

The Population Council

TD-AAP-012
5320069/53
ISN-33799

Contract No.	532-0069-C-00-2005-00
Project No.	532-0069
Project Title:	Assistance in Development and Implementation of a Comprehensive Population Policy and Plan for Jamaica
Quarterly Progress Report	
For the Period:	October - December 1983

Summary

In the October-December 1983 Quarter, there were two technical assistance missions of Population Council staff to Jamaica:

Dorothy Nortman worked with the staff of the National Family Planning Board from September 25 to October 5, 1983 on the preparation of "Rationale to Support Jamaican National Family Planning Board Fiscal Year 1984/85 GOJ Budget Request."

Tomas Frejka worked primarily with the staff of the National Planning Agency in the preparation of documents needed in the process of implementation of the National Population Policy.

1. National Family Planning Board 1984/85 Budget Request

In cooperation with the staff of the National Family Planning Board, mainly with Mrs. June Rattray, Mrs. Dorothy Nortman prepared a draft of "Rationale to Support Jamaican National Family Planning Board Fiscal Year 1984/85 GOJ Budget Request" (enclosed). Mrs. Nortman also consulted with the staff of the Ministry of Health, National Planning Agency, and the U.S.AID Mission and discussed various pertinent issues with them. In the document, the demographic objectives of Jamaica's population policy are discussed, and the document elaborated why it is considered necessary to increase the contraceptive prevalence rate to 70% of women of reproductive age by 1985. A significant activity that would help to bring about such an increase in the contraceptive prevalence rate would be the establishment of family planning parish clinics. Such family planning parish clinics would be under the direct control and operation of the National Family Planning Board. The document discusses the arguments against and in favor of establishing these clinics. In addition, all the other activities of the National Family Planning Board are discussed to support the budget request of (J)\$10 million for the 1984/85 budget.

2. Implementation of National Population Policy

Tomas Frejka worked with the staff of the National Planning Agency (November 13-18, 1983), primarily with Dr. Barbara Boland, Head of the Population and Manpower Division of the National Planning Agency, to prepare documentation that is needed for involving a broad range of institutions into the implementation of the National Population Policy. In line with the National Population Policy Implementation Plan that was approved at a meeting of the Population Policy Coordinating Committee on October 31, 1983, the following documents were prepared:

- A. a list of institutions to be involved in the implementation of the National Population Policy
- B. a model outline of a Population Policy implementation plan for individual institutions (enclosed)
- C. a background document summarizing pertinent knowledge and information for the implementation of the National Population Policy, entitled "Implementation of the National Population Policy: Background Information" (enclosed)
- D. a cover letter to institutions that will be asked to work on the implementation of the National Population Plan (enclosed)
- E. guidelines for interviews and meetings with representatives of institutions to ensure the preparation of the National Population Policy Implementation Plan.

3. Other Matters

Frejka assisted in securing a consultancy of a computer expert for the National Planning Agency to train staff on the computer that had been recently acquired. Due to unexpected delays, the consultancy was postponed to 1984. The Population Council secured and will provide various software and data files for the computer activities of the Population Unit of the National Planning Agency.

October 5, 1983

T. Frejka

Rationale to Support Jamaican National Family Planning Board

FY 1984/85 GOJ Budget Request

Demographic Considerations

The NFPB prepared its GOJ FY 1984-85 budget within the scope of its mandate to "ensure delivery of family planning services and coordinate the activities of all agencies in this field and in matters relating to family life and family planning education."¹ While the fundamental objectives of this mandate are to improve the social, economic, and health conditions of the people in Jamaica, specific demographic goals are seen as concomitants of these ends. Specifically, the demographic goals set before the NFPB are (1) to ensure a population of under three million by the year 2000; (2) to reduce the birth rate per thousand population (CBR) to 20 by 1990 (from an estimated 27.4 in 1982)²; and (3) to achieve replacement fertility by the late 1980's, i.e., a decline in fertility rates from a present average of 3.6 children per woman over the reproductive ages to slightly over 2.

The internal consistency of these demographic goals should be noted. Realization of the medium projection of the population projections prepared for the NFPB show a population size of 2,842,000 in 2000, a CBR of 19.2 during 1995-2000, a crude death rate of 6.3, and a general fertility rate (GFR) of 70, that is annual births per 1000 women aged 15-49, during 1995-2000. With respect to this latter figure, four points are to be noted that have crucial implications for the activities and budget of the NFPB.

First is the magnitude of the fertility decline called for, from a 1982

estimate of 121 births per 1000 women aged 15-49 to 70 by 1995-2000, or a decline of 42 percent in 15 years. Although the Government appreciates the ambition inherent in a decline of this magnitude, not sufficiently appreciated is a second point of importance, namely the pace of decline. The fact is that the earlier the start and the more rapid the pace to the target, the lower will the total population be, with a more favorable age structure (that is, less youth dependency), in the year 2000. Even more cogent is the unlikelihood of reaching the target at all without a quick start now. The NFPB's FY 1984-85 budget therefore reflects the Board's sense of urgency to achieve substantial fertility declines sooner rather than later between now and the year 2000.

The third point taken account of in the NFPB's 1984/85 budget concerns the age groups on which the brunt of the target fertility decline must necessarily fall. With Jamaica's cultural practice of early fertility, 68 percent of the current total fertility of 3.6 children is produced by women under age 30, 32 percent by women aged 30 and over. While there is nothing unusual in this fertility age pattern in developing countries, Jamaica is atypical in that one-fourth of the total fertility under age 30 is produced by teen-age women (who account for about one-third of total annual births). It is thus clear that the 42 percent decline in fertility over the next 15 years called for in Jamaica's population policy cannot possibly fall equally on all age groups across the reproductive age span. If fertility is to come down from 3.6 to a little over 2 children per woman, teenage childbearing must be drastically reduced. Moreover, a later average age at first birth seems to have ripple effects: the demographic literature extensively documents a high inverse correlation between age at first birth and total

fertility.

The fourth important demographic consideration that influences the NFPB's FY 1984/85 budget request concerns the bulge in the number of young women in the high reproductive ages that Jamaica is now experiencing. In absolute numbers, there are now 260 thousand women in the high fertility ages between 15 and 25 compared with 237 thousand in 1980 and 151 thousand in 1970. As a proportion of women of reproductive age 15 to 44, the 15 to 24 age group now comprises more than half, having risen from 46 percent in 1970 to 54 percent in 1982. The significance of this bulge in young women is the potential for more babies to be born even if the rate at which young women reproduce continues to decline. This has in fact already happened: in 1982 61,477 babies were born, 4 percent more than the 58,955 born in 1981, even though fertility rates in 1982 were probably no higher than in 1981. (The 1982 age specific fertility rates are not yet available.) In other words, not only must the rates of childbearing come down, but among young women they must come down appreciably to compensate for their increasing proportion among women of reproductive age if the target decline in the crude birth rates is to be achieved.

On the basis of the above demographic considerations, the NFPB has calculated that a contraceptive prevalence rate of 70 percent of women of reproductive age is required in 1985 to meet the Government's policy objectives. The present prevalence rate is estimated at 58 percent. It should be noted that with early childbearing and a low incidence and short duration of breastfeeding in Jamaica, contraception and abortion are the two major possibilities for controlling fertility. Since abortion is not part of the Government's program, the present FY 1984/85 budget request of

the NFPB is predicated on the contraceptive requirement to achieve a 70 percent prevalence rate by 1985. In absolute terms, this means an increase in the number of couples using contraception from about 246,000 at present to 315,000 in 1985.³

Family Planning Delivery System

Since the mid-1970's, when family planning was integrated into the Ministry of Health's Primary Health Care (PHC) Unit, the NFPB has not provided direct services to the population at large. The stimulus for integration came from the United Nations World Population Conference in 1974 where delegates from developing countries protested that family planning "alone" would not improve the quality of life of the world's poor people. While the validity of this proposition is self-evident, operationally it was widely taken to mean that family planning services should be delivered by multi-purpose personnel in multi-purpose clinics and distribution centers. The notion of a free standing clinic concentrating on the delivery of family planning services and supplies became taboo;--evidence of family planning "alone", even if primary health care and income generating projects were also visible operational activities in the community of a government's population and development policy.

In an attempt to clarify the meaning of integration, the United Nations Fund for Population Activities (UNFPA) convened a seminar in 1978. Its report (prepared by Ando of the UNFPA and Ness of the University of Michigan) concluded that integration was not a simple concept, that it was ill-defined, that there could be degrees of integration at both administrative and operational levels, and that delivery strategies should vary depending upon the circumstances within the community.

In Jamaica integration meant the absorption into the MOH of NFPB field staff (including 43 family planning education officers), nurses, and clinics. That MOH clinics and personnel would also be deployed to provide family planning services and supplies within their PHC and MCH activities was expected to result in a great expansion of contraceptive use, to a level sufficient to meet Jamaica's demographic and economic objectives. The role assigned to the NFPB was to coordinate all family planning activities but to be relieved of responsibility for the direct provision of services and supplies to family planning clients.

At the same time the NFPB's Medical Department was assigned the important operational role of procuring, storing, and distributing the contraceptive supplies, drugs, and medical equipment to the MOH clinics and commercial outlets in the CDC program. The cost of these items (except for some external funding) is borne by the NFPB GOJ funds. The rationale for this arrangement is to give the MOH a stake in delivering family planning services by providing it with supplies from outside the MOH budget.

In essence the relationship between the NFPB and the MOH is such that the latter is autonomous in and fully responsible for the servicing of family planning clients in the Government's program while the former feels responsible for the results achieved by the MOH. If the family planning record were adequate to meet the demographic objectives, this arrangement would be perfectly satisfactory. However, for a variety of understandable reasons, the family planning record falls short of the requirements to meet Jamaica's policy objectives.

In 1982 the Government program serviced an estimated 84,000 clients, a mere one percent increase over 1981 (although there was a 34 percent increase

in 1981 over a very low servicing level of 62,000 clients in 1980). Only half of the target number of clients was reached in 1982 and new acceptors totalled 33,316 compared with an estimated 40,000 to 50,000 required to meet the demographic targets. Moreover, the constraint to an expansion of clients is not a lack of contraceptive need or demand. The contraceptive prevalence survey conducted by the University of West Indies in 1979 found that 40 percent of the women interviewed said they did not want their last pregnancy and another 30 percent said their last pregnancy was mis-timed.

Limitations of the present family planning delivery system in Jamaica can be succinctly summarized as follows.

(1) In all integrated programs, that is programs in which multi-purpose workers deliver family planning services, family planning consultation inevitably commands much lower priority than more immediate curative and preventive (e.g., immunization, baby-weighing) health needs. Also, because multi-purpose workers need training in many substantive areas, their training in family planning communication, and in knowledge of contraceptive technology and potential side effects, tends to be very inadequate. This has proved to be the case in Jamaica as in other countries with integrated family planning programs.

(2) Although MOH clinics are close to their target in the number of clinics providing contraceptive services, 188 of the 352 presumably offering these services are Type I clinics, that is clinics staffed by one midwife assisted by two community aides who are responsible for maternal and child health, nutrition and immunization as well as family planning services.

(3) Two important target groups, males of all ages and youth of both sexes, are not likely to be MOH clinic patients. Finally,

(4) Under the present arrangement whereby the NFPB keeps the MOH clinics supplied with contraceptives, syringes for administering Depo-Provera, other medical equipment, etc., the NFPB responds to the requisition forms submitted by the clinics but has no authority to establish good accounting and inventory control procedures to insure that supplies are not wasted. Although the NFPB attempts to match the requisitions against the clinic records on contraceptive acceptors, the Board feels obliged to fill requisitions upon request and has no authority to transfer inventories from an over-supplied to an under-supplied clinic.

NFPB Clinics

A major part of the NFPB FY 1984/85 budget request is to cover the cost of establishing clinics which would be under the direct control and operation of the NFPB. Negative reaction to this request in previous budgets has been mainly on the following grounds.

(1) The MOH operates 383 clinics, of which 352 are already providing family planning services;

(2) Rather than invest scarce resources in the establishment of new clinics, a wiser investment would be to improve existing clinics;

(3) Single-purpose, free-standing family planning clinics do not conform to the integrated program concept;

(4) NFPB operated clinics would compete with MOH clinics for personnel and clients;

(5) A single purpose, free-standing clinic would draw a limited clientele because people do not like to be seen attending a contraceptive clinic; and

(6) The NFPB does not have the administrative and personnel capacity to establish and operate 15 clinics, one in each parish, within the one year period FY 1984/1985.

While these arguments are superficially convincing, closer scrutiny reveals their weaknesses. Arguments 1, 2 and 3 do not hold up because they rest only on the positive, without discounting for the negative attributes of the MOH multi-purpose clinics. To the extent that the family planning services in the MOH clinics can be improved, the Ministry would of course like to do so, but as discussed in the previous section, it is inherent in the nature of a multi-purpose health clinic to accord low priority to family planning because of the relative lack of urgency of the need. As already noted, family planning clients increased only one percent between 1981 and 1982 and recruitment is far below the level required to implement the Government's population policy.

As for argument 4, NFPB would no more compete with MOH clinics than they compete with each other. Indeed the idea behind the NFPB clinics is to reach people who are not serviced by the MOH or the CDC program and to produce a corps of well trained personnel. The NFPB sees its clinics as a referral center for difficult MOH cases and for treatment of side effects which are beyond the capacity of lesser trained staff of MOH clinics. As a referral center, with well-trained family planning personnel, and good follow-up of clientele, the NFPB clinics would complement, not compete with MOH clinics.

Argument 5 might have been valid a decade ago when institutional support for family planning practice was still a novel idea and contraception was a private matter not fit for public discussion. Today it may be more a mark of status than a stigma to be known as a responsible parent interested in

sacrificing quantity for quality of children. The Cumberland Road health Center in Spanish Town provides empirical evidence of client visibility. Although the Center is multi-purpose, it has a free-standing facility staffed by a nurse and clerk who do only family planning and it is very busy.

Finally, any merit in argument 6 is based on the feasibility of establishing 15 clinics in one year's time, not on any principle relating to the desirability^{of} or need for NFPB clinics. The Board considers it has the capacity to start one clinic in each parish if its budget request is approved. Resource people already known to the Board would be enlisted to find appropriate rental space; trained midwives and nurses in several parishes who would be interested and available are also known, and the present medical director on the staff of the Board, a M.D. trained in obstetrics and gynecology, would more appropriately function as the supervisor of the clinics than as the department head in charge of contraceptive procurement and distribution and related activities.

Another rationale for establishing NFPB clinics is the implausibility that 2000 PHC workers can be trained in the next two years for family planning (the public health nurses seem resistant to training the Community Health aides who are the nucleus of the PHC system) or that the Ministry of Agriculture will successfully train even a fraction of 6000 agricultural officers to incorporate family planning in their activities.

While the Board would like sufficient funds to be appropriated for 15 clinics, at an estimated cost of \$300,000 per clinic during FY 1984/85, at issue is recognition of the need for NFPB operated clinics to satisfy the unmet need for contraception and increase the contraceptive prevalence rate to the level necessary to meet the Government's demographic goals. The

establishment of a few clinics, if not 15, could serve as a test of the hypothesis that Board clinics would not draw clientele away from MOH clinics or the private sector but would contribute a net gain to contraceptive practice. An appropriate evaluation project is part of the clinic design.

NFPB FY 1984/85 Budget

The J\$10 million request is the cost estimate for the NFPB to execute its family planning coordinating role. which includes all present functions plus the cost of establishing and operating 15 new clinics. At \$300,000 per clinic, the budget request for the clinics is \$4.5 million. The coordinating activities, estimated to cost \$5.5 million, include the following.

- In the Medical Department

a. Payment for contraceptives, drugs, medical supplies and equipment out of GOJ budget. (This is a major cost. Although U S. AID meets some of the total cost of these items, it does not for example pay for Depo-Provera, the most popular method in Jamaica, or the syringes and other supplies necessary for its delivery.)

b. Site visits to MOH clinics, primarily in connection with the procurement, storage and distribution of contraceptives. at which time suggestions are also offered to improve service delivery;

c Training sessions on contraceptive technology for medical and paramedical personnel;

d. Marketing arrangements for the CDC program;

e. Liaison with the Association for Voluntary Sterilization and other donors concerned with service delivery projects;

f. Clinic programs, utilizing staff and resource personnel to go to factories and other establishments to provide lectures and contraceptives.

- In the IEC Department, a variety of projects that are less of a coordinating nature than they are educational and information campaigns designed to instil values and attitudes conducive to later age at first union or first birth, more stable mating patterns, improved child-parent relationship, and greater male participation in the economic support of their children. Examples are the mass media messages (radio, TV, advertising, posters, billboards); programs for males and adolescents, utilizing resource persons and staff who work with and through various organizations in Jamaica; a hot-line answering service (which is proving very effective); rap sessions (focus discussion groups) for high school students on NFPB premises; and working with school officials on matters of educational materials and design of curriculum for sex education and responsible parenthood. The IEC budget includes the cost of travel, stationery, printing, purchase of radio and TV time, etc., as well as cost of staff personal emoluments.

- In the Statistics Department, formal liaison with the MOH, Department of Statistics, and Registrar General. The NFPB Statistics Department is responsible for compiling and analyzing the data on family planning statistics from monthly reports of service delivery units. Related demographic data from the DOS and RG furnish denominators for computation of rates. The activities involve equipment (calculators, stationery) as well as travel, telephone, communication and staff personal emoluments.

- In the Special Projects Department, the Director works with the Project Director, monitors the activities and keeps track of expenditures and progress. Although the projects are funded by U.S. AID, NFPB staff monitor the projects and prepare the reports required by U.S. AID which does not

reimburse the NFPB for its input into the projects. The projects include ACOSTRAD (Association for Control of Sexually Transmitted Diseases), AFRC (Adolescent Fertility Resource Center), Male Motivation Program, an Integrated Nutrition/Family Planning Program, the Family Life Education Project (with the Ministry of Education), the NEET Project (which provides counselling and contraceptives to sexually active teenagers), and several research projects by the Department of Sociology at the University.

An Executive Director and Deputy (to come on board November 1983) manage and supervise NFPB activities. In addition there is a Board Secretary and a Department of Finance and Accounts. NFPB activities are varied and complex, involve liaison with all Government agencies as well as external supporters (public and private), and require expertise in various disciplines and a high degree of organizational skills.

Below is a concise summary of the NFPB'S FY 1984/85 budget request to the GOJ.

<u>Item</u>	<u>No. of full-time staff</u>	<u>NFPB GOJ FY 1984/85 Budget Request</u>
<u>By NFPB Dept.</u>		
Executive		
IEC		
Medical		
Statistics		
Special Projects		
Finance & Accounts		
Across Departments		
(Rent, Vehicles, telephone, stationery, etc.)		
 <u>By Expenditure Type</u>		
Personal emoluments		
etc. (large categories)		
 <u>Total</u>		
Existing Activities		
New clinics		

(NFPB to fill in the data)

1.

Model Outline of the National Population
Policy Implementation Plan

Comments

1. The main purpose for preparing a National Population Policy Implementation Plan in your organisation is to describe your programmes and activities that may have direct or indirect impacts on population trends and to clarify what you can do towards the achievement of the main goals of the National Population Policy. The following questions are guidelines to note:

- a) What are your present and future main activities/ programmes that may have an effect on population trends?
- b) For which segments of the population are they going to be particularly important?
- c) What are going to be the human and financial resources that will be needed to carry out your activities?
- d) What are going to be the time periods and deadlines for carrying out the work?

2. Since many institutions are taking part in this national effort, a model outline is being prepared to ensure consistency. Please follow the outline as best as you can, but do not hesitate to include other items that may seem necessary.

2.

Re 1. B. Outline of Individual Plan

Implementation Plan of National Population Policy

at

a. Ongoing activities

i) Programmes and projects

- to modify population trends in desirable directions
- to accommodate population trends

ii) Research

iii) Training

iv) Dissemination

b. Proposed new activities

i) Programmes and projects

- to modify population trends in desirable directions
- to accommodate population trends

ii) Research

iii) Training

iv) Dissemination

c. Timetable of items listed in sections a. and b. above, if applicable.

d. Budget.

15

B.

3. There will be some institutions that will be active in various aspects of implementation, i.e. they will have programmes and projects, as well as research, training and dissemination of activities. Other institutions will concentrate only in one area of activity and these institutions will obviously prepare only that part of the implementation plan.

4. In the preparation of the sections related to programmes and projects, you may wish to consult the paragraph Steps in Implementing the National Population Policy of the background information document.

5. Although it is noted above, do not forget to consider the budget implications of the proposed activities.

Implementation of the National Population Policy: Background Information

Jamaica now has a comprehensive National Population Policy which was tabled in Parliament on 12th July, 1983, as Ministry Paper No.27: National Population Policy (see attached). As stated in the Ministry Paper, the implementation of the national population policy requires the involvement of a wide range of institutions throughout Jamaica.

Since many institutions are continuously engaged in achieving various objectives of the National Population Policy, a more coordinated effort is needed to ensure the full implementation of the National Population Policy.

Basic Reasons for Formulating Population Policies

Countries decide to adopt population policies for two basic reasons:

- they perceive past and present population trends to be an obstacle to improving the well being of their citizens;
- there is a need to provide appropriate living conditions and services to the present and future population.

When Public and private organizations provide working and living conditions as well as services, such as employment, health, education, family planning, housing, information and transportation, they are indirectly working towards both modifying future population trends as well as accommodating as best as possible the present and future population.

Public and private policy measures can often have the dual impact of changing people's living conditions as well as their behaviour, including demographic behaviour. For instance, improved and prolonged formal education is useful in providing people with a better preparation for employment and their work careers, but education can also help them to make informed decisions about their health, the number of children they will have, where they want to work and live, and whether they want to move - all of which can exert an effect on the population situation.

Past and Future Population Trends in Jamaica

Jamaica's population trends since the 1960's have been going in desirable directions, but they are still far from satisfactory. The general health and mortality conditions of the population have been improving but infant mortality remains relatively high. Fertility and family size have been declining. The average family of the 1950's and 1960's had about 6 children whereas by the end of the 1970's women have been having 4 children, still too many for a large proportion of families to provide for a healthy, physical, mental and educational development of their children.

The high rate of natural increase of about 2% per year during the 1970's could have resulted in an increase of about 500,000 people. It was reduced to about 300,000 due to continued emigration. Even so, 250,000 Jamaicans were employed.

Jamaica's 1982 population of 2.1 million could increase to over 3 million by the year 2000 if the future decline of fertility were to be slow.

3.

If, however, by the end of the 1980's an average family size of 2 children per woman can be achieved, Jamaica's population in the year 2000 could be 2.5 million.

Basic Goals of the National Population Policy

The principal goals of the National Population Policy enhancing chances for improved social and economic development are:

1. A population not exceeding 3 million in the year 2000.
2. A continued increase in life expectancy at birth achieving 73 years by the year 2000.
3. A continued further decline in fertility, reaching an average of 2 children per woman by the late 1980's.
4. A reduction in out-migration through increased employment opportunities.
5. Achieving an optimal spatial distribution.
6. Improved satisfaction of basic human needs and improving the quality of life in housing, nutrition, education and environmental conditions.

The Need for an Implementation Mechanism

Since the implementation of the National Population Policy will be a concern of many organisations, the above ambitious goals cannot be achieved unless effective day-to-day procedures for coordinating activities needed to accomplish the goals are designed, accepted, and operationalised.

/

Such activities can and should be generated not only by those institutions directly involved in population related activities, such as in the health and education system but also by other institutions with activities that can have indirect effects on the population situation.

Steps in Implementing the National Population Policy

The Population Policy Co-ordinating Committee, with its Secretariat at the National Planning Agency, has been created by the Cabinet to organize and coordinate all activities leading to the achievement of the Population Policy goals.

Since the success of the actual implementation of the National Population Policy will depend, to a large extent, on the success that each and every institution will have in implementing its own plan, a wide range of public and private sector agencies are being approached to develop their own population related plans.

Attached is an outline of a National Population Policy Implementation Plan for individual organisations to assist them in preparing such a plan.

While preparing this Population Policy Implementation Plan, institutions might realize that they already have ongoing activities that contribute to achieving the goals of the Population Policy. Furthermore, they may consider expanding some of the activities, and/or designing new activities.

These activities might include programmes and projects of many different varieties, such as improvements in health services and sanitation; the provision of clean water; formal and informal

3.

education; provision of information; the improvement and/or creation of business and employment opportunities; the promotion of marketing opportunities for farmers and craftsmen; improving needed transportation networks; the construction of adequate housing; the expansion of the commercial networks; increasing access to family planning services and the commercial distribution of contraceptives; improving relationships within the family; and improving child care and nutritional practices. In addition, research, training and dissemination activities should be very important components of population policy implementation.

Once the sectoral plans are prepared, a nationwide National Population Policy Implementation Plan will be prepared. Members of the Population Policy Co-ordinating Committee will be in touch with each institution to assist in preparing individual implementation plans. Both the individual and the nationwide plans will then be presented and discussed at a National Population Policy Implementation Workshop scheduled for 3rd-4th May, 1984, where suggestions concerning methods to devise an effective monitoring and evaluating system will be discussed.



COVER LETTER

NATIONAL PLANNING AGENCY

P.O. BOX 634,

KINGSTON,

JAMAICA

_____ 19 _____

ANY REPLY OR SUBSEQUENT REFERENCE
TO THIS COMMUNICATION SHOULD BE
ADDRESSED TO CHIEF TECHNICAL DIRECTOR,
NATIONAL PLANNING AGENCY,
39-41 BARBADOS AVENUE

Dear

As you are aware, there is widespread serious concern that some of our population trends -- in mortality, fertility and migration -- are among the obstacles to economic and social development of our country.

The above concern is reflected in the fact that Jamaica now has a National Population Policy which was tabled in Parliament on 12th July, 1983.

Since the successful achievement of the goals of the National Population Policy depends on the active participation of all agencies concerned, the Population Policy Committee - established by Cabinet early 1982 - is organising a nationwide effort to further the implementation of the National Population Policy. The basic idea is to involve a broad variety of public and private institutions, including yours, to secure the participation of every Jamaican implementing the National Population Policy.

Each institution is being urged to prepare its own National Population Policy implementation plan which will become part of a nationwide National Population Policy implementation Plan. The enclosed documentation is to assist you and your staff in the preparation of such a plan. Members of the Population Policy Co-ordinating Committee will be contacting you for discussions about the nature and contents of your implementation plan.

Following on the development of your individual plan, a National Population Policy Implementation Workshop will be convened on 3rd and 4th May, 1984, where both the individual and the nationwide implementation plans will be presented.

22

2.

Should you require any further information, please get in touch with Dr. B. Boland, of the Population Policy Co-ordinating Committee Secretariat at the National Planning Agency, telephone 65815,65493 or 61766.

Thank you for your kind co-operation.

Yours sincerely,

Headley Brown,
Chief Technical Director,
and
Chairman,
Population Policy Co-ordinating
Committee.

- Enclosures:
1. Implementation of National Population Policy
(Background Information)
 2. Ministry Paper No. 27: National Population
Policy
 3. A model outline of the institutional National
Population Policy Implementation Plan.

23