public Health Advisor  
Agency for International Development  
P.O. Box 302 B  
U.S. Embassy  
Bridgetown, Barbados, W.I.

13 May 1982

Dear Mr. Laskin

Request for Participation in USAID Population and Development Project

The conference of CARICOM Health Ministers in Belize in July 1981, resolved to seek assistance in developing appropriate population policies for the region and to seek resources for expanded family planning programmes. (Resolution No. 28: "Population and Health") The Government of Antigua & Barbuda accordingly supports the CARICOM Health Secretariat in its moves to develop a range of population policy formulation activities. Similarly we welcome the proposed expansion of the activities of the International Planned Parenthood Federation (IPPF), to provide further assistance to Family Planning Programmes in the region.

2. We understand that USAID are to assist CARICOM and IPPF in these activities under a new Population and Development project. Following discussions between this Ministry and the Health Office of USAID/Barbados, we list below the proposed activities that Antigua & Barbuda is keen to participate in under this project:-

I. Policy

- a. Antigua & Barbuda would participate in regional seminars to assess demographic trends and their impact on development.
- b. Antigua & Barbuda would welcome the preparation and distribution of brief, non-technical reports to publicise the findings of the last census.
- c. Antigua & Barbuda would welcome assistance through CARICOM to establish a National Task Force. This task force would aim at producing an appropriate population policy for Antigua & Barbuda.

Mr. Mark Laskin

13 May 1982

- d. In the area of medical policy and family planning Antigua & Barbuda would participate in regional and national seminars to assess the latest worldwide research findings in family planning and their implications for Antigua & Barbuda. We understand that assistance would also be available for a Steering Committee of appropriate medical personnel to liaise with CARICOM in planning these policy activities.

## II. Improvement in the Delivery of Family Planning Services

- a. Training: The Ministry of Health will cooperate with IPPF and the University of the West Indies in the design and implementation of training courses to be funded by USAID. The courses will be for medical personnel at all levels. We understand that the emphasis will be on in-country training, rather than on scholarships to overseas courses. The courses will be developed in close cooperation with the ongoing Advanced Fertility Management courses at URI, Mona, Jamaica.
- b. Family Life Education: Antigua & Barbuda would send participants to 'training of trainers' activities aimed at increasing the Family Life Education resources of those involved in teacher training. Antigua & Barbuda would also welcome the development and preparation of appropriate Family Life Education materials for use in schools and clubs.
- c. Contraceptive Commodities: The Ministry of Health would welcome contraceptives supplied by USAID under this project for distribution through its ongoing Maternal and Child Health Programme.
- d. Non-clinic Distribution of Contraceptives: The Ministry of Health would liaise closely with the design teams of the proposed commercial retail sales programme to be organised through IPPF project office and funded under this project. All advertising and educational material to be used on these programmes shall be inspected and subject to the approval of the Ministry prior to their release.
- e. Clinic Equipment: The Ministry of Health understand that USAID are including funds under this project for the provision of clinic equipment for family planning purposes. Antigua & Barbuda would welcome assistance in this area. A list of clinics is attached that would offer family planning services should equipment be made available under this project. We recognise that project funds may not extend to equipping all the clinics on this list.

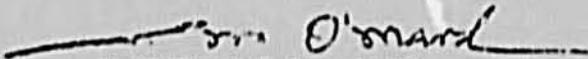
Mr. Mark Laskin

13 May 1982

- f. Clinic Improvements: Some of our clinics do not have the space to offer family planning services even if equipment were available. We would welcome assistance in modifying and improving existing clinics to enable the space or facilities to be made available. The attached list details in order of priority those clinics which require such improvement. Details of the improvements needed to provide family planning services are also given. Again we recognise that funds may not be available to cover all clinics on the list.
- g. Adolescent Programmes: The Ministry recognises the medical, social and economic problems associated with teenage pregnancies. We would welcome technical assistance and financial support to design and implement new programmes to improve the delivery of family planning services to young people.

3. The Ministry of Health looks forward to cooperating with the two executing agencies of this USAID project and will be pleased to provide your office with any further details required in the design of the project.

Yours truly

  
CHRISTOPHER M O'MARD  
Minister of Health

Enclosures

In Replying the Number and Date of this Letter should be quoted.

No. ....

1982-05-18.

Dear Mr. Wheeler,

Re: Participation in USAID Population and Development Project

By Resolution No. 28: "Population and Health" of the Conference of CARICOM Ministers responsible for Health in Belize in July, 1981 resolved to seek assistance in developing appropriate population policies for the region and to seek resources for expanded family planning programmes.

The Ministry of Health accordingly supports the CARICOM Health Secretariat in its moves to develop a range of population policy formulation activities subject to consultation with the Ministry of Finance and Planning. Similarly we welcome the proposed expansion of the activities of the International Planned Parenthood Federation, (IPPF) to provide further assistance to Family Planning Programmes in the region.

The Ministry understands that USAID are to assist CARICOM and IPPF in these activities under a new Population and Development project. Following discussions between this Ministry and the Health Office of USAID/Barbados, I list below the proposed activities that the Ministry is keen to participate in under this project, provided that fellowships, and/or other funds are made available for the various activities:

(1) Medical Policy & Family Planning

The Ministry would participate in regional and national seminars to assess the latest world-wide research findings in family planning and their implications for Barbados. I understand that assistance would also be available for a Steering Committee of appropriate medical personnel to liaise with CARICOM in planning these policy activities.

(11) Improvement in the Delivery of Family Planning Services

(1) Training: The Ministry will co-operate with IPPF and the University of the West Indies in the design and implementation

Handwritten notes and stamps in the left margin:  
MCTH  
✓  
✓  
✓  
✓  
25/04/82  
Mischel in IP.  
3/19/82  
M. J. ...

of training courses to be funded by USAID. The courses will be for medical personnel at all levels and the emphasis should be on in-country training rather than on scholarships for overseas courses. The courses will be developed in close co-operation with the ongoing Advanced Fertility Management courses at UWI, Mona, Jamaica.

- (11) Family Life Education: The Ministry would send participants to "training of trainers" activities aimed at increasing the Family Life Education resources of those involved in teacher training. The Ministry would also welcome the development and preparation of appropriate Family Life Education materials for use in schools.
- (111) Contraceptive Commodities: The Ministry would welcome contraceptives supplied by USAID under this project for distribution through its ongoing Medical and Child Health Programme.
- (1V) Non-clinic Distribution of Contraceptives:  
  
The Ministry would liaise closely with the design teams of the proposed commercial retail sales programme and the proposed Community Based Distribution programme to be organised through the IPPF project office and funded under this project. The Ministry will inspect and approve all advertising and educational material to be used on these programmes prior to their release.
- (v) Adolescent programmes: The Ministry recognizes the medical, social and economic problems associated with teenage pregnancies and would therefore welcome technical assistance and financial support to design and implement new programmes to improve the delivery of family planning services to young people.

With regard to the development of appropriate population policies as mentioned in paragraph 1 above, this matter will be referred to the Ministry of Finance and Planning for consideration, as they are responsible for such policies. The Ministry of Finance and Planning will be informed of the assistance which is available from USAID and requested to discuss the matter with you.

3.

The Ministry of Health looks forward to co-operating with the two executing agencies of this USAID project and will be pleased to provide your office with any further details required in the design of the project.

Yours faithfully,

*A.P. Daniel*

A.P. DANIEL  
Permanent Secretary.

Mr. William Wheeler,  
Gulf House,  
Broad Street,  
BRIDGE TOWN.

APD:evm.



B. Development of a comprehensive training program for health services personnel in family planning counselling and methods. This must be undertaken with the understanding that all in-country training is done in a way that reinforces the "health team" that we are developing. Specific areas are:

1. Physicians

- In-country updates on family planning methods.
- Fellowships to UWI/Jamaica course in surgical contraceptive (2)

2. Nurses

- Fellowships to Advanced Fertility Management course at UWI/Jamaica (3)
- Fellowships in training techniques/methods for nurses that will assume training responsibilities (2)
- Assistance in developing and conducting an in-country course for nurses in family planning techniques and counseling (approximately 50 nurses)
- Fellowships for the family planning program administration course at UWI/Jamaica (2)

3. Appropriate in-country training for public health inspectors, pharmacists and other members of the "health team".

C. Clinic renovations and equipment

We would appreciate as much assistance as can be provided in this area. A detailed request will be submitted shortly.

D. Family Life Education

We are currently developing a family life education program for use in our schools and would like:

- Fellowships for a specially designed course in the development of family life education programs for

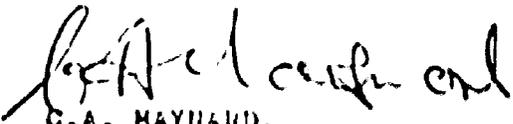
- Assistance with the procurement and production of classroom teaching materials.

E. Youth Activities

We will be opening an experimental youth center in Roubaix in July this year. We would appreciate help in equipping the clinic attached to this center and in development support for the health/family planning component of the centre's program. We would also appreciate assistance in developing a youth outreach program that would be run out of this centre.

I realize that the specifics of each area will have to be worked out later, but understand that the above (with the addition of details on clinic renovations and equipment) will be sufficient to allow you to approve the project. We look forward to participating in this project.

Sincerely yours,



C.A. MAYNARD,

Minister for Education and  
Health.

Telephone 2521

Ref: MEHW/55

Montserrat, W. I.

9th July, 1981

Mr. Mark J. Larkin,  
Regional Health/Nutrition/Population Adviser,  
P.O. Box 302,  
Bridgetown,  
Barbados.

Dear Mr. Larkin,

Many thanks for your letter of the 2nd June, 1981 requesting an outline of the priority needs of Montserrat in population/family planning programs.

Listed below are Montserrat priority needs:

- (a) Continuation of the training of the Family Nurse practitioners;
- (b) Provision of the attached list of commodities for the District Clinics. A delivery van is also required but this has been omitted from the list as your letter stated that given the limitations of the proposed budget it is not felt that it will be possible to provide vehicles;
- (c) Technical Assistance in the development of population policies and programs;
- (d) The formulation and implementation of Family Life Education Programme for Schools, Youth Groups and the Community in general;

I look forward to discussing and elaborating on the above areas of need sometime during the up-coming Health Ministers Conference in Belize.

With best regards,

Yours sincerely,

  
.....  
J. H. Hillier

LIST OF EQUIPMENT FOR PRIMARY HEALTH CARE PROJECT, DISTRICT HEALTH CLINICS

<u>ITEM</u>	<u>Nr</u>	<u>US \$ Each</u>	<u>US \$ Item Cost</u>
1. Refrigerator	6	250	1500
2. Revolving stools	12	90	1080
3. Detecto Pediatric Scale	12	175	2100
4. Aneroid Sphyg w/case	12	35	420
5. Haemoglobinometer	12	35	420
6. Sterilizer, Forceps 10"	24	20	480
7. S.S. Instrument tray 13½ x 9½ x 5/8	12	9	108
8. S.S. Sterilizer Drum 9½ x 6½	12	30	360
9. Anglepoise Lamps	11	45	495
10. Examination Couch w/lithotomy supports	11	50	550
11. Soiled dressing bins w/foot pedal	11	10	110
12. SS Instrument Trays 17 x 15½ x 5/8	12	12	144
13. Microscope	1	1000	1000
14. Filing Cabinet 4 - drawer	12	200	2400
15. Chairs	24	30	720
16. Desks	11	200	2200
17. Nurses visiting bag	12	25	300
18. Delivery Bags, complete	12	50	600
		<b>Total</b>	<b>14,987</b>

HEALTH DEPARTMENT, page 12  
GLENDON HOSPITAL,  
P. O. BOX 24,  
PLYMOUTH,  
MONTSERRAT, W. I.

29th March 19 82

Your ref. \_\_\_\_\_

Our ref. \_\_\_\_\_

Mr. Paul Klipman,  
USAID,  
US Embassy,  
Bridgetown,  
Barbados.

Dear Mr. Klipman,

Further to our discussions on March 8th, I am submitting our application to be included in the Family Planning Project. The delay in writing is due to the fact that I was off island for two weeks.

I am submitting our basic requirements but I can not put costing.

We will require:

1. a) Combined pills x 3,000 user months  
b) Copper T IUD x 50  
c) Couches with stirrups x 6  
d) Stirrup without straps x 4 pairs  
e) Speculums forceps.
2. Training for all nurse-midwives in family planning techniques - 36 persons.  
  
Training for ancillary workers - nursing assistants and other public health staff.
3. Assistance to modify a clinic to provide family planning services - EC \$12,000.

Should you require clarification, please contact me.

Yours sincerely,

*Florence Daley*  
Florence Daley  
Principal Nursing Officer



ST. CHRISTOPHER NEVIS

Ref. No. H/D11

Ministry of Education, Health & Social Affairs,  
P. O. Box 333,  
NEWSTEAD BUILDING,  
ST. KITTS, W. I.

23rd March 1982

Mr Mark J. Laskin  
Regional Health/Nutrition/  
Population Advisor  
P O Box 302  
Bridgetown  
BARBADOS

Dear Sir

I have to refer to your correspondence of 5th January 1982 re  
Contraceptive Commodities.

There is great need to repair and extend Health Centres to meet the  
Family Planning requirements. In your last visit we discussed possibili-  
ties for Cayon Health Centre and St Pauls Health Centre.

There is co-ordination with Family Planning Association in Family  
Life Education Programme in schools and Young Mother's Clubs in St. Kitts.

We would like to establish an out-reach programme for youths through-  
out St. Kitts - Nevis.

We would also like to see on site training of all Nurse/Midwives in  
Family Planning Techniques, so that all clinics will have at least one (1)  
Nurse trained in Family Planning, attached to each Health Centre.

Equipment:-

	ACTION	INFO	
Examination Tables			6
Examination Lamps			6
Instrument Trolleys			6
Instrument Trays and Cover			12
Specula (disposable)			1,000
Specula (Metal)			200
Scissors curved			12
Scissors straight			12
Vulvaclum Forceps			12
Bowls (Medium)			24
Kidney dishes (Medium)			24
Syringes 5 cc (disposable)			5,000
Syringes 2 cc			5,000

Mr Mark J. Lackin

- 2 -

23rd March 1982

Needles 1" disposable	5,000
Needles ½" disposable	5,000
Cotton Wool	
Glass Slides	50 boxes
Sterilizing drums	
Sterilizers boiling type	6

- (1) Microgynon is used and very highly acceptable.
- (2) Norminest is also used but the pregnancy rate is relatively high in comparison to other O.C's.
- (3) Ortho - Novum is not used.

Copper "T"s are gaining popularity and expulsion rate and cramps are less experienced.

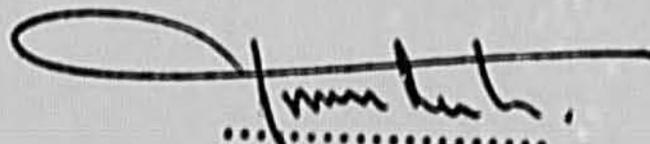
The Saf - T - Coil is not used.

Lippes Loop is used sizes 'C' and 'D' but the expulsion rate is relatively high.

Diaphragms are increasing. The Coil Spring is the only one available, but I agree that the arching spring is preferable and would be grateful to have Arching Spring diaphragm available.

Pregnancy Test. Presently we are out of stock and the demand is great. The Pregnostican Dry Dot is preferred as it is easily stored, and quite accurate.

Yours faithfully



.....  
O A Hester  
Permanent Secretary



Communications on this subject  
should be addressed to:-

THE MINISTER

and the following  
Number quoted:

17th May ..... 10.....82

Mr. Wheeler  
USAID  
Barbados.

Dear Mr. Wheeler,

REQUEST FOR PARTICIPATION IN USAID POPULATION  
AND DEVELOPMENT PROJECT

At the Conference of Ministers responsible for Health held in Belize in July, 1961, the Ministers resolved to seek assistance in developing appropriate population policies for the region and to seek resources for expanded family planning programmes. (Resolution No. 20: "Population and Health"). The Government of Saint Lucia accordingly supports the CARICOM Health Secretariat in its move to develop a range of population policy formulation activities and welcome the proposed expansion of the activities of the International Planned Parenthood Federation, (IPPF) to provide further assistance to family planning programmes in the region.

We understand that USAID are to assist CARICOM and IPPF in these activities under a new population and development project. Following discussions between this Ministry and the Health Office of USAID/Barbados, we list below the proposed activities that Saint Lucia is keen to participate in under this project.

I. Policy

1. Saint Lucia would participate in regional seminars to assess demographic trends and their impact on development.
2. Saint Lucia would welcome the preparation and distribution of brief, non-technical reports to publicize the findings of the 1960 census.
3. Saint Lucia would welcome assistance through CARICOM to establish a National Population Task Force. This task force would aim to produce an appropriate population policy for Saint Lucia.
4. In the area of medical policy and family planning Saint Lucia would participate in regional and national seminars to assess the latest worldwide research findings in family planning and their implications for Saint Lucia. We understand that assistance would also be available for a steering Committee of appropriate medical personnel to liaise with CARICOM in planning these policy activities.

II. Improvement in the Delivery of Family Planning Services

1. Training: The Ministry of Health will cooperate with IPPF and the University of the West Indies in the design and implementation of training courses to be funded by USAID. The courses will be for medical personnel at all levels. We understand that the emphasis will be on in-country training rather than on scholarships to overseas courses. The courses will be developed in close cooperation with the ongoing Advanced Fertility Management courses at UWI, Mona, Jamaica.

2. Family Life Education:

Saint Lucia would send participants to "training of trainers" activities aimed at increasing the Family Life Education resources of those involved in teacher training. Saint Lucia would also welcome the development and preparation of appropriate Family Life Education materials for use in schools.

3. Contraceptive Commodities:

The Ministry of Health would welcome contraceptives supplied by USAID under this project for distribution through its ongoing Maternal and Child Health programme.

4. Non-clinic Distribution of Contraceptives:

The Ministry of Health would liaise closely with the design teams of the proposed commercial retail sales programme and the proposed Community based Distribution programme to be organized through the IPPF project office and funded under this project. The Ministry will inspect and approve all advertising and educational material to be used on these programmes prior to their release.

5. Clinic Equipment:

The Ministry of Health understand that USAID are including funds under this project for the provision of clinic equipment for family planning purposes. Saint Lucia would welcome assistance in this area. A list of clinics is attached that would offer family planning services were equipment made available under this project. We recognize that project funds may not extend to equipping all the clinics on this list.

6. Clinic Improvement:

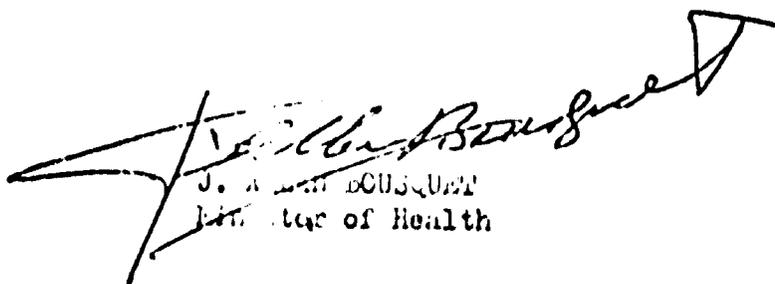
Some of our clinics do not have the space to offer family planning services even if equipment were available. We would welcome assistance in modifying and improving existing clinics to enable the space or facilities to be made available. The attached list details those clinics which require such improvement in order of priority.

7. Adolescent programmes:

The Ministry recognizes the medical, social and economic problems associated with teenage pregnancies. We would welcome technical assistance and financial support to design and implement new programmes to improve the delivery of family planning services to young people.

8. The Ministry of Health looks forward to cooperating with the two executing agencies of this USAID project and will be pleased to provide your office with any further details required in the design of the project.

Yours sincerely,



J. A. BOUSQUET  
Minister of Health



Mr. William B. Wheeler,

6th May, 1982.

- Management course at UWI/Jamaica.
- Fellowship in training techniques/methods for Nurses that will assume training responsibilities.
- assistance in developing and conducting an in-country course for Nurses in Family Planning Techniques and counselling (approximately 50 Nurses).

3. Fellowship to the Family Planning Program administration course at UWI/Jamaica.
4. Assistance with appropriate in-country training for Public Health Inspectors, Assistant Nurses, Dispensers and other members of the Health Centre team.

(c) Clinic renovations and equipment:

We would appreciate assistance with expansion/renovations to existing clinics so as to make them suitable for providing family planning services. We also will need some minimal equipment needed for family planning service delivery. A list of the clinics that need work and necessary equipment has already been given to Allen Randlov.

(d) We are interested in exploring the possibility of developing programs specifically for teenagers, or in modifying our existing programs so that they better serve the needs of teenagers. If USAID can assist with some of the costs, including staff salaries, involved in starting such programs it would be appreciated. We do, however, recognize that such programs should be designed to use existing staff/facilities to the extent possible and that if USAID does provide salary support, that it will be for no longer than 18 months at which time the Government of St. Vincent would be responsible for continuing the program(s).

(e) Community based distribution of contraceptives and commercial retail sales of contraceptives are project elements that are of interest but which will need to be discussed further before we can say that they are appropriate for St. Vincent.

(f) Family Life Education:

We are currently developing a family life education program for use in our schools and would like:

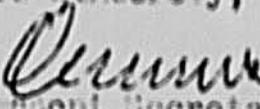
1. Fellowships for a specially designed course in the development of family life education program for Tutors at the Teachers College.
2. Assistance with the procurement and production of classroom teaching materials.

(3)

I realize that the specifics of each area will have to be worked out later, but understand that the above information will facilitate the rapid approval and start-up of this effort.

We look forward to participating.

Yours sincerely,

  
Permanent Secretary  
Ministry of Health.

Caribbean Community Secretariat  
Bank of Guyana Building  
P.O. Box 10827  
Georgetown  
Guyana

COMMCOM

97/30  
PID:rbh.

1982-05-06

SEARCHED	INDEXED	SERIALIZED	FILED

Handwritten notes: "S" and "L" in the SERIALIZED and FILED columns respectively. "MTH" written vertically on the right side of the table.

Dear Mr. Wheeler,

Please be so good as to refer to my letter of April 10, 1981, in which I asked you to arrange for Dr. P.L. Boyd, Chief of our Health Section, to begin discussions with your staff about possible cooperation in the area of population, health and development.

I am writing now to make a formal request for the assistance of USAID in a project that would deal with some of the demographic problems of our Member States, specifically Barbados and the so-called Less Developed Countries.

The areas in which we are particularly interested to cooperate include population policy, the creation of greater awareness of the issues among the public, including the leaders, and the orientation of the medical and other health staff. As you know, we have a strong ministerial mandate for this activity.

We look forward once more to cooperating with you in a programme area which is highly relevant to human development in the Caribbean Community.

Yours sincerely,

*Kevin Singh King*  
SECRETARY GENERAL

Mr. William Wheeler  
Director  
USAID RDO/Caribbean Office  
P.O. Box 302  
Bridgetown  
BARBADOS

i. High Season Airfares as of 3/1/82 (US Dollars): Source: BITS

<u>Round Trip to Barbados</u>		<u>Round Trip to Jamaica</u>	
Dominica	\$152.00	Dominica:	\$459.50
Antigua	143.00	Antigua	271.50
St. Vincent	100.00	St. Vincent	407.50
St. Lucia	93.00	St. Lucia	400.50
St. Kitts	247.00	St. Kitts	554.50
Montserrat	202.00	Montserrat	509.50
Belize	581.00	Belize	494.50
Grenada	105.00	Guyana	367.50
Guyana	<u>192.00</u>	Barbados	<u>307.50</u>
Average:	\$202.00	Average	\$420.00
Atlanta GA:	\$650.00		
Washington, D.C.:	\$583.00		

ii. Per Diem Rates as of 3/1/82: Source: Controller

Dominica	\$ 79.00
Antigua	146.00
St. Vincent	89.00
St. Lucia	115.00
St. Kitts	79.00
Montserrat	93.00
Belize	78.00
Guyana	76.00
Barbados	<u>148.00</u>
Average:	\$100.00

iii. Consultancy fees:

U.S. \$271.15 (Maximum allowable rate for AID direct contract)  
W.I. \$150.00



**B. Country Population Reports**

Consultants fees	▪	5,000.00
Computer Time AID/W	▪	1,000.00
Printing	▪	<u>55,000.00</u>
<b>Total</b>	▪	<b>61,000.00</b>

**C. Regional Awareness Seminar**

**1. Background Materials: Publication of population reports**

**10,000.00**

**2. Seminar Expenses**

**a. Participants**

Travel: 80 x 202 **16,160.00**

Per Diem: 100 x 80 **8,000.00**

**b. Consultants**

Demographer (US)

Salary: \$221.15 x 4 **884.60**

Travel Washington D.C./Barbados **583.00**

Per Diem: 148 x 3 **444.00**

**c. Honorarium for 5 speakers: 100 x 5 **500.00****

**d. Conference Room/Miscellaneous **1,000.00****

**1. Background Materials **10,000.00****

**2. Seminar Expenses **27,572.00****

**Total **37,572.00****

**Approx. **38,000.00****

**D. Rapid Presentations - S & T/Population**

Cost per presentation is estimated at approximately \$63,000. This includes technical assistance, development of programs and equipment.

**E. Demographic Training**

1. Participants (18)	<u>67,296</u>
Travel: Barbados - 202 X 16 X 3	9,696
Per Diem: Barbados - 100 X 16 X 12 X 3	57,600
2. Consultants	21,970
RSSAW U.S. Bureau of Census	
Salary: 150 X 2 X 30	= 9,000
Travel (Wash Dc/Barbados)	
583 X 6	= 3,498
Per Diem: 148 X 2 X 32	9,472
3. Conference Room/Miscellaneous	<u>250</u>
<b>TOTAL</b>	<b>89,516</b>

**2. Medical Policy****A. Steering Committee Meetings**

UNI, CARICOM, IPPF, CMA, AID

**Travel**

Jamaica/Barbados	<b>\$ 307.50</b>
Guyana/Barbados	<b>192.00</b>

**Per Diem**

100 X 2 X 2 =	<b>400.00</b>
---------------	---------------

**Consultant**

Daily Rate \$221.15 X 2	<b>442.30</b>
Travel Washington D.C./Barbados	<b>583.00</b>
Per Diem 148.00 X 3	<u>445.00</u>
	<b>2,369.80</b>
<b>Approx.</b>	<b>2,400.00</b>

**B. Regional Seminar on Family Planning Policies**

I. 20 participants 2 days	
Travel 210 x 20	4,200.00
Per Diem 100 x 20 x 2	4,000.00
	<hr/>
	8,200.00

**Consultants**

Daily Rate 221.15 x 2	422.30
Travel Washington, D.C./Barbados	583.00
Per Diem 148 x 3	445.00

Consultants 1,470.30

TOTAL = 9,670.00

Approx \$10,000.00

Two planned = \$20,000

**C. National Seminars (18)**

I. Conference/Miscellaneous **500.00**

II. Consultants (?)

Travel

Jamaica/Barbados \$ 307.50

Guyana/Barbados 192.00

Salary \$100.00 x (4) 400.00

Per Diem 100.00 x (4) 400.00

**Total \$1,799.50**

1800 x 18 = 32,400 Approx. \$33,000

D. Short Term Observational Training (12)

Travel

Barbados/Jamaica	\$ 307.50
Per Diem 100.00 x 7	700.00
<b>Total</b>	<b>\$1,007.50</b>

1,007.50 x 8 = \$8,019.00

3. CARICOM Administration

	<u>TOTAL</u>	<u>AID</u>	<u>CARICOM</u>
Project Manager	30,000		30,000
Project Administrator	48,000	48,000	
Administrative Staff	48,000	36,000	12,000
Operating Expenses	30,000	30,000	
Travel	30,000	30,000	
Office Space	16,000		16,000
Central CARICOM			
Support	13,000		13,000
	<u>215,000</u>	<u>144,000</u>	<u>71,000</u>

## II. IMPROVEMENT IN SERVICE DELIVERY

### A. High Season Airfares and Per Diem as of 03/01/82 (U.S. dollars):

Source: BITS, CONTROLLER

i. <u>Jamaica to:</u>		<u>Per Diem</u>
Dominica	459.50	\$ 79.00
Antigua	271.50	146.00
St. Vincent	407.50	89.00
St. Lucia	400.50	115.00
St. Kitts	554.50	79.00
Montserrat	509.50	93.00
Belize	494.50	78.00
Guyana	367.50	76.00
Barbados	307.50	148.00
Average	419.17	Average 100.00

### ii. Consultants (2) Salary 150/day

Cost for one consultant for five days.

Dominica	459.50 + 750 + 475	1,684.50
Antigua	271.50 + 750 + 876	1,897.50
St. Vincent	407.50 + 750 + 534	1,691.50
St. Lucia	400.50 + 750 + 690	1,840.50
St. Kitts	554.50 + 750 + 475	1,779.50
Montserrat	509.50 + 750 + 558	1,817.50
Belize	494.50 + 750 + 468	1,712.50
Barbados	307.50 + 750 + 890	1,947.50
	<b>TOTAL</b>	<b>14,371.50</b>
	<b>x 2 =</b>	<b>28,743.00</b>

## B. Project Costs by Activity

### i. Training

#### 1. Doctors

a. John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). Two doctors per year for four years. Training

two weeks per doctor.

Unit Cost

Average Airfare	420.00
Hotel Per Diem 100 x 4	1,400.00
JHPIEGO Course	2,500.00
	<hr/>
	4,320.00
Eight suggested	32,560.00

**b. On-site Training**

Consultants	29,900.00
Conference Room/Miscellaneous	1,500.00
	<hr/>
TOTAL	30,500.00

**c. Seminar on Family Planning Techniques**

Seven one day Seminars Planned.

Unit Cost

Consultants UWI 150.00 x 2	742.30
U.S. 221.15 x 2	
Per Diem 100 x 2	200.00
Air Fare 420.00	1,003.00
583.00	
Miscellaneous	1,000.00
	<hr/>
TOTAL	2,945.30
x 7 =	<u>20,675.00</u> = 51,000

**2. Nurses**

Fertility Course UWI Jamaica

Unit Cost

Course	1,200.00
Travel	420.00
Per Diem	1,200.00
	<hr/>
TOTAL	2,820.00

11. 14 Nurses Years 1 + 2 = \$2,820 x 14 = 39,480.00  
 For training as trainers

iii. 14 nurses for Years 3 + 4 = \$2,820 x 14 = 39,480.00  
(for advanced training)

iv. On-Site Courses

UWI Contract (Salary, Travel, Per Diem)	28,000.00
Country Support: Honorariums, incidental	<u>14,000.00</u>
Training expenses	42,000.00

3. Other Family Planning Personnel

Costs of all this training activity to be met by AID/W through a central contract with Development Associates.

a. In-Country Training Courses for:

Community Health Aides (210)	6,000.00
Nurse Aides (210)	6,000.00
Public Health Inspectors (100)	2,000.00
Pharmacists & Pharmacy Employees (100)	<u>4,000.00</u>
	18,000.00

b. Two week course at Mona for Family Planning Administrators

Units Cost

Tuition and per diem	3,000.00
Air fare	<u>420.00</u>
	3,420.00
Five Participants =	<u>17,000.00</u>

Total Cost of Training for Other Family Planning Personnel =	<u>35,000.00</u>
--	------------------

3. Family Life Education

a. 2 week course in FLE (Antigua)

Air fares 6 x 143	858.00
Hotel/Per Diem 146 x 14 x 6	13,140.00
Consultants	2,000.00
Miscellaneous	<u>1,500.00</u>
	17,498.00

b. In-country Seminars	
Air fares 143 x 6	858.00
Per Diem	2,500.00
Consultants	2,500.00
Miscellaneous	<u>3,500.00</u>
	TOTAL 9,358.00
c. Publications	
	TOTAL <u>40,000.00</u>
	TOTAL 66,856.00

vi Commodity Supply and Distribution

1. Commodity Supply

AID/W Office of Population calculated a total commodity demand for AID Contraceptives of \$298,000 over life of project for the seven countries of Antigua, Barbados, Dominica, Montserrat, St. Kitts/Nevis, St. Lucia and St. Vincent. (See Cable 068050 Annex C). The demand is calculated from the Centers for Disease Control projections for contraceptive usage until 1986, the costs are based on AID/W bulk purchase commodity costs.

The estimates are to fully supply requirements for:

- a. Public Health Systems for distribution through Government Clinics.
- b. Adolescent Clinic and Outreach activities funded under this project.
- c. Five Community Based Distribution Programs launched under this project.
- n.b. The commodities for the commercial retail sales activity are costed and supplied separately. (see below).

2. Technical Assistance to Government Programs

Salaries (Center for Disease Control)	
175 x 120	21,000.00
Air fares Atlanta/Barbados 6 x 650	3,900.00
Per Diem	18,900.00
Inter-Island Travel 210 x 16	2,360.00
Miscellaneous	<u>2,000.00</u>
	TOTAL 49,160.00

3. Community Based Distribution

<u>Unit Costs</u>	AID	
<u>Vehicle</u> : Purchase	7,000	
Operation & Maintenance (2,000 + 4 years)	8,000	
<u>Training</u> :	1,500	
<u>Promotional Materials</u>		
(Average costs)		
i. Posters	1,500	} = 3,500
ii. CBD Signs	1,000	
iii. Radio Spots	1,000	

Commodities - no additional cost to project. Supplied via procurement system previously outlined and costed.

Salaries: Personnel for CBD

Personnel for each CBD project will be provided by the implementing agency, typically the local Family Planning Association. One full time manager for each project will be required at a salary of \$4,500 per year.

Promotional and distribution activities for the CBD project will be incorporated into all FPAs staff job descriptions. The change in emphasis in the allocation of staff time is difficult to cost as it will be a gradual process as the CBD projects develop. By Year 4, the FPA's can expect to be providing the equivalent of two full time staff for the CBD projects at a cost of \$3,500 per person year.

Total counterpart contribution to CBD

	<u>Manager</u>	<u>Promotion &amp; Distribution</u>
Year 1	3,500	3,500 x 1/2
Year 2	4,500	3,500 x 1
Year 3	4,500	3,500 x 1 1/2
Year 4	4,500	3,500 x 2
	<u>18,000</u>	<u>17,500</u>

**TOTAL = \$35,500**

COMMERCIAL RETAIL SALES (CRS)  
(Single cycle Perle &  
Panther 3-pack)

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u> <sup>1</sup>	<u>Year 4</u>
CYP Distributed	8,390	9,760	11,260	12,480
Sales to Public (US\$)	100,339	116,481	134,698	148,939
<b>COSTS</b>				
Advertising/Marketing	75,500	72,200	48,000	27,100
Salary (Sales Supervisor)	12,000	14,000	5,000	5,000
Travel	14,000	14,000	4,000	4,000
Training	5,500	2,000	3,000	1,600
Handling (3%)	1,546	1,795	2,075	2,295
Distribution (25%)	13,285	15,421	17,833	19,718
Retailers (50%)	33,222	38,564	44,597	49,311
<b>GROSS LOCAL COST</b>	155,053	157,980	124,505	108,424
Less built-in ad allowance <sup>2</sup>	(18,343)	(21,084)	(24,455)	(27,005)
<b>NET LOCAL COSTS</b>	136,710	136,896	100,050	81,419
Commodities Export CIF <sup>3</sup>	51,594	59,890	69,257	76,579
<b>TOTAL EXPENSE (less revenue)</b>	87,965	80,305	34,609	9,059
<b>COST/USER/YEAR</b>	10.48	8.23	3.07	0.73
<b>TOTAL CASH COST</b>	140,251	141,006	104,802	86,674

<sup>1</sup> Assumes Sales Supervisor is reduced to less than half time in second and third years.

<sup>2</sup> An advertising allowance of US\$24.5/CC cycle and US\$1/condor 3-pack is included in the CIF cost.

<sup>3</sup> Excludes cost of commodities. With commodity costs included:

COMMODITIES CIF	87,051	101,210	115,840	129,386
TOTAL EXPENSE (less revenue)	123,424	121,611	81,192	61,866
COST/USER/YEAR	14.71	12.46	7.21	4.96
TOTAL CASH COST	175,710	182,334	151,385	139,481

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>
<b>I. EXPENSES</b>				
<b>A. ADMINISTRATION</b>				
1. Sales Supervisor	12,000	14,000	5,000	5,000
<b>B. PROMOTION</b>				
1. Advertising/Marketing	75,500	72,200	48,000	27,100
2. Sales Travel	14,000	14,000	4,000	4,000
<b>C. PRODUCT EXHIBIT COST*</b>				
1. Containers	24,549	28,923	33,298	36,889
2. OCS	8,703	9,883	11,505	12,685
<b>D. TRAINING</b>	5,500	2,000	3,000	1,000
<b>TOTAL COST</b>	<b>140,252</b>	<b>141,006</b>	<b>104,803</b>	<b>86,674</b>
<b>II. REVENUE</b>				
Estimated Revenue to Project (CIP Price)	51,594	59,890	69,257	76,579
<b>III. NET COST</b>	<b>88,658</b>	<b>81,116</b>	<b>35,546</b>	<b>10,095</b>
Number of Users (CYP)	8,390	9,760	11,260	12,480
Net Cost/CYP	10.57	8.31	3.16	0.81

\* CIP price minus advertising allowance (excluding cost of commodities)

**iii. Extension of Clinical Services**

A. Equipment: (See attached list of equipment): Average  
\$2,000

1. Antigua: To introduce FP into clinical services, equipment will be required for all clinics including those not being renovated:

15 clinics x 2,000 = \$30,000

2. Dominica: To make equipment additions and improvements to 10 clinics, to fully equip 5 clinics.

10 x 500 = \$5,000

5 x 2000 = 10,000

\$15,000

3. St. Lucia: To equip 10 clinics

10 x \$2,000 = \$20,000

4. St. Vincent: To equip 10 clinics

10 x 2,000 = \$20,000

5. Montserrat: To introduce FP into clinic service

6 x 2,000 = \$12,000

6. St. Kitts/Nevis: To improve equipment in 12 FP clinics and add FP services to another 3 clinics.

12 x 500 = 6,000

3 x 2,000 = 6,000

12,000

**Total Equipment = \$109,000**

EQUIPMENT LIST

Medical Equipment for Health Centers

<u>Item</u>	<u>Unit Price</u>	<u>No.</u>	<u>Cost</u>
<u>U.S. Purchase</u>			
Gynecological table	238.50	1	\$ 238.50
Examining stool (Taboret)	66.50	1	66.50
Foot stool	25.90	1	25.90
Utility stand	105.00	1	105.00
Gooseneck examining lamp	35.80	1	35.80
Scale physician adult metric	161.15	1	161.15
Mercurial Sphymomanometer	70.00	1	70.00
Stethoscope biauricular	6.65	1	6.65
Fetoscope (Pinard)	35.00	1	35.00
Dressing jar	25.50	2	51.00
Emesia basin	6.50	2	13.00
Instrument tray w/c	25.92	2	51.84
Instrument tray	8.73	1	8.73
Medium size speculum	9.15	6	54.90
Large size speculum	10.80	3	32.40
Small size speculum	8.70	2	17.40
Sterilizer Instrument - Boiling type	800.00	1	800.00
Sound uterine	9.10	2	18.20
Forceps uterine tenaculum	19.00	2	38.00
Thermometers	0.50	6	3.00
Sub-total (estimate cost)			\$1,834.30
Plus 10% for shipping =			183.43
			<u>\$2,017.73</u>
			*****

1. Antigua

The following clinics require the addition of a room so that family planning services can be delivered from them: Parham; Bethesda; Cedar Grove; John Hughes; Johnson Point; Potters; Piggots.

The precise architectural details of the additional room will vary according to the nature of the existing clinic structure. In each case however, a 10-foot-by-10-foot room with block walls, a cement floor and a sheet roof will be required. The room will have all necessary plumbing and electrical fixtures.

The estimated cost of materials and labor for this additional room is calculated at EC\$100 per square foot (at 1982 prices).

100 square foot X EC\$100 = US\$3,775 per clinic

Non-clinical equipment will also be required in the form of cupboards, shelves, desks and chairs, at a cost of US\$400 per clinic.

Total costs for Antigua: 7 X \$4,175 = \$30,000

2. Dominica

The clinics at Vical, Calibishi, Castelbruce, Wesley, Delicies, Grand Fort, Salibia and Grand Bay will be improved or extended under this project to provide family planning services. The details are as follows:

Vical: Repairs to roof, doors and ceilings, internal partitions. Estimated cost EC\$10,000.

Calibishi: Badly hurricane damaged. Unable to deliver family planning services as no appropriate examination room is available. Repairs to existing structure (roof, ceiling, doors, paint, windows) and electrical modifications. Estimated cost EC\$20,000.

La Plaine and Wesley: Renovations needed to enable adequate family planning services to be delivered. Roof in need of major repair. Windows. No adequate plumbing. Also plan to enclose waiting area for clients to make clinic attendance more likely. (Clients currently have to sit in the sun or rain whilst waiting). Estimated costs EC\$20,000 per clinic = \$40,000.

Grand Fort, Grand Bay, Delicies, Castelbruce, Salibia: These five clinics all require an extension in order to effectively deliver family planning. Additionally there is

a need for an enclosed waiting area and some repairs to the existing roofs. The Ministry of Health estimate this work will cost a total of EC\$70,000.

Total clinic improvement costs for Dominica (Year I costs) US\$54,000.

Also non-clinic equipment for the eight clinics at US\$400 per clinic = US\$3,200.

Total clinic improvements for Dominica = \$57,000.

3. Montserrat

Extensions and improvements to Bephel clinic entailing windows, plumbing, roof, electricity and non-clinic furniture estimated at a total cost of EC\$13,000.

Total costs Montserrat \$5,000.

4. St. Kitts/Nevis

A total of US\$27,000 has been reserved for St. Kitts/Nevis to carry out extensions to eight clinics. Details are still being awaited.

5. St. Lucia

The following clinics require modifications to their internal structure and minor renovations to enable family planning services to be delivered. These alterations are mainly to add partitions to enclose a private area for examinations and counseling. The renovations are to the roofs, windows and to improve waiting areas to make the clinic more amenable to the potential client. Vieux Fort (EC\$10,000), Dennery (EC\$10,000), Canaries (EC\$8,000).

La Croix Health Center requires an extension to enable an examination room and an operating area for sterilizations to be added. This extension will cost EC\$14,000. Similarly Gros Islet will require a similar extension at EC\$14,000. The clinics at Castries, Mon Repos, Micoud, Babaneau, Richford, La Fargue, T. Rocher and Boguis all require extensions for a family planning room at EC\$10,000 per clinic.

Total clinic improvement costs for St. Lucia = US\$56,000  
(Year I cost)

Clinic Improvements

St. Vincent

2 comprehensive clinics need work

1. Biabou is really small - needs an extra room 10ft X 10ft and screen off the waiting area, exam couch and light.
2. Calder is big enough but run down, needs screens to privacy of patients can be guaranteed.

Fence around year

new paint

better internal partitions

8 regular clinics to be upgraded to comprehensive clinics

- |                      |                    |
|----------------------|--------------------|
| 3. Belair            | 11. Spring Village |
| 4. Lowman's Windward | 12. Rose Hall      |
| 5. Camden Park       | 13. South Rivers   |
| 6. Layou             | 14. Barrouaille    |
| 7. Enhams            | 15. Richlaud park  |
| 8. Diamond Village   | 16. Paget Farm     |
| 9. Byera Hill        |                    |
| 10. Troumaka         |                    |

All will require an extra 10ft X 10ft room

Re: Construction: they will have Ministry of Works contracted to do the work. Estimate 10 x 10 room will cost US\$4,000 for block walls, cement floor, sheet roof and necessary plumbing, electrical fittings, ceiling, windows and doors.

16 clinics at \$4,000 = \$64,000

CLINIC IMPROVEMENTS SUMMARY

Antigua	\$ 30,000
Dominica	\$ 57,000
Montserrat	\$ 5,000
St. Kitts/Nevis	\$ 27,000
St. Lucia	\$ 56,000
St. Vincent	<u>\$ 64,000</u>
TOTAL COST	<u>\$239,000</u>

Inflation is not included in these figures. Most of this activity will be spread across years one, two and three of the project. The Budget figures have been adjusted accordingly.

Budget for Youth Clinics

<u>Unit Costs</u>	<u>AID</u>	<u>Countries</u>
Clinic Equipment (See Attached)	2,000	-
Furniture (See Attached)	800	-
Supplies (500 x 4)	2,000	
Promotional Mention	2,400	
Equipment	2,000	
Salaries: Nurses	7,125	11,765
Doctors	-	4,000
Clinic Alterations	1,500	
Maintenance	-	<u>1,000</u>
	<u>17,825</u>	<u>16,765</u>

- n.b. Salaries: AID will pay Year 1 salaries for nurses and 50% Year 2. Doctors' salaries will be met by government where voluntary attendance on a roster basis for twice monthly sessions cannot be arranged.

Unit cost of \$18,000 to RDO/C

7 units = \$126,000.

A total of 9 person months of Technical Assistance will be provided to design and support the Youth Clinic Program. This will allow two weeks to each program in the first year and a further week per year thereafter.

TA @ \$5,000 per person months for 9 months = \$45,000

So total Youth Clinic costs = \$171,000

Detailed Description of Furniture  
for Youth Clinics

Desk 1	=	\$ 200
Chairs for Nurse and Doctor 2 @ \$50	=	100
Chairs for Clients 3 @ \$30	=	90
Cupboards for Storage of Equipment and Commodities 2 @ \$25	=	50
Card and File System 1	=	250
Other	=	100
	= approx	<u>\$800</u>

Source: G50

DETAILED DESCRIPTION OF CLINIC EQUIPMENT  
FOR YOUTH CLINICS

<u>Item</u>	<u>Unit Price</u>	<u>No.</u>	<u>Cost</u>
<u>U.S. Purchase</u>			
Gynecological table	238.50	1	\$ 238.50
Examining stool (Taboret)	66.50	1	66.50
Foot stool	25.90	1	25.90
Utility stand	105.00	1	105.00
Gooseneck examining lamp	35.80	1	35.80
Scale physician adult metric	161.15	1	161.15
Mercurial sphygmomanometer	70.00	1	70.00
Stethoscope binauricular	6.65	1	6.65
Fetoscope (Pinard)	35.00	1	35.00
Dressing jar	25.50	2	51.00
Emesis basin	6.50	2	13.00
Instrument tray w/c	25.92	2	51.84
Instrument tray	8.73	1	8.73
Medium size speculum	9.15	6	54.90
Large size speculum	10.80	3	32.40
Small size speculum	8.70	2	17.40
Sterilizer Instrument - Boiling type	800.00	1	800.00
Sound uterine	9.10	2	18.20
Forceps uterine tenaculum	19.00	2	38.00
Thermometers	0.50	6	3.00
<b>Sub-total (estimate cost)</b>			<b>\$1,834.30</b>
<b>Plus 10% for shipping</b>			<b>183.43</b>
			<b><u>\$2,017.73</u></b>

Budget for Youth Outreach

<u>Unit Costs</u>	<u>AID</u>	<u>Countries</u>
Vehicle	7,000	-
Operation & Maintenance (2,000 x 4 = 8,000)	3,000	5,000
Educational Equipment & Material	2,500	-
Salaries	10,500	17,500
	<u>23,000</u>	<u>22,500</u>

Unit cost @ RD0/C = \$23,000

Eight Units = \$184,000

A total of 11 person months of Technical Assistance will be funded under the project to design and support the Youth Outreach Projects. This will allow two weeks to each program in the first year and a further week per year thereafter.

11 person months TA @ \$5,000 per month = \$55,000

So total cost of Youth Outreach =  $\begin{array}{r} 184,000 \\ \underline{55,000} \\ \$239,000 \end{array}$

Male Attitude Survey

- 90 days professional services of one social scientist @ \$150 per day	▪	<b>\$13,500</b>
- 100 days travel and per diem @ \$100 per day and air fare	▪	<b>11,500</b>
- Report preparation, printing and distribution	▪	<b>3,000</b>
- Resource (Questionnaires; computer time; research assistant)	▪	<u><b>2,000</b></u>
		<b>\$30,000</b>

**III. Beneficiary Contribution - Source CARICOM**

<b>I. <u>Per day salary Rates in LDC's</u></b>	<b>(U.S. Dollars)</b>
Doctors	26.00
Nurses	7.00
Allied Health Workers	7.00
Pharmacists	17.00
Public Health Inspectors	9.00
Teachers	7.00
Principals	14.00
Chief Education Officers	21.00
Family Planning Administrators	14.00
Community Development Workers	7.00

**I. Counterpart In-kind Contribution**

<b>A. <u>Demographic Policy</u></b>	<b>\$27,000</b>
1. National Population Task Force	2,800
2. Conferences	4,200
3. Demographic Training	20,160
<b>B. <u>Medical Policy</u></b>	<b>\$3,000</b>
Seminar	840.00
National Seminar	1200.00
Short-term Training	840.00
<b>C. <u>Training</u></b>	
Doctors	20,000
Health Professionals	13,000
JHPIEGO	2,000
Seminar on Family Planning Techniques	4,800
Nurses	10,050
Allied Health Workers	10,000
Other	1,870

## B. AID Supply Requirements

The data presented in Tables 1-4 are estimates of contraceptive use and AID's supply requirements for the seven project countries for 1982-1986. In order to estimate use and AID's supply requirements, the following methodology was used.

1. The 1980 population of women age 15-44 in the seven project countries were estimated either from preliminary 1980 census data or by using the latest available population projections. Then the 1980 populations of women age 15-44 were projected by single years for 1981 through 1986 (Table 5). It should be emphasized that population growth rates were difficult to establish for these countries because of the unknown magnitude of future migration in the region.
2. Contraceptive use by method was then estimated for the project years. For five of the countries (St. Lucia, St. Vincent, Dominica, Antigua, and Barbados) the results of contraceptive prevalence surveys conducted in these countries in 1981 were used as a baseline (Tables 6-10). For St. Kitts-Nevis and Montserrat, data on contraceptives dispensed/issued by the family planning associations on these islands in 1977-1981 were used for this purpose (Table 11).
3. By multiplying the population projections by the prevalence rates, the number of women 15-44 contracepting by method were estimated. Then the number of cycles of oral contraceptives, units of condoms, vaginal methods and injections to be used each year of the project were determined by multiplying the estimated number of women using each of these methods by the number of units of each contraceptive that is equivalent to 1 Couple Year of Protection (CYP), e.g., 13 cycles of oral contraceptives, 120 condoms, 4 tubes (20 tablets each) of foaming tablets or cream, jelly, foam, and 4 injections. Injections were included in order to estimate the number of doses that will need to be supplied by non-AID sources.
4. The next step was to determine contraceptive use by source of contraception. This was done by using data on source of contraception by method from the contraceptive prevalence surveys. Thus, this step identifies which agencies will be recipients of AID commodities, i.e., Ministries of Health and CBD programs, and the amount of contraceptives they will distribute.
5. The last step in determining AID's supply requirements was to multiply estimated use of the different contraceptives by the Ministries of Health and CBD programs by a factor that will increase the amount of contraceptives to be procured from 50 to 70 percent over estimated usage in order to fill the pipeline. These factors are 1.7 for 1983, 1.6 for 1984, and 1.5 for 1985 and 1986. AID commodities should start to become available in the region the last quarter of CY 1982 for use in CY 1983.

Estimates of AID's oral contraceptive requirements assumes that only Noriday and Norminest will be used by the programs. These estimates may be reduced if other oral contraceptives are procured from non-AID sources.

AID supply requirements for IUD's and diaphragms will be determined at a later date. However, it should be noted that use of these methods is minimal in the project countries. For example, the largest number of IUD's and diaphragms that were prescribed in 1980 in the region was by the Barbados Family Planning Association which inserted 634 IUD's and fitted 73 diaphragms.

TABLE 1

Estimated Oral Contraceptive Use and AID Supply Requirements  
1982-1986

<u>Country/Program</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
<u>St. Lucia</u>					
FPA <sup>1</sup>	43,800	40,200	21,600	16,800	15,000
MOH <sup>2</sup>	-	6,000	28,200	34,800	39,600
<u>St. Vincent</u>					
FPA <sup>1</sup>	-	-	-	-	-
NFPP <sup>3</sup> (Plus CBD <sup>5</sup> )	35,400	38,400	45,600	53,400	61,200
<u>Antigua</u>					
FPA <sup>1</sup>	4,800	4,800	4,800	4,800	5,400
MOH <sup>2</sup>	2,400	1,800	2,400	1,800	2,400
CRS <sup>4</sup>	-	5,400	9,600	15,000	18,600
<u>Dominica</u>					
FPA <sup>1</sup>	1,800	1,200	1,200	1,200	1,200
MOH <sup>2</sup>	16,800	15,000	14,400	13,800	13,800
CBD <sup>5</sup>	-	3,600	4,800	6,000	7,800
<u>Barbados</u>					
FPA <sup>1</sup>	39,600	37,200	34,800	35,400	34,200
MOH <sup>2</sup>	7,200	4,200	6,000	7,800	9,600
CRS <sup>4</sup>	-	25,800	33,000	37,800	45,600
<u>St. Kitts/Nevis</u>					
FPA/MOH <sup>1,2</sup>	18,000	19,000	20,000	21,000	22,000
CRS <sup>4</sup>	-	16,900	20,280	23,200	25,190
<u>Montserrat</u>					
FPA/MOH <sup>1,2</sup>	3,200	3,300	3,400	3,500	3,600
<b>TOTAL</b>	<b>173,000</b>	<b>222,800</b>	<b>250,080</b>	<b>276,300</b>	<b>305,190</b>
1. FPA <sup>1</sup>	90,000	83,400	62,400	58,200	55,800
2. MOH/NFPP <sup>2,3</sup>	61,800	65,400	96,600	111,600	126,600
3. CBD <sup>5</sup>	-	3,600	4,800	6,000	7,800
4. FPA/MOH <sup>1,2</sup>	21,200	22,300	23,400	24,500	25,600
5. CRS <sup>4</sup>	-	48,100	62,880	76,000	89,390
Total AID Supply Requirement** (2 + 3 x factor)	-	117,300	162,240	176,400	201,600

\*Oral contraceptives for the CRS programs will be centrally funded by AID under a separate project.

\*\*Assumes that AID oral contraceptives will be used exclusively. Thus, these estimates may be reduced if non-AID commodities are used.

<sup>1</sup>FPA - Family Planning Association

<sup>2</sup>MOH - Ministry of Health

<sup>3</sup>National Family Planning Program

<sup>4</sup>Commercial Retail Sales

<sup>5</sup>Commercial Retail Sales

TABLE 2

Estimated Condom Use and AID Supply Requirements  
1982-1983

Country/Program	1982	1983	1984	1985	1986
<u>St. Lucia</u>					
FPA <sup>1</sup>	36,000	30,000	18,000	18,000	12,000
MOH <sup>2</sup>	-	18,000	36,000	48,000	54,000
<u>St. Vincent</u>					
FPA <sup>1</sup>	-	-	-	-	-
NFPP <sup>3</sup> (Plus CBD) <sup>4</sup>	126,000	150,000	180,000	192,000	192,000
<u>Antigua</u>					
FPA <sup>1</sup>	12,000	12,000	12,000	12,000	12,000
MOH <sup>2</sup>	6,000	6,000	6,000	6,000	6,000
CRS <sup>5</sup>	-	12,000	18,000	24,000	36,000
<u>Dominica</u>					
FPA <sup>1</sup>	6,000	6,000	6,000	6,000	6,000
MOH <sup>2</sup>	18,000	18,000	18,000	12,000	12,000
CBD <sup>4</sup>	-	18,000	24,000	30,000	36,000
<u>Barbados</u>					
FPA <sup>1</sup>	30,000	24,000	18,000	18,000	12,000
MOH <sup>2</sup>	-	6,000	6,000	6,000	6,000
CRS <sup>5</sup>	-	126,000	168,000	186,000	192,000
<u>St. Kitts/Nevis</u>					
FPA/MOH <sup>1,2</sup>	60,000	60,000	60,000	60,000	60,000
CRS <sup>5</sup>	-	144,000	180,000	212,400	237,900
<u>Montserrat</u>					
FPA/MOH <sup>1,2</sup>	18,000	18,000	18,000	18,000	24,000
<b>TOTAL</b>	<b>312,000</b>	<b>648,000</b>	<b>768,000</b>	<b>848,400</b>	<b>897,900</b>
1. FPA <sup>1</sup>	84,000	72,000	54,000	54,000	42,000
2. MOH/NFPP <sup>2,3</sup>	150,000	198,000	246,000	254,000	270,000
3. CBD <sup>4</sup>	-	18,000	24,000	30,000	36,000
4. FPA/MOH <sup>1,2</sup>	78,000	78,000	78,000	78,000	84,000
5. CRS <sup>5</sup>	-	282,000	366,000	422,400	465,900
Total AID Supply Requirement (2 + 3 x factor)-	-	367,200	432,000	441,000	459,000

\*Condoms for the CRS programs will be centrally funded by AID under a separate project.

<sup>1</sup>FPA - FPA - Family Planning Association

<sup>2</sup>MOH - Ministry of Health

<sup>3</sup>NFPP - National Family Planning Program

<sup>4</sup>CRS - Commercial Retail Sales

<sup>5</sup>CBD - Community-Based Distribution

TABLE 3

ANNEX F

Page 4 of 5

Estimated Vaginal Method\* Use and AID Supply Requirements  
1982-1986

<u>Country/Program</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
<u>St. Lucia</u>					
FPA <sup>1</sup>	670	570	560	530	540
MOH <sup>2</sup>	-	190	560	970	1,280
<u>St. Vincent</u>					
FPA <sup>1</sup>	-	-	-	-	-
NFPP <sup>3</sup> (Plus CBD) <sup>5</sup>	1,100	1,500	2,100	3,190	3,450
<u>Antigua</u>					
FPA <sup>1</sup>	180	220	240	290	340
MOH <sup>2</sup>	-	10	20	20	20
CRS <sup>4</sup>	-	150	350	600	870
<u>Dominica</u>					
FPA <sup>1</sup>	-	10	10	10	15
MOH <sup>2</sup>	110	100	130	210	260
CBD <sup>5</sup>	-	90	230	560	770
<u>Barbados</u>					
FPA <sup>1</sup>	510	390	380	380	360
MOH <sup>2</sup>	-	50	50	60	60
CRS <sup>4</sup>	-	2,160	2,640	3,300	4,030
<u>St. Kitts/Nevis</u>					
FPA/MOH <sup>1,2</sup>	1,125	1,150	1,175	1,200	1,225
<u>Montserrat</u>					
FPA/MOH <sup>1,2</sup>	310	330	350	370	390
<u>TOTAL</u>	<u>4,005</u>	<u>6,920</u>	<u>8,795</u>	<u>11,690</u>	<u>13,610</u>
1. FPA <sup>1</sup>	1,360	1,190	1,190	1,210	1,255
2. MOH/NFPP <sup>2,3</sup> (Plus CBD)	1,210	1,850	2,860	4,450	5,070
3. CBD <sup>5</sup>	-	90	230	560	770
4. FPA/MOH <sup>1,2</sup>	1,435	1,480	1,525	1,570	1,615
5. CRS <sup>4</sup> **	-	2,310	2,990	3,900	4,900
AID Supply Requirement (2 + 3 x factor)-		3,298	4,944	7,515	8,760

\*Principally foaming tablets (90 percent). Figures cited are tubes of 20 foaming tablets and tubes/cans of jelly, cream, and foam.

\*\*Foaming tablets for the CRS programs will be centrally funded by AID under a separate project.

- <sup>1</sup>FPA - Family Planning Association  
<sup>2</sup>MOH - Ministry of Health  
<sup>3</sup>NFPP - National Family Planning Program  
<sup>4</sup>CRS - Commercial Retail Sales  
<sup>5</sup>CBD - Community-Based Distribution

TABLE 4

Estimated Injection Use\*  
1982-1986

<u>Country/Program</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
<u>St. Lucia</u>					
FPA <sup>1</sup>	1,280	1,070	1,100	1,120	1,230
MOH <sup>2</sup>	-	330	460	610	670
<u>St. Vincent</u>					
FPA <sup>1</sup>	-	-	-	-	-
NFPF <sup>3</sup>	1,860	2,100	2,620	3,190	3,780
<u>Antigua</u>					
FPA <sup>1</sup>	560	610	650	690	730
MOH <sup>2</sup>	440	500	530	560	600
CRS <sup>4</sup>	-	-	-	-	-
<u>Dominica</u>					
FPA <sup>1</sup>	460	470	480	500	520
MOH <sup>2</sup>	2,910	2,970	3,020	3,170	3,320
CBD <sup>5</sup>	-	-	-	-	-
<u>Barbados</u>					
FPA <sup>1</sup>	1,250	1,380	1,470	1,600	1,720
MOH <sup>2</sup>	590	650	810	1,010	1,190
CRS <sup>4</sup>	-	-	-	-	-
<u>St. Kitts/Nevis</u>					
FPA/MOH <sup>1,2</sup>	650	675	700	725	750
<u>Montserrat</u>					
FPA/MOH <sup>1,2</sup>	225	250	275	300	325
<u>TOTAL</u>	<u>10,225</u>	<u>11,005</u>	<u>12,115</u>	<u>13,475</u>	<u>14,835</u>
1. FPA <sup>1</sup>	3,550	3,530	3,700	3,910	4,200
2. MOH/NFPF <sup>1,3</sup>	5,800	6,550	7,440	8,540	9,560
3. CRS/CBD <sup>4,5</sup>	-	-	-	-	-
4. FPA/MOH <sup>1,2</sup>	875	925	975	1,025	1,075

\*Injectables will be supplied by IPPF and/or UNFPA.

<sup>1</sup>FPA - Family Planning Association

<sup>2</sup>MOH - Ministry of Health

<sup>3</sup>NFPF - National Family Planning Program

<sup>4</sup>CRS - Commercial Retail Sales

<sup>5</sup>CBD - Community-Based Distribution

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## 5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?  
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

Yes, See CDF IV Project Paper.  
Yes.

## A. GENERAL CRITERIA FOR PROJECT

1. Continuing Resolution Unnumbered; FAA Sec. 634A; Sec. 653(b).

The project was included in the FY-1982. Congressional Presentation at \$3.0 million. Under current policy all projects are notified to congress prior to authorization.

(a) Describe how authorizing and appropriations Committees of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

Not applicable.

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- A. 4. FAA Sec. 611(b); Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? **Not applicable.**
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? **Not applicable.**
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. **Yes, Project is regional in nature and will be so executed.**
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. **Not applicable.**
8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. **Not applicable.**

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a.d. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

9. FAA Sec. 612(b), 616(h):  
Describe steps taken to

Not applicable.

assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

10. FAA Sec. 612(d): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

11. FAA Sec. 601(e): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

12. APPROPRIATION ACT SEC

Not applicable.

521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 107(b), 111, 113, 201(a): extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor

The project will attempt to improve the lot of the rural poor women by allowing them free choice in stemming the numbers of unwanted pregnancies and improving economic standards.

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8.1.a. intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106, 107. is assistance being made available; (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(1) (103) for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; 103A if for agricultural research, full account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with programs carried out under Sec. 104 to help improve nutrition of the people of developing countries

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B.1.b.(1) through encouragement of increased production of crops with greater nutritional value, improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration of programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(2) (104) for population planning under sec. 104(b) or health under sec. 104(c); if so, (i) extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

(4) (105) for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

Project will integrate family planning activities into on-going health care delivery system.

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8.1.b.(4) and (ii) extent to which assistance provides advanced education and training of people in developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(5) [106; ISDCA of 1980, Sec. 304] for energy, private voluntary organizations, and selected development activities; if so, extent to which activity is: (i) (a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; (b) facilitative of geological and geophysical survey work to locate potential oil, natural gas, and coal reserves and to encourage exploration for potential oil, natural gas, and coal reserves; and (c) a cooperative program in energy production and conservation through research and development and use of small scale, decentralized, renewable energy sources for rural areas;

(ii) technical cooperation and development, especially with U.S. private and voluntary or regional and international development, organizations;

(iii) research into, and evaluation of, economic development process and techniques;

(iv) reconstruction after natural or manmade disaster;

(v) for special development problems, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small laborintensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

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B.1. c. [107] is appropriate effort placed on use of appropriate technology? (relatively smaller, cost-saving, labor using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor.)

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least developed" country)?

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

As a regional project section 110 (A) does not apply

This project does not involve construction. Justification for a four year project is warranted by the complex nature of the project and need for long-term population assistance.

Project will utilize local resources (manpower) to maximum extent possible and has been developed co-jointly with host governments.

Yes.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to

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B.2.a. repay the loan, at a reasonable rate of interest. Not applicable.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? Not applicable.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102? Yes.

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? Yes.

No.

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Life of Project  
From FY 82 - FY 86  
Total RDB/C Funding: \$3,970,000  
Date Prepared: March, 1982

Project Title and Number: Population and Development Project (538-0039)

Narrative Summary	Objectively Verifiable Indicators	Means of Verifications	Important Assumptions
<p><b>Goal:</b> To bring population and resources into better balance within the Eastern Caribbean by reducing the birth rate.</p>	<ul style="list-style-type: none"> <li>- GNP per capita increased</li> <li>- reduced social service deficit</li> </ul>	<ul style="list-style-type: none"> <li>- annual statistical and economic reports.</li> </ul>	<ul style="list-style-type: none"> <li>- productive capacities to provide social services and employment remain constant or increase.</li> <li>- natural resource deterioration is halted.</li> </ul>
<p><b>Purpose:</b> To reduce the number of unwanted pregnancies in the Eastern Caribbean.</p>	<p>Increase in contraceptive prevalence by 25% over life of project.</p>	<p>contraceptive prevalence surveys.</p>	<ol style="list-style-type: none"> <li>1. Policy environment will remain favourably disposed towards implementation of FP services.</li> <li>2. Public health system retains current service delivery capacity.</li> <li>3. Contraceptives can be introduced into the commercial sector.</li> </ol>
<p><b>Outputs:</b> Revitalize Regional and National demographic and medical policies as the outcome of increased awareness of population problems.</p> <p>2. Increased FP service availability and use through public, private and commercial sectors.</p> <p>a) Training provided to doctors, nurses, allied health workers.</p>	<ul style="list-style-type: none"> <li>- Revised formal population policies in at least 3 countries.</li> <li>- Informal changes occur in all countries.</li> <li>- 7 National Population Task Forces established</li> <li>- increased public dialogue</li> <li>- country reports distributed</li> <li>- 7 RAPID presentations</li> <li>- 3 regional seminars</li> <li>- changes in medical protocols liberalizing distribution of contraceptives</li> <li>- 1 regional and 20 national medical seminars held.</li> </ul> <p>Contraceptive acceptors increased.</p> <p><u>Physicians</u></p> <ul style="list-style-type: none"> <li>- 8 doctors trained in VSC</li> <li>- 70 doctors trained on-site</li> <li>- 100 doctors trained through refresher seminars.</li> </ul> <p><u>Nurses</u></p> <ul style="list-style-type: none"> <li>- established local capacity for nurses in FP on a permanent basis.</li> <li>- 20 in advanced fertility management.</li> <li>- 14 FP nurses trained as FP trainers.</li> </ul>	<ul style="list-style-type: none"> <li>- document examination.</li> <li>- project evaluation and expert assessment.</li> <li>- meetings, records of NPTF 's</li> <li>- monitoring media</li> <li>- publication and distribution</li> <li>- seminar reports.</li> <li>- expert review of regional and national medical protocols.</li> </ul> <p>Service delivery records.</p>	<ul style="list-style-type: none"> <li>- proposed policy will have an impact on availability of FP services.</li> <li>- seminars and updates will have an impact on changing medical policies, protocols and service</li> <li>- IFPP and local governments continue present or increased levels of support for FP services as UNFPA phase out.</li> </ul> <p>Training will increase quality and quantity of services available.</p>

Allied Health Workers and Others

- 400 allied health workers in basic family planning
- 3 administrators
- 140 pharmacists

Outputs: Training Continued)

sex education

Family Life Education

- 1 training-of-trainers instructor at each teacher training college within the region.
- 280 trained teachers in sex education
- core materials for sex education teaching developed.

Government Programs

- PHN logistics capacity improved
- continuous and available supply of contraceptives in 7 countries

Commercial Program

- product advertising campaign implemented.
- commercial distribution system established in 3 countries distributing for 61 of couples at risk

Community Based Distribution (CBD)

- 3 CBD systems established with 420 distributors and 10,000 active users by end of project.

- Management assistance provided to public health services in variety of areas (12 pmo).

- 60 clinics provided with basic FP equipment and minimal refurbishing

- 8 adolescent clinics established serving approximately 20,000 teenagers/year by end of project.

- 10 youth outreach programs established, 60,000 youths reached.

- 90% teenage mothers counselled on FP services available.

- training records

- materials produced.

- CDC trip reports; and
- CDC reports/evaluation

- media monitoring

- sales records of contraceptives; and
- contraceptive prevalence surveys.

- contraceptive prevalence surveys

- service statistics

- experts reports

- equipment supply reports

- engineering monitoring reports.

- IFFF evaluations.

- clinic records.

- Governments will implement sex education component in FLE curriculum.

- public health systems will be able to effectively utilize available contraceptives and technical assistance.

- commercial distributors and advertisers will remain interested.

- no further restrictions on contraceptive advertising.

- community based systems will be utilized.

- community support and volunteerism will remain high.

- availability of equipment and adequate facilities are essential for FP services delivery.

- pilot innovative approaches currently operating can be expanded successfully

- adolescents will utilize contraceptive services if made properly available.

C) Improvement of Clinic Services

D) Adolescent Services Expanded

In assessing the economic feasibility of the Project, the benefits to be derived from averting a birth must be weighed against the costs. The benefits are equivalent to the stream of future consumption minus the stream of future production of an additional member of the populace. That is, each child born represents a new claim for some minimum level of support--clothing, education, food, health, housing etc. Hence, a stream of resource requirements or cost are imposed by each additional birth. The consumption of these resources mean that less resources will be available for investment, a factor that will tend to retard the country's economic growth. On the other hand, each individual born represents some future production potential. Prior to joining the labor force, the individual will not be making an economic contribution. Once the individual joins the labor force, his contribution will depend on his work status. If the individual is unemployed or underemployed his contribution will be minimal. Given the significant employment problem in the Region, this is a distinct possibility. Consequently, the benefits to be derived from averting a birth are equal to the present value of the consumption of the additional individual minus the present value of the individual's production where future sums are discounted to reflect the fact that a dollar today is worth more than a dollar tomorrow.

The costs of averting a birth consist of actual

Project costs, including any USAID or host country contributions as well as the value of the time spent by the user in receiving contraceptive services.

In sum, the Project will be considered economically viable if the benefits to be derived from averting a birth exceed the costs. To make this determination, benefits and costs of averting a birth will be computed for each state participating in the project, including Barbados and the LDCs of Antigua, Dominica, Grenada, Montserrat, St. Kitts, St. Lucia and St. Vincent;

#### Consumption

In assessing the Project's viability we will calculate the lifetime consumption stream for an individual in each participating state. To accomplish this, data on consumption per capita for the populace as a whole must be secured. Such data may be obtained from IBRD Economic Memoranda. Since we are interested in calculating the lifetime consumption stream, the data for consumption needs to be allocated by year. In order to do so, we need consumption weights and data on population distribution. A plausible assumption for the consumption weights is that a child aged 0-4 consumes one fourth of average adult consumption; 5-9, one half; and 10-14, three fourths; while the adult population is assumed to run from 15-59 with people 60 and over consuming half that of an adult.<sup>1/</sup>

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<sup>1/</sup> See "Economic Evaluation Procedures for Use with Population-Related Projects," a study prepared by Warren Robinson and Wayne Schytjer.

Population distribution data can be found in the 1970 Population Census compiled by the University of the West Indies at Jamaica. Such data was available for all states with the exception of Antigua. Utilizing the data on average per capita consumption, the consumption weights, and the age distribution data, average annual consumption each age group was calculated for each country for which data were available. This, in turn, enables us to calculate the lifetime consumption streams.

#### Production

We also need to calculate the lifetime production stream. As a proxy for production, gross domestic product (GDP) will be used. To obtain per capita GDP data that are required for calculation of the production stream, IBRD Economic Memoranda will again be employed. We will assume that all production is undertaken by the population aged 15-59; age distribution data for the group was obtained, as before, from the 1970 census. Given the assumption that the 15-59 is responsible for production, we were able to use the age distribution and per capita GDP data to compute the lifetime production stream.

#### Benefits of Birth Averted

To compute the benefits of a birth averted, one needs only to take the difference between the consumption and production streams and discount at an annual rate of 15 percent. That children also provide a stream of utility to the bearer suggests that the value of a birth averted is an overestimate. However, this, in

all likelihood, is not a serious omission. Births will be averted by those individuals choosing to reduce fertility and additional children will lower the satisfaction to the bearer derived from children already born. On the other hand, benefits will be underestimated by our ignoring the "wage productivity" effect. According to the "wage productivity" effect, the increase in consumption that is permitted through the reduction of population growth to those engaged in productive employment will increase their productivity.

#### Conclusion

To assess the Project's viability, the value of a birth averted will be compared to the cost of a birth averted. In computing the costs of averting a birth, we will use only those costs incurred by USAID. We did not include as a cost the value of time spent by users in securing contraceptive services. This appears plausible given the likelihood that most users will be either unemployed or underemployed. For all states, the benefits of a birth averted exceeded the cost of a birth averted by large margins. Consequently, the Project is economically viable.