

UNCLASSIFIED
CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE CARIBBEAN REGIONAL POPULATION AND DEVELOPMENT			2. PROJECT NUMBER 538-0039	3. MISSION/AID/W OFFICE RDO/C
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 538-85-01	
A. First PRO-AG or Equivalent FY 82	B. Final Obligation Expected FY 86	C. Final Input Delivery FY 86	<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total \$			From (month/yr.) 07/82	
B. U.S. \$ 3,500.00			To (month/yr.) 09/84	
			Date of Evaluation Review 10/05/84, 04/18/85	

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
<p><u>CARICOM COMPONENT</u></p> <p>There is much scope for increasing awareness of population issues, and the level of demographic skills among middle level statisticians. To this end the following actions need to be undertaken:</p> <ol style="list-style-type: none"> 1. A full time person with demographic training should be hired to monitor and work with National Population Task Forces in each country to expedite completion of policy documents and their presentation to the respective governments. 2. A media campaign plan should be developed for early implementation in order to increase awareness and educate the public about population and development issues. 3. The demographic training component should be redesigned in order to provide appropriate training for local statistical units as well as technical assistance in specific demographic studies of the LDCs. 	<p>CARICOM</p> <p>CARICOM/ RDO/C</p> <p>CARICOM/ RDO/C</p>	<p>06/30/85</p> <p>08/31/85</p> <p>08/31/85</p>

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)
<input checked="" type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A.	<input type="checkbox"/> Continue Project Without Change
B.	<input type="checkbox"/> Change Project Design and/or
	<input checked="" type="checkbox"/> Change Implementation Plan
C.	<input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

RDO/C: Holly Wise, RHPDO *Wise* IPPF/WHR: Dr. E. Hosein (Project Director)
 Neville Selman, PA
 Kim Finan, CDO *Finan* CARICOM: Roderick Rainford (Secretary General)
 Blaine Jensen, A/PRM *Jensen*
 Darwin Clarke, SPS/EVAL *Clarke*
 Terrence Brown, D/DIR *Brown* Cecilia Karch, *Karch*

12. Mission/AID/W Office Director Approval

Signature: *James S. Hollaway*
 Typed Name: James J. Brown, A/DIR, RDO/C
 Date: 5/29/85

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4. The PACD for the CARICOM component should be extended to correspond with that for the IPPF/WHR component. This would enable a more realistic time frame for completing project implementation, promotion of policy dialogue and consciousness raising.	RDO/C	06/30/85
5. The budget for the under-financed media program should be substantially increased. This can be achieved by reallocating funds from other line items, thus obviating the need for additional funding for the CARICOM component.	CARICOM/ RDO/C	06/30/85

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<u>IPPF/WHR COMPONENT</u>		
1. Project management at the Caribbean Office should be strengthened by hiring additional management and technical personnel.	IPPF/WHR	02/28/85
2. There should be a careful review of (a) sub-grant agreements with national governments and their execution including the method of disbursing funds from IPPF/WHR and (b) IPPF/WHR New York Office costs and the method of reporting financial data.	IPPF/WHR RDO/C	12/31/85
3. A re-assessment needs to be undertaken of funds allocated for clinic equipment and renovations on a country-by-country basis. This re-assessment should aim at achieving greater impact from the use of these funds.	IPPF/WHR	09/30/85

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4. IPPF/WHR needs to take action to minimize delays in disbursement of funds for clinic renovations.	IPPF/WHR	Completed 12/31/84
5. A country by country training needs assessment should be conducted. The assessment should focus on more cost effective training for participants.	IPPF/WHR	09/30/85
6. RDO/C should consider the proposal for funding for Grenada and amend the grant agreement accordingly.	RDO/C	06/30/85

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YD-AAR-262-A
ISN: 39913

MID-TERM PROJECT EVALUATION REPORT
CARIBBEAN REGIONAL POPULATION AND DEVELOPMENT PROJECT
538-0039
FUNDED BY
THE REGIONAL DEVELOPMENT OFFICE/CARIBBEAN
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

GRANTEES:
INTERNATIONAL PLANNED PARENTHOOD FEDERATION/
WESTERN HEMISPHERE REGION, INC.
AND THE
CARIBBEAN COMMUNITY SECRETARIAT (CARICOM)

December, 1984

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COMPOSITION OF EVALUATION TEAM

- * Wayne Greaves, M.D. - Medical Epidemiologist,
Howard University
- Ms. Debra Haffner, M.P.H. - Director, Community Services and Public
Relations, Planned Parenthood of Metropolitan
D.C.
- Jerry Bailey, Ph.D., - Social Science Analyst, ST/POP/R.
- Cecilia Karch, Ph.D., - Social Scientist, RDO/C.

*Team Leader

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I. PROJECT EVALUATION SUMMARY (PES) PART II

A. SUMMARY

The Population and Development Project (538-0039) is well underway and except in a few areas is proceeding according to plan. Delays in project implementation have affected both the CARICOM and IPPF/WHO components and some project activities are slightly behind schedule.

The project as initially conceived included the development of benchmarks to determine baseline data before and after intervention efforts. Benchmarks to be developed by IPPF/WHO included: (i) Contraceptive Prevalence Surveys in each country; and (ii) determination of baseline data on attendance and contraceptive use at selected clinics prior to and after improvement of clinic services. On the CARICOM side, countries, through their National Population Task Force, were to assess the level of awareness of population issues among political leaders before and after mounting a comprehensive campaign to raise the level of awareness.

Benchmarks were not developed as envisioned in project design. Baseline Contraceptive Prevalence Surveys were not completed in all countries prior to intervention efforts. Similarly, none of the CARICOM countries has conducted the survey on awareness among political leaders, but intervention efforts such as the Regional Awareness Conference and Medical Contraceptive Policy seminars have already been held. In fairness, the Grant Agreement with CARICOM does not require the survey to be performed.

Considerable progress has been made in improving clinic services. This has been achieved through training of clinic personnel, renovating selected clinics and providing equipment to some clinics. Introductory training courses in family planning developed by IPPF/WHO have been well received. Weaknesses in the design of the training component have been the lack of provision for specific training in counselling, supervision of service providers, and lack of effective in-country in-service programs. Physician response to seminars has been disappointing and this component has been considerably scaled down. Commodity supply and distribution systems have been developed and implemented in each country with the help of personnel from the Centers for Disease Control, Atlanta, Georgia. These systems appear to be functioning smoothly and efficiently. Adolescent extension programs are in the embryonic stages but there are plans for further development of this project component. A concern, however, is that some activities have been started without adequate training of personnel in adolescent counselling.

Major problems encountered in project implementation have been related to the inefficiency of country governments and lack of commitment of their leaders. This has frequently led to unnecessary delays in signing subgrant agreements and in implementing project activities. Another major problem has been the high rate of turnover of project personnel at USAID, CARICOM and in several countries. Personnel changes have contributed to delays in project implementation and sometimes to poor communication among key officials. At the country level a concern is that personnel who are committed to family planning are often functioning in several capacities and seem stretched to their limit. Other problems in implementation of project activities include the very limited funding for promotional assistance under CARICOM and the lack of effective monitoring of in-country activities.

Given the purpose of the project, "to reduce unwanted pregnancies in the region", the PACD and perhaps funding are not appropriate. Project goals and outputs are also unrealistic for the current time frames. In Barbados where family planning activities have been conducted for more than two decades only recently has the population reached replacement level. A 1980 survey of contraceptive use conducted in Barbados revealed that 37 percent of women 15-49 years old were using a method. It seems unreasonable to expect a 25 percent increase in contraceptive prevalence even in Barbados, much less countries less interested in family planning, by the end of the project.

B. EVALUATION METHODOLOGY

This evaluation is intended as a mid-term assessment of the Caribbean Regional Population and Development Project (538-0039) to determine progress toward attainment of project objectives. The evaluation is in accordance with provisions of Article 5 of the project Grant Agreement with the Caribbean Community Secretariat (CARICOM) and the Grant Agreement with International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). The scope of work was developed by USAID/RDO/C and is presented as Appendix I.

The evaluation was conducted September 10 through October 5, 1984 by a team of four consultants, three of whom were relatively familiar with the region and the project. Consultants had a half-day briefing by USAID officers Holly Wise and Neville Selman on September 10 before beginning the evaluation. Consultants visited St. Lucia, St. Vincent and the Grenadines, Dominica, Grenada and Guyana. In each country, formal and informal interviews were held with key Government and/or program officials, including staff of the various Ministries of Health and Family Planning Associations. A list of persons contacted in each country is shown in Appendix II. Each interview lasted an average of 60 minutes. Two consultants spent two days in Guyana holding discussions with key persons at CARICOM headquarters. Visits were made to both government-operated and private clinics offering family planning services in most of the countries visited and where possible to physicians' offices. In addition to site visits, consultants reviewed project documents including copies of the Grant Agreements, clinic records, records of contraceptive usage at various clinics and spoke with persons who had received IPPF sponsored training in family planning. In St. Lucia, several key persons were absent and could not be interviewed. In Grenada, Ministry of Health personnel were not very accommodating or helpful. Unfortunately, two cables requesting that the evaluation visit be postponed never arrived at the Health and Population Development Desk of RDO/C until after departure of two members of the Evaluation Team for Grenada.

This evaluation is therefore based upon the consultants' interpretation of project documents, quarterly reports, technical reports and perceptions from interviews held with several persons associated with the project. Evaluation of specific components of the project was based on grant agreements with IPPF/WHR and CARICOM. The views, opinions and recommendations are necessarily colored by the consultants' varied perspectives and understanding of regional influences but an attempt was made to present factual observations, consensus opinions and recommendations.

Debriefing was held Friday, October 5, 1984 with USAID/RDO/C personnel in Barbados. A draft evaluation report was completed and submitted to Holly Wise at USAID/RDO/C.

C. EXTERNAL FACTORS

Several external factors have had a significant impact during the course of the project. The first was the death of two key personnel in the CARICOM Health Section, Dr. Philip Boyd, Chief, of CARICOM's Health Section and Mr. Evan Drayton, Project Administrator. This created serious administrative difficulties in project administration. At present, communication between RDO/C and CARICOM personnel, Ms. Audrey Hinchcliffe and Mr. Terence Goldson, is not optimal. Much will depend on Dr. Boyd's successor, and on Terence Goldson, who replaced Mr. Drayton. A new Chief of the Health Section of CARICOM has not yet been appointed. Ms. Audrey Hinchcliffe is acting as Chief in addition to working as Health Development Officer.

The second important factor, affecting the project was the change in governments and Ministry of Health personnel. In St. Vincent and the Grenadines, for example, a new government was recently elected. Antigua re-elected the previous government but there is a new permanent secretary. Perhaps the most dramatic change in government occurred in Grenada which experienced a multiforce invasion on October 15, 1983. The use of force in Grenada has resulted in political divisions among some CARICOM members. The interim administration has not given the project priority and has not been enthusiastic about project activities. Elections in Grenada are scheduled for December 3, 1984. It is unclear which party will win the elections or what their support for the project will be like. The sole government obstetrician-gynecologist on the island is a strong proponent of natural family planning. He refuses to recommend any other method of contraception, and shows little appreciation for the overall aims of the project. With his strong influence, a cadre of devoted nurses and the Roman Catholic Church's Family Life Council, it will be an uphill battle for the project to succeed unless strong support comes from the future elected government.

Finally, there have been several changes in USAID project personnel since the Grant Agreements were signed in 1982. Mark Laskin and then Allen Randlov have been replaced and the two current personnel Ms. Holly Wise and Mr. Neville Selman are new to USAID/RDO/C. Mr. Selman worked previously as a CARICOM consultant, however. Overall, the changes in personnel have slowed project implementation and sometimes created problems in communication.

D. INPUTS

The total funds allocated to the CARICOM part of the project amount to \$600,000; funds allocated to IPPF/WHO total \$2.6 million.

Grant funds to CARICOM were provided for four major aspects: (i) demographic policy initiative (\$250,000), (ii) medical policy initiative (\$70,000), (iii) program support (\$140,000), and (iv) administration (\$140,000). Technical assistance was specifically provided via the Population Reference Bureau for the publication of Country Population Reports under the demographic policy initiative. Please see Appendix III.

Grant funds to IPPF/WHO are provided under six categories as follows: (i) training in family planning for physicians, nurses and other support personnel and training in family life education (\$234,000), (ii) commodity supply and distribution to facilitate community based distribution of contraceptives (\$167,000), (iii) improvement of clinic services including providing for clinic renovations and equipment (\$425,000), (iv) adolescent extension services including provision of adolescent clinic facilities and outreach programs (\$474,000); (v) technical program support (\$470,000); and (vi) administrative support (\$787,000). Please see Appendix IV.

With respect to the CARICOM component, the evaluation team feels that inputs to CARICOM need to be modified to achieve project purpose. To improve the effectiveness of CARICOM policies there is need for a full time person, preferably a trained demographer, to provide in-country follow-up on CARICOM initiatives in member countries. This person would work with National Population Task Forces and be trained to make RAPID presentations. Also, the budget distribution of funds seriously limits the amount available for promotional assistance.

With respect to the IPPF/WHO component, training of nurses and paramedical personnel has been conducted in six countries and by the end of 1984 this aspect of training will have been completed in the original seven countries and Grenada. The IPPF/WHO Grant Agreement as written does not provide for (a) specific training in counselling for nurses delivering family planning services, (b) training of persons working with adolescents - not even those functioning in adolescent clinics, nor (c) for training of supervisory personnel in techniques of supervision and management. Given the high incidence of teenage pregnancies in the region, training programs designed to improve the counselling skills of nurses and others delivering care to adolescents should be a vital part of the overall training initiatives.

We also feel that training of supervisory personnel is important to assure maximum productivity of trained nurses. The response to physician training programs has been very poor in countries where seminars have been held. Training of physicians has therefore been appropriately de-emphasized, after consultation with USAID.

The IPPF/WHR Grant Agreement does not accurately reflect the amount of work and effort involved in executing the several aspects of the program in all seven countries. (A list of active subgrants is shown in Appendix V). The current Project Manager, Angela Cropper, is over-extended and functioning more at the level of a technical advisor or assistant than as a manager. Additional inputs should include provision for more management and technical personnel at the Caribbean Office.

Although inputs have generally been in a timely fashion, delays have occurred in the procurement of clinic equipment and in disbursement of funds for clinic renovations. These factors have somewhat diminished the impact of clinic improvements. Also, the allocation of funds for renovations in some countries does not appear to be related to actual country needs and should be reassessed.

E. OUTPUTS

The CARICOM component of the project was expected to revitalize Regional and National demographic and medical policies as the outcome of increased awareness of population problems. The table shown below compares actual outputs to projected outputs.

<u>CARICOM</u>	
<u>Projected Outputs</u>	<u>Actual Outputs</u>
Revised formal population policies in three countries	None so far
Informal changes in all countries	Ongoing
Seven National Population Task Forces	Established
Increased public dialogue	Ongoing
Distribution of country reports	Ongoing
One Regional Medical Seminar	Antigua, September, 1983
Twenty National Medical Seminars	Antigua, St. Vincent, St. Kitts, Montserrat and Barbados.
Three Regional Awareness seminars	One held in St. Lucia, April, 1984

The IPPF/WHR component of the project was expected to lead to increased family planning service availability and use through public, private and commercial sectors. This was to be achieved through the following: Training of doctors, nurses and allied health workers; improved commodity supply and distribution in government, commercial and community sectors; improvement of clinic services; and expanded adolescent services. The relationship of actual outputs to projected outputs is shown on the next page.

IPPF/WHR

<u>Projected Outputs</u>	<u>Actual Outputs</u>
70 MDs trained on-site	Change in implementation
100 MDs attended refresher seminars	To be scheduled in latter half of Project
14 nurses trained in fertility management	(7 scheduled for October, 1984; 7 more for 1985)
14 nurses trained as family planning trainers	14 trained in 1983

One Training of Trainers instructor at each teacher training college	2 from each country (14) in Antigua, August 1983 by CFP.
40 teachers per country trained in sex education	80 trained so far

PHS logistics capacity improved.	Major improvements made.
Continuous available supply of contraceptives in seven countries.	Implemented and ongoing.
5 CBD systems established	All established except in St. Vincent

Technical assistance for improved clinic service delivery	Not yet offered but being considered
Clinics refurbished and/or equipment supplied	37 clinics scheduled for renovations; one-third already completed; equipment supplied to approximately 50 clinics.

8 Adolescent clinics established	Several clinics established in Barbados, St. Lucia, St. Kitts, Dominica and one in Antigua.

8 Youth Outreach programs

Established in Barbados and
St. Lucia; embryonic in
Dominica, Antigua and St.
Kitts.

Some projected outputs have yet to be realized and others have been changed for logistical reasons. For example, none of the countries has so far developed a population policy and it is unlikely that three countries will have revised their policy by the PACD, December 31, 1985. Twenty national seminars are now considered unnecessary. Instead, CARICOM is considering additional awareness seminars after each country has had at least one national seminar. Minor problems were associated with the country population reports. CARICOM felt that the member-countries should have been consulted prior to their release. Distribution nevertheless proceeded and there have been few complaints.

Among the IPPF/WHR outputs changes have occurred in physician training. It was initially planned that 10 physicians from each of the seven countries would attend a one-week in-country course on Family Planning. Physicians, however, have been unwilling to spend so much time in training and away from their practice. Subsequently, half-day or one-day seminars have been held. Even then, physician response has been poor. Refresher seminars are planned in accordance with the Grant Agreement as updates to follow the adoption of regional and national medical contraceptive policies. However, given the poor physician response to training initiatives, the need for these seminars should be assessed.

Changes have also occurred in teacher training. Training has been carried out through the Caribbean Family Planning Affiliation (CFPA). The loss of the leadership and expertise of Ms. Allison Lewis has led to a setback in this area. Original plans were for the training of 40 teachers in each country but only two training courses have been held; one in Montserrat and the other in St. Kitts. Adolescent extension programs are now being mounted and it is too early to assess their effectiveness.

F. PURPOSE

The purpose of the Caribbean Regional Population and Development Project is to reduce the number of unwanted pregnancies in the region. End of Project Status (EOPS) conditions include (i) development of effective regional and national population policies, (ii) delivery of a wide range of family planning services through government clinics, (iii) improved clinic facilities and trained staff delivering family planning services, (iv) greater accessibility to contraceptives through commercial outlets, (v) an efficient, economical and appropriate system for commodity supply and distribution, and (vi) adolescent outreach programs that address the problem of teenage pregnancy. In general progress is being made in all the above categories.

1. CARICOM

CARICOM has developed both a Regional Population Policy (see Appendix VI) and Medical Contraceptive Policy. Both have been approved at the Regional level. However, only St. Vincent and the Grenadines and Antigua have so far developed a National Medical Contraceptive Policy. None of the CARICOM member countries has developed a National Population Policy but National Population Task Forces (NPTFs) have been appointed by the respective governments in seven countries: Barbados, Montserrat, Dominica, St. Kitts, St. Lucia, Antigua and St. Vincent and the Grenadines (see Appendix VII). The NPTFs have generally suffered from lack of effective leadership and political commitment to the concept of population development. If the current trend continues most countries are unlikely to develop an effective national policy before the PACD, December 31, 1985.

2. IPPF/WHR

Except for Antigua and Montserrat family planning services are now available through polyclinics or health centers as part of the Government's program. Negotiations are continuing in Antigua and Montserrat. The recent change in the Permanent Secretary in Antigua might facilitate Government involvement in family planning service delivery. Contraceptive methods offered through government clinics include barrier methods, oral contraceptives, injectable hormones and IUDs. In a few countries, usually at the city hospital, sterilizations are performed for women. Vasectomies are rarely performed.

IPPF under its Grant Agreement with USAID has allocated approximately a quarter million dollars for clinic renovations (Appendix VIII) in six countries. So far, renovations have been completed at seven sites, and are underway at 11 other sites (Appendix X). Clinic renovations also need closer scrutiny before work is begun. Some renovations have been little more than patchwork (reflecting limited allocations of funds under the Grant Agreement) and inappropriate for the desired use of the clinic.

To improve the availability of contraceptives the existing Community Based Distribution (CBD) program was expanded in Barbados and new CBD programs have been developed in St. Lucia, Montserrat and Dominica. Attempts to establish a program in St. Vincent and the Grenadines have been plagued with difficulties. The Dominica program is not well established and there is government opposition to the CBD concept. The future of the program is therefore uncertain.

An efficient, economical and appropriate system for commodity supply and distribution has been developed with the technical assistance of personnel from the Centers for Disease Control, Atlanta, Georgia. Other than problems related to late ordering of supplies by countries or delays in shipment there are no significant problems.

Programs that target adolescents e.g. special youth clinics, peer counsellor programs and workshops for youth outreach workers have been started. These efforts must, however, be considered embryonic at this time. IPPF has cooperated with the Tulane Operational Research project in some of these ventures. IPPF/WHR has plans for increasing its emphasis on adolescent outreach programs and for training persons who will work with adolescents. Since there is no provision for training of personnel to work with adolescents this will require discussion with USAID.

G. GOAL AND SUBGOALS

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.

Although subgoals are not specified in the Grant Agreement the following may be considered as subgoals: (a) implementation of a comprehensive campaign to raise awareness and promote commitment and action to support family planning services among leaders in the public and private sectors, and (b) improving the ability of countries to deliver adequate and timely family planning services.

It is too early to measure progress in accomplishing the stated goal, but there has been progress towards the achievement of subgoals. The campaign to raise awareness of family planning issues has not been as effective as was anticipated. On the other hand, significant progress has been made in clinic improvements and delivery of family planning services by trained personnel.

Some progress has been due to Project contributions, but the availability of contraceptives and training through UNFPA has undoubtedly had some effect on improved service delivery. Lack of progress in mounting an effective "awareness campaign" may be related to the loss of key CARICOM personnel at a critical phase of implementation. Lack of effective leadership, limited funds and personnel for such a campaign precluded any greater impact.

H. BENEFICIARIES

The direct beneficiaries of this project are those women who as a result of project activities are able to reduce unwanted pregnancies. Indirect beneficiaries include individual governments of CARICOM member-countries and their population which now stands at 5 million. By controlling population growth this project can be expected to have a favorable impact in important social areas such as: (a) reduction of poverty, (b) a sufficient number of full-time jobs, (c) self-sufficiency in food, (d) education for all and (e) health for all.

I. UNPLANNED EFFECTS

There have been no major unplanned effects during project implementation that require changes in project design or execution. Minor unexpected effects have, however, been noted. The initial close working relationship of IPPF/WHR and Tulane in the Adolescent Clinic and Outreach Programs can no longer in reality be considered joint ventures. Each agency has contributed its share to adolescent programs but there is little dialogue or collaboration in decision making or project execution. The Tulane component has generally been better organized and executed and it may be that there is now little need or reason for close collaboration with IPPF/WHR.

The second unexpected result worth noting is the publication of a paper on Depo-Provera by Carl Browne, Health Educator, in St. Vincent and the Grenadines. This is an example of local review and consideration of scientific evidence and probably would not have occurred if a National Medical Contraceptive Policy had not been developed.

J. LESSONS LEARNED

Several lessons can be learned from this project. Perhaps the over-riding lesson is that major difficulties are involved in mounting an effective population and development program in Caribbean countries. Although there is obvious need for such a program several governments remain uncommitted to project implementation even after signing sub-grant agreements. This fact along with the management problems of governments virtually precludes project execution according to time frames in the Grant Agreements. There is also the time and effort required to change people's perception of population issues and family planning in a region where the Roman Catholic Church is a powerful force in opposing major components of the project. Delays in mail and difficulties associated with local travel in several countries also add to the problems.

Time and effort are required before project implementation to court the support and commitment of political leaders and to establish rapport with key individuals. Caribbean countries are understandably more interested in receiving grant funds than following project guidelines meticulously and their priorities are sometimes different from those of USAID. Some aspects of the Grant Agreement are overly specific and do not allow for flexibility in various countries (e.g. training of teachers in sex education, see Page 6). These issues need to be carefully but thoroughly explored early in the negotiation process.

Compared to the short-term inputs offered by USAID, countries are more concerned about building a lasting infrastructure with well trained personnel. These differences in perspective as in Dominica, St. Lucia and possibly Grenada can lead to resentment of international agencies.

Benchmarks as indicators of progress in project implementation have not been established so as to provide optimal data. For example, baseline contraceptive prevalence surveys are only now being completed in Montserrat and St. Kitts even though intervention programs have already been started. In fairness, surveys were to have been carried out by an agency other than IPPF prior to project implementation. Questionnaires to assess the awareness and attitudes of political leaders prior to the formation of National Population Task forces have not been completed in any country. Future similar projects should therefore, require benchmark indicators as an integral part of project implementation. This would allow for objective end-of-project evaluation. Unfortunately, it is now too late to address the issue of benchmarks.

Substantial progress has been made in accordance with the Grant Agreement. CARICOM has proved itself to be an effective policy maker and has provided legitimacy to the project from the perspective of the various member countries. CARICOM for several reasons has been much less effective in promoting regional awareness of population issues or stimulating project implementation. IPPF/WHR personnel at the Caribbean Office have been very effective in moving the project along despite several organizational constraints. Some of the constraints have been intra-organizational. IPPF/WHR organizational issues should be addressed in the upcoming IPPF/WHR project review. Additional project staff are needed at the Caribbean Office to effectively administer the Grant. In addition, the operating expenses of the New York Office relative to the Caribbean Office should be carefully examined as the Caribbean Office has been seriously under-budgetted.

Because of the presence of several international agencies offering aid to Caribbean countries, it is critical for efficiency and impact not to duplicate projects or initiatives. Any project development strategy must consider the role of other agencies providing aid in the same field. UNFPA through PAHO is the major source of aid for family planning projects other than USAID. However, other initiatives such as the Tulane OR project, the Caribbean Contraceptive Social Marketing Program, etc. need to be well coordinated. The Tulane OR project in Barbados is doing precisely what the Grant Agreement had obligated IPPF/WHR to do in Barbados. Similarly, personnel in many of the countries received previous training in Family Planning, etc., virtually identical to training offered by IPPF/WHR. Demographic training represents a similar problem. Previous training was offered by CELADE in 1983. UNFPA is now offering \$100,000 for demographic training and under the Population and Development Project USAID has allotted \$100,000 for similar training. Unless there is coordination of these programs training is likely to be piecemeal, have little overall impact and include the same persons repeatedly. Even after training there is little provision for resources with which the trainees can function. In some countries visited, statisticians did not have even programmable calculators, far less a computer. Some of these difficulties in training may be solved by closer communication among the various agencies through a Project Advisory Committee that meets regularly and is chaired by USAID Personnel. Training, however, will need to be tied to available resources or those that can be provided. It is also important to determine in each country what the actual training needs are rather than simply assuming that each country has the same needs. These needs should be clearly identified before any Grant Agreements are signed.

Evaluation of the project was based on country visits, formal and informal interviews with key individuals, review of project documents and site visits to clinics. In retrospect, we believe that it would have been worthwhile spending time at the IPPF/WHO, New York Office since this is where the Project Director is located. In addition because of the method of reporting financial data it would have been useful to meet with the Financial Manager. Future evaluations should allow for time at the University of the West Indies to interview personnel associated with the project (e.g. Professor Hugh Wynter).

Our evaluation focussed on the Windward group of islands; conclusions from the evaluation must be considered in this context. These conclusions should not be construed as an overall evaluation of the project despite likely similarities in some of the Leeward Islands. Future evaluations could be improved by: (1) including a larger sample frame of countries, (2) allowing more time for evaluators to receive and review the several documents associated with the project and in the absence of the above to have a longer and more detailed briefing, (3) using a single evaluator in any one country rather than having evaluators overlap, and (4) by prearranging itineraries for evaluators in each country so that time is not wasted trying to obtain appointments after arrival. In St. Lucia, for example, several key persons were on leave or otherwise unavailable during our brief evaluation visit. In Grenada, delays in receipt of two cables resulted in an unfriendly reception at the Ministry of Health. It might also have been preferable to have scheduled our CARICOM visit earlier so as to meet with Ms. Audrey Hinchcliffe as part of the team in Guyana. In short, preplanning should be accorded greater emphasis in future evaluations.

K. SPECIAL REMARKS

Some aspects of the IPPF/WHO grant have been implemented in ways different from those specified in the Grant Agreement. These changes have been typically for pragmatic reasons and have generally improved project implementation. However, it is tedious to work through a document which in several places is no longer relevant to current initiatives. The evaluation team suggests that USAID personnel meet formally with IPPF/WHO personnel to sort out the differences and consider drafting a revised Grant Agreement so that it more accurately reflects current methodology. Major changes have occurred in the areas of physician training, the timing of in-country training courses vis-a-vis training of nurses in family life education and fertility awareness, and in the adolescent outreach component of the IPPF/WHO grant.

In addition to the problem with benchmarks alluded to earlier, a serious flaw in the project design is the failure to address supervision of service providers and training of personnel in counselling (also mentioned earlier). Research by Finkle, Ness and Simmons shows that the frequency of supervision, the supervisory style (supportive versus investigative), the number of persons supervised by each supervisor and the unit of command are important determinants of a system's productivity. It may be possible to address these issues in a revised grant to IPPF/WHO. Training and technical assistance in supervisor training and in counselling (including a special component on adolescents) might substantially improve use of family planning services and contraceptive methods.

Grenada has recently come under the umbrella of the Population and Development Project. Judging from our visit to Grenada and given the current political situation and lack of enthusiasm among Ministry of Health personnel it appears prudent to postpone further discussions until after the upcoming general elections. Since the CBD program will lose its funding by the end of CY-84, however, urgent consideration should be given to providing funds to continue this program. CBD is well established in Grenada and is a major aspect of family planning service delivery.

II. DISCUSSION

A. ASSESSMENT OF OVERALL PROJECT DESIGN

Population and Development (538-0039) is a highly ambitious project involving many components and several agencies. The project has advanced significantly to mid-term despite several constraints. This project needs to be seen as one with long-term goals with major implications for regional resources.

Firstly, while the purpose and goal of the project as outlined in the log frame have merit and are increasingly viewed as socially desirable by Caribbean governments, neither the purpose, goal nor outputs could realistically be expected to be achieved at the end of the project (PACD), given the time frame and funds allocated. While this is true for the overall project, it is extremely relevant to the CARICOM component which focuses on institutional building and attitudinal changes.

Secondly the project was conceived as an entity with many components and several participating agencies which necessitated careful coordination and synchronization. This aspect was not well designed and problems have arisen as a result of major flaws in timing and several components coming on stream simultaneously. For example, aspects of the CARICOM project aimed at sensitizing governments to various population issues: these aspects should have occurred prior to several operational aspects under the IPPF grant.

Thirdly, as the project contains discrete sub-components these components needed to be assessed initially both in terms of overall project purpose and goal as well as their own individual integrity. Separate log frames should have been designed both for each participating country as well as for the CARICOM and IPPF components. In this manner the cultural, political and other differences among the participants would have been calculated and the project made more flexible.

Fourthly, greater attention should have been given to ensuring that A.I.D., CARICOM and IPPF were able to gather baseline data for benchmarks before implementation of major components of the project.

Fifthly, certain assumptions of the project with respect to its purpose and goal seem unrealistic. According to the log frame the purpose of the project is to reduce unwanted pregnancies in the Eastern Caribbean. The indicator cited to measure the success of purpose is "increase in contraceptive prevalence by 25% over the life of the project". There are a number of problems associated with this assumption. (1) This project is not the only actor in the region; PAHO and UNFPA have been involved in family

planning and contraception projects for many years. Thus it would be difficult to attribute success in reduction of pregnancy to this project.

(2) As indicated above, it is unrealistic to expect an increase of 25% in contraception use over the entire region, across-the-board, even where there is considerable opposition to contraception, and particularly over the life of a project of three years duration. Project designers should have established country specific targets which could have been realistically achieved by the completion date and which would work toward the long-term goal of reducing birth rates and unwanted pregnancies.

Perhaps more realistic purpose would have included sensitizing the public and the leadership to population and development issues, institution building and implementation of population planning mechanisms and services.

In summation, this is a very ambitious project and much can be seen in hindsight. At mid-term we are able to better understand the project setting and the social, cultural and institutional conditions which allow for identification of more plausible indicators and the sharpening of outputs and targets. Also, very importantly, areas which were underfinanced, such as training and equipment for IPPF and media for CARICOM, can be reassessed. Suggested changes are recommended in the body of the text. Despite various constraints, both external and due to project design, progress can be seen on many fronts. With revisions considerable success could be achieved.

B. ASSESSMENT OF CARICOM COMPONENT

1. PROJECT DESIGN

The project was designed to raise the level of awareness "among key leaders of the consequences of present demographic trends on the socio-economic development of the countries and to upgrade outmoded family planning practices and procedures among the medical profession". To this end, CARICOM was contracted to implement a consciousness-raising campaign among leaders in the public and private sector. The medical profession was also targetted for change in medical policies and practices in family planning. At PACD the medical and public sector leadership are expected to have "formulated appropriate and effective policies and protocols to adequately address demographic and family planning issues". Specific indicators to achieve those results include:

The establishment of eight (8) National Population Task Forces.

The distribution of Country Population Reports.

The holding of three (3) regional conferences.

The holding of one (1) regional and twenty (20) national medical seminars.

The presentation of two RAPID population projections.

The training in demography of up to twenty (20) mid to upper level statisticians.

The training in modern contraceptive techniques for medical professionals.

The revision of formal population policies in at least three (3) countries.

An increase in public dialogue and "informal changes" in all countries.

Examination of these activities at mid-term indicates that despite serious problems of turnover of personnel, CARICOM has made some progress in implementing most of these activities. Discussion of each however, reveals certain flaws in the project design which have either been changed in process or are in need of revision at mid-term.

- (1) Responsiveness to the project on the part of individual countries in the setting up of National Population Task Forces has been slow. However, seven Task Forces have been established. To date, the effectiveness of the Task Forces has been minimal. Most of them have only met two to three times since the inception of the project and meetings have been at the request of CARICOM consultants and in preparation for this evaluation. The composition of the Task Forces varies. Consideration needs to be given to widening membership to include representatives from Ministries concerned with education, and economic development and planning. Some Task Forces include representatives from Church groups, labor unions, and the business sector, others do not. Appendix VII lists Task Force Membership in participating countries as of September 13, 1984.

However, establishment of Task Forces per se does not indicate that policy changes are being given priority. CARICOM has confirmed that individual countries have had to be prodded and urged to appoint persons to the Task Force and to hold regular meetings. Both the Regional Awareness Conference in April and the UNFPA International Conference on Population in August of this year have stimulated countries to firmly establish their Task Forces. Presently, there is a momentum which was absent in the past. The top down approach of the project may have contributed to lack of interest as Permanent Secretaries viewed NPTFs as just another CARICOM task.

- (2) Distribution of Country Population Reports has not occurred within the time frame envisioned by the project. The reports produced by the Population Reference Bureau (PRB) are well done and clearly indicate the impact high fertility has in the development process and are useful tools for policy makers. However, misunderstandings between CARICOM and PRB delayed the timely distribution of these reports to individual countries before the Regional Awareness Conference. Distribution is only now commencing. Also, after the intervention a decision was taken to replace Montserrat with Grenada. A Montserrat report has not been done and additional funding will be required to do so.
- (3) The Regional Awareness Conference was to occur as the third stage in the process of policy dialogue after the establishment of NPTFs and the distribution of Country Reports. Although this did not occur, indications (which are largely estimates based on personal interviews) are that the conference heightened consciousness and stimulated the establishment of bona fide NPTFs. There has been no formal follow-up by CARICOM through questionnaire or other surveys to determine the impact of the Conference. Publications of the Conference proceedings have not yet been distributed. Materials have been reproduced, however, and should shortly be mailed to participants.

- (4) Medical seminars have been held in five countries, and two more are scheduled for the remainder of the year. Two countries, St. Vincent and Antigua, have produced medical policy documents, and Montserrat is expected to have a document shortly. The momentum from the Regional Awareness Conference and the ready acceptance of the draft medical policy document from CARICOM with country specific revisions indicates that well-defined issues within easily definable parameters are better understood and are more relevant to the needs of the respective countries, than are the more amorphous, wide range of demographic issues and policy. Indications are that the twenty medical seminars built into the project design will not be necessary and that remaining funds in this component could be reallocated.
- (5) RAPID presentations were held in St. Lucia in April. One was regional and presented to the Conference participants, and the other was country specific and shown to policy makers after the Conference. Feedback indicates that participants considered the presentation of great value and impact. Suggestions for further use of RAPID presentations towards EOPS are given in Section E.
- (6) Up to the present there has been no utilization of the \$100,000 set up for demographic training, despite CARICOM's request to countries for potential trainees. The Grant Agreement specifies that limited training support is available through the ISPC. The Grant Agreement also mandates that an upper level statistician in the Barbados Central Statistical Office should be trained by ISPC. This has not occurred. The reasons for disinterest appear to be the following:
 - (a) Project design failed to account for the number of courses in demographic training available to regional statisticians, both long and short-term. For example: In 1983 a CELADE/ECLA/UNFPA intensive course in demographic analyses was held in Trinidad with participants from around the region. Also, a new regional body, CISTAR (Caribbean Institute for Statistical Training and Research) is presently being proposed with \$100,000 backing by ECLA.
 - (b) The statistician concerned in the Barbados Central Statistical Office was on contract to program 1980 census data and has completed his task and taken up a new job.
 - (c) Courses offered by ISPC are considered to be too costly for the region.
 - (d) Long-term training for statisticians is problematic for short-staffed LDC governments. Where such training has and is occurring, it is being done through channels other than this project. Short, in-house, specific training may be more relevant and suggestions to this effect are made in Section E.

- (7) The \$10,000 funded for Observational Training has not been utilized as outlined by the project. The two requests for funding do not fall under the stipulations of the Grant Agreement. It appears that doctors either do not see the relevance of such training and/or do not consider it of high enough priority to leave their practice for the duration of such seminars.
- (8) Revision of formal population policies in at least three countries is unlikely to occur at PACD. It was perhaps unrealistic to assume that this could be accomplished given the time frame, funding, and part-time administration of this component of the project. A more realistic and realizable indicator would be the formal presentation of a policy document on population to the respective governments of all participating countries. In fact, at mid-term no country has been able to write a draft that has been submitted to Parliament. CARICOM surmises that at PACD possibly only St. Vincent and St. Lucia will have such a document approved by their respective governments.
- (9) It is very difficult to assess increased public dialogue and "informal changes" without established benchmarks. The media component of the project became bogged down in a contract dispute with a private advertising firm. CARCIOM's Communications Section has run a series of radio spots, but evaluation of their impact has not yet taken place. The role of the media in creating awareness of population issues has been under-utilized. This is one area where the project design needs to be revamped. Wider use of the media would permit greater access to target groups.

2. CONSTRAINTS TO IMPLEMENTATION

Lack of progress in achieving outputs by mid-term is not simply a problem associated with project design. There are many constraints to implementation of such a project which exist in the participating states, the likely effect of which were apparently not considered. Other developments, especially relating to CARICOM personnel, have also led to interruptions in the implementation process.

a) Personnel

The major setback here were the deaths of the key personnel, the Project Director at CARICOM (Dr. Philip Boyd) and the Project Administrator (Mr. Evan Drayton). This certainly affected both project momentum and monitoring of LDC components such as the NPTFs. Changes in incumbent RHPD Officers at RDO/C have also occurred, causing discontinuity in the crucial function of USAID in this Project. To some extent, the hiring of Neville Selman, who had been a consultant for CARICOM and assisted the formation of NPTFs, alleviated the situation.

Frequent turnover of staff, among participating states, either because of internal transfers at the leadership level (e.g. Permanent Secretaries) or because of heavy migration of service staff, caused disruptions at the local level which set back the implementation process. These movements are outside the influence of implementation agencies: they simply have to make fresh starts as necessary.

In addition, local Ministries have small corps of administrative supervisory personnel who are all pressed into servicing projects by myriad external agencies making inputs into the local system; they can only do so much under each project for each agency.

(b) Communication Difficulties

Other constraints exist which are associated with the communication problems of CARICOM. These are well known and obviously were taken into account when the project was designed. Nevertheless, the distance of Georgetown from the participating countries and the fact that the Project Administrator is a half-time position impedes effective monitoring. Additional bureaucratic hurdles exist with respect to CARICOM's liaising with individual countries which is through Foreign/External Affairs. This Ministry then passes information on to the Ministry with which the CARICOM project is associated.

Constraints to effective implementation also arose as a result of the approach by CARICOM of drafting policy statements expected to be implemented by member states. Civil servants tend to view the project as another chore, rather than a policy tool generated from within the country. It is also debatable whether the Permanent Secretary in Health is the most appropriate head for a NPTF as CARICOM has outlined. An equal case could be made for someone in Planning or a prominent citizen, especially in those countries where population issues are still viewed as volatile and associated only with family planning and contraception.

Constraints to effective implementation have also occurred because of misunderstandings and poor communication between AID and CARICOM. Much of this is due to personnel changes; and the length of time necessary to establish good working relationships. These can be resolved through dialogue and more regular communications beyond that required by quarterly reports.

(c) Political Commitment

Generally, the political commitment at present for such a Project is superficial. The signing of sub-grant agreements by Governments, or other formal indications of interest, do not necessarily reflect a deep desire for the activities. More often projects are assented to simply as a means of encouraging the flow of funds into a system. Thus the political determination to realise the objective is weak.

It is therefore necessary during the implementation process, to create the commitment which is presumed to exist prior to project design.

While Caribbean governments and peoples recognise the value of external assistance, their political consciousness can cause suspicions and resentment of external agencies. This conflict between reliance on, but resentment of, international assistance and agencies, creates a delicate arena in which 'external' implementing agencies have to function: the path and rate of the implementation process often cannot take the form prescribed in contracts between such 'external' agencies.

All the above elements of political behaviour - commitment, determination, consciousness - unduly afflict an already politically sensitive dimension of national (and now international) relationships viz. population and family planning programs. Such programs are notoriously difficult to implement anyway, and especially so where the stimulus is from outside. It is therefore imperative that USAID and its contractors tread carefully if progress, inevitably slow, is to be steady and sure.

For all these reasons the time frame for this Project, given the stated objectives, warrants review.

3. CHANGES IN PROJECT DESIGN DURING IMPLEMENTATION

The following comprise changes in project design which have occurred during implementation.

- (1) Although the Grant Agreement foresaw utilization of National Health Councils as an aid to formation of NPTFs, the Councils were never formed by CARICOM nor played a role in the project.
- (2) The number of participants at the Regional Awareness Conference was expanded beyond those involved in developing and implementing national population programs in participating countries to include invitees from throughout the Commonwealth Caribbean. Representatives from regional and international organizations were also invited. The thrust of the Conference was changed to include preparation for the International Conference on Population which was held in Mexico in August. As the implementation of the project was behind schedule very few NPTFs had met more than once. Thus the initial reason for the conference was no longer valid. CARICOM has not yet distributed the proceedings of the Conference to participants.
- (3) CARICOM has disputed the distribution of the PRB Country Reports arguing that each should be cleared by the respective country before dissemination. CARICOM has argued that the regional organization should have had final editorial approval before publication. This is disputed by PRB.
- (4) A contractor was never hired by CARICOM to prepare fact sheets, bulletins or pamphlets on population issues. CFPA was used at the Regional Awareness Conference, and the CARICOM Communications Section prepared a broadcast series that was aired in August. There is an unresolved dispute over a contract with an advertising agency.

- (5) The \$100,000 allocated for Demographic Training has not been utilized.
- (6) The \$10,000 allocated for Observational Training has not been utilized as outlined by Grant Agreement. There has been little response by the medical profession.
- (7) Technical assistance has been provided with minor changes to that envisioned by the Agreement. Instead of utilizing one contractor for a five month contract, three contractors at various times were hired. Thus, the project lost some continuity. Promotional Assistance is under-financed, but also has not been adequately utilized

C. ASSESSMENT OF IPPF COMPONENT

1. TRAINING

Training has been a major component of the IPPF/WHR Grant Agreement. Under the agreement funds have been provided for the training of physicians, nurses and allied health personnel. Training of physicians has been modified because of difficulty in persuading physicians to attend training seminars. Instead of one-week courses, a half-day or one day seminar in Contraceptive Technology is offered. These are didactic sessions and are usually arranged with the help of in-country obstetrician-gynecologists or personnel from the Centers for Disease Control, Atlanta, Georgia. The quality of training has been high but little impact has been realized.

IPPF/WHR has also sponsored one-week training courses in family planning for public health nurses and allied health personnel. By the end of 1984 IPPF/WHR will have conducted training courses in eight countries including Grenada. This training is designed as an introduction to family planning and covers a wide range of topics from genital anatomy and physiology to sexually transmitted diseases. Pre-test and post-test evaluations are an integral part of the course. The courses have been well attended (approx. 40 persons per course) and received. Attendees have generally felt the courses to be useful, interesting and of high quality. Short-term impact has been an increase in knowledge but the long-term impact though not formally assessed appears to be minimal. This is not entirely surprising given the introductory and theoretical nature of the course and the lack of follow-up. The original plan was for local physicians to supervise and work with trainees after the course but this has not occurred.

In general, most nurses who attended IPPF/WHR training have remained in the family planning field. St. Vincent, however, is an exception where an estimated one-third of nurses who attended the training course are no longer working in family planning.

In addition to in-country training, fellowships are offered to graduate nurses to attend an advanced course in Fertility Management at UWI, Jamaica. Fourteen nurses are scheduled to attend this course. The first group of 7 nurses will take the course in October 1984. A change is proposed for the other 7 nurses and they will take a course in Adolescent Fertility. This is partly an attempt to address the lack of training in adolescent issues and partly because of the questionable need for training in Advanced Fertility Management. Fourteen nurses also attended the Training of Trainers course at UWI, Jamaica in 1983. Costs associated with the training courses have been very high. The cost associated with eight-week training of fourteen nurses was approximately US\$53,000. Under the terms of the Grant Agreement it was intended that training of nurses at UWI, Jamaica would occur during the first two years of the project. These trained nurses, two from each country, were expected to return and develop and participate in in-country training programs. This would have meant waiting two years before developing in-country courses. Fortunately, implementation of this component was modified by IPPF/WHR. Training was conducted in-country by IPPF/WHR personnel while nurses were being trained at UWI.

In keeping with the Grant Agreement 20 teachers from teacher training colleges in the region attended a training course in Antigua. This course was offered through the Caribbean Family Planning Affiliation (CFPA). The purpose of the course was to provide training in family planning and sex education within the context of a Family Life Education curriculum. The course lasted for four weeks rather than two weeks as originally planned. This was because CFPA felt more time was necessary for the course. In-country courses were to follow and be given by CFPA's education/training officer with support from local experts in each country. Only two such courses have been held, one in Montserrat and one in St. Kitts. This was probably due to the loss of CFPA's education/training officer.

2. IMPROVEMENT OF SERVICES

In all countries except Montserrat (and now Grenada) family planning services are now offered through government clinics. In most countries local FPAs still offer clinical services but in general FPAs concentrate more on information and education programs. Service delivery through government clinics allows more access to family planning services since a client may choose from many clinics and in most countries services are available 8:00 a.m. - 4:00 p.m. every week-day.

Training of nurses, albeit introductory, has made many nurses more knowledgeable and comfortable working in family planning. This theoretically might translate into better care. Some nurses stated that they now take better histories from clients and have a better understanding of the importance of family planning. In fairness, no provision was made to assess the impact of training and hence it is unclear to us if the IPPF/WHR training and training of nurses at UWI has had any great impact on service delivery. Training of personnel to work with adolescents is important and relevant; in many areas adolescents account for 20 to 25 percent of family planning clients. Yet there has been no training in this area.

Supply management and distribution has improved considerably. There is in place in each country a well designed, efficient and appropriate system for commodity management. The system was designed with expert help from the Centers for Disease Control, Atlanta. Some countries, however, have storage rooms that need to be upgraded and modified. A minor problem is the delay in commodity requests and reports from countries.

Under the Grant Agreement funds were provided for renovations and equipment for clinics. These funds have been so small relative to the need that in general, renovations have mostly been akin to patchwork in several clinics and other clinics lack essential equipment such as tenacula, specula, sterilizers and stirrups for exam tables. The basis in the Grant Agreement on which funds were allocated to individual countries is unclear and does not seem to consider actual in-country needs. There have been problems in the procurement and receipt of clinic equipment partly because of A.I.D. regulations on procurement and probably related to delays at the New York IPPF/WHO office. The result is that clinic equipment has arrived sporadically and some clinics that have been renovated are not equipped for some time. This diminishes the impact of this aspect of the project activities. Problems have also arisen concerning the disbursement of funds from the IPPF/WHO New York Office to countries for renovations. Because advances are tied to receipt of quarterly reports from countries and reports are often overdue, funds are withheld until reports are submitted. Although this may be a useful built-in control it results in unnecessary delays in renovations.

Improvements in Adolescent Services are now being addressed. It is therefore premature to assess the effectiveness of the various strategies employed. A serious short-coming has been the lack of training of personnel in counselling and in specific techniques for working with adolescents. In some countries e.g. Barbados, special youth clinics are held at the government-run polyclinics. In other countries special adolescent clinics and youth outreach programs are being developed. A concern is that outreach efforts are not well focused and may be over-ambitious. In countries where there is overlap with Tulane OR projects, collaboration is less than ideal.

D. RECOMMENDATIONS FOR ACHIEVING PROJECT OBJECTIVES

Despite the complexity of the project design the evaluation team found that project activities were moving ahead fairly smoothly and proceeding on target towards project objectives. However, there are a few specific recommendations that are made to enhance project effectiveness.

1. CARICOM

Only approximately 25 percent of the CARICOM budget has been used so far and there is much scope for escalating awareness of population issues, sustaining the momentum achieved by the International Conference on Population in Mexico in August, and increasing the level of demographic skills among middle level statisticians.

RECOMMENDATIONS

1. That a full-time person with a demographic background be contracted for the duration of the project to monitor and work with the NPTFs in each country in the completion of policy documents and their presentation to the respective governments. This person should also be trained to give RAPID presentations.
2. Given the momentum achieved by the Mexico Conference it is opportune to convene a Regional Conference aimed specifically at policymakers such as Ministers of Health, Education, Planning, Finance and their Permanent Secretaries.
3. An important oversight of the project has been the under-utilization of the media to create awareness and educate the public about population and development issues. This sub-component was seriously under-financed at \$10,000. The problem has been compounded by contractual disputes with an advertising agency. However, this needs to be addressed now and a media campaign plan developed, either with an advertising agency directly, or utilizing CARICOM and CFPA for specific aspects. Both television and radio spots should be utilized in addition to CANA reports.
4. Little attention has been given to the \$100,000 provided for demographic training under the project. This training component needs to be re-designed in a manner to take into account the problems of statistical departments which are seriously understaffed and lacking in hardware. Serious consideration should be given to the recruitment and training of two demographers/statisticians to be attached to the OECS Economic Secretariat in Antigua. These persons could provide in-country training for local statistical units and aid in specific demographic studies of the LDC's. Short-term specialized courses and seminars such as on Social Indicators could be mounted in the region.
5. Consideration needs to be given to extending the PACD by one year. This would correspond with the end of project date of the IPPF/WHO component. This is deemed practical given the delay in implementation of the project, the time consuming aspect of policy dialogue, consciousness raising and the delays caused by the deaths of key personnel.

It is possible to re-allocate funds among line items such as reducing the allocation to demographic training and increasing the media budget considerably. Thus, extension of the PACD by one year will not necessitate additional funding for the CARICOM component.

2. IPPF/WHR

1. The IPPF/WHR Project Manager, Angela Cropper, has done a superb job but has had to play too many roles. We believe that additional project management and technical personnel are needed at the Caribbean Office. This is preferable to increasing the technical assistance component with its high overhead costs.
2. Subgrant agreements and their execution including the method of disbursement of funds from IPPF/WHR should be closely examined. Similarly, IPPF/WHR New York Office costs and the method of reporting financial data needs careful review.
3. Funds allocated for clinic equipment and renovations should be re-assessed on a country-by-country basis. Either more funds should be allotted for clinic improvements or efforts should be limited to a few key clinics in each country to achieve greater impact.
4. Delays in the disbursement of funds for clinic renovations should be analysed and minimized.
5. A country by country training assessment needs should be conducted. UWI training fellowships for nurses, because of their high cost and minimal impact on Family Planning Services, should be discontinued or severely curtailed. Instead, courses in counselling (with an emphasis on adolescents) and supervisory management should be offered.
6. Funds should be provided for the Grenada Planned Parenthood Association's CBD program. Present funding will expire at the end of CY-84 and this important program will be discontinued unless new funds are available.
7. Discussion of project initiative and activities with the Ministry of Health in Grenada should be postponed until after the upcoming general elections.
8. The Project Advisory Committee, chaired by USAID personnel and including representatives from USAID IPPF/WHR, the Tuiane Project, CCSMP, CARICOM, CFP, PAHO and similar agencies should be convened at least quarterly. These meetings would allow for information sharing on various related projects and enhance communication among members of the Advisory Committee.

These proposed recommendations, such as additional project staff, funds for clinic equipment and renovations, the Grenada CBD program and training in counselling and supervision, if implemented, will require additional funding of the IPPF/WHR component.

III. OBSERVATIONS AND RECOMMENDATIONS BY COUNTRY VISITED

A. ST. VINCENT AND THE GRENADINES

1. CARICOM COMPONENT

A National Population Task Force was appointed by Cabinet in April, 1983. A list of Task Force members is shown as Appendix VII. Proposals are underway to increase the size and composition of the Task Force. A National Population Policy has yet to be developed.

A National Medical Policy seminar was held in St. Vincent and the Grenadines, May 31 - June 1, 1984. Twenty-seven persons including nurses, doctors and CARICOM officials attended. A National Medical Policy was adopted at this meeting. One important result of the conference was that family planning services are now available from 8:00 a.m. to 4:00 p.m. daily in all clinics, instead of being restricted to a few hours on selected days. The new Minister of Health and the Permanent Secretary appear to be interested in the project and in developing a population policy.

2. IPPF/WHR COMPONENT

(i) Training

Two five-day workshops on family planning and family life education were held in November, 1983. A total of 107 nurses, community health aides and public health inspectors attended. A one-day seminar on Contraceptive Technology was also held in November, 1983. Approximately 25 physicians attended. Two senior nurses also received fellowships to attend an eight-week Training of Trainers course held at UWI January through March, 1983. There has been little follow-up to the IPPF in-country training programs.

(ii) Commodities are stored at the Kingstown Clinic in a locked room. This store-room is not optimal, since many contraceptives are directly exposed to the sun for most of the day. The room is not air-conditioned. The inventory system developed by CDC personnel is well established and no problems were noted. Mr. Saunders has direct responsibility for the supply system. He checks and fills orders, and arranges transport of contraceptives to the various clinics. No CBD program currently exists but negotiations are continuing.

(iii) Improvement in Clinic Services

Renovations are planned for 14 clinics. Renovations have been completed at three clinics (See Appendix IX). The cost of clinic renovations is estimated at \$63,358. Clinic renovations at those clinics visited appear to represent marginal modifications of existing structures and appear to have had little impact on improved service delivery. It would probably have been preferable to concentrate funds and efforts in a few clinics for greater impact.

(iv) Adolescent Extension Programs

Adolescent activities are still at the planning stage. A draft subgrant agreement is being reviewed by the Ministry of Health. It proposes establishing special adolescent clinics at four Health Centers. These clinics will operate once a week in the late afternoon after regular clinic hours. Youth outreach activities will rely primarily on community youth leaders. They will undergo training to raise their level of knowledge and awareness of family planning issues. Family Life Educators will also be used in youth outreach efforts, and they too will receive training in family planning. The type and extent of training, however, is unclear.

3. RECOMMENDATIONS

1. Training in counselling techniques and adolescence should be initiated for all District Nurses. The training should include appropriate on-site follow-up and observation. All future training should emphasize the practical application of new information.
2. Staff at the youth clinics under consideration need to be trained in working with adolescents. Community Health Aides can be used to develop specific outreach techniques. The proposed peer counselling program should be recommended.
3. Educational materials for clinics should be evaluated. Method posters and instructional aides should be easily visible and readily available. CFPAs should be encouraged to develop short, easy-to-read pamphlets and single page instruction sheets on the most popular contraceptive methods. Emphasis should be placed on warning signs. Additional audiovisual materials should be considered.
4. Signs and clinic schedules should be clearly displayed at each clinic site.
5. The composition of the Task Force should be broadened to include non-health officials.

B. ST. LUCIA

1. CARICOM COMPONENT

A National Population Task Force was appointed by Cabinet in February, 1983. There are eight members on the Task Force. Four meetings have been held since February, 1983. Attendance has been good. Between meetings relevant literature is circulated to members for review and comments. A National Population Policy document is being developed. There are plans to have open discussions in the community to allow the populace a chance to have their input. A Medical Contraceptive Policy has yet to be developed. Project activities received a boost after the Regional Awareness Conference held in St. Lucia, April 30 - May 1, 1984 and again after the Population Conference in Mexico. All Task Force members attended the Regional Awareness Conference. Attendees were particularly impressed by the RAPID presentation by the Futures Group. The Minister of Health, the Permanent Secretary and Prime Minister are all supportive of the project and progress can be expected in St. Lucia.

2. IPPF/WHR COMPONENT

(i) Training

IPPF/WHR sponsored two one-week workshops for nurses and family life educators in October, 1983. Approximately 86 persons attended. Training was designed to equip attendees with family planning information in preparation for the delivery of services by Ministry of Health personnel. The training course in St. Lucia as in other countries covered a wide range of topics including, contraceptive methods, communication styles, human sexuality and sexually transmitted diseases. The course was introductory in nature. Attendees seemed to have enjoyed the course, but it was difficult to determine what impact it made on service delivery.

Other training sponsored by IPPF/WHR included two one-day seminars for physicians held in June, 1983 and two three-day workshops on family planning for community health aides held in June, 1984. One graduate nurse attended the eight-week UWI course on Advanced Techniques in Family Planning and two other nurses attended the UWI Training of Trainers course. A structure for in-service training does exist, but it has not been used for family planning education. Nurses attend a meeting quarterly where topics are discussed. Clinical training under the supervision of local physicians was to follow the IPPF/WHR workshops which were largely theoretical. This, however, has not worked out well.

(ii) Commodity Supply

There is an efficient and well organized system for the supply and distribution of contraceptives. The system, as in the other countries, was designed with help from CDC personnel. There is also a well-run CBD project conducted by the FPA. Since October, 1983 the FPA has established 36 outlets including drug stores, restaurants, bars, private homes and shops. In contrast, to family planning services at health clinics or at the family planning clinic where a wide range of methods is available, only condoms and vaginal tablets or foams are distributed in the CBD program. Oral contraceptives will soon be included as part of the program. Distributors keep approximately one-third of the sales price of any contraceptives sold. The FPA has set a target of 80 outlets by 1986. Two of the initial 36 have dropped out.

(iii) Improvement in Clinic Services

Six clinics were selected by the Ministry of Health for renovation under the project. Four of these have already been completed. Various pieces of equipment have also been supplied to these and other clinics. Equipment include sterilizers, tenacula, examining tables, lamps and vaginal specula. Renovations at some clinics appear not to have been well thought out. Nurses complain that they had no input into the design. At the Castries Clinic despite the use of fans the entire clinic area is extremely hot and humid, particularly in the afternoon, and not suited for a family planning clinic. A limitation in service delivery in St. Lucia is that medical policy does not allow trained nurses to insert IUDs except under a physician's supervision.

(iv) Adolescent Extension Programs

Adolescent outreach efforts have focussed on a teen-counselling program jointly started by IPPF/WHO and Tulane University as an operational research project. IPPF is no longer actively involved in the project since the Tulane group has assumed responsibility for the OR part of the program. The program seems to have been well conceived and well implemented. Peer counsellors were trained for one-week in April, 1984 before the program was started. Subsequently, the Marchand Clinic was renovated with IPPF/WHO funds and nine trained peer counsellors meet there to hold information sessions four evenings a week. A special teen clinic is held on two of these evenings. Group sessions, individual counselling and clinic services with a nurse are available and are well attended. At the Dennery Clinic peer counselling only is available. At Vieux Fort a teen clinic is also in operation.

3 RECOMMENDATION

1. Training in counselling (with emphasis on adolescents) should be offered to district nurses.
2. Training in supervisory techniques should be offered to all community nursing supervisors.
3. In-service clinical training needs to be better organized and implemented with the assistance of local physicians.
4. The dual system of commodity prices should be standardized or the systems should be clearly explained to all clinic staff.
5. Renovations at the Castries clinic appear not to have been well conceived. The clinic is extremely hot and should be air-conditioned.
6. The St. Lucia Family Planning Association is doing an excellent job and should be given continued support.
7. The design of the joint Tulane OR adolescent project with IPPF/WHO should be changed to allow Tulane full responsibility for the project.
8. Physicians should be encouraged to support trained nurses in the insertion of IUD's in women attending family planning clinics.

C. DOMINICA

1. CARICOM COMPONENT

A National Population Task Force was appointed by Cabinet in September, 1983. It consists of nine members, none from the Ministry of Education. Although the Permanent Secretary Ms. Eudora Shaw is the Chairperson, three of the five meetings held have been chaired by Mr. Michael Murphy, the Deputy Chairman. A National Population Policy has yet to be developed. Plans are underway for collecting data on the level of awareness of political leaders about family planning issues, but is considered to be a difficult and expensive proposition. A Medical Contraceptive Policy has yet to be developed. Overall, it appears that (i) the Task Force suffers from a lack of effective leadership; (ii) that a population policy is not a priority with the government; and (iii) at least some politicians including the present Health Minister and the Director of Health Services are very much opposed to CBD programs and other project activities.

2. IPPF/WHR COMPONENT

(i) Training

The standard IPPF/WHR one-week workshop on family planning will be offered to nurses in October, 1984. It is expected that approximately 34 primary health care nurses will attend the workshop. Training of teacher educators will follow later. Two nurses have already completed the UWI Training of Trainers course in Jamaica. No physician seminars have been held because of the ongoing UWIDITE course in family planning. However, six district medical officers participated in the UWIDITE course on family planning.

(ii) Commodity Supply and Distribution

The system instituted by the Centers for Disease Control is working well. Recently the Ministry of Health has centralized supply ordering and distribution. A Compaq-Q computer has been acquired and soon all commodity data will be computerized, but family planning supplies will be handled manually until personnel develop computer expertise and permanent staff are assigned. A drawback to this system is that only a small area of the store-room is air-conditioned and even the computer area can become quite hot and humid. One wonders how often computer problems will arise and how easy it will be to effect repairs.

A CBD program has recently been started under a subgrant agreement with the Dominica Planned Parenthood Association (DPPA). The contract was signed in March, 1984 and the program started in June, 1984. There are 10 outlets currently operating in the Roseau area. These include 6 pharmacies, a restaurant, a bar, a canteen and a cinema. In three rural areas, La Plaine, Veille Casse and Marigot, there is a home delivery program with one local resident acting as supply person. Condoms, foams, tablets and oral contraceptives are available through the CBD program.

Distributors receive a 25 percent commission on sales. It appears that the program will be successful under the enthusiastic leadership of Ms. Lucia Blaize. However, it should be noted that political leaders do not view the program favorably.

(iii) Improvement in Clinic Services

Nine clinics were scheduled for renovations. One is already completed and three others are now being renovated. The cost of renovations is estimated to be \$53,527. Clinic sites were not visited during the Dominica evaluation. Thus, no comment can be made about renovations. Some clinic equipment has already been provided and more is to follow.

(iv) Adolescent Extension Programs

IPPF/WHR and the Tulane OR group have cooperated to provide adolescent services in Dominica. IPPF/WHR provided funds to establish separate clinics for teens. Tulane's role is to provide support to collect data which will be used to evaluate different service delivery strategies and to pay some of the service delivery costs. The Tulane teen project will test the difference between providing family planning services in physically separate clinics for teens and in youth clinics with special hours within existing clinics.

Other adolescent extension activities are minimal. IPPF/WHR held a three-day workshop for youth officers and field workers in June, 1984. This was considered to be the initial step. This has been followed-up.

3. RECOMMENDATION

1. National Population Task Force members would benefit from a workshop on Population Development and the role of the Task Force. This could be arranged through CARICOM and the Minister of Health should be invited to attend. A RAPID presentation might provide additional impact.
2. The present Task Force chairperson appears overworked and vague about population issues and should be replaced, probably by the Deputy Chairman.
3. The composition of the Task Force should include a representative from the Ministry of Education and from Finance and Planning.
4. The survey to assess the awareness of political leaders should be abandoned.
5. A workshop on counselling techniques should be planned for clinic nurses.
6. The CBD program should be supported. It offers increased accessibility to family planning methods.

D. GRENADA

Grenada has only recently been included under the Population and Development Project and the purpose of our visit to Grenada was to assess the prospects for further future project involvement.

1. CARICOM COMPONENT

A National Population Task Force was appointed by the interim government in August, 1983. Three meetings were held since that time. The Task Force is no longer functional. Dr. Bernard Gittens, the former chairman and a Minister in the previous government, was replaced but his successor and indeed the Ministry of Health has not shown any interest in revitalizing the Task Force or addressing population issues. The perception of the Evaluation Team is that (i) there have been several changes in Ministry of Health personnel; (ii) confusion and disorganization exist within the Ministry; (iii) key health personnel are not committed to developing a population policy; and (iv) government officials seem unwilling to address new issues or programs because of upcoming elections which will almost certainly mean changes in health personnel and perhaps policies.

2. IPPF/WHR COMPONENT

i. Training

The only activity performed under this grant so far is training. In May, 1984, IPPF/WHR held two one-week training courses for nurses. A total of 120 nurses and allied health personnel attended. This was the first introduction of Ministry of Health nurses to family planning. The course was introductory and trainees will require follow-up training with emphasis on clinical and counselling skills, before family planning services are offered at Ministry of Health clinics.

ii. SERVICE DELIVERY

The Ministry of Health operates 34 medical centers around the periphery of Grenada. Seven of these are "health centers". Surrounding each health center are four or five "medical stations".

The seven health centers are located in the main village in the area. They are staffed by public health nurses, a district medical officer, a family nurse practitioner, an environmental health officer, a district nurse, a pharmacist or pharmacy aide, and a community health aide. The family nurse practitioner has had one year of additional training in St. Vincent and the Grenadines and can function quasi-independently. These centers offer ante-natal care, well-baby care, sexually transmitted disease screening and treatment, and in a few places post-natal care.

The medical stations act as satellites to the health centers. They are staffed by a district nurse, who is trained in mid-wifery, and one or two community health aides. The DMO and the public health nurse usually visit each site once weekly.

At this writing, the Ministry of Health does not offer family planning at its clinics. Indeed, they are only just beginning to introduce post-natal care at the medical stations. Two field nurses from the Grenada Planned Parenthood Association (GPPA) are currently funded to visit eight Ministry of Health medical stations throughout Grenada to offer family planning services. They go out as a team, carrying a satchel of supplies, and use the Ministry of Health clinics to examine women. Often, because there is only one exam room, they must wait for the district nurse to finish before they see clients. In the first half of CY-84, they provided family planning services to 608 women, one third of whom were new acceptors.

This visiting program by the GPPA on behalf of the Ministry of Health has gone on in some form for 20 years. For the past two years GPPA has been informed that the Ministry of Health would be absorbing the program. This year, after it did not appear this would happen, GPPA continued the program, asking for funds from IPPF/WHO (which they received in April) and borrowing from other programs, so they could continue delivering services without interruption. GPPA has once again been told by IPPF/WHO that their funding for the field nurses will be discontinued at the end of the calendar year. The Ministry of Health is expected to take over the program January 1, 1985, but plans are still quite vague.

iii. COMMUNITY BASED DISTRIBUTION

Grenada has a well established CBD program. It has been in operation since 1979. There are 100 outlets, 86 of which are on Grenada. Outlets include groceries, shops, discos, and bars. (No private residences are used).

Contraceptive distributors work on a volunteer basis. Distributors have recently been given a watch as a token of GPPA's appreciation. They receive one-to-one training on methods and record-keeping. They are given a metal sign to display in their windows. The sign has the logo of GPPA and the name. There is a yearly seminar for distributors, where they receive updates and "pep talks". Contraceptives are available free.

In the first quarter of 1984, 35,038 condoms and 546 tubes of neosampoon were distributed. CBD is promoted by a nicely designed yellow poster, periodic ads in the newspaper, and through education programs. They have asked CFPA to design bumper stickers advertising CBD.

Each distributor is visited by Mr. Alexis, Program Director, on a quarterly basis. He keeps comprehensive records on supplies on hand, supplies distributed and supplies refilled. The field outreach workers also check with the CBD outlets on a regular basis, and advise Mr. Alexis if they need additional supplies. If a trip is not scheduled, the field nurses are asked to carry supplies. The supply system seems well established and functions smoothly.

Only condoms and neosampoon are available. GPPA is waiting for the Ministry of Health to become involved in family planning before requesting permission to distribute oral contraceptives. All supplies have been from IPPF/WHO. IPPF/WHO has informed GPPA that their budget will be cut from \$96,000 to \$73,600 in 1985. The Executive Director has plans to eliminate the CBD program to make up for these cutbacks.

3. RECOMMENDATIONS

1. Postpone further project discussion and initiatives until after elections.
2. The CBD project should be picked up under 538-0039 funding. It is distributing nearly 140,000 condoms a year. If it stops, there would likely to be an upsurge in fertility and sexually transmitted diseases.
3. A training needs assessment should be undertaken. Training, emphasizing practical medical and counselling skills as well as training on working with adolescents, should be developed. Observation and follow-up should be included. The priority should be thorough training of one district nurse from each health center and medical station.
4. A highly motivated, bright person within the Ministry of Health and committed to family planning should be identified as the project coordinator.
5. UNFPA and IPPF/WHR should meet to ensure that their efforts are coordinated and not duplicative. It seems particularly important to coordinate approaches to the Ministry of Health.
6. The GPPA should receive management support and technical assistance. The clinic, with 165 visits a month, has unused capacity. The absence of the statistician has resulted in many incomplete records.

APPENDIX I

SCOPE OF WORK -538-0039

1. Examine the progress being made towards designing and implementing demographic and medical policies at both the regional and national levels.

Assess:

- a) The effectiveness and composition of the National Population Task Forces (NPTFS);
 - b) The extent of changes in population policies in country.
 - c) The quality and local impact of individual country reports, other interventions to increase population awareness;
 - d) The quality and impact of training of personnel at all levels and in all fields, provided for under the project and including such aspects as numbers trained, costs, the numbers trained still at work in the fields for which training was provided.
 - e) What initiatives, if any, have been or are being taken to develop the institutional capacity to undertake more training in region, in country;
 - f) The extent of changes in medical policies and/or practices in country;
 - g) The attitudes of members of the medical profession towards changes in medical policies and their willingness/effectiveness in making changes.
2. Evaluate the in-country capacity to effectively extend family planning services.

Assess:

- a) The extent to which service delivery in country has improved;
- b) The relevance and impact of training on service delivery;
- c) Improvement in supply management (including forecasting requirements, ordering, clearance and storage arrangement) and distribution of commodities;
- d) Improvements in clinic services and utilization;
- e) Improvement in service delivery to special target groups (e.g. adolescents).

3. Review the project design with a view to determining:
 - a) Its appropriateness;
 - b) Changes which may have occurred during project implementation;
 - c) What changes should be recommended.
4. Examine
 - a) The effectiveness of both the CARICOM and IPPF/WHR roles within the project implementation arrangements;
 - b) The effectiveness of both CARICOM and IPPF/WHR in helping to establish bench marks to facilitate measurement of changes;
 - c) The effectiveness of the coordinating mechanism. (i.e. Project Advisory Committee, also IPPF/WHR, CARICOM and RDO/C.
5. Identify the constraints to future implementation and recommend changes necessary to achieve project objectives.

APPENDIX II

PERSONS INTERVIEWED BY COUNTRY

1. BARBADOS

1. Ms. Holly Wise, Regional Health and Population Development Officer, USAID/RDO/C
Mr. Neville Selman, Population Advisor USAID/RDO/C
Ms. Angela Cropper, Project Manager, International Planned Parenthood Federation/Western Hemisphere Region
Ms. Pauline Russell-Browne, Field Administrator, Tulane University
Mr. Enric Connolly, Project Manager, Caribbean Contraceptive Social Marketing Project
Ms. Gail A. Washchuck, Project Advisor, Caribbean Contraceptive Social Marketing Project

2. ST. LUCIA

- Ms. Una Thomas, Maternal Child Health/Family Planning Coordinator
Ms. Glenda Faustine, District Nurse, Gros Islet Health Center
Mr. Raymond Louisy, Executive Director, Family Planning Association
Ms. Theresa Louisy, Nurse, Family Planning Association
Mr. Lawrence, CBD, Director, Family Planning Association
Ms. Anesta Haynes, Peer Counsellor, Marchand Clinic
Mr. Cornelius Lubin, Permanent Secretary, Ministry of Health, Housing and Labor

3. GRENADA

- Dr. Alexis, Chief Medical Officer
Dr. Doreen Murray, Deputy Chief Medical Officer
Mr. Winston Duncan, Executive Director, Grenada Planned Parenthood Association
Nurse Euldrica Honore, Grenada Planned Parenthood Association
Mr. Vaughn Phillip, Grenada Planned Parenthood Association
Mr. Alexis, Grenada Planned Parenthood Association
Ms. Gloria Harrick, Secretary, Grenada Planned Parenthood Association
Nurse Margaret Johns, Ministry of Health, Medical Center
Nurse Perrault, Senior Public Health Nurse
Mr. John Frances, Chief Statistical Officer
Dr. Bernard Gittens, Medical Practitioner
Dr. Desmond Noel, Consultant Obstetrician/Gynecologist
Reverend Philip Ponce, Member, National Population Task Force.

4. ST. VINCENT AND THE GRENADINES

Hon. Herbert Young,	Minister of Health
Ms. Irma Young,	Permanent Secretary, Ministry of Health
Mr. Carl Brown,	Health Educator, Ministry of Health
Ms. Valerie Murphy,	Health Educator, Ministry of Health
Dr. H.A. Jesudason,	Senior Medical Officer, Ministry of Health
Mr. John Saunders,	National Family Planning Program Administrator
Sister Labbay,	Senior Nursing Officer
Ms. Louise Sandy-Deane,	Principal Nursing Officer

5. GUYANA

Mr. Archie Moore,	Director, Functional Cooperation, CARICOM
Mr. Terence Goldson,	Project Administrator, CARICOM
Mr. Cheryl France,	Project Assistant, CARICOM
Ms. Audrey Hinchcliffe,	Health Development Officer, CARICOM
Mr. E.A. Sills,	Chief Finance Officer, CARICOM
Mr. Roderick Sanatin,	Communications Specialist, CARICOM

6. DOMINICA

Mr. Eudora Shaw,	Permanent Secretary, Ministry of Health
Mr. Michael Murphy,	Chief Statistician
Ms. Lucia Blaize,	Executive Director, Dominica Planned Parenthood Association
Sis. Dorothy James,	Health Educator
Ms. Sylvia Charles,	Economist, Economic Development Unit
Dr. Bernard Sorhaindo,	Consultant Obstetrician-Gynecologist
Dr. Desmond McIntyre,	Director of Health Services

APPENDIX III

POPULATION AND DEVELOPMENT PROJECT (530-0039)

CARTOON REPORT FOR PERIOD ~~XXXXX~~ 1 APRIL - 31 MAY 1984

SUMMARY

Financial Report

Project Component	Amount Projected	Previous Expenditures	Expenditures	Total Expenditures	% Disbursed	Time Elapsed (months/36)	Funds Available
I. DEMOGRAPHIC POLICY	<u>250</u>	<u>0.4</u>	<u>3.6</u>	<u>4.0</u>			<u>246.0</u>
National Pop. Task Force	53	0.4	-	0.4			52.6
Country Pop. Reports	60	-	-	-			60.0
Regional Awareness Seminars	37	-	3.6	3.6			33.4
Demographic Training	100	-	-	-			100.0
II. MEDICAL POLICY	<u>70</u>	<u>19.3</u>	<u>0.0</u>	<u>20.1</u>			<u>49.2</u>
Steering Committee Mtgs.	3	3.2	-	3.2			(0.2)
Regional Seminars	21	10.5	-	10.5			10.5
National Seminars	36	5.2	0.8	6.0			30.0
Observational Training	10	0.4	-	0.4			9.6
III. PROGRAM SUPPORT	<u>140</u>	<u>30.6</u>	<u>6.6</u>	<u>37.2</u>			<u>102.0</u>
Technical Assistance	90	30.6	6.6	37.2			52.8
Promotional Assistance	10	-	-	-			10.0
Evaluation	30	-	-	-			30.0
Audit	10	-	-	-			10.0
IV. ADMINISTRATION	<u>140</u>	<u>39.2</u>	<u>3.2</u>	<u>43.1</u>			<u>96.2</u>
Project Administration	52	13.6	-	13.6			38.4
Administrative Staff	33	13.1	2.4	15.5			17.5
Operating Expenses	27	0.1	-	0.1			26.9
Travel	28	12.4	1.5	13.9			14.1
TOTALS	600	89.5	14.9	104.5			495.5

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APPENDIX IV

IPPF/WHR BUDGET STATUS REPORT
JULY 30, 1982 - JUNE 30, 1984

	<u>APPROVED BUDGET</u>	<u>TOTAL EXPENDITURE AS AT 3/31/84 TOTAL</u>	<u>BALANCE to Approved Budget</u>
Training	234,000.	151,096.36	82,903.64
Commodity Supply and Distribution	167,000.	87,140.09	79,859.91
Improvement of Clinic Services	425,000.	102,068.53	322,931.47
Adolescent Extension	474,000.	-	474,000.00
Program Support	470,000.	102,892.34	367,107.66
Administration	787,000.	330,271.60	456,728.40
	<u>2,557,000.</u>	<u>773,468.92</u>	<u>1,783,531.08</u>
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IPPF/WHR

ACTIVE SUB-GRANTS UNDER 538-0039 AS AT JUNE 15, 1984

SUB-GRANTEE	PROGRAMME	AMOUNT (US\$)	LIFE OF PROJECT
ANTIGUA, M.O.H. -0039-11	Training	2,500	Sept. '83 - Dec. '86
	Commodity Supply	12,000	Spet. '83 Dec. '86
	Adolescent Programme	38,655	Jan. '84 - Dec. '86
		<u>53,155</u>	
ANTIGUA, P.P.A. -12	Adolescent Clinics	14,822	June '84 - June '86
BARBADOS, M.O.H -21	Training	1,000	June '83 - Dec. '86
	Commodity Supply	7,000	Sept. '83 - Dec. '86
	Adolescent Clinics	41,300	Feb. '84 - Dec. '86
		<u>49,300</u>	
BARBADOS, F.P.A. -23 -24	CBD	24,780	Jan. '83 - Dec. '86
	Youth Outreach Programme	24,882	June '84 - Dec. '86
		<u>49,662</u>	
MONTSERRAT, M.O.H. -51	Training	2,000	April '84 - Dec. '86
	Commodity Supply	6,500	Sept. '83 - Dec. '86
	Adolescent Programme	22,600	Sept. '83 - Dec. '86
	Clinic Renovations	5,000	
	<u>36,100</u>		
MONTSERRAT, P.P.A. -52	CBD	12,404	May '83 - Apr. '86

SUB-GRANTEE	PROGRAMME	AMOUNT (US\$)	LIFE OF PROJECT
ST. LUCIA, M.O.H. -0039-61	Training Commodity Supply Clinic Renovations Non-Clinical Services	2,500 12,000 58,993 14,240 <u>87,733</u>	May 9 '86 - Dec. '86 Sept. '83 - Dec. '86 Sept. '83 - Dec. '86 May '83 - Dec. '86
ST. LUCIA, F.P.A. -62	CBD	11,847	Jan. '83 - Dec. '85
ST. KITTS, M.O.H. -41	Training Commodity Supply Adolescent Clinics Clinic Renovations	2,000 6,500 25,200 29,696 <u>63,396</u>	May '83 - Dec. '86 Sept. '83 - Dec. '86 May '83 - Dec. '86 May '83 - Dec. '86
ST. KITTS, F.P.A. -42	Outreach Programme	13,250	June '84 - Dec. '86
DOMINICA, M.O.H. -31	Training Commodity Supply Adolescent Clinics Clinic Renovations	2,500 12,000 46,416 52,527 <u>112,943</u>	Sept. '83 - Dec. '86 Sept. '83 - Dec. '86 Sept. '83 - Dec. '86 Aug. '83 - Dec. '86
DOMINICA, P.P.A. -32	CBD	10,330	April '84 - Dec. '86
ST. VINCENT, M.O.H. -71	Training Commodity Supply Clinic Renovations Non-clinical Services	2,500 12,000 65,358 7,815 <u>87,173</u>	May '83 - Dec. '86 Sept. '83 - Dec. '86 May '83 - Dec. '86 May '83 - Dec. '86

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APPENDIX VI

C A R I B B E A N C O M M U N I T Y S E C R E T A R I A T

Revised June 1984

POPULATION POLICY

FOR THE

CARIBBEAN COMMUNITY

Draft prepared in the Health Section
as a basis for discussion

POPULATION POLICY FOR THE CARIBBEAN COMMUNITY

INTRODUCTION

The ultimate goal of regional cooperation in the Caribbean Community, is to improve the quality of human life. Socioeconomic development, health and population growth interact to promote or impede attainment of that goal. In our circumstances population growth exerts a very strong influence on health, as it does on other aspects of development. Population change is one of the great public issues of our time, having profound significance for human wellbeing. Caribbean population trends were the first of the Principal Health Issues to be identified by the Health Ministers Conference in its "Declaration on Health for the Caribbean Community" (1982). Although population growth is cause for concern to every citizen in the Caribbean Community, relatively few people appreciate its serious implications for the future quality of life in Member Countries, or the close relationship between population and development.

The basis for an effective solution to population problems is, above all, socioeconomic transformation. We do not look upon population change as an isolated phenomenon, nor do we propose to influence it by a narrow approach. It is an integral part of the complex process of social and economic development. Accordingly, activities that seek to effect population trends are not substitutes for a broad development strategy; they should, rather, be integrated within this strategy in order to achieve a more rational and balanced development.

The components of population growth are three: fertility, mortality and migration. However, only two of these can be manipulated by states so that they affect population growth. Although high mortality clearly impedes population growth, no government could adopt a policy which advocates high mortality. Family planning, as one of the major

activities that can influence population trends, is an integral and important part of the health and development strategy of the Caribbean Community, as well as of the strategy for the integration of women in development. However, the adoption of family planning programmes by Caribbean countries is fairly recent and has been relatively slow. Moreover, their impact on population growth is not immediate, although very effective in the long term. Historically, migration has been the component which has had the greatest impact both on population growth and on population structure. For instance, the declines in total population in almost every island, and the predominance of females in the population during the late nineteenth and early twentieth centuries resulted from the large migration of males to work on the Panama Canal.

II THE CARIBBEAN POPULATION

The population of the Member States of CARICOM stands at 5 million as of mid-1983. The overall rate of natural population growth (births minus deaths) is a relatively high 2.8% per year, although considerable variation exists within the Region. For example, the rate of natural increase in Barbados is 0.9%, in Saint Lucia it is 2.9%. High rates of natural growth are masked to some extent by consistent patterns of high emigration. When emigration is factored in, the rate of population growth was a more moderate 1.4% per year between 1960 and 1970 and has dropped to 1.1% per year between 1975 and 1980.

Most of the CARICOM States have entered that stage of the demographic transition which is characterized by falling death rates and birth rates. Mortality rates in the Region range from 5/1,000 to 11/1,000. The expectation of life at birth is over 60 throughout the Region; the average is 67. Further efforts should be made to reduce mortality, particularly infant mortality, in rural areas and urban slums. Birth rates, too, have been decreasing steadily over the past decades, and in some countries (e.g. Barbados, Montserrat at 18/1,000) are quite low.

Despite the region-wide declines, birth rates remain high in some countries. For example, the birth rate in Belize where, on the average, women have more than 5 children, is 36/1000.

Substantial emigration has long been a characteristic feature of the Eastern Caribbean countries. Although statistics on emigration are not wholly reliable, it appears that at least 3 million people have emigrated from the Commonwealth Caribbean area between 1950 and 1970. Although the reduction in the working-age population has taken some of the edge from severe unemployment problems and remittances have contributed to the income of family members left behind, there has been a loss of educated and skilled young people disproportionate to their numbers in the population. Increased restrictions on immigration in receiving countries have intensified the pressure of population growth in the Caribbean.

The combination of high fertility and emigration of working-age population has led to a disproportionately young (and aging) population. Forty to fifty per cent of the population is under 15 years of age. This means that a large number of people are entering the reproductive age. Even though our fertility rates have fallen and even if we reduce them further to "replacement level" (approximately 2.1 children per couple), births will greatly exceed deaths well into the future so that a Less Developed Country of the Caribbean Community could double its population within a few years of the turn of the century. The doubling of the population of a small island is hardly a matter for complacency.

In the Region, adolescent pregnancy has been, and remains, a problem of considerable import. More than 1 in 10 teenage girls become pregnant every year. The large number of adolescent girls in the population has led to a high proportion (nearly one-third) of all births in the Region attributable to teenage mothers. Girls under 20 years of age produce up to 80 per cent of first births. Adolescent fertility, with its

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with its attendant social, economic and psychological difficulties, makes a major contribution to current rates of population growth in the Region.

Recent fertility and contraceptive prevalence surveys have demonstrated that there is an appreciable number of women who do not want more children and who do not use an effective means of contraception. This is reflected in the high percentage of women - more than 50% in some countries - who did not want their last pregnancy.

The number of people over 60 in the Caribbean Community is increasing and is expected to reach 600,000 by the year 2000. This has implications for our geriatric services, retirement policies, social services, economic policies, and even our cultural attitudes. There is now need for a regional action plan to achieve for the aging social and economic security and a place in the development strategy.

Socio-Economic and Health Implications

A series of factors in recent years have combined to aggravate the economic situation in the Caribbean. The quadrupling of oil prices, a worldwide recession, and large increases in prices of imported food-stuffs, without an offsetting increase in international demand for the Region's major exports and services, have had serious adverse effects. Economic growth has stagnated and in many instances living standards have deteriorated. High unemployment and underemployment is one crucial problem.

Population growth exacerbates these social and economic problems. The President of the Caribbean Development Bank has drawn attention to rapid population growth as one of the factors contributing to the high level of unemployment in the towns, which he has identified as our single greatest socio-economic problem. Unemployment (averaging 17% and in some age groups reaching 35%) and underemployment (30 to 50% of the working population) is due in large part to the incapacity of the economic system

to absorb the massive arrival of young people into the labour force. The unemployment figures do not reveal the seriousness of the problem since many of those counted as employed actually earn very little and unemployment has a disproportionate impact upon young adults and women.

For communities living on islands with limited space and limited resources, population growth is obviously a serious matter. The pressure on national income, jobs, available arable land, food and water supplies, health services, hospitals, school places, housing and general well-being are all too evident. Traditionally, emigration has been perceived as an effective means of relieving this pressure on resources. But mainly because of the global recession and, in the U.K., the impact of a large third-world population, receiving countries have been restricting the opportunities for emigration. In other words, national resources are under even greater strain than usual. Large families trying to survive on a limited income can contribute to juvenile delinquency and to a new cycle of pregnant teenagers.

Social programmes addressing the issues of unemployment, poverty and the socio-economic tensions mentioned above have been implemented recently in various countries, but the results have not been significant, in large part because of the age structure of the population inherited from past demographic trends. In this regard, in spite of recent fertility declines, the pressures of youth on the labour market and on housing, and their weight in the total future fertility, will continue to be dominant until the end of the century, especially with the likelihood of decreased emigration as a result of the adoption of more restrictive policies in the traditional receiving countries.

In the Regional Food and Nutrition Strategy, the inadequacy of the family planning programme has been identified as one of the major factors underlying the problem of malnutrition in the Caribbean Community.

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It is highly significant that the definitions of Primary Health Care and Essential Health Care adopted by the Conference of Ministers responsible for Health include family planning in a very short list of basic components. Primary Health Care is the strategy that has been adopted for achieving Health for All by the Year 2000.

In the Declaration on Health Policy (1982), family planning is included among the essential components of the 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 complications in childbirth. 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 sickness and death, but also in higher mortality rates among the newborn. The age (whether too young or too old) of the mother is also a significant factor, women over 35 years of age being 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 who is still breast feeding when the mother becomes pregnant during the lactation period. 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 attention and pregnancy among teenagers is now a major health and social issue causing great concern to all Member 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 termination of pregnancy. In these circumstances, adolescents often have less access to health care and family planning.

The problem of illegal termination of pregnancy is closely related to family planning, because it is in many respects the neglect of family planning that has made illegal termination of pregnancy and the resulting deaths and disability major health issues in the Caribbean Community. Deaths from illegal termination of pregnancies 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 most Member Countries, the termination of pregnancy laws are greatly in need of review. The evidence clearly shows that illegal termination of pregnancies carried out by unqualified persons under unhygienic conditions and late in pregnancy contributes considerably to morbidity among women caused by excessive blood loss, internal infection and shock, frequently occurring in such situations. The effects are immediate and long-term, affecting subsequent pregnancies.

One very important aspect of induced termination of pregnancy - whether legal or not - is when it is performed; termination 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 services and little or no financial resources) to obtain termination of pregnancy at a sufficiently early stage. This is especially serious for adolescents, who are seeking termination of pregnancy in increasing numbers. Furthermore, termination of pregnancy has to be seen in relation to the availability of contraceptive methods, for which it can never substitute.

The First Meeting of Ministers with responsibility for the Integration of Women in Development, held in Dominica in April 1981, adopted a comprehensive resolution requesting action to address the issues outlined above, recognising that family planning is a significant

component of the programme to promote the full participation of women on an equal basis with men in the educational, economic, social and political life of the community.

Policy makers in the Caribbean have to concern themselves with three types of mobility: internal movement within a Territory; intraregional movement within the Caribbean between CARICOM Member Territories; and international migration mainly to metropolitan countries.

Internal movement tends to be mainly a movement from the rural areas to the towns. In the smaller Territories, workers can travel daily to work in the towns. But in the larger Territories, the population has to live in the towns to enjoy their attractions, especially the attraction of employment. This movement results in many of the problems associated with urbanization: over-crowding, pressure on services like housing, water, health services, waste disposal and electricity - together with the neglect of agriculture in the rural areas. Although only a few of the Territories like Jamaica and Saint Lucia are affected by internal migration, the resulting problems are real and difficult to solve. In addition, the movement is difficult to stop because control implies the denial of one of the basic human rights, freedom of movement.

Historically, movement within the Commonwealth Caribbean has followed certain patterns. In the past, Guyana and Trinidad have been the main receiving countries. Although Guyana now ranks high among the sending countries, Trinidad has remained an important destination for the Windward Islands. Barbados has also become an important destination for the Windwards, while the Leeward Islanders tend to move north to the U.S. Virgin Islands. Thus, intra-regional movement flows towards economic development, and the inflow of non-nationals puts additional pressure on the resources of the receiving countries. Following the global trend, these receiving Territories have tried to restrict the numbers entering their Territories during the recent recession. Thus, freedom of movement within the Caribbean Community has become an extremely difficult issue.

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Whenever Caribbean Migration is discussed, it is usually taken to mean International Migration. International Migration is usually perceived positively both by Caribbean individuals and Governments. Opportunities for migration are pursued whenever they occur and to almost whatever country. Over 100 years of this type of movement have resulted in a general desire and propensity to move of Caribbean people. It has also resulted in what has been called the institutionalisation of migration: a situation in which people come to see migration as the means of achieving anything.

Caribbean Governments and policy makers have to look critically at international migration. Although Caribbean countries do benefit from this movement, it also has serious disadvantages. International migration tends to be skill and education selective, and results in a loss to the Caribbean countries of those very people who can contribute most to the development of the Caribbean. Further, this movement tends to foster a perception of home as an inferior place, lacking in opportunities. Such a perception needs to be eradicated if commitment to Caribbean development is to be nurtured.

III POPULATION POLICY: CONSIDERATIONS, OBJECTIVES AND MEASURES

A. Considerations

1. Population growth in the Caribbean Community is having, and will continue to have, a deleterious effect on the possibility for social and economic progress and on the health of our citizens.
2. The effects of population growth have been masked somewhat to date because of high levels of emigration. As the outlets for emigration become more restricted, the socio-economic problems and tensions will become more visible.

3. The young age structure of the population means that current demographic trends will continue at least until the end of the century, leading to continued structural imbalances, particularly regarding employment.
4. Population growth rates can be lowered in two ways: greater emigration and reduced fertility. The first is not a viable option, since emigration is unlikely to increase over the next decades. Indeed, we would wish to encourage our citizens to remain at home and to welcome returning migrants. This leaves reduced fertility as the primary means of slowing population growth.
5. There is no single path towards reducing fertility. Historically, socio-economic development - particularly increased education, fairer income distribution, better health conditions, and improved status of women - has been linked with lower fertility. Family planning programmes have been demonstrated to be an effective way of reducing fertility. The paths toward fertility reduction are not mutually exclusive. Socio-economic development programmes as well as family planning programmes should be conducted.
6. All individuals have the basic human right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.
7. The task of providing information, education and means resides not only with Ministries of Health but with other government ministries and the private sector as well.



8. We do not question the fact that there is diversity among Member Countries or that national sovereignty supersedes every other consideration.

B. Goal and Objectives

The ultimate goal of this Population Policy is to contribute to an improvement in the quality of life of the population of the Region through the achievement of a rational balance between population, in qualitative and quantitative terms, and resources.

The objectives are as follows:

1. To provide favourable demographic conditions for social and economic development in the Region in the next two decades.
2. To promote continued improvement in health status in the Region, in particular to increase life expectancy, improve the health of mothers and children and reduce the incidence of illegal termination of pregnancy.
3. To reduce the number of unplanned pregnancies.
4. To contribute to balance rural, urban, and regional development in accordance with regional and national development strategies.

C. Policy Measures

To meet these objectives, the following measures will be carried out:

1. Each Member State will formulate a national population policy. Although policies will differ according to individual country circumstances, each government should give consideration to the following common elements:
 - a) Analyzing relationship between population growth and social-economic development and health, including an examination of demographic and developmental trends and projections.
 - b) Determining maximum population size compatible with development prospects by the year 2000, establishing clear goals in such areas as health (life expectancy), family size and, if practicable, migration.
 - c) Creating a national population task force to coordinate, set guidelines and monitor the implementation of the policy.
 - d) Assigning responsibility for carrying out each component of the policy to governmental agencies as well as to the private sector.
 - e) Including demographic considerations in socio-economic development planning.
 - f) Improving the delivery of family planning services by:
 - 1) increasing supplies and improving their distribution, particularly at the community level and through commercial channels;

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- 2) increasing the capacity of clinic services, e.g. by providing appropriate equipment and extending the period such services are provided;
 - 3) developing special programmes for adolescents;
 - 4) providing non-health service related family planning service delivery (commercial, community based, etc.);
 - 5) providing orientation for doctors and other health staff in the most up-to-date family planning techniques;
 - 6) emphasizing education and information for men as well as for women;
 - 7) ensuring that participating in the family planning programme is wholly voluntary.
-
- g) Increasing awareness at all levels about population trends and their consequences.
 - h) Improving family life and health education (including sex education and family planning education) programmes for young people, both in and out of school.
 - i) Reviewing laws, policies, and regulations which affect population growth. This should include laws which affect fertility, status of women, migration, citizenship and mortality directly and indirectly.

- j) Improving the collection and analysis of statistical and other information.
- k) Strengthening research and evaluation.
- l) Emphasizing the importance of and devising ways to improve the status of women, particularly regarding employment and education.
- m) Increasing budgetary allocations for those activities which influence population growth - from both internal and international sources.

2. The CARICOM Secretariat will:

- a) Develop a campaign to make the Caribbean leadership more aware of the relationship between population, health and development and the problems engendered by too rapid population growth;
- b) Provide technical assistance to Member States in the development and implementation of national population policies;
- c) Attract international funds for the development of population-related activities;
- d) Work with the University of the West Indies and other relevant agencies and groups to devise ways to improve the collection and analysis of data and the evaluation of programmes;

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APPENDIX VII

CARICOM/USAID POPULATION AND DEVELOPMENT PROJECT

NATIONAL TASK FORCE MEMBERSHIP

AT

13 SEPTEMBER, 1984

BARBADOS

1. Sr. Medical Officer of Health (Environmental) - Chairman
2. Chief Project Officer, Ministry of Health - Deputy Chairman
3. Director of Finance and Planning or Nominee
4. Director of Statistical Services or Nominee
5. Permanent Secretary, Ministry of Labour, Social Security and Sport or Nominee
6. Executive Director, Barbados Family Planning Association
7. Director, Institute of Social and Economic Research, UWI, Cave Hill Campus
8. A Medical Officer of Health
9. Director, Women's Bureau, Ministry of Information and Culture
10. Executive Director, Barbados Chamber of Commerce or Nominee.

DOMINICA

1. Mrs. E. Shaw - Permanent Secretary, Ministry of Health and Education - Chairperson
2. Mr. M. Murphy - Statistical Officer, Ministry of Finance - Deputy Chairman
3. Dr. Carissa Etienne - Medical Officer, Community Health
4. Miss Hyacinth Elwin - Director, Women's Desk
5. Mrs. Sylvia Charles - Economist, Economic Development Unit
6. Ms. Dorothy James - Health Educator
7. Ms. Lucia Blaize - Executive Secretary, Dominica Planned Parenthood Association
8. Mr. A. Joseph - Representative, Trade Unions
9. Representative, Roman Catholic Church.

MONTSERRAT

1. Rev. Cecil Weekes - Representative, Christian Council - Chairman
2. Ms. M. Bass - Chief Community Development Officer
3. Dr. Ronnie Cooper - Medical Adviser, Family Planning Association
4. Ms. D. Greenway - President, Family Planning Association
5. Mr. Max Greer - Head, Statistical Department
6. Mr. Joseph Kirwan - Representative, National Youth Council
7. Mr. Hogarth Sargeant - Crown Counsel.

SAINT CHRISTOPHER-NEVIS

1. Mr. Hugh Heyliger - Director, Planning Unit - Chairman
2. Mrs. Dulcie Richardson - Principal, Teachers' College
3. Dr. Steve Clexton - Consultant Obstetrician/Gynaecologist
4. Mrs. Sylvia Garnett - Assistant Matron, Joseph N. France Hospital
5. Mrs. Diane Francis-Delaney - Superintendent, Public Health Nurses
6. Mrs. Marlene Liburd - Executive Director, Saint Christopher Family Planning Association
7. Mr. Llewelyn Newton - Secretary, Nevis Family Planning Association
8. Mrs. Marjorie Morton - Assistant Secretary, Prime Minister's Office
9. Mr. Calvin Cable - Representative, Manufacturers' Association
10. Mr. Denzil Crooke - Representative, Rotary Club.

SAINT LUCIA

1. Hon. Clarence Rambally - Minister of State in the Ministry of Agriculture - Chairman
2. Mr. Cornelius Lubin - Permanent Secretary, Ministry of Health
3. Ms. Merle Alexander - Director of Statistics, Prime Minister's Office
4. Dr. Anthony deSouza - Director of Health Services
5. Mr. Raymond Louisy - Director, Family Planning Association
6. Miss Joan Slack - Senior Crown Counsel
7. Mr. Steve Annius - Representative, Business Community
8. Fr. Theophilus Joseph - Priest, Vieux Fort.

ANTIGUA AND BARBUDA

1. Mr. H. Barnes - Permanent Secretary, Ministry of Health - Chairman
2. Mrs. S. Archibald - Training Officer
3. Ms. I. Wallace - Superintendent, Public Health Nurses
4. Dr. G. O'Reilly - President, Antigua Planned Parenthood Association
5. Ms. J. Roberts - Chief Statistician
6. Rev. C. Athill - Antigua Christian Council
7. Dr. K. Heath - Consultant Obstetrician/Gynaecologist
8. Ms. A. Blaize - Health Educator
9. Ms. G. Tonge - Director, Women's Desk.

St. Vincent and the Grenadines

1. Mr. Herbert Young, Minister of Health
2. Ms. Erma Young, Permanent Secretary, Ministry of Health
3. Dr. Jesuadson, Senior Medical Officer, Ministry of Health
4. Ms. Faustine Eustace, Executive Director, Planned Parenthood Association
5. Mr. John Saunders, Administrator, National Family Planning Program
6. Mr. Jeffrey Venner, Labor Commissioner
7. Mr. Telemaque, Central Planning Unit
8. Mr. Wilfred Olivierre, Chief, Statistical Officer
9. Mr. Clem Balleah, Chief Community Development Officer
10. Ms. Renee Baptiste, Local Attorney

APPENDIX VIII

IPPF/WHR

FUNDS COMMITTED IN SUB-GRANTS FOR CLINIC RENOVATIONS

	<u>US\$</u>
MONTSERRAT	5,000
ST. KITTS-NEVIS	29,696
ANTIGUA	38,864
DOMINICA	53,527
ST. VINCENT	65,358
ST. LUCIA	58,993
	<hr/>
	251,438
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STATUS OF CLINIC RENOVATIONS

COUNTRY	RENOVATIONS COMPLETED	RENOVATIONS IN PROCESS	RENOVATIONS NOT YET REGUN	STATUS AS AT JUNE 15, 1984
ANTIGUA			Parham All Saints Cedar Grove	Sub-grant in preparation
DOMINICA	Marigot	Delices Portsmouth Roseau (3/4 finished)	Castle Bruce Goodhope Wesley Vieille Case Calibishie Medical Stores	
MONTSERRAT		Bethel Clin.		
ST. KITTS		Cayon Nurses Quarters, St. Paul's	St. Paul's	Under discussion with Dept. of Pub. Works and priv. contractor
ST. LUCIA	Castries) La Croix-) Maingot) Dennery) Med. Stores, Victoria) Hospital)	Vieux Fort Canaries Gros Islet		In use
ST. VINCENT	Campden Park	Biabou Clin. Belair H.C.	Loumans Calder Layou Enhaus Diamond Vge. Byera Hill Troumaca Rose Hall Spring Vge. Barraouallie Richland Park	In use A lot of work done A lot of work still to be done

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DOMINICA

PROJECT COMPONENTS	CONTRACTED WITH	CONTRACT SIGNED	VALUE OF GRANT (DIRECT SUPPORT ONLY) US\$	PRESENT STATUS
<u>Training</u>				
Nurses	Ministry of Health	November 1983	113,443	Scheduled for Oct. 1984
Teacher Educators		(Duration: Sept. 1983 - Dec. 1986)		Completed
Teachers				Not yet trained
Commodity Supply and Distribution	" " "			System established; ongoing supply.
Clinic Renovations	" " "			In Process
Provision of Clinic Equipment	" " "			Some provided; ongoing procurement
Conducting special health clinics for adolescents	" " "			In Process (Tulane)
Field Work with Adolescents	" " "			Has started via Youth Officers
Community Based Distribution Programme	Dominica Planned Parenthood Assoc.	March 1984 (Duration: April 1984 - March 1986)	10,330	In process

CRENADA

SEPTEMBER 1984

Grant amended February 1984 to include Grenada

Activities Since Then

Present Status

1. Extension of Grenada Planned Parenthood Association clinic services to health stations till end of 1984.

GPPA not under 538-0039
US\$15,000 from other IPPF Sources

Activities continuing
2. Orientation of Ministry of Health to Project. Formal invitation to participate sent to Government of Grenada June 1984.

No reply
3. Preliminary one-week visit to identify Project components carried out September 1984.

Report in preparation
4. 2 five-day introductory Training Workshops for Nurses and Community Health Aides carried out May 1984 to facilitate integration of services by end of 1984.

ST. KITTS-NEVIS

PROJECT COMPONENTS	CONTRACTED WITH	CONTRACT SIGNED	VALUE OF GRANT (DIRECT SUPPORT ONLY) US\$	PRESENT STATUS
1. <u>Training</u>				
Physicians	Ministry of Health	September 1983 (Duration: Sept. 1983 - Dec. 1986)	63,416	1st Seminar held April 1984
Nurses				Scheduled for Oct. 1984
Teacher Educators				Completed
Teachers				Not yet completed
2. Commodity Supply and Distribution	" " "			System established; ongoing supply
3. Clinic Renovations	" " "			In process
4. Conduct special health clinics for adolescents	" " "			Activities have begun arrangements now being consolidated
5. Field work with adolescents, parents	St. Kitts-Nev. Fam. Planning Assoc.	May 1984 (Duration: June 1984 - May 1986)	13,250	In process
6. Male Attitude Study	(Carried out by IPPF)			Completed April 1984
7. Contraceptive Prevalence Survey	(Carried out by IPPF)			Will be completed this quarter

PROJECT COMPONENTS BY COUNTRY - USAID-IPPF/WHR 538-0039

SEPTEMBER 1984

ST. VINCENT

PROJECT COMPONENTS	CONTRACTED WITH	CONTRACT SIGNED	VALUE OF GRANT (DIRECT SUPPORT ONLY) US\$	PRESENT STATUS
<u>Training</u> Physicians Nurses Auxiliary Health Staff Teacher Educators Teachers Commodity Supply and Distribution Clinic Renovations	Ministry of Health " " " " " "	May 1983 (Duration: May 1983 - Dec. 1986)	87,673	One Seminar held Completed Completed Completed Not yet begun System established; ongoing supply In process
Conduct special health clinics) for adolescents))) Field work for adolescents)	M.O.H. By amendment to main Grant	Not yet signed	20,709	Not yet begun
Community Based Distribution Programme	Not yet started			Not yet begun

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MONTSERRAT

PROJECT COMPONENTS	CONTRACTED WITH	CONTRACT SIGNED	VALUE OF GRANT (DIRECT SUPPORT ONLY) US\$	PRESENT STATUS
1. <u>Training</u>	Ministry of Health	September 1983 (Duration: Sept. 1983 - Dec/ 1984)	36,100	1st Seminar held April 1984 Introcl. training done done April 1984 Completed
Physicians				
Nurses				
Teacher Educators and Teachers				
2. Commodity Supply and Distribution	. . .			System established; On-going supply
3. Clinic Renovations	. . .			Completed
4. Provision of Clinic Equipment	. . .			Some provided; on-going procurement
5. Establishment of F.P. Services as part of MCH Programmes	. . .			Not yet started
6. Conduct special health clinics for adolescents	. . .			Not yet started
7. Field Work with Adolescents	. . .			In process
8. Community Based Distribution Programme	Montserrat Fam. Planning Assoc.	June 1983 (Duration: May 1983 - April 1985)	12,404	In process
9. Contraceptive Prevalence Survey	Carried out by IPPF			Will be completed

TRAINING ACTIVITIES CARRIED OUT UNDER 518-0019

BY IPI /WHR AS AT SEPTEMBER 15, 1984

ACTIVITY	DATE	DURATION	PARTICIPANTS	TEACHING RESOURCES	GENERAL OBJECTIVE
1. Workshop in Contraceptive Management	Feb., 1983 Barbados	2 days	7 persons (1 per participating state) with responsibility for supplies	CDC	To advise MOH officers on arrangements and systems required for managing contraceptives provided under grant
2. F.P. & FLE Workshops: 2 five-day sessions	June 1983 Barbados	10 days	95 Nurses and Teachers	IPPI/WHR; CDC; UWI; PAHO; BFPA	To upgrade nurses' F.P. information and skills; to equip teachers with F.P. knowledge for use as guidance counsellors
3. Medical Seminars: 2 half-day lectures	June 1983 Barbados	1 day	Approx. 80 Physicians and final year medical students	CDC; UWI	To upgrade F.P. knowledge
4. Medical Seminars: 2 one-day seminars	June 1983 St. Lucia	2 days	Approx. 50 Physicians and Senior Nurses	CDC; MOH, St. Lucia	To upgrade F.P. knowledge
5. Training of Trainers	Jan. - March 1983. UWI, Jamaica	8 weeks	7 Fellowships: Barbados 1 Montserrat 1 St. Kitts 1 St. Lucia 2 St. Vincent 2	UWI, J'ca (ATRFM)	To provide skills for future in-service training in respective countries
6. Training of Trainers	June - Aug., 1983. UWI, Jamaica		7 Fellowships: Antigua 2 Barbados 1 Dominica 2 Montserrat 1 St. Kitts 1	UWI, J'ca (ATRFM)	To provide skills for future in-service training in respective countries

ACTIVITY	DATE	DURATION	PARTICIPANTS	TEACHING RESOURCES	GENERAL OBJECTIVE
7. F.P. & F.L.E. Workshops: 2 five day sessions	August 1983 Antigua	10 days	90 Nurses, C.H.A.'s, Public Health Inspectors	IPPF/WHR; CDC; CFPA	To equip health staff with F.P. information and skills in order to embark on provision of F.P. services in MOH health services
8. Medical Seminar	August 1983 Antigua	1 day	Approx. 20 Physicians	CDC	To upgrade F.P. knowledge
9. Training of Trainers Course in Sex Education	August 1983 Antigua	4 weeks	14 instructors from Teacher training institutions in participating states (2 from each country)	CFPA	To train educators in how to equip teachers to teach Sex Education in school system
10. F.P. & FLE Workshops: 2 five-day sessions	October 1983 St. Lucia	10 days	86 Nurses and Family Life Educators	IPPF/WHR; CDC; CFPA; MOH, St. Lucia	To equip with F.P. informa- tion and skills in order to embark on provision of F.P. services by MOH personnel
11. F.P. & FLE Workshops: 2 five-day sessions	November 1983 St. Vincent	10 days	107 Nurses, C.H.A.'s, Public Health Inspectors	IPPF/WHR; CDC; MOH, St. Vincent	To upgrade nurses' F.P. information and skills, to introduce auxiliary health staff into F/P. service delivery
12. Medical Seminar	November 1983 St. Vincent	1 day	Approx. 25 Physicians	IPPF/WHR; CDC	To upgrade F.P. knowledge
13. F.P. & FLE Orientation Seminar	Feb. 1984 Montserrat	3 days	8 Community Development Officers	CFPA	To orient to Adolescent Programme/F.P. issues
14. Teaching Sex Education Course	March 1984 Montserrat	1 week	20 Teachers	CFPA	To follow up August 1983 Course with Teachers

ACTIVITY	DATE	DURATION	PARTICIPANTS	TEACHING RESOURCES	GENERAL OBJECTIVE
14. Workshop for Community Officers, District Nurses, Field Workers, Youth Leaders	March 1984 St. Kitts	5 days	25 Officers	MOH, St. Kitts	To equip with F.P. III information to support Youth Outreach Programme
15. Medical Seminar	April 1984 St. Kitts (For St. Kitts and Montserrat)	1 day	Approx. 20 Physicians and Senior Nurses	IPPF/WHR; CDC	To upgrade F.P. knowledge
16. F.P. & FLE Workshop	Apr 1 1984 Montserrat	5 days	22 Nurses	IPPF/WHR; CDC; MOH, Montserrat	To equip nursing personnel with F.P. information and skills in order to embark on provision of F.P. services through MOH health services
17. Peer Counsellors' Workshop	April 1984 St. Lucia	5 days	24 Counsellors	IPPF/WHR; Tulane; MOH, St. Lucia	To embark on A.H. Clinics with peer counselling activities
18. F.P. & FLE Workshops: 2 five-day sessions	May 1984 Grenada	10 days	121 Nurses, Field Educators, C.H.A.'s	IPPF/WHR; CDC; UWI, Barbados, MOH, Grenada	To prepare nursing and auxiliary health personnel for provision of F.P. services through MOH programme
19. Peer Counsellors Workshop	May 1984 Montserrat	3 days	25 Counsellors	IPPF/WHR	To equip with F.P. information and counselling skills for Youth Outreach Programme
20. Workshop for Youth Officers	June 1984 Dominica	3 days	7 Youth Officers	IPPF/WHR; MOH, Dominica	To orient to F.P. & FLE concerns to be addressed as part of their routine duties in Youth Outreach Programme

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ACTIVITY	DATE	DURATION	PARTICIPANTS	TEACHING RESOURCES	GENERAL OBJECTIVE
21. F.P. Workshop for Community Health Aides: 2 three day sessions	June 1984 St. Lucia	6 days	96 Community Health Aides	MOH., St. Lucia	To equip with F.P. information to support delivery of F.P. services
22. Training Course in FLE for Nurses and Teachers	Sept. - Dec. 1984 Barbados	2 weeks full time in Sept. 1 day per wk/10 wks; thereafter 2 wks full time in Dec.	15 Nurses 15 Teachers	Ministry of Health and Ministry of Education	To equip with FLE to support Adolescent Programmes in Health and Education sectors
TRAINING ACTIVITIES SCHEDULED TILL DECEMBER 31, 1984					
23. F.P. & FLE Workshops	October 1984 Dominica	5 days	34 Primary Health Care Nurses	IPPF/WHR; CDC; MOH, Dominica	To equip this category of nursing staff with F.P. information and skills to carry out F.P. duties
24. Medical Seminar	October 1984 Barbados	1 day	130 Physicians and final year medical students	IPPF/WHR; UWI, B'dos; BAMP; BFPA; CDC	To upgrade knowledge about MCH care
25. F.P. & FLE Workshop	October 1984 St. Kitts	5 days	25 Nurses and Field Educators	IPPF/WHR; CDC; MOH, St. Kitts	To upgrade F.P. information and skills
26. Training Course in F.P. Techniques for Graduate Nurses	Oct. - Nov. 1984 UWI, Jamaica	8 weeks	7 Fellowships Antigua 1 Barbados 1 Montserrat 1 Dominica 1 St. Kitts 1 St. Lucia 1 St. Vincent 1	UWI, J'ca	To provide training in clinical F.P. skills

A. CROPPER
IPPF/WHR-CARIBBEAN
SEPTEMBER 15, 1984