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UNCLASSIFIED

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

CARIBBEAN REAGIONAL

PROJECT PAPER

POPULATION & DEVELOPMENT

Amendment No 3

AID/LAC/P-371
CR DR/P-082-3 P-329

Project Number: 538-0039

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: C (A = Add, C = Change, D = Delete)
Amendment Number: 3
DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Regional Development Office/Caribbean (RDO/C)

3. PROJECT NUMBER: 538-0039

4. BUREAU/OFFICE: LAC 05

5. PROJECT TITLE (maximum 40 characters): Population and Development

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 90

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4)
A. Initial FY 82 B. Quarter 4 C. Final FY 89

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

A. FUNDING SOURCE	FIRST FY 82 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(500)	(-)	(500)	(4,085)	(3,581)	(7,666)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	-	-	-	-	984	984
Other Donor(s)						
TOTALS	500	-	500	4,085	4,565	8,650

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. AUTHORIZATION TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PN	400	400		4,666	-	3,000	-	7,666	-
(2)									
(3)									
(4)									
TOTALS				4,666	-	3,000	-	7,666	-

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
410 | 420 | 430 | 440 | 450 | 460

11. SECONDARY PURPOSE CODE: 444

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

13. PROJECT PURPOSE (maximum 480 characters)

To increase the impact and sustainability of family planning programs in the Eastern Caribbean.

14. SCHEDULED EVALUATIONS
Interim MM 09 YY 88 | MM YY | Final MM 09 YY 90

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☒ 000 ☐ 941 ☒ Local ☐ Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)
The purpose of this amendment is to add $3,000,000 and extend the PACD by two years to increase the impact and sustainability of family planning programs in the Eastern Caribbean.

17. APPROVED BY
Signature: Alfred Bisset
Title: Al Bisset
Acting Director, RDO/C
Date Signed: MM 06 DD 26 YY 87

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM 07 DD 06 YY 87

AID 1330-4 (8-79)

PROJECT AUTHORIZATION
AMENDMENT NUMBER THREE

NAME OF PROJECT: Population and Development

PROJECT NUMBER: 538-0039

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Caribbean Regional Population and Development Project was authorized on July 28, 1982 and amended on June 21, 1985 and September 25, 1986. I hereby further amend said Authorization as follows:-

   (a) By adding an additional Three Million United States Dollars (US$3,000,000). This increases the total authorized amount to Seven Million Six Hundred and Sixty-Six Thousand United States Dollars (US$7,666,000). The Project Assistance Completion Date of December 31, 1988 is also hereby changed to December 31, 1990.

   (b) By adding to the project definition the following new purpose: To increase the impact and sustainability of Family Planning programs in the Eastern Caribbean.

2. All other terms and conditions of the original Authorization, as amended, shall remain in full force and effect except as hereby specifically amended.

SIGNATURE: Alfred Bisset

TYPED NAME: Alfred Bisset

TITLE: Acting Director

DATE: June 26, 1987

POPULATION AND DEVELOPMENT (538-0039)
PROJECT PAPER AMENDMENT NUMBER TWO

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LIST OF ACRONYMS AND ABBREVIATIONS

BFPA	Barbados Family Planning Association
CARICOM	Caribbean Community Secretariat
CBD	Community Based Distribution (of Contraceptives)
CCSMP	Caribbean Contraceptive Social Marketing Project
CDC	Centers for Disease Control
CEO	Chief Executive Officer
CFPA	Caribbean Family Planning Affiliation Ltd.
CPS	Contraceptive Prevalence Survey
CSM	Contraceptive Social Marketing
EC	Eastern Caribbean
FLE	Family Life Education
FP	Family Planning
FPA	Family Planning Association
IEC	Information, Education, and Communication
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
OR	Operations Research
PAC	Project Advisory Committee
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
RDO/C	Regional Development Office/Caribbean
SOMARC	Social Marketing for Change (The Futures Group)
S&T/POP	Science and Technology Bureau/Office of Population
UNFPA	United Nations Fund for Population Activities
WRA	Women of Reproductive Age (15-44 Years Old)

I. SUMMARY AND RECOMMENDATIONS

A. Recommendation

The AID Regional Development Office/Caribbean (RDO/C) recommends authorization of an amendment to the Population and Development Project (538-0039) to increase life of project funding by $3,000,000, extend the PACD to December 31, 1990, and to amend the project purpose.

B. Summary Project Description

The Project, as amended in Project Paper Amendment #1, September 25, 1986, has an authorized LOP funding level of $4,666,000. The purpose of the Project was to reduce the number of unwanted pregnancies in the region. The project components, implemented through four institutions, include: policy development; expansion of family planning service availability; commodity supply; clinic renovation; operations research; and contraceptive prevalence surveys.

The new project purpose under this Amendment is to increase the impact and sustainability of family planning programs in the Eastern Caribbean. This will be accomplished through establishment of an appropriate policy environment, greater use of private sector delivery mechanisms, improved management and efficiency of private voluntary and public sector organizations, and development of a regional institutional capability to provide technical and managerial support to family planning institutions. Four new activities will be initiated under this Amendment to be implemented concurrently with the on-going activities: management assistance and training; private sector programs; information, education, and communication campaigns; and coordination of regional training programs.

The Management Assistance component consists of four elements: (1) training and technical assistance in program management for the Caribbean Family Planning Affiliation, Ltd. (CFPA) and the national Family Planning Associations (FPAs) in the Eastern Caribbean; (2) development of a management information system for CFPA, the affiliated FPAs, and the Barbados Family Planning Association (BFPA); (3) training and technical assistance in revenue generation strategies and techniques for CFPA and the affiliates; and (4) technical assistance and training in contraceptive commodity supply logistics.

The Information, Education, and Communication component consists of development of educational and motivational campaigns to be used in the EC region to encourage family planning. The campaigns will be conducted using a mixture of media and will be targetted to specific audiences for maximum impact.

The Private Sector Programs consist of introducing family planning clinics and counseling services into five industrial or manufacturing sites in the region. The Project will cover development and setup costs for the clinics and a sponsoring organization will be responsible for all recurrent costs after the project.

The Training Program consists of technical training in family planning and family life education for new personnel in the field, refresher training to highlight service delivery improvements, and exchanges within the region to encourage new program initiatives. CFPA will also serve as a regional clearinghouse on training programs to improve coordination among the different funding agencies.

By the PACD, the project will have raised the contraceptive prevalence rate for the region to at least 40% and at least 2,250 couples will be receiving contraceptive services from private sector work-based clinics, representing a 55% contraceptive prevalence rate in participating firms.

C. Financial Summary (US$ 000)

Elements	Project to Date		Amendment	Total	
	AID	Counterpart	AID	AID	Counterpart
Policy Studies	729	167	-	729	167
Services Delivery	3,797	817	50	3,847	817
Management Assist.	-	-	862	862	-
Private Sector	-	-	470	470	-
IE & C	-	-	455	455	-
Tech. F.P. Training	-	-	189	189	-
Grant Administration	-	-	819	819	-
Contingency	-	-	155	155	-
Sub-total	4,526	984	3,000	7,526	984
AID/W Commodities	140	-	-1/	140	
TOTAL	4,666	984	3,000	7,666	984

1/ Commodity costs ($150,000) are included under the Management Assistance line item in the sub-element of Commodity Logistics.

II. BACKGROUND

A. RDO/C Strategy

1. Population Sector Strategy

A major objective of AID's population program is to enhance each individual's freedom to choose voluntarily the number and spacing of children. The RDO/C population sector strategy to increase access to voluntary family planning services takes a three-pronged approach: development of an appropriate policy environment; improvement of the quality and efficiency of available services; and expansion of the base for service and commodity delivery. The policy element is directed toward increasing the understanding and commitment of policymakers and leaders on population issues and the adoption of appropriate population policies and medical protocols by Caribbean governments. To improve the quality of services and efficiency, USAID activities have been directed toward strengthening family planning institutions by improving technical knowledge, physical facilities, contraceptive availability and managerial expertise. The third element is directed toward expanding the base for service and commodity delivery through community-based distribution (CBD) systems, contraceptive social marketing (CSM) programs, and work-based family planning service delivery in private sector industrial and commercial firms.

2. USAID Management Strategy

In keeping with the Mission goal to consolidate project management units and reduce the management burden on RDO/C staff, all population activities are being combined into one project. This project amendment will combine on-going population activities with selected activities from the Family Planning Information, Education, Communication and Training (IEC&T) Project (538-0116) and begin new activities to introduce family planning services into commercial and industrial firms.

B. USAID Activities

1. Population and Development (538-0039)

The primary vehicle for population activity in the region has been this project, which has provided US$4,526,500 of technical assistance, training, commodities, clinic improvements, and operations research since 1982. The bulk of the assistance provided in the Project has been channeled through IPPF/WHR to strengthen and expand family planning activities in public sector health clinics. Current Project activities will not be affected by the inclusion of new activities in this Amendment. The implementation of the on-going components will

continue as described in Amendment #1 and will, for the most part, be implemented separately from the activities described in this Project Paper Amendment. The status of each of the on-going project components is as follows:

a. Regional Population and Medical Policy

This component, implemented by CARICOM, consists of providing national governments with assistance in formulating population policies and medical protocols affecting family planning. The PACD for this activity is September, 1987, by which time it is expected that a minimum of six governments will have implemented a national population policy. This amendment does not fund any additional activities or change the completion date for this component.

b. Increase Family Planning Service Availability

Service delivery support activities undertaken by IPPF include establishment of adequate numbers of clinical facilities in at least six countries and establishment of CBD programs. This activity will continue as described in Amendment #1 through the expected PACD of December 1988. No additional funding will be provided under this amendment.

c. Training for Doctors and Allied Health Workers

Under this component, 281 doctors, 213 nurses, and 417 health workers have been trained in various aspects of family planning through overseas training, regional workshops, and in-country training. This training component will continue at a reduced level as described in Amendment #1 through the expected PACD of December 1988. No additional funding will be provided for this component under this amendment.

d. Commodity Supply

IPPF has been responsible for distributing family planning commodities to public sector health clinics, private voluntary family planning associations, and through community-based distribution systems. The current distribution system continues to have problems in maintaining adequate supplies and in developing effective CBD systems. A regional workshop in contraceptive supply management will be conducted by IPPF after a review of the current system to identify and improve specific weaknesses.

Under the proposed Amendment, CFPA staff will be trained to assume the coordination and distribution role currently performed by IPPF after the December, 1988 PACD for IPPF involvement.

Eventually, it is hoped that the national medical authorities will assume these functions for the public sector services and integrate family planning commodity supply systems with the standard drug supply systems established under the Regional Pharmaceuticals Management Project (538-0134).

e. Improvements to Public Sector Clinics

Public sector clinic renovations under the initial project included provisions for purchasing basic family planning equipment and making modest renovations in 39 existing public health facilities in all countries except Barbados. Under Amendment #1 an additional $101,800 was allocated for improvements to additional clinics. This activity should be completed by the end of 1988 and will not receive any additional funding under Amendment #2.

f. Contraceptive Prevalence Surveys

IPPF will continue to do follow-up Contraceptive Prevalence Surveys for the remaining countries, including St. Lucia, St. Vincent, Dominica, Antigua, and Barbados as indicated in the amended project. No additional funding will be allocated for this activity under the present amendment.

g. Operations Research

This component, conducted by Tulane University for the first half of the Project, is currently being implemented by the Population Council as described in Amendment #1. The final five OR studies to be completed have not yet been identified, but high priority areas for research include identification of pricing policies for cost-effective provision of commodities and services, and media mix and exposure levels for intensive motivational campaigns. A subject of particular interest is the impact on contraceptive prevalence which can be obtained by saturating a market with educational and motivational campaigns using the most effective combination of media campaigns and exposure levels. The islands with the most severe population problems will be encouraged to conduct such a study.

The Population Council representative will be consulted in the design of the management information system to assure that it will be useful in collecting basic data from an operations research standpoint without unduly burdening the system with nonessential data requirements. The representative will collaborate on the management training component to clarify how operations research is conducted and how it can be used as a management tool.

h. Contraceptive Social Marketing

Only a limited amount of funding ($50,000 over the life of the project) has been provided to date to the Contraceptive Social Marketing Program. This contraceptive distribution program, relying solely on commercial advertisers, distributors, and retailers, will be expanding its current base of Barbados, Saint Lucia, and Saint Vincent and the Grenadines to the other Caribbean islands (e.g. Antigua, Grenada, Saint Kitts and Nevis) over the coming year. The program is funded primarily through The Futures Group SOMARC program with S&T/POP. However, an additional $50,000 will be allocated to this activity under this Amendment to assist with the expansion into the other islands.

2. Information, Education, Communication, and Training (538-0116)

The IEC&T Project, ending in June, 1987, has been implemented through the Caribbean Family Planning Affiliation (CFPA) and has been the primary vehicle for support to the private voluntary family planning organizations. This project has concentrated on development of IEC strategies, production and distribution of supporting promotional materials, support for regional advocacy of family planning, training in family planning education, and technical assistance for fund-raising and training. The IEC programs have been presented in print, radio, and video format; training has been conducted through regional seminars and in-country workshops for nurses, teachers, and field workers. Selected activities from this project will be included for further funding under this Amendment as described in Section III C.

III. PROJECT DESCRIPTION

A. Project Strategy and Rationale

The demographic situation in the Eastern Caribbean has been fully described in previous documents, including the Project Paper, Amendment #1, and the "Family Planning Development Project Assessment and Recommendations for New Project Directions" report. The problems identified in the previous project documents focused on legal, political, physical, administrative, medical, and cultural impediments to family planning services. The on-going project activities as well as the new activities proposed under this Amendment will continue to address these constraints.

Previous activities under this Project and the IEC&T Project have addressed the most critical gaps in service delivery, particularly in the public sector, and have substantially improved acceptance of the concept of family planning in the region. Nonetheless, a notable gap still exists between knowledge and usage of family planning services and commodities: recent surveys suggest nearly universal awareness of at least one family planning method while prevalence of use is still only 35 percent by women of reproductive age. This prevalence rate is still modest by most standards; certainly when compared to rates exhibited by developing countries at similar socio-economic levels. Moreover, most of the existing services are heavily dependent upon external technical and financial assistance, thus requiring continued heavy subsidization and rendering them vulnerable to disruption from external influences. Therefore, additional assistance is needed to consolidate previous successes, improve the program impact on contraceptive usage, and develop a broader and more self-sufficient base for providing family planning services.

Specific constraints to efficient and effective provision of family planning services on a more sustainable basis include managerial weaknesses in existing private voluntary and governmental family planning organizations, substantial technical reliance on foreign PVOs, and excessive dependence on financing from external donors and government programs.

Weak Program Management. While FPA's have been successful in promoting family planning as a concept, the high levels of awareness have not been translated into contraceptive usage commensurate with the level of socio-economic development in the region. In part, this is due to a well- intentioned but passive management style which has continued existing programs without rigorous analysis and review of project impact. Little effort has been made to manage programs more actively through development of national and regional strategies, to establish

clear goals and objectives linked to work plans, or to conduct critical evaluations of program impact on fertility rates or the relative cost-effectiveness of different programs and service delivery mechanisms. As a result, efficiency of operations and effectiveness of programs are poorly understood.

In addition to the lack of programmatic rigor and direction, many specific examples of management weaknesses exist. The commodity supply logistics system in IPPF for distribution of contraceptive commodities to FPAs and public health ministries, introduced early in the project with assistance from the Centers for Disease Control, is still plagued by problems in delivery schedules, poor supervision, inadequate and late reporting of stocks, and the lack of uniform reporting or control systems. In this case, lax management resulting in the unavailability of contraceptive supplies for several weeks could jeopardize years of effort in developing the habitual use of contraceptives.

The effectiveness of community-based distribution systems working through the FPAs has been limited by poor coordination by part-time managers, poorly trained and motivated retailers, lack of promotional materials, and inadequate institutional support. Program management has been hampered by generally weak managerial control of the operations, inadequate monitoring and evaluation procedures, poor organizational plans (including organizational structure, clear job descriptions, and office policies and procedures), lack of set goals and work plans, weak accounting and financial management, and poorly trained staff. The costs in efficiency and impact of the programs as a result of these managerial weaknesses is difficult to measure due to the dearth of reliable information.

Reliance on External Technicians. IPPF has been the major institutional support for government health programs, the CFPA, and the national FPAs for several years. In addition to providing program financial support, the Project-funded IPPF/WHR regional office has been responsible for coordinating all commodity distribution and providing training to staff and professionals involved in family planning. Under the project, CARICOM has had responsibility for administering special studies and activities on population policy and Tulane University and the Population Council have assisted FPAs with operations research. While this support has been both effective and necessary to improve family planning activities in the region, the purpose of external assistance is to provide a bridge for building capacity in local entities rather than to foster dependence on non-indigenous institutions. Therefore, the time is now appropriate to reduce dependence on external organizations. As the first step, CFPA is becoming a registered PVO.

Dependence on External Sources of Financing. Family planning organizations in the private voluntary sector are almost entirely dependent upon financing from external donors, including USAID, UNFPA, and IPPF (which is in turn partially dependent on USAID financing). Public sector family planning activities, recently introduced in many government health programs, are dependent upon the continuation of government budgetary support for these activities. This leaves the population programs highly vulnerable to changes in political support and economic conditions. It also discourages independent program development by FPA and government managers based on specific country needs. The development of a broader base of financial and material support for family planning activities, through fund raising activities, fees, service charges, and pricing policies, is necessary to minimize the dependence of these programs on donor financing.

The project strategy to improve the impact of family planning programs and to increase the self-reliance of local implementing institutions in the region consists of (1) concentrating regional family planning coordination and support activities in one indigenous institution, (2) improving management of existing regional and national programs, (3) broadening the base of financial support through assistance in revenue generation, (4) improving coordination between the private voluntary and public sector efforts, and (5) making family planning services and commodities available from as many independent sources as possible. Selected elements of the program will also be used to target more intensive family planning campaigns to those countries with the most severe problems. These institutional and programmatic changes will improve physical and psychological access to family planning services, increase the efficiency and impact of current program resources, reduce dependence on external institutions and donors, and increase the self-sufficiency of nongovernmental programs. Developing clinics to deliver family planning services in profit-making firms can expand the base for delivery of services and provide revenue to FPAs. This strategy is consistent with the Mission's strategy of promoting the private sector role in development and its desire to reduce the management burden on staff by limiting the number of separate activities and management units to monitor.

All family planning support activities, including training, materials development and dissemination, management/technical assistance, and commodity supply will be channeled through one indigenous institution. The Caribbean Family Planning Affiliation will be strengthened and its operations expanded from information, education, and advocacy of family planning to include provision of services to affiliated FPA's, private sector firms, and, to a lesser degree, to government health ministries. It will also gradually assume some functions which are currently performed by IPPF, primarily commodity distribution and training.

The management and technical capability of organizations providing family planning services in the Eastern Caribbean will be improved through training, technical assistance, and the selective use of operations research to assure that the highest degree of cost-effectiveness is achieved. As part of this program, all family planning associations will be assisted in developing and implementing revenue generation strategies to reduce their dependence on external sources of financing.

A key element of the strategy encompassed in this Project Amendment is to expand the base of family planning service and commodity providers to include private sector organizations and businesses. By placing commodity distribution and provision of services on a more commercial basis wherever possible and by incorporating them into employee benefit packages, the Project will increase the total resources available for family planning activities, improve access to such services and supplies, and reduce financial dependence of family planning programs on external donors. In addition, it will allow public and PVO family planning efforts to concentrate more heavily on the high-risk, hard-to-reach target groups like young and/or unemployed women.

B. Goal and Purpose

The program goal of this project is to bring population and resources into better balance within the Eastern Caribbean by reducing the birth rate.

The Project Purpose is to increase the impact and sustainability of family planning activities in the Eastern Caribbean. This will be accomplished through establishment of an appropriate policy environment, greater use of private sector service delivery mechanisms, expanded educational and motivational campaigns, and improved management, efficiency and technical capability of private voluntary and public sector family planning institutions.

The expected achievements at the end of the project are that the contraceptive prevalence rate for the region will increase to at least 40% from the current estimate of 35% and that at least 2,250 women will be receiving contraceptive services from private sector work-based clinics, representing a 55% contraceptive prevalence rate among the women employees.

C. New Project Components

The amended Project will include the continuation of existing activities, assumption of some activities previously conducted under Project 538-0116, and initiation of several new activities. Existing components, inplemented through IPPF, Population Council, and CARICOM,

are focused on improvements in public sector delivery channels, studies, and policy development. These activities will continue to be implemented as described in Amendment #1 through the PACD for those activities (9/30/87 and 12/31/88). New project components will concentrate on improving performance in non-profit organizations and will be implemented through the Caribbean Family Planning Affiliation (CFPA). Therefore, the project will be implemented along two parallel tracks through the end of 1988: one set of activities implemented by the Caribbean Office of IPPF/WHR and the other implemented by CFPA.

The geographic scope of the new project components will include the seven Eastern Caribbean countries plus Barbados. The seven EC countries will participate in all of the regional activities (management assistance, IEC, and training). Barbados will participate in the management information system and management training and technical assistance. The private sector program will be implemented in selected countries in the region on the basis of the selection criteria described under that component.

The new activities include (1) support for targeted information, education, and communication campaigns to promote knowledge of contraceptives and motivation to use them, (2) management assistance and training to CFPA, the affiliated FPAs, and BFPA, (3) private sector programs to extend family planning services through industries, businesses, and unions, and (4) the establishment of a coordinated regional training system.

1. Information, Education and Communications

Since early 1980, RDO/C has been supporting the development and dissemination of information, education and communications (IEC) strategies through the Caribbean Family Planning Affiliation. The current project supporting this activity--the Family Planning Information, Education, Communications and Training Project--is scheduled to end in June, 1987.

Seven years of support to the CFPA have resulted in an increasingly sophisticated and capable institution which has earned the reputation as the definitive organization promoting family planning messages in this region. The CFPA has mastered the delivery of IEC campaigns through a broad variety of media including radio spots, posters, pamphlets, press releases, news supplements, and videos. They are as comfortable developing stand-alone motivational themes for young women, young men and young mothers as they are in designing their "Annual

Regional Campaign," a three-month multi-media effort from October through December of each year which includes the celebration of "Caribbean Family Planning Day" on November 21. This latter effort includes a number of public ceremonies and media events which are orchestrated in each country. CFPA has also prepared a number of educational materials designed to teach family life education and family planning methods. Judging by the magnitude by which demand for CFPA materials outstrips supply, these efforts are well received by family planning associations and public sector family planning programs which use them.

So as not to lose the momentum which has been generated during the IEC&T Project, motivational and educational communication strategies will continue to be supported through the CFPA under this amended project. While maintaining attention to critical target audiences such as young and/or unemployed men and women, the amendment will support IEC efforts which address two particularly troublesome and related problems in contraceptive use: method discontinuance and inaccurate information about family planning methods.

Method discontinuance. User discontinuance of contraceptive methods is a problem which requires continuous attention by family planning programs. Even when dissatisfaction does not result in absolute discontinuance but in method switching, the evidence suggests that the user generally goes from a more to a less reliable method of family planning, e.g., from oral contraceptives to condoms, thereby increasing the probabilities for user and/or method failure and a resultant pregnancy. Except in those few cases where more reliable methods are medically contraindicated for an individual user, most family planners feel that women should maintain use of the more advanced methods. Under this project, CFPA will develop an IEC strategy specifically targeted to current contraceptors with a message which encourages them to continue using their method.

Inaccurate information. One of the reasons for discontinuing contraceptive use is the prevalence of inaccurate information about reproductive health in general and contraceptives in particular. One common misconception about the use of orals frequently voiced by women as their reason for discontinuance is the mistaken notion that "the body needs a rest" after being on orals for a year or two.

Two operations research studies conducted by Tulane University under the Population and Development Project looked at the issue of knowledge of reproduction, contraceptives and sexually transmitted diseases. Both of these studies demonstrated the degree of misinformation which exists among young people on these topics. The Dominica study of young people and their knowledge of reproductive health and family planning revealed the following:

Table 1
Misconceptions Regarding Conception

	Males		Females	
Percentage that:	15-16	17-19	15-16	17-19
Believe a girl cannot get pregnant the first time she has sex	53.1	49.3	64.9	43.5
Believe a girl will not get pregnant unless she has an orgasm	59.2	55.0	74.5	65.8
Does not know when a girl is most likely to get pregnant	99.0	94.3	96.3	91.6

Misinformation about conception and contraception is difficult to assess unless respondents are asked specific questions about the result of an action (or inaction). Yet contraceptive prevalence surveys and other common research methodologies in family planning do not specifically test actual knowledge. Rather, these surveys probe for ability to name contraceptive methods then take the "leap of faith" conclusion that an ability to name methods demonstrates correct knowledge of those methods. Given the complexity of medical implications of birth control alternatives, it is not surprising that the "common knowledge" available to most people contains a substantial amount of misinformation.

Under this project component, a series of promotional and motivational campaigns, using a mixture of media (video, radio, pamphlets, booklets, posters, etc), will be developed and distributed to all of the affiliated FPAs. These campaigns will focus on inaccuracies in and gaps of information on contraceptive methods, joint responsibility, male role in family planning, and young adult fertility. The campaigns will strive both to dispel incorrect information about reproductive health and contraceptive methods and to ensure wide dissemination of new research findings which promote family planning practice.

This component will also include a regional workshop to assist affiliates in improving their communications strategies, developing limited IEC materials to promote national family planning events or reach specific audiences, developing add-on products for the

CFPA materials, and selecting appropriate media for different messages. This training is not intended to be comprehensive enough to develop sophisticated IEC capabilities in each of the FPAs, but rather to develop basic understanding of communication strategies to assist in their program development.

A series of seven one day seminars will be held in each of the seven EC countries for influential business, government, community, and media leaders to promote the concept of family planning, familiarize these leaders with CFPA and FPA programs, and to solicit financial and volunteer support for the associations.

The USAID contribution to this component will consist of production and distribution costs of educational and motivational materials, seminar costs, training costs, and salary and travel costs for the audio-visual officer.

2. Management Assistance

This component is designed to improve the capability of CFPA and the participating affiliates in program design and evaluation, financial and operational management, commodity supply logistics, and revenue generation. The capacity will be developed within CFPA to provide continuing management assistance to the affiliates. The component consists of four elements:

- Improved program management in CFPA, affiliated FPAs and BFPA.
- Development and implementation of a management information system for CFPA, affiliated FPAs, and BFPA.
- Expansion of revenue generation activities by CFPA and its affiliates.
- Improvement of the commodity supply logistics system.

a. Program Management Assistance

The most critical challenge facing the family planning organizations in the region over the next several years will be to develop methods of starting and maintaining ever increasing numbers of women of childbearing age as contraceptors. The number of women of reproductive age will increase 42% (from 161,300 to approximately 228,500) between 1980 and 2000. In the absence of massive increases in funding, the organizations must become far more efficient and programs must be managed well to achieve the greatest possible impact at the lowest possible cost. This will require managers to efficiently use resources in the most effective programs.

This activity will improve the capability of managers in CFPA, BFPA, and the affiliated FPAs to design, evaluate, and manage programs most effectively. As a result of the technical assistance and training provided under this component, all of the participating country managers will better understand the nature of management and will be able to use management techniques for program design and implementation.

At the heart of the management improvement system will be improvement in the use of basic management tools--annual goals and objectives, integrated work plans and budgets, and annual review and revision of programs based on performance. While the FPAs are already performing these management functions as part of their IPPF affiliate duties, these efforts are primarily seen as reporting requirements to ensure funding subventions and not as integral, useful tools for managers. This activity will be closely coordinated with the IPPF Program Planning and Budget Review (PPBR) system currently in use to assure that no conflicting or duplicative requirements are imposed. Critical to this activity will be the development of a management information system (activity (b.) below) to provide current and accurate information in a form usable for decisionmaking by managers. FPA managers will be taught how to use the information provided to evaluate the cost-effectiveness of their programs, to determine the most efficient means of complementing government health programs, and to increase the efficiency of their staff and financial resources. The annual project analysis and review will also assist FPA directors in identifying needed research to be undertaken in the operations research component of the Project.

A study of the cost-effectiveness of current activities will be used to provide baseline indicators and to identify means of linking program activities to impact on contraceptive usage and ultimately to impact on fertility rates. This study will be used as a starting point as FPA directors set specific contraceptive prevalence goals for their islands each year and build a program mix to achieve those goals. The information can then be refined and improved each year by analyzing information from the MIS system.

Technical assistance also will be provided to develop a quick, low-cost methodology to measure program impact on contraceptive usage which can be used for rapid, relatively reliable annual surveys. Currently, measurement of program impact is keyed to the comprehensive and costly Contraceptive Prevalence Surveys which are performed every five to ten years. The rapid surveys will not replace CPSs, but rather will be used to supplement them for use in evaluating programs on an annual basis.

In order to implement an improved management system in each FPA and in CFPA, an assessment of management needs will be carried out in each participating institution. Based upon this survey, a training and technical assistance plan will be developed to tailor skill development activities to the specific needs of each participating FPA and to the CFPA. A one week general training course, offered to managers in all of the affiliates, will include overviews of general program management, monitoring and evaluation, financial management, organizational design and personnel systems, and the use of operations research from a management viewpoint as well as some topics identified in the needs assessment. As follow-up, one week training/program review sessions will be held annually to enhance management skills and review progress over the past year. In these sessions, each FPA director will review and discuss the successes and problems encountered in implementing the previous year's plan. A representative of each FPA's board of directors also will be encouraged to attend these training and program review meetings. Other training programs will be used to meet unmet training needs identified in the survey.

After the annual week of training, up to two weeks per year of follow-up technical assistance will be provided to each individual FPA to refine and finalize their strategies and workplans for the coming year. Technical assistance in financial management and accounting will also be provided to improve current systems and better integrate them into the MIS system and program review process.

This component will consist of twelve person-months of technical assistance, annual training programs for thirty people, special training programs for twenty people, and salary payments for the CEO and program coordinator of CFPA. A CFPA staff member will be assigned to work as counterpart to the management and training advisor(s) to provide continuity and develop a continuing management assistance program for the FPAs.

b. Development and Implementation of a Management Information System for CFPA and the Eight Participating FPAs

The lack of available information on even the most elementary level--the cost of providing services, number of people reached, impact of activities, and relative cost-effectiveness--is a serious constraint to effective program design and management. Without cost data and analysis, managers are unable to make critical decisions on resource allocation among programs and countries, integrating public, private sector and voluntary family planning programs, and program strategy. To the limited extent that managers are currently making such decisions, it is being done in a vacuum. Program evaluations to date have concentrated on activities rather than impact or efficiency.

Managers know that supplies have been distributed or that presentations have been made, but are unable to estimate the impact on contraceptive usage or even the cost of providing the service.

This component will provide the basis for future monitoring and evaluation activities as well as the day to day administration, logistics, and financial management of the program. Development of this system will be integrated with other program activities, including the development of a systematic monitoring and evaluation procedure, operations research, and improvement of the commodity supply logistics system to assure that all information needs of regional and national FPA managers are being met in one integrated system. Care will be taken to avoid duplication of information gathering as well as the imposition of unnecessary data collection burdens on the voluntary agencies. When installed and functioning, this system will provide reports and analysis for management decisions and can be used to identify special evaluation and research needs.

The system will be based in CFPA with hardware and software provided by the Project and will use information provided on a monthly basis by the affiliates. The system will consist of reporting forms and data from the FPAs which will then be analyzed by CFPA and returned to the FPAs for use by FPA Executive Directors. Computer facilities in each of the affiliated FPAs will allow for assessment locally prior to cross-country regional analysis and dissemination at the CFPA. Computerizing data collection and analysis at the local level should assist the smaller FPAs in program design, management, and evaluation by enhancing the capabilities of the limited staff which operate these organizations. The Barbados Family Planning Association, which is not affiliated to CFPA, will also receive a computer and training in the system for their own use and will provide summary analyses of their activities to CFPA for comparison with other family planning programs in the region.

Design and implementation of this system will be coordinated by the program coordinator in CFPA. Short term technical assistance will be contracted for systems analysis, identification of hardware and software requirements, and adaptation of software to provide a turnkey system. The system design will be closely coordinated with current reporting requirements and systems used for IPPF so as not to duplicate or conflict with currently required systems. The system designer will also be responsible for training CFPA, BFPA, and FPA staff and management in the use of the system. In order to assure efficient usage of this system, at least one short refresher course will be conducted in each year of operations. The system designer will also be responsible for on-site installation of the system and troubleshooting to work out any "bugs".

CFPA will serve as a central clearinghouse for information and cross-country analyses. Experiences, successes, effective materials, and innovative local campaigns can all be centralized in CFPA for discussion and distribution in the other FPAs. In conjunction with the program for intervisiting (activity (d) below), this program will strengthen all of the affiliates and encourage innovative program development.

This component will consist of six person-months of technical assistance to set up and install the system, computer and equipment purchases, and training for twenty people from CFPA, the affiliates, and BFPA. A CFPA staff member will be assigned to work as a counterpart with the systems designer to serve as system operator and provide technical assistance to staff and managers of the affiliates. General training in usage of the computer facilities, beyond the MIS system itself, will be provided to other BFPA and CFPA staff to ensure maximum productivity of the systems.

c. Revenue Generation

The FPA's are currently supported by IPPF core funding grants and AID regional project funding, with such funding representing between 60% and 100% of the total revenues of participating FPA's. Some FPA's raise revenue through cost recovery programs (e.g., sales of commodities through the CBD program and fees charged for clinical services) which can represent up to 40% of their revenue. In addition to these traditional sources of revenue, the Grenada FPA raised almost 12% of its operating budget (EC$11,000) last year through fund-raising activities; CFPA raised $23,500 from such efforts. Many FPA's receive some in-kind support from the local governments, ranging from the free use of clinic and hospital space, duty-free import of commodities, assignment of government nurses to the FPA, and waived stamp duties.

To date, revenue generation/cost recovery and fund-raising activities appear to be a low priority rather than a serious effort to raise significant amounts of capital for CFPA and its affiliates. The activities conducted have not generated enough to pay for the staff and expenses incurred. Little effort has been made to develop other revenue sources through aggressive grantsmanship, imposition of fees, sale of services to the private sector, and other cost-recovery activities.

It is recognized that fees and service charges, while clearly necessary to make the FPA's more self-sufficient, must be instituted with caution so that potential clients are not discouraged from using the services. The relationship between cost of services and demand for the services is not well understood for the Eastern Caribbean

region. There is some indication that demand for free services will not be significantly greater than would demand for services provided at a nominal price because of consumer perception of the lack of quality of free goods. Thus, if demand is highly inelastic below a certain price level, then it would not make any sense to reduce prices below that level. On the other hand, it would be counterproductive to turn away anyone who might want the services simply because they cannot pay.

As part of the operations research component, research into alternative pricing policies will be conducted to assist CFPA and FPAs in developing their own comprehensive pricing policies and revenue generation plans. The assistance provided under the privatization component will also be coordinated with this component in order to promote methods for FPAs to sell services to industrial and commercial firms.

In addition to cost recovery programs, special efforts should be made to increase program revenues through fund-raising activities. Activities which have been tried to date (e.g., teas, raffles, etc.) have not been particularly lucrative in part due to the lack of expertise in professional fund-raising. Under this project the CFPA and its affiliates will receive technical assistance and training in methods of increasing program revenues through cost-recovery/fee-for-services activities as well as fund-raising programs generally associated with the non-profit sector.

Technical assistance will be provided to work with the CFPA staff to hold a regional workshop on revenue generation, proposal development, and fund-raising. As a follow-up to the regional workshop, each participating FPA will receive direct assistance in formulating a revenue generation strategy, and setting specific fund-raising objectives. An information clearinghouse will be established within CFPA to provide information and assistance on potential funding sources, proposal deadlines, and other relevant information.

In order to implement this component, project assistance will provide five person months of technical assistance, training costs for twenty people and program support for innovative revenue generation efforts. The CFPA will provide one-half of the salary of a full-time person as counterpart contribution to this effort.

d. Commodity Supply Logistics

Presently, the Barbados office of IPPF/WHR is responsible for coordinating the distribution of contraceptives from AID/W to government health clinics, FPAs and the CBD program. In 1986,

618 tubes of foams and jellies, 88 cartons of condoms (528,000 units), 94,800 cycles of oral contraceptives, 48,000 tabs of vaginal foaming tablets, and 877 IUDs and other physical barriers were distributed, primarily to government clinics.

The logistics system established for supply and distribution of contraceptives was developed with assistance from CDC in Atlanta. IPPF recognizes that the current system needs improvement. Last minute delivery schedules, poor supervisory systems, and the lack of a uniform control system have resulted in commodity shortages in both government and FPA outlets. The CBD program, which also is supplied through this system, is plagued with management problems. To some degree, the problems in the distribution system are attributed to the perceived imposition of excess reporting requirements on the public health office staff and nurses.

Short term technical assistance will be used to analyze the system and identify weaknesses in data collection and reporting procedures. It also will look for ways to better integrate the public sector family planning commodity supply system with the normal health department data collection system and reduce the reporting load on field staff. The eventual goal is to have all commodity procurement for public sector health programs integrated into the standard pharmaceutical supply and distribution system, with each government ordering commodities directly and maintaining adequate national stores. Project efforts will be directed toward MOH assumption of these responsibilities in each of the participating islands. CFPA will continue to have responsibility for coordinating supplies for FPAs and the CBD program. The technical assistance provided under the first amendment is being used to support a workshop in commodity logistics. Responsibility for this workshop rests with IPPF, however CFPA participation will be included.

During 1988, a CFPA staff member will work concurrently with the IPPF commodity supply specialist to improve the process and to distribute commodities. In 1989, after direct IPPF participation in the Project has ended, responsiblity for commodity distribution will be assumed by CFPA.

The project will finance three person-months of technical assistance and $150,000 in commodities to implement this component.

3. Private Sector Programs

Promoting active participation of private sector enterprises in family planning programs has proven to be an effective and cost-efficient means of expanding the base of service providers, increasing the amount of resources available for family planning, and

providing benefits for both employers and employees in many parts of the world. When incorporated into an employee benefit program, work-based family planning can improve factory efficiency by reducing absenteeism, training costs, and sick leave. Work-based facilities can substantially reduce the amount of time women employees require to obtain such services during work hours. Effective family planning resulting in planned, smaller, and well-spaced families can substantially reduce the amount of lost work time due to parenting responsibilities, well-child medical checkups, or illness of the mother.

Although the concept of work-based family planning is sound and has been successfully implemented in other countries, the introduction of this program into the Eastern Caribbean is made more difficult by regional demographics. The relatively small populations and the limited number of firms employing more than 100 people significantly limit the potential sites. Therefore, this component will largely be implemented in industrial parks which concentrate enough industries in one area to make such an activity financially feasible.

A preliminary feasibility study has identified several sites with potential for a viable family planning program, including the Dennery Industrial Park and the Vieux Fort Industrial Park in St. Lucia, Camden Park in St Vincent, Frequente Industrial Estate in Grenada, and the Harbor, Newton, and Wildey Industrial Parks in Barbados. (Annex D provides a more complete discussion of the criteria used to identify these sites and a preliminary analysis of the cost per acceptor.) These sites, and others identified during project implementation, will be more fully evaluated and selected for participation based on the following criteria: financial feasibility of the clinic, severity of the national population problem, level of commitment from the sponsoring company, geographical balance, and replicability. Prior to development of any subproject, a firm commitment for recurrent cost support from the first year of clinic operation will be required from the sponsoring organization.

Over the life of the project, family planning clinics will be developed in five industrial settings. The steps for subproject development will be as follows:

a. A preliminary market research survey of employees will be conducted to determine the family planning needs and preferences of the employees, current sources and costs of family planning services, need for other obstetric and gynecological services (e.g. pap smears or pregnancy tests), and interest in day-care or other health related services.

b. A financial feasibility analysis will also be conducted which; examines possible legal constraints including title to and use of potential sites, assesses coverage already available through national insurance or private insurance schemes, and determines the level of employer co-financing and appropriate capitation rates. Based on this information, project staff will determine the staffing, equipment, and commodity requirements and develop a detailed subproject design and budget. This subproject design will include the level, degree and timing of recurrent and capital cost-sharing by participating industries.

c. Space for a modest free-standing family planning clinic will be provided by the Industrial Development Corporation or the sponsoring organization. The clinics will require approximately 50 square meters of space to provide adequate room for a waiting room, exam room, counseling area, supply room, and restroom facilities. Space for the clinics will first be sought from participating industries if possible as a form of counterpart contribution. If adequate facilities are not readily available, a suitable facility will be refurbished or constructed. Should the interested parties, including AID, determine that it would be more cost efficient to construct a new facility rather than renovate a property which is not appropriate, CFPA will contract for construction of a new structure.

d. The facility will be renovated and equipped as a family planning clinic under the direction of the local FPA, CFPA, and the technical assistance team.

e. Staff will be recruited and trained and a physician will be contracted for sessional work.

f. CFPA and the local FPA will develop an IEC campaign specifically designed for the workers in the industrial estates to promote usage of the facility.

g. Management and bookkeeping procedures will be implemented and staff trained by the technical assistance team with assistance from CFPA and the local FPA. The clinic will submit quarterly progress reports describing activities and expenditures.

h. CFPA will provide family planning contraceptive supplies to the clinics financed by the project.

In the case of projects developed on Barbados, the technical assistance team will work through the BFPA directly rather than through the CFPA.

This component will consist of eight person-months of technical assistance, startup and equipment costs to establish private sector programs, and expense support for counterpart assistance in CFPA, BFPA and the affiliated FPAs. Renovation or construction of clinic facilities will be provided when necessary. A staff member of CFPA (or BFPA in Barbados) will be assigned to work with the technical assistance team on at least one feasibility study and implementation consultancy for on-the-job training so that they will develop the skills to undertake similar studies at other possible sites in the future.

4. Coordinated Regional Training Program

The CFPA training agenda under the Project amendment will focus on two training activities: conducting training-of-trainers programs, and serving as a regional clearinghouse on training programs scheduled throughout the region by all funding agencies.

Training in family planning and family life education is available through several multilateral donor and implementing agencies in this region in addition to USAID, e.g., UNFPA, PAHO, and the Swedish Development Agency. RDO/C itself has funded training through the Caribbean Office of IPPF/WHR, CARICOM, CFPA, Johns Hopkins (JHPIEGO), and the Social Development Center under the Population and Development Project. In the absence of close coordination and monitoring, duplication of effort, confusion, unmet needs, and inefficient staff utilization are inevitable. To improve coordination of these separate training programs, a regional training calendar will be developed and maintained by the CFPA under this project. The training calendar will seek to include training scheduled throughout the region by all participating agencies. In clearinghouse fashion, the training calendar will include the schedules, costs, issues, audience, focus, etc. of the various offerings for distribution to public and private sector family planning organizations. This information system will also track the names of those who have received training under the various programs to identify the growing cadre of professionals in family planning from and available to this region.

In addition to the management training and IEC training workshop noted above, the CFPA will continue to provide some level of technical training in family planning and family life education. The audience and focus of this training program will consist primarily of new personnel working in the family planning field although refresher training, particularly to highlight new research findings and service delivery improvements will also be offered. As part of this function, CFPA will arrange intervisiting among affiliated and outside programs to keep members informed about what is working in other countries in the region.

Project assistance will be provided for CFPA training, personnel salaries, expenses, material and support costs to fund the training of trainers activities and intervisiting program.

IV. FINANCIAL PLAN

A. Summary of Cost Estimates

The total cost of the Project as previously amended was $5,650,000, of which $4,526,500 was AID grant funds, $139,500 went for commodity procurement to AID/W to the centrally-funded agreement, and $984,000 was in counterpart contributions. This Amendment will add a total of US$3,000,000 in AID grant funds, for a total grant amount of $7,526,500 and total project costs (and authorization) of $7,666,000. As a regional project, there is no minimum required counterpart contribution. While some counterpart contribution is anticipated (e.g., part of the salary of the CEO at CFPA), in general, the activities to be financed in the Amendment will not require counterpart funding to achieve the purpose, therefore, no additional formal counterpart funding will be added in this Amendment.

The Amendment No. 2. elements are Management Assistance; Information, Education, and Communication; Private Sector Clinic Development; and Technical Family Planning Training. In addition, project financing will be used for grant administration costs, including CFPA expenses for grant management, support staff, evaluation, and AID project officer salaries and expenses to monitor project implementation and financial management.

Project resources will be used to directly assist the seven OECS affiliates (Antigua, Dominica, Grenada, Montserrat, St. Christopher and Nevis, St. Lucia, and St. Vincent and the Grenadines) and Barbados. The associations in the British Virgin Islands, Anguilla, Aruba, Belize, Curacao, St. Martin, and Suriname are eligible for limited support only. The family planning associations in Guadeloupe, Martinique, Guyana, and the U.S. Virgin Islands are not eligible for any project support.

Table 2.
Project Budget Summary by Component
(US$ 000)

Component	Project to Date		Amendment	Total	
	AID	Counterpart	AID	AID	Counterpart
Policy Studies	729	167	-	729	167
Services Delivery	3,797	817	50	3,847	817
Management Assist.	-	-	862	862	-
Private Sector	-	-	470	470	-
IE & C	-	-	455	455	-
Tech. F.P. Training	-	-	189	189	-
Grant Administration	-	-	819	819	-
Contingency	-	-	155	155	-
Sub-total	4,526	984	3,000	7,526	984
AID/W Commodities	140	-	-1/	140	
TOTAL	4,666	984	3,000	7,666	984

1/ Commodity costs ($150,000) are included under the Management Assistance line item in the sub-element of Commodity Logistics.

The budget elements outlined in Table 2 are more fully described below and in the Financial Tables (Annex E) to this paper.

Table 3
Estimated Expenditures by Year
($US 000)

Elements	1987	1988	1989	1990	Total
IEC	10	175	175	95	455
Management Assistance					
Management Improvement	-	160	120	30	310
Management Info. Systems	-	120	80	20	220
Revenue Generation	3	60	60	14	137
Commodity Logistics	-	100	60	35	195
Private Sector Clinics	-	170	170	130	470
Tech. F.P. Training	-	88	60	41	189
Grant Administration					
CFPA CEO & Proj. Coord.	11	47	47	58	163
CFPA Staff & Operations	21	108	108	119	356
RDO/C Project Management	25	100	100	75	300
Contingencies	10	50	50	45	155
SOMARC	50	-	-	-	50
TOTALS	130	1,178	1,030	662	3,000

B. Methods of Implementation and Financing

The Amendment elements will be implemented through several mechanisms. A Cooperative Agreement will be signed with CFPA to provide technical assistance and training to the Eastern Caribbean affiliate members, to produce and disseminate IEC materials, and to renovate/construct five clinics to be located in industrial sites. All financing will be through direct reimbursement. Although Fixed Amount Reimbursement is the preferred method of financing for construction, the Grantee will be using the direct reimbursement method for liquidating Project advances and therefore is considers it to be appropriate and most convenient.

A direct AID contract will be signed with a consulting firm to provide technical assistance in management assistance, commodity logistics management and establishing private sector clinics; and to purchase computer equipment for the MIS system and medical equipment for the private sector clinics. All financing will be through direct reimbursement.

Contraceptive commodities will be purchased through a buy-in with the centrally-managed contraceptive procurement system. A direct AID contract through a buy-in will also be used to add funding to the SOMARC project.

RDO/C project management will be contracted directly by AID and financing will be through direct reimbursement.

Method of Implementation	Method of Financing	Amount
Technical Assistance:		
Cooperative Agreement (CFPA)	Direct Reimbursement	710,000*
Direct AID Contract (TA firm)	Direct Reimbursement	495,000
Direct AID Contract (SOMARC)	Central Project Buy-in	50,000
Commodities and Equipment:		
Direct AID Contract (TA firm)	Direct Reimbursement	145,000
Direct AID Contract (AID/W)	Central Project Buy-in	150,000
Training:		
Cooperative Agreement (CFPA)	Direct Reimbursement	305,800
Direct AID Contract (TA firm)	Direct Reimbursement	45,000
Construction:		
Cooperative Agreement (CFPA)	Direct Reimbursement	125,000
Grant Administration:		
Cooperative Agreement (CFPA)	Direct Reimbursement	519,200
RDO/C Project Management	Direct Reimbursement	300,000
Contingency		155,000
	TOTAL	3,000,000

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* Includes technical staff, travel costs and other technical assistance costs.

V. IMPLEMENTATION PLAN

Project implementation will become progressively less complex over the extended life of the Project. During the first phase of the amended Project, there will be twelve activities being implemented by five organizations. The policy development component implemented by CARICOM will end in September, 1987 and all IPPF activities will end in the second year of the project, December 1988. Operations research activities will continue to be implemented by Population Council through December, 1988. The specific implementation arrangements described in Amendment #1 for the on-going activities conducted by IPPF/WHR, CARICOM, Population Council, and the Futures Group/Frank B. Armstrong, will continue as described in Amendment #1.

A. Implementing Mechanism

Amendment No. 2 activities will be implemented through several methods. A cooperative agreement will be signed with CFPA to conduct training, develop IEC campaigns, coordinate technical assistance, manage the MIS and commodity supply systems, and coordinate the private sector program with affiliated FPAs. To make this possible, CFPA is in the process of becoming registered as a foreign PVO. The cooperative agreement instrument was selected because of the substantial AID involvement which is expected in the Project, primarily through the direct AID contracting of all technical assistance.

Coordination of the CFPA component with the on-going program elements implemented by the other institutions will continue to be a function of the Project Advisory Committee (PAC) which meets annually to work out scheduling and coordination in implementation issues. Day to day coordination will be arranged on the staff level by the CFPA program coordinator working with her counterparts in Population Council, IPPF, and BFPA.

Technical assistance for management training, development of the MIS system, private sector clinic development, commodity supply systems, and revenue generation will be contracted directly by RDO/C using international competitive procedures. RDO/C will also directly contract with the Health and Population Advisors.

In order to initiate some project activities during the contracting and procurement process, the Mission will fund approximately $50,000 of pre-award technical assistance with PD&S funds through a buy-in with the centrally-funded Enterprise Project. It will primarily be used to carry out the detailed feasibility studies for private sector clinics.

B. CFPA Responsibilities

The new components initiated under this Amendment will be implemented and coordinated through the CFPA under the overall direction of the Chief Executive Officer. CFPA has hired a program coordinator who will have primary responsibility for managing and coordinating project activities. The coordinator will work with the technical assistance team in all areas, be responsible for managing the MIS system and commodity logistics system, and assist in project contacts with the FPAs. The current training officer will have primary responsibility for arranging the timing of seminars and training and developing the regional training information clearinghouse. The audio-visual officer will be responsible for producing and distributing IEC materials and the public relations officer will be in charge of all revenue generation activities.

CFPA will subcontract with companies participating in the private sector clinic program to cover personnel costs, construction, and other costs not covered under the technical assistance contract.

Using the project-designed management information system, CFPA will produce quarterly reports on activities, costs, estimated impact, workplans, etc. and will forward copies of all such reports to RDO/C. In addition, an annual report will be prepared and sent to RDO/C detailing accomplishments of the previous year and setting out a workplan for the coming year. These reports will address logistics information, commodities consumed, revenues generated, forecasted needs, method mix, numbers of acceptors, numbers of defaulters, and linkages to program activities.

C. Barbados Family Planning Association

The BFPA will participate in selected training activities, development of work-based clinics, and in development of an MIS system. The executive director of BFPA will be responsible for coordinating all contacts with the Project and working with the technical assistance team. Staff members are currently being trained in computer usage to be prepared for introduction of the MIS system and one staff member will be assigned primary responsibility for the system. BFPA will arrange all contacts with industrial sites in Barbados in preparation for developing the work-based clinics.

D. Private Sector Clinics

The privatization activities will be coordinated through CFPA, with the local FPAs being the primary contact point for all in-country meetings and activities. Care will be taken to involve the FPAs at every

stage and assure that the program will be identified in each country with them. Primary responsibility for financial analysis and clinic design will rest with the technical assistance team, with assistance from affiliate counterparts. Funding for purchase of all clinic equipment and supplies will be included in the technical assistance contract. Construction/renovation expenses will be administered through CFPA. Engineering requirements would be minimal. Assistance in designing and supervising construction of an appropriate facility or renovating an existing structure could be provided by personnel from the Ministry of Work. Construction would be carried out by local contractors. Estimated construction costs are about $50/s.f. or approximately $25,000 per clinic.

E. AID Program Management

Program management and monitoring for all project activities will be the responsibility of the USAID Health and Population Advisors assigned as Project Officers, under the direction of the Chief of the Health, Population, and Education Office. Project funding will be provided for salary and expenses of the advisor(s) to be assigned monitoring responsibility.

The Project Officer(s), in collaboration with the contracting officer, will be responsible for competing, contracting, and monitoring the technical assistance contract. USAID will retain specific approval rights for any subcontracts or subgrants issued through CFPA for private sector clinics or specific activities on participating islands. USAID will also retain approval rights of new personnel hired by CFPA to work on the project.

F. Procurement of Goods and Services

All technical assistance will be obtained through a direct USAID contract through formal competition. The contract will include all required technical assistance as well as equipment and training for the MIS system and equipment and supplies to set up the family planning clinics in industrial sites. CFPA will be responsible for local procurement of materials when necessary, construction of family planning clinic facilities for work-based clinics, and contracting for its staff and production of IEC materials. The USAID Project Officers will be contracted directly by USAID. Contraceptive commodities will be purchased directly through AID SER/COM.

G. Implementation Schedule

Table 5
Implementation Schedule

Key Activity	Completion Date															
	1987			1988				1989				1990				
	6	9	12	3	6	9	12	3	6	9	12	3	6	9	12
PD&S TA buy-in arranged	*														
Pvt. Sct. Feasibility Study	***														
Draft RFP	*														
Sign CFPA Agreement	*														
CBD Notification	*														
IEC Campaigns begin	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Issue RFP	*														
Select TA Firm		*													
Issue PIO/T for TA Contract		*													
Sign TA Contract		*													
TA team Arrives		*													
Management Assessments: FPAs				*											
Baseline Study Completed				*											
Logistics System Training					*										
1st Private Sector Clinic (PSC1) Staff Training				**											
1st PSC1 Established					*										
2nd PSC1 Staff Trained					**										
2nd PSC1 Established					*										
Rapid Survey System Developed					*										
3rd PSC1 Staff Training					**										
3rd PSC1 Established					*										
MIS System designed & installed				******											
1st Management Training session					*										
Interim Evaluation					**										
Revenue Generation Training						*									
4th PSC1 Staff Training							**								
4th PSC1 Established							*								
5th PSC1 Staff Training								**							
5th PSC1 Established								*							
2nd Management Training Session									*						
3rd Management Training Session													*		
Final Evaluation															*

H. Evaluation Plan

The evaluation plan for this activity consists of both on-going monitoring of project activities by means of evaluative methodologies which will be developed for the project (i.e., the "rapid response" contraceptive usage surveys and data from the management information systems), an "in-house" (USAID) interim evaluation based on data received from the program, as well as a structured in-depth final evaluation.

Contraceptive prevalence surveys scheduled through the first amendment to the Project Paper comprise one quantitative data-gathering process which will continue to be used in judging program performance. These will be augmented by annual impact assessments of contraceptive usage and program impact. Programatically, it is anticipated that once the management information systems are on line, they will provide essential information both to the family planning associations themselves as well as to the CFPA and AID on the efficacy and efficiency of project inputs. This continuing review of program data will facilitate on-going assessments and mid-course corrections to fine tune activities for greater benefit.

An interim evaluation will be conducted by USAID in March, 1989 for the purpose of assessing progress being made by the CFPA and its affiliates towards the project goals. This interim evaluation will examine all program data generated from the CPSs, the "rapid survey" assessments, and the management information systems.

A final evaluation will be conducted in September, 1990. It will specifically attempt to assess the impact of the management training and information systems on program effectiveness and the effect improved management had on contraceptive prevalence levels in the participating countries. The evaluation report will make recommendations as to whether this strategy was an effective means of increasing contraceptive usage in the region.

A separate evaluation will be conducted to review the achievements and potential of the private sector clinic program. This evaluation will assess the impact of this means of service delivery on contraceptive prevalence in the workplace, financial feasibility of the program, and replicability of the program within the region without further subsidization. It will attempt to assess the relative cost effectiveness of such programming vis-a-vis other service delivery modes.

The evaluation plans for on-going Project activities will remain as described in Amendment No. 1.

I. Financial Review

A financial review of CFPA activities will be included in the cooperative agreement. Agreement language will prohibit the CFPA from disbursing these funds without prior written USAID approval.

VI. ANALYSES FOR AMENDED ACTIVITIES

A. Financial

1. Recurrent Costs: CFPA

CFPA currently has an annual budget of approximately $300,000, of which approximately 60% goes for staff salary and travel expenses, 20% is for production and distribution of materials, 20% is for administrative and office costs. Its revenues for the three year period of the amended project are projected to be $1.6 million from the AID grant, including salary payments for most of the employees and most of the materials production costs; $424,000 from IPPF which is for salary, meetings, overhead, and special projects; $75,000 from UNFPA for funding a special project to establish a data bank for FLE materials; $59,000 from a British PVO, Population Concern, for seminars and material development and $1,575 from membership fees. The AID grant will provide approximately 75% of CFPA's budget for the three year Project amendment period.

Under the best of circumstances, CFPA will not be financially independent in the foreseeable future. To a large degree, this situation is due to the nature of the institution. Neither public sector nor private sector, any PVO working in population planning will inevitably be dependent on outside financing to some degree because charging the full costs of services and commodities to the final users would result in a much lower demand and therefore would defeat the very purpose of the organization. This situation is by no means unique to the EC region--family planning associations throughout the world are dependent upon donor or charitable donations. Therefore, from a practical point of view, it is unreasonable to expect that an FPA will be able to be completely self-financing. Nor is it probable that they will have to be; it is unlikely in the extreme that all funding sources, including IPPF core funding, USAID population sector support, and other donor support, will be discontinued in the near future. This situation obtains to an even greater degree for the CFPA which does not provide family planning services to the community directly but rather seeks to serve the needs of the FPAs who do.

More importantly, the issue of institutional sustainability is not particularly critical to the achievement of the project purpose. Project activities implemented through CFPA being financed by this amendment will not require any recurrent cost financing to achieve their impact. The services provided by this project--IEC campaigns, improved program strategy, design, and implementation, and training--are self-contained. The promotional campaigns and training will have a direct and continuing impact on contraceptive utilization through greater public awareness and improved program management.

Although the project will be in the position of developing capabilities which cannot be supported without substantial continuing donor assistance, it is a reasonable assumption that such donor support will be forthcoming in future years, whether through USAID or through the many other government, international, and private foundation supporters of family planning efforts in the developing world.

2. Recurrent Costs: Private Sector Programs

The Project will finance development costs for the work-based family planning clinics under the privatization component on the condition that the recurrent costs will be covered by the sponsoring organization or firm. The clinics will generate revenue through the sale of services to employees, but such revenue may not be adequate to cover all operating costs. Therefore, the employers or sponsoring organizations will be required to make annual contributions to support the service. The owners of some of the firms interviewed clearly indicated that they would be willing to pick up a reasonable amount of operating costs if the Project covered the development costs. The level, degree and timing of cost-sharing by participating industries will be finalized prior to initiation of clinic development.

In other countries where family planning services have been successfully introduced into private sector firms, the firms themselves usually accrue direct financial benefits through reduced costs for pregnancy related fringe benefits, such as maternity leave and sick leave. In the EC countries, however, National Insurance Schemes cover all such costs and therefore any savings would be realized by the NIS rather than the sponsoring firm. In such cases, it may be possible for governments to assume some of the recurrent costs if negotiated carefully, including secundment of staff, donation of clinic space or relief from taxes, etc. The sponsoring firms would still receive benefits which will affect plant efficiency in the form of reduced absenteeism related to maternity and parental responsibilities, lower employee turnover and retraining costs, and improved employee morale and productivity. Although employers in the region have expressed a strong interest in making these services available, their willingness to continue covering the recurrent costs will depend on the level of support required.

Based on the feasibility study undertaken for this component (See Annex D), the following revenue and expense projections were developed assuming a high (75%), medium (55%) and low (35%) level of acceptors in the work site. The revenue projections were developed using assumptions about reasonable prices to charge for the services. The work-based clinics would be more convenient and private, offering a higher quality care than those available in public sector or FPA clinics, and therefore would be justified in charging somewhat higher fees but

still significantly less than the charges made by private physicians. The actual schedule of fees and prices will be evaluated through operations research to determine optimal systems of pricing the services and could be much higher than those conservatively estimated for the feasibility study.

Table 6
Revenue and Expense Projections for Work-Based Clinics
(US$)

	High Usage (75%)	Medium Usage (55%)	Low Usage (35%)
Revenue	7,500	5,500	3,500
Expenses	18,000	18,000	18,000
Deficit	(10,500)	(12,500)	(14,500)

Based on the the assumption of medium usage, the sponsoring firm would be required to contribute $12,500 per year, or approximately $22 per employee per year assuming an average number of 550 female employees in each plant. These figures are conservative, as some of the industrial sites have more women employees. In Barbados, where the average number of female employees in the Harbour, Newton, and Wildey Industrial Parks is 1,698, these conservative assumptions would be changed substantially and the program would require a much smaller subsidy from the sponsoring organizations. Given the severe population problems in St. Vincent and St. Lucia, special effort will be made to establish a program on those islands if a willing sponsoring organization can be found, despite the less favorable financial feasibility.

Detailed revenue and expense projections will be developed as part of the implementation of this component and employers will be presented with specific budgets for the clinics. At that point, the decisions will be made as to whether the cost of the clinics is higher than firms are willing to pay. Given the illustrative budgets shown above, the Mission believes that the estimated company contributions will be acceptable to the sponsoring firms.

B. Economic Analysis

Economic analysis of population projects is notably difficult. The value of an additional person to a society is not easily or comfortably reduced to economic terms and, unlike other factors of production, the potential contribution of each individual is unique. In spite of these difficulties, however, social investments must be

understood in terms of their probable impact on the economy and society. Some degree of measurement and assessment is necessary to justify the investment in relation to other possible investments. (Interestingly, the need for impact analysis is intuitively obvious if the project goal were pro-natalist instead of population control.) Common sense tells us that, beyond some extreme point, excess population will destroy a society that is no longer able to feed, clothe, house, or protect its citizens. The difficulty of knowing at what point a population crosses into this "excessive" zone, and therefore when and what type of action is needed, has stymied everyone from Rev. Malthus to present day economists.

Beyond the philosophical issues of quantifying the impact of population growth, the nature of the analysis presents formidable problems. The costs and benefits of population control may not be fully felt for generations, which makes such projects poorly suited to the standard economic analysis methods of discounting future values for present value comparisons. Estimation of the eventual costs and benefits over such a long period is complicated beyond measure by a series of intertwined production and consumption functions. Moreover, much of the impact of information and education campaigns will be motivational and will touch on many people indirectly, causing behavioral changes over decades.

With this in mind, the economic analysis attempts to provide some reasonable means of comprehending the economic impact of the project on three levels. The macroeconomic review considers the impact of the project on the economy as a whole. The microeconomic analysis looks at the economic impact of family planning on an individual family. The cost-effectiveness of this approach to population control will be discussed. In addition, an attempt will be made to relate project outputs in terms of contraceptive usage to impact on fertility rates.

1. Macro economic analysis

On a theoretical level, the process of analyzing the economic feasibility of a population project is straightforward. The value of an additional individual in an economy can be measured by the net lifetime production, which is the difference between the amount the individual produces in a lifetime and the amount that he or she consumes. An individual with a low level of productivity, living at or slightly above subsistence, will have a zero, or even negative, net lifetime production level. Therefore, analysis of a population project would use existing data and future projections on production, consumption, investment, government expenditures, savings, etc. to determine whether declines in fertility represent a marginal gain or loss to the economy.

In practice, this calculation is exceedingly complex and is made more so by the time factor inherent in individual production curves--i.e., children must grow up before becoming productive and old people become less productive. Therefore, any serious analysis must be based on some very broad assumptions. Marginal productivity of an individual's labor over a lifetime is highly dependent upon the ability of the economy to adequately utilize additional labor when that individual joins the workforce 15-20 years after birth. The ability of a future economy to efficiently utilize this individual is in turn dependent upon actions which will happen in the meantime--savings, investment, consumption, growth, environmental quality and productive capacity, education and health expenditures, productivity--many of which in turn are a function of the population level. In fact, it can be argued that population growth will have a real, although uncertain, impact on current productivity levels--i.e., mothers leaving the workforce to have children, the impact of psychic satisfaction of family life on productivity, etc. In the Caribbean, this calculation is made even more difficult by the historically high levels of migration, in some cases to the point of population declines. The economic cost of this flight of human capital must be balanced against the gains derived from repatriation of earnings, in-country investment, and return to the country after retirement.

The basic macroeconomic argument for population control is that if current marginal productivity of labor is low and falling, each person born today over and above the replacement rate will consume more than they produce over a lifetime. Savings, being a function of per capita income, will be smaller for a given level of production with a growing population. Government expenditures are related to population size, so greater amounts of public investment must be made in social services. The combination of these three pressures result in lower levels of capital investment. Since future changes in economic efficiency flow mainly from current levels of capital expenditures, large current populations reduce the ability of the economy to grow and create employment for the children being born.

While the calculation of numbers to reflect costs and benefits over the next 60 to 80 years is largely an exercise in economic pyrotechnics, the application of common sense within this theoretical framework can be useful. Current unemployment rates are indicative of the current marginal productivity of labor in the region. Whatever the "full employment" level of the EC nations, it is surely well below the current unemployment levels of 15-30%. In order to improve utilization of the current labor supply, the total production of the economy would have to grow at a faster rate than the increase of the population, assuming a constant level of labor intensiveness. This is clearly not happening in most of the EC countries. Unemployment rates increased substantially during the recession years of 1980-1984 (Table 7). While the situation since that time has improved in some countries, creation of new jobs has not significantly reduced the high levels of unemployment. Therefore, it is reasonable to assume that the current marginal

productivity of labor and average productivity of labor is low and falling. Under these circumstances, any additional births over the replacement rate will probably increase unemployment and result in negative lifetime production. Even if a large percentage of these additional individuals migrate, the EC nations bear the full brunt of the consumption phase of early life while gaining only a small portion of future productivity.

Table 7
Unemployment and Growth in Employment in EC, 1980-1984

	Unemployment Rate 1980	Unemployment Rate 1984	Annual Growth in employment 1980-1984	Annual Growth in workforce 1980-1984
Antigua	10	20 (a)	2.4	2.1
Dominica	13	20	NA	3.3
Grenada	16	25-30	-2.0	2.0
Montserrat	7	NA	NA	NA
St. Kitts & Nevis	10	19	1.1	2.2
St. Lucia	16	25	1.8	3.5
St. Vincent	17	23	1.3	3.5
Barbados	7	18.3	-2.0	-0.1

(a) This figure for Antigua is probably high
Source: Zaba (1986), USAID (1985)

On the basis of this framework, it is reasonable to argue that any additional births over the replacement level will represent a drain on the economy. Therefore, the state is justified in spending the equivalent of the lifetime net consumption costs of the population above the replacement level in attempting to control the population. Even this significantly understates the true cost to society of high unemployment, potential increase in crime, degradation of the resource base, and social and political instability. As island states, the carrying capacity of the EC nations is notably finite and the costs of exceeding that carrying capacity are difficult to estimate. In this, each island is a microcosm of the world and to some degree the experience of each of these islands will be instructive as to what awaits the rest of the world.

The Project activities, of course, are not expected to reduce population growth rates to the replacement levels. Therefore, some relationship must be developed between project activities, contraceptive prevalence rates, and impact on population growth rates.

a. Linking Contraceptive Usage to Fertility

The indices of project accomplishment are in terms of the direct impact of project activities--more couples using contraceptive techniques. However, the measurement of project benefits are all in terms of costs and benefits associated with actual births. Clearly, the ultimate goal is fertility reduction. Several short-cut

methods can be used to estimate the impact of contraceptive usage on fertility rates. For purposes of this analysis, we will use the general fertility rate applied to the number of additional women contracepting each year. Rather than simply adding up the number of women, it is important to look at the number of women per year who are contracepting because the important issue is births per year. The general fertility rate (GFR), which is the number of children born per thousand women of childbearing age, is the best measure available for this purpose. However, this calculation actually substantially understates the actual impact because the GFR represents the universe of at-risk women whether or not they are sexually active (the CPS's indicate that about 60% would be sexually active). The women interested in contraception, however, are by definition sexually active and therefore much more likely to have children. While a more rigorous analysis can be made using age specific fertility rates and contraceptors, the general analysis is adequately informative for purposes of this illustrative analysis.

The formula to be used is:

$$\text{Births averted} = \frac{c1 * GFR}{1000} + \frac{c2 * GFR}{1000} + \frac{Cn * GFR}{1000}$$

where c1 equals the number of additional women contracepting in the first year, c2 in the second year, etc. GFR represents the general fertility rate (number of children born per 1000 women of childbearing age). The anticipated result of the project, if the contraceptive prevalence rate increases from 36% to 40%, is shown in Table 8.

On the basis of this analysis, the following estimations can be made of the relationship between contraceptive usage and fertility.

Table 8
Couple Years of Protection and Impact on Fertility

	Total number of women of reproductive age	Additional contraceptors	Reduction in unwanted pregnancies
1988	190,000	7,600	874
1989	195,000	7,800	897
1990	200,400	8,016	922
1991	203,000	8,120	934
1992	206,000	8,240	948
1993	209,000	8,360	961
1994	212,000	8,480	975
1995	215,000	8,600	989
1996	218,000	8,720	1,003
1997	221,000	8,840	1,017

Source:
Women of reproductive age from UNFPA, interpolated for in years.
Assumption that CP rate increases from 36% to 40% average for region.

The impact of this reduction in fertility would be a reduced level of of consumption. Assuming that beyond the replacement level the population will be marginal producers and production will just cover consumption once they start working, the net excess consumption will be that amount consumed during the pre-work years (age 0-15). Using the conservative amount of $200/year as representing half of adult consumption and assuming an inflation rate of 4%, the net present value of this 15 years of consumption would be $1,943 per person with a discount rate of 10%. On these assumptions, the discounted value of the resources freed for other uses (i.e., not consumed) by the estimated reduction in fertility through 1997 will oe $11,224,283 using a discount rate of 10%. While these figures by no means reflect the value of human contribution, they do give some indication of the amount of resources affected in comparison to the project costs.

2. Micro economic analysis

Micro level benefits of additional investment in family planning, for either public or private sector activities, exist when there is a substantial unmet demand for family planning services and the cost of contraception doesn't exceed the cost of having children. This demand is indicated where there is a difference between desired and actual family size or the number of reproductive age women who do not want additional children and yet are not practicing family planning. According to some of the contraceptive prevalence surveys, as many as 44% of women with 3-4 children indicated that the last pregnancy had not been wanted and as many as 60% - 80% of women over age 30 did not want any additional children. More to the point, 20-40% of the younger women also said that they did not want any more children.

As noted, over a fifteen to twenty year period, the primary impact of a population project is to decrease consumption. On a family basis, this means that income and consumption per remaining family member is increased. A rough calculation could be made by assuming that a child aged 0-4 consumes one-fourth the average adult amount, children of 5-9 consume about one-half; and children 10-14 about three quarters. With this rough calculation, a child consumes on the average one-half of the present per capital adult consumption per year through age 15. Therefore, if the costs of obtaining and purchasing contraceptive information and commodities are less than that level, they should be financially attractive. (The implicit assumption in this analysis is that the costs of childrearing will be directly borne by the mother. In the case of pregnancies in young women still living at home, the primary financial burden may well fall upon the baby's grandparents rather than the mother.)

In the EC region (excluding Barbados with its much higher standard of living), the average per capita consumption is approximately $310. Household surveys for the region do not exist, so one can only estimate what adult consumption might be. A conservative estimate would place average adult consumption around $400. The average cost of obtaining contraceptives, including transportation, lost wages, and the cost of the contraceptives themselves, might range from $60 to $100, depending on a number of variables, including type of contraceptive, employment, travel distance, etc. (based on estimates in the Mamlouk report). Although such numbers are at best only very rough approximations, they do indicate the order of magnitude by which the costs of having children outweigh the costs of contraception. Therefore, it is clear that family planning activities are attractive on a micro basis if the couple does not intend to have additional children.

The analysis of the balance of costs and benefits on a micro level is fairly straightforward for the privatization elements of the project. Assuming that recurring costs are fully covered, the cost-benefit balance of the activity will be measured by its success or failure. If employers and employees are willing to pay the full costs of the program, then they are valuing the benefits at a level at least equal to the costs. The benefits to employees may include many intangibles such as convenience, peace of mind, etc. The benefits to the employer will reflect not only financial savings for medical costs and sick leave, but also increased efficiency in the workplace due to reduced absenteeism, lower retraining costs, higher morale, and improved health. The financial feasibility of this component is treated separately in the financial analysis.

3. Cost effectiveness

A thorough cost-effectiveness or cost-efficiency analysis cannot be made for each project component or FP educational or delivery approach due to lack of relevant data. The project components, particularly the management training, MIS system, and operations research, are designed to produce this data for future program review and evaluation.

Nonetheless, it is obvious that the nature of the project activities are such that they lend themselves most appropriately to a regional rather than a national focus. Particularly in the EC region, the small size and limited resources of each island argue strongly for a single regional center for production and distribution of materials, technical assistance, training, etc. The marginal cost of adding an additional country to the training program or distribution of materials is negligible compared to the costs of establishing separate programs in each country.

The media-based, promotional nature of a population program lends itself most efficiently to areas with large populations, thus allowing the program to take advantages of marketing economies of scale. The absence of such economies in the scattered islands with relatively small populations means that such programs are inherently more expensive per new contraceptor than programs in other areas might be. The same problem holds true for the privatization activities, the development costs of which are being borne by relatively small numbers of women in each workplace. However, this statistical problem does not lessen the potential dangers of uncontrolled population growth on the islands. Therefore, to some extent, the EC must be prepared to spend more per capita on population programs than other regions might, just as it must make other concessions to its geographical and demographic characteristics.

In terms of program strategy, however, some issues of cost effectiveness arise. The alternative approaches even for a regional program are to widely distribute educational and motivational efforts throughout the region or to concentrate such efforts on the areas with the greatest problem or the highest potential for response. An analysis of the strategy of saturating the high risk islands, such as St. Vincent and St. Lucia, with a combination of educational and motivational campaigns, will be evaluated as part of the operations research component. The degree to which the response to each additional input exceeds the response achieved elsewhere will be useful in estimating optimal media mix and exposure levels elsewhere, although the results may not be directly transferable due to cultural differences.

The activities to be funded under this Amendment will clearly have an impact on contraceptive knowledge and usage through the campaigns and improved management. In addition, the private sector program will leverage additional resources into family planning activities, thus increasing the total resources available for family planning purposes. A comparison of this analysis with previous analyses for this project will show that no new benefits are expected to accrue as a result of the new activities. This is misleading because previous analyses have not considered the costs of the components included in this Amendment, even though these activities have been planned prior to Amendment #1. Therefore, the estimated benefits are contingent upon successful completion of all of these activities.

Previously, the number of beneficiaries has been underestimated because beneficiaries were measured by the number of additional women contracepting at the end of the Project. However, the relevant statistic is not a static before and after reading, but rather the number of couple years of protection (CYP), or the number of contraceptive person years. Each year of protection represents a reduction in the fertility rate for that year and hence is an end in itself.

Using the figures in Table 8 above, and assuming that project benefits will continue to accrue for a period of ten years, the total number of additional CYP as a result of this project will be 82,776. Given the nature of the project activities (policy changes, management improvements, education campaigns), it is not unreasonable to assume that project benefits will continue to accrue for at least ten years. Given this assumption, the cost per additional CYP will be about $49 for expenditures from FY 1987 to the end of the project.

C. Institutional/Administrative Analysis

1. Caribbean Family Planning Affiliation (CFPA, Ltd.)

a. Background

The Caribbean Family Planning Affiliation, Ltd., was established in 1973 in joint affiliation with IPPF/WHR to provide support to its affiliated Family Planning Associations in the Eastern Caribbean. It currently serves 21 affiliated FPAs in the region (Barbados, Jamaica, and Trinidad and Tobago are not members and are independently affiliated with IPPF/WHR). Under the terms of USAID assistance, the FPAs of the following seven member countries participate directly in project funded activities: Antigua/Barbuda, Dominica, Grenada, Montserrat, St. Christopher and Nevis, St. Lucia, and St. Vincent and the Grenadines. The associations of the British Virgin Islands, Anguilla, Aruba, Belize, Curacao, St. Martin, and Suriname are eligible for limited support only and the associations of Guadeloupe, Martinique, Guyana, and the U.S. Virgin Islands are not eligible for any project support.

The overall goals of CFPA are to "motivate at-risk men and women to limit and space their families and to develop the institutional capacity of FPAs and public sector institutions and other private sector institutions to respond to the projected increases in demand for family planning services". Its primary activities have been the development and promotion of IEC materials, conducting contraceptive prevalence surveys, training, and conducting a radio program for NFPA. CFPA is currently developing two new projects--a Data Bank/Clearinghouse for family life education materials financed by UNFPA and development of seminars and workshops financed by Population Council. These activities are separately funded and the data bank activities will be performed by staff members dedicated to that one task.

b. Technical and Managerial Capability

The technical capability of CFPA in developing educational and informational campaigns and in conducting training has been well proven over the past several years as it has developed the reputation of being the predominant source of high quality educational and motivational material in the region.

CFPA is headed by a Chief Executive Officer and has nine other full-time staff members including a training officer, audio-visual officer, fund-raising/public relations officer, financial manager, program coordinator, office manager, and three support staff. In addition, a documentation officer and a secretary are working on the UNFPA data bank project and one secretary works on IPPF activities. The staff capabilities are adequate to perform their functions.

CFPA is currently receiving USAID funding as a subgrantee of IPPF/WHR under Project 538-0116. Current audits reviewed by the RDO/C financial analyst have shown that CFPA is financially sound and has adequate financial management. The areas in which CFPA management is not as strong are primarily related to program efficiency and will be addressed through training and the use of technical assistance provided by the Project. These management areas are not crucial to the successful implementation of the project activities because of the addition of technical assistance and therefore do not represent a significant obstacle to working through CFPA.

c. Absorptive Capacity

In the past, CFPA has administered a program of approximately $300,000 per year, of which approximately $190,000 was from USAID projects through the IPPF/WHR subgrant and approximately $95,000 was from IPPF's own resources. The remainder of CFPA's revenue has come from fund raising, member fees, and miscellaneous income sources. The current project will increase its annual operating budget to approximately $465,000 per year, an increase of 55% over current levels. This increase will be used to pay for two additional staff members (a program coordinator and a bookkeeper), to produce IEC materials, and to conduct training. CFPA management will also be responsible for coordinating the use of a technical assistance team provided under a direct AID contract.

The primary impact of this grant on CFPA will be in two areas:

1) As a new non-U.S. PVO and as direct grantee of the project funds, CFPA will have to comply with many new financial and organizational requirements, including development of detailed cash flow projections, responsibility for liquidating vouchers on a timely basis, and compliance with AID requirements for local contracting and procurement.

2) CFPA has heretofore concentrated on provision of IEC materials, regional advocacy of FP programs, and some training. The activities included in this Amendment will expand its role into providing services directly to affiliates, including management technical assistance, data processing and analysis through the MIS system, and commodity supply coordination and distribution.

In the judgment of the Mission, CFPA will be able to handle the increased management burden imposed by this project without undue difficulty given the additional staff to be hired and the assistance of the technical assistance team. The AID project officer(s) will work closely with CFPA management to assure that they have an adequate understanding of AID contracting and advance payment requirements.

d. Alternative Implementing Organizations

During project design a consultant team reviewed alternative organizations through which to work: the Caribbean office of IPPF, the Barbados Family Planning Association, and CARICOM. It also explored the possibility of working through non-indigenous consulting organizations. The team recommended that the project be implemented through CFPA to reduce the current complicated structure of program management in population planning and to increase reliance on local institutions. The team specifically noted CFPA's excellent relationships with the FPAs and governments as well as its reputation as a provider of high quality IEC materials in recommending it as the primary implementing organization. There are no alternative organizations which would be able to implement this project more effectively than CFPA.

2. Barbados

The Barbados Family Planning Association (BFPA) is the oldest and most effective family planning institution in the region, having just completed its 31st year of operation. The BFPA is staffed by twelve professionals, including one full-time doctor, six nurse-midwives, and five other technical and administrative staff. The annual budget is B$860,000, of which 14% is derived from fees and service charges, 5% from fund-raising, 63% from government subsidies, and 18% from IPPF. BFPA is the major provider of family planning services on the island, with clinics providing daily service. Commodities are sold at a subsidized rate in a well organized CBD distribution system. It also runs a series of IEC activities in the community with a range of institutions and cooperates closely with the Ministry of Health in providing post-partum services to mothers who deliver at Queen Elizabeth Hospital.

The contraceptive prevalence in Barbados is 38% and population growth is largely under control at roughly the replacement level.

3. CFPA Affiliated FPAs

Antigua: The Antigua Planned Parenthood Association (APPA) is staffed by thirteen people, including an executive director, two field workers, one CBD officer, three project officers, four technical assistants, and two support staff. In addition, three

part-time sessional doctors work at the clinic. The annual budget of the APPA is around $75,000, of which $34,000 comes from fees and service charges, $51,800 is provided from IPPF, and $16,000 is from other donors. The other revenue is from fund-raising, member fees, etc. APPA is the primary provider of services and IEC on family planning on the island, with a clinic/office in St. John's which provides clinical services twice weekly. The CBD program has outlets in other parts of the island, but these do not reach all communities. The Government's role in family planning has been to allow public health nurses to distribute commodities out of their clinics at no cost. This is done on a haphazard basis in about a third of the clinics. APPA also has a sex education program in selected government schools and counseling sessions in the clinics. The contraceptive prevalence rate in Antigua is around 31%, the lowest of the countries surveyed.

Dominica: The Dominican Planned Parenthood Association (DPPA) is primarily active in IEC activities, with a limited role in distributing commodities. It also has an active community outreach program aimed at youth. The six staff members (an executive director, two FLE officers, an accountant and two support staff) operate on an annual budget of EC$63,895. The revenues primarily come from IPPF and AID projects, with some additional revenue derived by fundraising and sale of contraceptives. Approximately 37% of the women in fertile age groups in Dominica are using contraceptives.

Grenada: The Grenada Planned Parenthood Association is involved in IEC activities, operates a clinic at its headquarters on Scott Street, St. George's and at Grenville and manages a CBD program. The staff of five persons includes an executive director, a family life educator, two clinic nurses and a secretary. The annual budget is EC$85,000 of which 51% comes from external sources, 36% from contraceptives, donations and fees, 12% from fund-raising, and 1% from membership fees.

Montserrat: The Montserrat Planned Parenthood Association, an affiliate of IPPF, has been the major provider of family planning services on the island to date. It operates a clinic in Plymouth where subsidized commodities and free services are provided. The three person staff, comprised of a director, youth officer and driver/projectionist, is funded 68.6% through local fund-raising with 17% of the revenues coming from sales of services, 8% as a grant from government and the balance of 6.4% from external sources. The annual budget is EC$37,000. Fifty-three percent of the women on the island are using contraceptives at the time of the most recent CPS.

St. Kitts-Nevis: The St. Kitts-Nevis Planned Parenthood Association has an office in Basseterre. It is primarily active in IEC activities and in distributing commodities through a CBD program. The three person staff consists of an executive director, administrative assistant and secretary. Its annual budget of EC$113,000 is supported by IPPF contributions of EC$93,800, AID projects, and small amounts from membership fees and fund-raising. The most recent CPS indicated that 40% of the women-in-union were using contraceptives, but this figure might be too low.

St. Lucia: The St. Lucia Planned Parenthood Association is the primary provider of family planning services in a combined program with the Ministry of Health. The association has a clinic in Castries and distributes commodities to government clinics over the island. Programs include a CBD program, IEC clinics, and youth outreach clinics. Government support for family planning has increased in recent years and MOH staff are made available to the association through cooperative agreements. The 12 full-time staff members include the executive director and clinic nurses. The annual budget of EC$110,000 is comprised of 53.6% from sale of commodities and clinic services and 46.4% from external sources including IPPF grants.

St. Vincent: The St. Vincent Planned Parenthood association is primarily involved in IEC activities and an FLE program with the government National Family Planning program providing the services. Family planning services are available on a daily basis from the MOH clinic in Kingstown and on certain days in other clinics. The five person staff consists of the executive director, three family life educators, and a typist. The association budget is EC$75,987, of which EC$42,880 comes from IPPF, EC$11,703 from other donors, EC$300 from sale of commodities, and EC$12,000 from subscriptions and fund-raising. At the time of the most recent contraceptive prevalence survey, 33% of the fertile women in St. Vincent used contraceptives. A follow-up survey is scheduled in 1987.

D. Social Soundness Analysis

A comprehensive update of the social soundness analysis was made in September, 1986 for the first amendment to the Project. The activities to be funded under this amendment represent a continuation and expansion of the original activities of family planning services and promotion. The proposed new activities, management improvement and providing family planning services through employee benefit plans, are simply means of improving and expanding the delivery base for the same family planning activities. Therefore, no new issues on the social acceptability of family planning are raised by this amendment and the social soundness analysis perfonned for the first amendment is still valid.

VII. SPECIAL PROVISIONS

1. Workplans

Prior to disbursement for project activities other than for the costs of CFPA Staff and operations, the Recipient will, unless agreed to in writing, furnish in form and substance satisfactory to AID a work plan for the first year of operation that will detail proposed activities, implementation timing and the projected expenditures.

Similar acceptable annual work plans will be submitted to RDO/C at the beginning of the second and third year of the Agreement.

2. Contracts and Subagreements

Notwithstanding the terms of Standard Provisions 15 and 17 entitled "Procurement of Goods and Services "and Subagreements", respectively, CFPA will submit all contracts and subagreements to be awarded to the Agreements Officer for prior approval.

3. CFPA Professional Staff

CFPA will consult with RDO/C regarding the selection of all professional staff.

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Life of Project:
From FY87 to FY90
Total U.S. Funding: $7,666,000
Date Prepared: May 18, 1987

Project Title & Number: POPULATION AND DEVELOPMENT PROJECT, (538-0039), AMENDMENT # 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes:	Measures of Goal Achievement		Assumptions for achieving goal targets:
To bring the population and resources into better balance within the Eastern Caribbean by reducing the birth rate	- GNP per capita increased. - Reduced social service deficit.	Annual statistical and economic reports.	- Productive capacities to provide social services and employment. - Natural resource deterioration is halted.
PROJECT PURPOSE:	Conditions that will indicate purpose has been achieved: End of project status.		Assumptions for achieving purpose:
To increase the impact and sustainability of family planning activities in the Eastern Caribbean	1. Contraceptive prevalence rate for the region is at least 40% by 1990. 2. Support for family planning (FP) on a national level. 3. Increased geographic and psychological accessibility to FP services through a broad range of service delivery modes. 4. A stronger role by private sector in delivery of FP services. 5. Greater self-sufficiency, improved management capability and less donor reliance by regional private FP umbrella organizations and national FP associations (FPAs). 6. Well-trained cadre of professionals implementing FP programs in the region in private & public sectors.	1. Contraceptive prevalence surveys (CPSs) and service statistics 2. Cabinet-approved population and medical policies. 3. Operations Research (OR) and other user survey results. 4. User statistics, program reports. 5. Project evaluation, review of annual reports. 6. Reports on training programs and training evaluations.	- Barriers to access to and use of contraceptives will be reduced. - Private sector and unions will appreciate the connection of FP services to economic improvements in the workplace. - Incentives will exist to maintain trained professionals in the region.

Outputs	Magnitude of Outputs outputs:	Assumptions for achieving	
1. Private sector FP programs established.	1. 5 private sector programs.	1. Project reports, evaluations	FPA & select employees will be given time & opportunity for training in management of such
2. Management assistance programs implemented for the CFPA and FPAs in program and financial management, staff upgrading, revenue generation, management information systems (MIS) development and logistics managment.	2. 1 round of needs assessments in each program country; 2 regional and annual (3 per country) country-specific training programs; training materials.	2. Project reports, evaluation, service delivery modes. Training will increase the quality of services provided.	
3. MIS designed and in place in the CFPA and affiliates.	3. 8 MIS (1 in each country and CFPA).	3. Monthly management reports generated by the system	
4. Targetted IEC campaigns conducted for special audiences.	4. 4 radio spots, posters and billboards; 7 "influentials" seminar campaigns per country.	4. Monitoring media and media schedules	Government support of FP and its public promotion will continue.
5. National population and medical policies established.	5. 7 National Task Forces created; 9 country reports distributed; medical policies in each program country; population policies in 4-5 countries.	5. Published population and medical policies	
6. Non-clinical contraceptive distribution programs established.	6. 1 Community-based distribution (CBD) program in 4-5 countries; 1 contraceptive social marketing (CSM) program in 5-6 program countries.	6. Project reports, evaluations & contraceptive sales reports commodities for these programs	Governments will continue allowing duty-free entry and advertising for
7. Training programs for nurses, doctors, allied health workers, teachers, and other FP technicians.	7. 20 nurses trained in advanced fertility management; 14 nurses trained as trainers of FP; FP integrated into nursing curricula; 8 doctors trained in voluntary surgical sterilization; 400 allied health workers and school administrators trained in FP; 1 trainer-of-trainers instructor at each teachers' training college; 280 teachers trained in family life education; refresher training for the above and core material developed for FP and sex education.	7. Training records, project reports, training evaluations and reviews of materials developed	Training will result in more capable service providers which will translate into better delivery of services
8. Regional clearinghouse of training programs throughout the Eastern Caribbean.	8. One regional clearinghouse at CFPA.	8. Project reports will share and coordinate their FP work & training schedules.	Other FP service providers
9. MOH clinics renovated and equipped for FP programming.	9. 50 clinics renovated & equipped	9. Contractor reports	
10. Operations Research programs undertaken and the OR method institutionalized in the region.	10. 15 OR studies undertaken and program managers from each FPA and MOH trained in OR methodology	10. OR final reports, evaluation	
11. Contraceptive Prevalence Surveys (CPSs)--baseline and follow-up studies.	11. Baseline CPSs in 8 countries; follow-ups in 5 countries	11. PS reports	

Inputs:	Implementation Target (type and Quality) inputs:	Assumption for providing
1. Technical Assistance	Technical Assistance	
Long-term	18 person-months	Project reports, workplans
Short-term	16 person months	
2. Participant Training	Participant Training	"
(In country:)		
FPA staff	80 staff & volunteers	
Private Sector Project Managers	15 managers	
Nurses	20 family planning nurses	
Allied Health Workers	400 health workers	
Teachers	280 teachers	
(Third Country:)		
Physicians	80 physicians	
Nurses	14 nurses as FP trainers	
3. Commodities	Commodities	PIO/Cs, work orders
Contraceptives	AID/W contraceptives ($443,000)	
Microcomputers	8 micros (1 per country and CFPA)	
Private sector clinic equipment	See Annex 4 for equipment list	
Public sector clinic equipment	For 50 clinics	
4. Project Management	Project Management	
CFPA Grant	Personnel, administration, supplies ($1.632 million)	
CARICOM	Personnel, administration, supplies ($729,000)	
IPPF	Personnel, administration, supplies ($3,373,000)	
Tulane/Population Council	Personnel, administration, supplies ($516,000)	
The Futures Group	Personnel, administration, supplies ($270,000)	
RDO/C Project Officer(s)	($300,000)	
5. Construction	Construction	Work orders, workplans
Public sector clinic renovation	50 clinics	
Private sector clinic renovation/construction	5 clinics	

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ACTION AID-2 INFO AMB DCM CHRON 4

ANNEX B

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O 270217Z FEB 87
FM SECSTATE WASHDC
TO AMEMBASSY BRIDGETOWN IMMEDIATE 7334
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UNCLAS STATE 056655

LOC: 013 535
27 FEB 87 0218
CN: 06101
CHRG: AID
DIST: AID

27 FEB 1987

ACTION	HPE
DIR	✓
D/DIR	✓
MGT	✓
RLA	
RCO	
PO	✓
PO/ED	
PO/POD	
CONT	✓
PD&M	
POD	✓
PSD	
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DUE:	27/03/03
TAKE	
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NO:	

AIDAC RDO/C FOR AL BISSETT

E.O. 12356: N/A
TAGS:
SUBJECT: POPULATION AND DEVELOPMENT AND IMMEDIATE HEALTH CARE DELIVERY PROJECTS

REFS. BRIDGETOWN 00476; BRIDGETOWN 00761

1. AA/LAC HEREBY: (1) CONCURS IN INCREASING LOP FUNDING FOR THE POPULATION FOR DEVELOPMENT PROJECT BY DOLS 3 MILLION TO A NEW TOTAL OF DOLS 7.666 MILLION; (2) AUTHORIZES THE RDO/C MISSION DIRECTOR TO REVISE THE PROJECT PURPOSE AND AMEND THE PP; (3) APPROVES THE CARIBBEAN FAMILY PLANNING ASSOCIATION, LDT. AS THE GRANT RECIPIENT ON A NON-COMPETITIVE BASIS; AND (4) EXTENDS THE PACD FOR THE PROJECT TO 12/31/90.

2. AA/LAC HEREBY APPROVES A TWO MONTH NO-COST PACD EXTENSION FOR THE IMMEDIATE HEALTH CARE SERVICES PROJECT (543-0003). AFTER RECEIPT AND REVIEW OF THE PROPOSAL FROM PROJECT HOPE AND DISCUSSION OF THE MISSION'S PROPOSAL AT THE ACTION PLAN REVIEW, DECISIONS WILL BE TAKEN ON THE PROPOSED LOP INCREASE FOR THE IMMEDIATE HEALTH CARE DELIVERY PROJECT, PACD EXTENSIONS FOR BOTH PROJECTS, AND AA/LAC CONCURRENCE IN NON-COMPETITIVE SELECTION OF PROJECT HOPE AS A GRANT RECIPIENT. WHITEHEAD
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PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance, B (2) applies to projects funded from Development Assistance Loans; and B. 3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP-TO-DATE?	Not applicable, regional project
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 525; FAA Sec. 634A Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project;	A Congressional Notification was sent forward and expired on March 24, 1987.
2. FAA Sec. 611(a) (1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	Not applicable, Project contains total of $125,000 for construction and renovation activities.
3. FAA Sec. 611(a) (2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	No action required.

4.	FAA Sec. 611(b); FY 1987 Continuing Resolution Sec 501 If for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)	Not applicable
5.	FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	Not applicable
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multi-lateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	This is a regional project.
7.	FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monpolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	To the extent the project fosters private sector participation in providing family planning services, it will support (b).

8.	FAA Sec. 610(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs including use of private trade channels and the services of U.S. private enterprise).	Not applicable
9.	FAA Sec. 612(b), 636(h); Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services and foreign currencies owned by the U.S. are utilized in lieu of dollars.	Not applicable
10.	FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No
11.	FY 1987 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	Not applicable
12.	FY 1987 Continuing Resolution Sec. 558. (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study variety improvement or introduction consultancy, publication, conference, or training) are such activities	Not applicable

(a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?

13. FY 1987 Continuing Resolution Sec. 559. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807." which allows reduced tariffs on articles assembled abroad from U.S. made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

The project activities are designed to increase the impact and sustainability of family planning programs in the Eastern Caribbean. As such, they have no direct bearing on the manufacture for export to the U.S. or to third country markets of the cited goods. Hence, the Lautenberg amendment is deemed inapplicable in the case of this population activity

14.	FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?	Yes
	Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests and help countries identify and implement alternatives to colonizing forested areas: (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help and destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical	Not applicable

forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies.

15. FAA Sec. 119(q) (4) - (6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? — Not applicable

16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? — Not applicable

17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? — No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and ensuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions, (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status, and (e) utilize and encourage regional corporations by developing countries.

The project will attempt to improve the lot of urban and rural poor women by allowing them free choice in stemming the number of unwanted pregnancies and improving economic standards.

b. FAA Secs 103, 103A, 104, 105, 106, 120-121 Does the project fit the criteria for the source of funds (functional account) being used?

Yes

c. FAA Sec. 107. Is emphasis placed on use of appropriate technology relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Not applicable

d.	FAA Sec. 110, 124(d). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	This requirement does not apply to regional projects.
e.	FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes. The targetted group is poor urban and rural females.
f.	FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	The Project utilizes local resources manpower to the maximum extent possible and was developed jointly with host governments and other local institutions
g.	FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No.

	Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization?	No.
	Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning.	No.
h.	FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?	No.
	If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?	No.
i.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes.
j.	FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges, and universities and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	None

k.	FAA Sec. 118(c) (13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?	Not applicable
l.	FAA Sec. 118(c) (14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce postive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas.	Not applicable
m.	FAA Sec. 118 (c) (15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (c) the colonization of forest lands or (d) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute	Not applicable

significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

Opportunities for Private Sector Family Planning Service Delivery Projects in the Eastern Caribbean

It is acknowledged that industry in the Eastern Caribbean States is not as developed as in many other AID-recipient countries, perhaps partially due to geographic as well as other reasons. Although this constrains the potential for the expansion of family planning services in the industrial sector, it does not preclude all opportunities for such a program. Opportunities for community-based distribution in industry do exist and have been somewhat developed (e.g. Belle Fashions in St. Lucia). However, a critical mass of potential acceptors for the provision of on-site services in any single firm is unlikely to be commonplace.

Nonetheless, this absence of a critical mass of potential acceptors in single firms is mitigated by the existence of industrial estates [1] in at least four countries which effectively centralize the location of the Eastern Caribbean's relatively smaller firms. It is these industrial estates that present the best opportunity to develop family planning activities in the private for-profit sector. The implementation of these family planning services would distribute the recurrent costs of family planning among users, employers and, perhaps, unions while also alleviating part of the burden on public sector resources. Due to high levels of absenteeism, staff turnover, retraining and other costs that can be linked to child care and child illness responsibilities among employees, a number of the leaders of industry and of specific firms have expressed their interest in supporting these activities.

For the purposes of this exercise, sites were visited in the countries of St. Vincent, St. Lucia, and Barbados and information was obtained for Grenada. Other potential sites in the Eastern Caribbean have been mentioned as well, particularly Antigua, although these have not been investigated.

Information obtained from the St. Lucia National Development Corporation and interviews of the largest employers in St. Vincent and St. Lucia, two countries with the highest percentage of women of reproductive age, highest total fertility rates, and lowest contraceptive prevalence rates, reveals the following information about the largest employers in these two countries:

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[1] Factory shells are constructed by the local governments at central industrial estates and combined with other incentives to attract firms to manufacture locally.

Table 1

St. Vincent and the Grenadines - Camden Park Industrial Estate

Firm	Approximate Work Force	Estimated Female Work Force
St. Vincent Children's Wear	250*	250
Container Corporation	60	5
St. Vincent Sporting Goods (Wilson)	200	100
Pico (St. Vincent) Ltd.	125	125
St. Vincent Electronics	80	80
Flour and Rice Mills	50	?
Pipe Factory	20	?
Brewery	50	?
	835	560

* Also employs approximately 1,500 women working at their homes.

Table 2

St. Lucia

Firm	Approximate Work Force	Estimated Female Work Force	
Castries' Apparel	400	400	
Belle Fashions	600*	600*	
Crown American	135	100	
Cariman	110	100	
Brabo	115	100	
Hortex	150	140	
Nehoc	100	85	
Kosiah MIlls	100	90	
Data	100	90	
Roses's Apparel	65	60	
Harlim	65	60	
Soft Furnishings	65	60	
Manu-Matics	60	55	
Pyramid Fashions	60	60	
Ramco Plastics	60	45	
St. Lucia Garments	30	25	
KLV	30	25	
Tolyn	25	20	
	2,270	2,115	93%

* Currently employ over 400 women, plan to expand to 600 this year.

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As a rough indicator of total employment on St. Vincent and St. Lucia, the St. Vincent Employer's Federation estimates its membership as 40 firms employing a total of approximately 4,000 workers, considerably exceeding the number of workers at the Camden Park Industrial Estate. In St. Lucia, the National Insurance Scheme [2] (NIS) reports that 17,000 workers contributed to the NIS in 1986, although NIS estimates that approximately 12,000 workers are covered by the NIS. (The difference is due to the timing of workers going on and coming off the payroll). Nonetheless those employers listed in Tables 1 and 2 were most often cited as the largest employers in these two countries.

The information in Tables 1 and 2, combined with interviews with managers of several firms, suggests a few ways in which work-based family planning services would be feasible to implement in the islands of St. Lucia and St. Vincent. (Note that these plans are the result of preliminary efforts and thus are included only as background, illustrative examples). Project activities could be implemented at the following sites:

1) Camden Park Industrial Estate, St. Vincent;
2) Vieux Fort Industrial Estate, St. Lucia;
3) Castries Apparel, Bissee Industrial Estate, St. Lucia.
4) Belle Fashions, Denerry Industrial Estate, St. Lucia

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[2] The National Insurance Scheme in St. Lucia was established in 1979. Women are entitled to 13 weeks of maternity allowance at 60% of their pay plus a $200 maternity grant. The National Insurance Scheme in St. Vincent has been proclaimed although the statutory regulations have not yet been passed. Benefits are expected to be the same as in St. Lucia. Employers will contribute approximately 3% of payroll costs and employees approximately 2% of their wages.

St. Vincent

At Camden Park Industrial Estate, just outside Kingstown, St. Vincent, approximately eight manufacturing concerns are established (see Table 1). Impromptu interviews with the general managers of five of these firms revealed a variety of perspectives on family planning. Some employers currently allow IEC activities to be conducted at the factory (films, posters, talks) and permit the women employees to take time off to go to family planning clinics. Other employers are less interested in, although not resistant to, their employees' participation in family planning. Approximately 600 women work in the Camden Park Industrial Estate, sewing garments, assembling electrical parts, manufacturing sporting goods, etc. Some of these women obtain family planning services at the nearby Camden Park Health Center, sponsored by the Government of St. Vincent. Based on anecdotal information, the pregnancy rate is moderate. It is anticipated that a free-standing family planning clinic at the Camden Park Industrial Estate could serve all the employees at the estate.

St. Lucia

At St. Lucia, interviews with the major employers and the Development Authority revealed several opportunities for the development and implementation of work-based family planning services in two different models: a clinic serving several factories in Vieux Fort, and perhaps a clinic serving several factories in Castries (Bissee); and a clinic serving one factory in Dennery.

1. Vieux Fort Industrial Estate

The following firms are operating at the Vieux Fort Industrial Estate:

Firm	Estimated Employees
Hortex	150
Brabo	115
Nehoc Industries	100
Kosiah Mills	100
Data	100
Manumatics	60
Total	625

Of these 625 employees, it is estimated that virtually all are women. The General Manager of Nehoc Inustries, Mr. Desmond Paul, volunteered that he would be happy to have his factory serve as a model for a family planning program and that he was confident that the other employers in the Vieux Fort Industrial Estate would also be receptive. Although the offer is very encouraging, the size of the workforce at Nehoc may not justify their own clinical project. The most effective model for reaching these approximately 600 women would probably be one centrally-located clinic serving all of the factories in the Industrial Estate.

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In addition to the above employers located at the Vieux Fort Industrial Estate, the following other firms are also doing business in Vieux Fort in other parts of the town:

Firm	Estimated Employees
Crown America	135
Cariman	110
St. Lucia Garments	30
Tolyn	25
KLV	30
Total	330

Most of these employees are women also. It is not certain, however, that their work sites would be located close enough to participate in the family planning clinic that would be established at the Vieux Fort Industrial Estate.

2. Dennery Industrial Park - Belle Fashions

The only firm doing business at Dennery Industrial Estate is Belle Fashions; they occupy the entire estate. Belle Fashions currently employs over 400 women and is in the process of finishing the construction of their third factory shell in order to expand the work force to 600 women this year.

The General Manager, Mr. Auguste, is very interested in making family planning services more accessible for his workers. He estimates that 15% to 20% of the women deliver children each year. For the past three years, Belle Fashions has been a CBD site for the St. Lucia FPA, although the manager and the CBD agent report that enthusiasm among the workers is not as great as it was originally. Counseling and motivational activities have not been conducted since the start of the program. The General Manager indicated his interest in financially supporting the program after a period of time and if development costs were borne by the project.

3. Bissee Industrial Estate

At Bissee Industrial Estate, near the capital city of Castries, the following firms are doing business.

Firm	Estimated Employees
Castries Apparel	400
Roses Apparel	65
Harlin	65
Soft Furnishings	65
Total	595

The General Manager of Castries Apparel expressed to the General Manager of the St. Lucia National Development Corporation an interest in providing family planning services. Due to scheduling constraints, this could not be confirmed or elaborated.

In addition to the firms identified above, there are several firms doing business at the Gros Islet Industrial Estate in St. Lucia including Pyramid Fashions and Ramco Plastics. It is estimated that the total number of women employed at the Gros Islet Estate is 100-200. Although a target population of this size does not appear to justify a full service delivery capability, the General Manager of Pyramid Fashions expressed an interest in at least participating in a CBD program.

Barbados

On Barbados, at least nine industrial estates have been developed by the Barbados Industrial Development Corporation:

1. Harbour Industrial Park
2. Pelican Industrial Park
3. Newton Industrial Park
4. Wildey Industrial Park
5. Six Roads Industrial Park
6. Grazettes Industrial Park
7. Grantley Adams Industrial Park
8. Pine Industrial Estate
9. Webster Industrial Park

Of these industrial parks, Harbour Industrial Park and Pelican Industrial Park are located quite close to one another and may be considereed as one for services provision. The following is the employment distribution of the largest industrial estates; Harbour Industrial Park (combined with Pelican Industrial Park), Newton Industrial Park and Wildey Industrial Park.

Table 3

Harbour Industrial Park, Bridgetown

Firm	Male	Female	Total
Caribbean Data Services	20	255	275
Barbados Childrens Wear	20	470	490
Bico	9	132	141
Koves Co.	23	102	125
Barbados Glassworks	3	1	4
EDA Industries	8	119	127
Oran	65	55	120
Drapery Specialists	5	20	25
Hooper Garment	1	54	55
Mico Garment Factory	30	125	155
Naime Enterprises	3	34	37
Yankee Garments	12	74	86
Caribbean Marble	10	1	11
Burke Wireworks	5	2	7
Supreme Industries	14	6	20
Carib Printers	7	7	14
Byrd Data	2	7	9
Cottage Creations	1	10	11
Kirton's Furniture	17	8	25
IDC Handicraft Division	19	63	82
Maxrone	2	20	22
Tropical Weavers	3	22	25
Jesse Jeans	1	24	25
Arezzo	3	20	23
Fantasy Garments	4	25	29
Cadogan Industries	1	3	4
Total	288	1,659	1,947

Table 4

Newton Industrial Park, Christ Church

Firm	Male	Female	Total
Century Pipes Limited	16	4	20
Concrete Products Ltd.	24	2	26
Corcom W.I. Ltd.	55	610	665
Microdata	14	123	137
Transistor Barbados Ltd.	11	269	280
Ward Leonard Electric	3	23	26
Universal Flavors	13	6	19
Pan Indiana Ltd.	4	46	50
Hiline Industries	4	16	20
Barbados Computer Assembly	8	101	109
Galt Ltd.	3	37	40
Thorn-Mod Barbados	8	96	104
TRW Resistive Products	28	235	263
Haas Precision Industries	4	74	78
Kamer Industries	7	7	14
Belltronics	50	200	250
Total	252	1,849	2,101

Table 5

Wildey Industrial Park, St. Michael

Firm	Male	Female	Total
Alamac Trading Co. Ltd.	n.a.	n.a.	33
Edmont Barbados	31	358	389
Courtesy Garage, Ltd.	n.a.	n.a.	192
I.P.C. Barbados	19	346	365
Electric Sales and Service	n.a.	n.a.	61
Elkay Ltd.	8	4	12
Banks Barbados Breweries	111	8	119
Harris Paints	26	9	35
Catelli Food Products	23	24	47
L.G. Miller	20	25	45
Elias Industries	15	85	100
H&K Knitting	20	80	100
Micky Ltd.	5	25	30
NAC Data	2	24	26
Surf & Sand Beachwear	5	60	65
Moore Paragon	27	27	54
Gulf Stream Industries	17	1	18
Coles Printery	51	44	95
Harris Nail & Wire Works	12	0	12
Wilson SW & Co.	8	31	39
Paper Convertors	11	14	25
Coles Printery	n.a.	n.a.	108
Letchworth Press	63	37	100
Kingshore Ltd.	6	22	28
Charles McEnearney & Co.	n.a.	n.a.	98
Kaida Foods	1	7	8
Total	481	1,231	2,204

The distribution by age and sex for all employers at Wildey Industrial Park not being available, the total of men and women was estimated by applying the same distribution as for those firms at Wildey that did provide the data: 72% female and 28% male. Therefore, the estimated distribution for Wildey Industrial Park is 617 male employees and 1,587 female employees.

To summarize, the following is the estimated distribution of the work force for the three parks:

	Men	Women	Total
Harbour Industrial	288	1,659	1,947
Newton Industrial Park	252	1,849	2,101
Wildely Industrial Park	617	1,587	2,204
Total	1,157	5,095	6,252
Average for three parks	386	1,698	2,084

Grenada

In Grenada, RDO/C with the Grenada Industrial Development Corporation is in the process of building an industrial estate, ~~Fuentes~~ Industrial Park, which is expected to be completed in approximately six months (October 1987). Virtually all the employees at the park are expected to be women. Firms scheduled to occupy the park and their planned personnel are the following:

Firm	Work Force
Johnson Sportswear	300
Johnson & Johnson	108
Smith Kline Beckman	30
Abbott Labs	60
Schering Plough	40
Total	538

A central shell that would perhaps have a canteen, a day care center and provide basic primary health care is also planned for Fuentes Industrial Estate. This would be particularly attractive for family planning services since it would distribute the fixed cost of the building across several services. It may also make a family planning clinic less conspicuous and more attractive to any acceptors who might be self-conscious about obtaining services at the work site. Moreover, the coupling of fee-for-service day care services with family planning services has often been suggested in this milieu both as a potential means of generating revenue to support family planning and as a marketing tactic to generate traffic of potential acceptors at the site. This could provide a good opportunity for testing such a model. However, the potential for an operating surplus from day care services should be carefully studied prior to implementaton.

Of the islands and possible sites mentioned, the best prospects for developing and implementing a balanced program of private sector family planning services appear to be:

Site	Potential acceptors Male	Female	Total
1. Barbados (either Harbor, Newton or Wildey Parks)	386	1,698	2,084
2. St. Lucia (Belle Fashions, Dennery Industrial Park)	0	600	600
3. St. Lucia (Vieux Fort Industrial Park)	0	625	625
4. St. Vincent (Camden Park)	275	560	835
5. Grenada (Fuentes Ind'l Estate - projected)	0	538	538
	661	4,021	4,682

Assuming implementation of services at the five sites used previously as examples (Vieux Fort Industrial Park, St. Lucia; Dennery Industrial Park, St. Lucia; Camden Park, St. Vincent; Fuentes Industrial Park, Grenada; and one industrial park in Barbados) the following is a summary of women acceptor projections by various prevalence levels:

	Estimated Women Employed	High (75%) Acceptance	Moderate (55%) Acceptance	Low (35%) Acceptance
Vieux Fort	625	469	344	219
Dennery	600	450	330	210
Camden Park	560	420	308	196
Fuentes	538	404	296	188
Barbados	1,698	1,274	934	594
Total	4,021	3,017	2,212	1,407

Assuming that 55% acceptance targets are attained at the completion of year one of service delivery and that acceptance levels remain stable for year two, the couple years of protection obtained would be:

Year 1:	1,189
Year 2:	2,377
Total Life of Project:	3,566

For the provision of services, five sites would be identified to introduce the delivery of a wide variety of clinical and non-clinical family planning services. Sites would be selected on the basis of the financial feasibility of the subproject; number of people served; severity of the population problem in that particular country; level of commitment from employers, trade unions or other sustaining organization; geographic balance; and replicability of the subproject to other areas. A commitment from a sustaining organization to continue services after project support would be a pre-requisite for the development and implementation of services. Based on preliminary discussions, this does appear to be obtainable. At the completion of the project, the sustaining organization will maintain the level of achievement reached during the project without further assistance from AID.

The objectives of each subproject will be to introduce modern family planning methods in the for-profit, private sector and industrial estates in the Eastern Caribbean; to recruit and serve a minimum of 200 acceptors of family planning; to develop the capacity of the sustaining organization to maintain or expand the level of family planning services achieved under the subproject without additional inputs from the project or AID after the completion of the subproject.

The project will provide funds for supplies, office equipment and clinical equipment; technical assistance in such areas as record keeping and information management, contraceptive logistics, clinic mangement and evaluation, and motivational and clinical training for staff.

The industrial estate or sustaining organization will provide designated space for family planning and will commit to sustaining the clinic after the expected two-year duration of project activities.

AID will provide contraceptive supplies.

In order to implement services at these illustrative sites, the following activities would be required:

- o A preliminary market research survey of the employees in each proposed service area would be conducted to determine the family planning needs and preferences of the employees and to verify that the provision of family planning services at this location would be appropriate. Based on this information, a determination of staffing configurations and whether full-time or part-time services are most appropriate would be made. This survey will include data on projected total population, by age and sex, to be served by each subproject; projected family planning service delivery capacity per subproject; projected monthly average family planning users by method, per subproject; projected contraceptive requirements and sources of supply, by subproject; proposed staffing of each subproject and the associated family planning and MCH equipment and supply needs; summary of other health facilities providing family planning services to this population and the implications for project development; analysis of fees the target population is willing to pay for services; level of interest in inclusion of day-care services and other services (e.g. pregnancy tests and pap smear) for a fee.

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o The Industrial Development Commission of each country or the firms involved would provide space for a modest free-standing family planning clinic (approximately 50 square meters of space, adequate for waiting room, exam room, counseling area, supply room, restroom facilities).

o Under the guidance of CFPA and the local FPA, the facility would be renovated and equipped as a family planning clinic (see illustrative equipment and supplies list).

o Under the supervision of CFPA and the local FPA, a qualified nurse-midwife would be recruited and trained; a physician would be identified for coverage on a sessional basis (e.g., one session per week).

o USAID would contribute family planning contraceptive supplies for the duration of the project through CFPA for sale to the acceptors.

o CFPA and the local FPA would develop an IEC campaign specifically designed for the workers at the industrial estates to motivate the workers to take advantage of the services.

o Clinic management procedures and recordkeeping would be implemented under the supervision of CFPA and the local FPA.

o Quarterly progress reports would be produced by the nurse-midwife in coordination with the local FPA and submitted to CFPA, USAID and the Enterprise Program. Reports will include data on the following: quarterly family planning users, by method, per subproject (including new users and transfer users); revenues and expenditures; motivation activities conducted; stock of contraceptives and sources of supply per subproject.

The plan for supporting these activities would entail collaboration between several entities: the government of each island would provide the space for each clinic at each estate; the implementing organization, would support the equipping, training, and other development costs of each clinic in collaboration with CFPA and the local FPA's; the users would contribute to the cost of services by either purchasing contraceptives or on a fee for service basis; the employers or another sustaining organization would, at the completion of the project, agree to support the recurrent costs of the clinic.

During the project start-up phase provision for confirming both sustainability for project-assisted demonstrations and for ripple effects to non-assisted private organizations which may add family planning will be included.

The tables that follow estimate the expense budget for a clinic for years one and two (under project support) and the annual operating costs for a clinic after the termination of project support. These estimates will, of course, vary with the size and utilization of the clinic.

ILLUSTRATIVE ANNUAL EXPENSE BUDGET PER CLINIC (EC$)

	Year 1	Year 2*	Total Project Support	Projected Annual Operating Cost Year 3...
Personnel				
Nurse-Midwife (.5FTE)	12,000	12,840	24,840	13,739
MD coverage	4,200	4,494	8,694	4,808
Motivators	1,650	1,765	3,415	1,889
Clerk (.5FTE)	2,000	2,140	4,140	2,290
Subtotal	19,850	21,239	41,089	22,726
Equipment				
Clinical	10,800		10,800	2,160
Office	6,750		6,750	1,350
Supplies	10,800	11,556	22,356	12,365
F/P Commodities	8,100	8,667	16,767	9,274
Rent & Utilities	0	0	0	0
Market Research Survey	3,000	0	3,000	0
I E C Materials	2,000	200	2,200	200
Motivator training	2,200	0	2,200	0
Total (EC$)	63,500	41,662	105,162	48,075
Total (US$)	23,519	15,430	38,948	17,805

* estimate 7% inflation

Budget Notes:

Although attempts were made to corroborate these figures with local authorities, by and large they are estimates.

Nurse - midwife: .5 FTE at annual salary of EC$24,000.

Physician Coverage: .1 FTE (one half day session per week) at annual salary of EC$42,000.

Motivators: Stipends for eleven motivators (one motivator per every 50 female employees) at EC$150 per motivator.

Clerk: .5 FTE clerk at EC$4,000 annual salary.

Equipment and supplies: Estimated using experience from other similar clinics in other regions and countries. See illustrative equipment and supplies list below. Assume 5 year depreciation for purposes of estimating recurrent costs.

F/P Commodities: Donated by AID in years 1 and 2.

Rent and Utilities: Contributed by industrial, development corporation.

Motivator training: 11 motivators trained at EC$200 per trainee.

ILLUSTRATIVE EQUIPMENT LIST

Clinical Equipment:

Angle poised lamp
Sphygnomanometer
Instrument tray
Solution stand/basin
Dressing jar/swabs
Stethoscope
Gyn exam table
Microscope
File cabinet
Commodity storage cupboard
Instrument cupboard
Writing table (2)
Rotating stool
Chairs
Benches
IUD kits
Air conditioner
Sinks
Shelves
Electricity
Pedal bin
Flashlight
Privacy Screen
Instrument trolley
Thermometer
Weighing scale
Rubber sheet
Pillow and cover
Washable sheets (#6)
Washable gowns (#6)
Towels (#2)
Vaginal specula (1 sm, 4 med, 1 lg)
Sponge holding forceps (#6)
Straight tenacula
Artery forceps (#6)
Uterine sounds
IUD removal hook
Alligator forceps
Curved scissors
Kidney dishes
Large lifting forceps (cheattles) (#2)
Stainless steel containers with lids (#4)
Shelves

US$4,000

Office Equipment:

Typewriter	$ 500
Desk and Chair	500
Miscellaneous	1,000
	US$2,500

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ILLUSTRATIVE CLINICAL SUPPLIES LIST

Albustix, clinistix, litmus paper
Pregnancy testing kit
Cotton balls
Guaze
Syringes, 5cc, 12 boxes
Syringes, 25cc, 12 boxes
Needles, 12 boxes
Antiseptic solutions: Dettol
Saulon
Lysol
Alcohol
Betadine
Soaps

Medications (analgesics, antibiotics, vaginal suppositories)
Disposable gloves

US$4,000

This indicates that the development and implementation of each subproject will cost a total of $38,000 over the estimated two-year term of each subproject. (Smaller clinics at the sites on the smaller islands may require less; a larger clinic on Barbados may require more.) At the termination of project support, each subproject is estimated to require an expense budget of $18,000 to meet projected annual operating costs (recurrent costs), although costs will vary according to utilization.

Three projections of revenue for family planning services for the smaller clinics have been developed, based on levels of utilization and method mix as follows.

Conservatively assuming 550 women employees at each of four sites (Vieux Fort and Dennery, St. Lucia; Camden Park, St. Vincent; and Fuentes Industrial Park, Grenada) and projecting acceptors at three levels for sensitivity - high (75%), medium (55%), and low (35%), the number of acceptors at each of the four sites would be the following:

550 women at 35% acceptance = 193 acceptors

55% acceptance = 303 acceptors

75% acceptance = 413 acceptors

The 1983 contraceptive prevalence surveys for St. Lucia and St. Vincent identify the following method mix on St. Lucia and St. Vincent:

Method	Percentage
Oral	40%
Female sterilization	28%
Condom	10%
Injection	10%
IUD	6%
Vaginal methods	3%
NFP	3%
	100%

A retail audit conducted for the social marketing project reveals that the following is the range of prices for orals, condoms and spermicides in commercial pharmacies:

	Low	High
Orals	BDS$ 2.50	BDS$17.50
Condoms (pkg of 3)	1.00	3.00
Spermicides	2.08	21.75

A survey of the local family planning associations reveals the following fees (EC$) charged for services:

	Grenada FPA	St. Lucia FPA	St. Vincent FPA	Antigua FPA
Orals	$ 2	$1	$5	$1-$2
Condoms	.125	.10		.25
Injection	$ 5	$3		$10
IUD	$20			$10
Spermicides	$ 2		$2	$ 5

Anecdotal information indicates that private physicians charge from EC$20 to EC$50 for a visit and that charges for lab tests etc. are additional.

Considering that the clinics to be implemented under this project will be expected to provide high quality services at convenient locations with reduced waiting time and intensive motivation and follow-up of defaulters, it may be feasible to charge a slightly higher fee than the FPA's, yet substantially less than private physicians and pharmacists.

ILLUSTRATIVE FEE SCHEDULE

Service	Fee
Oral	EC$ 5.00
Condom (apiece)	.25
Injection	10.00
IUD	20.00
Vaginal methods	5.00
Natural family planning	-0-
Annual visit (including pap smear, hematocrit and hemoglobin testing)	15.00

The following assumptions were made for purposes of projecting revenue:

1. Data gathered at St. Lucia and St. Vincent support the assumption of 550 female workers per clinic.

2. For IUD acceptors, assume that 50% of the projected target are served in Year 1 and 50% in Year 2. For all other acceptors, assume attainment of acceptor targets at end of Year.

3. The units of service/product per acceptor column (column 4) are 50% of projected annual utilization per acceptors for Year 1, thus allowing for a gradual increase in acceptors over the first year, and 100% of projected annual utilization in Year 2.

4. Annual visits include pap smear and hematocrit and hemoglobin testing.

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TABLE 6

YEAR 1 Revenue Projection (High Utilization Scenario)

METHOD	PCT.	ACCEPTORS	UNITS/ ACC.	UNITS of SERVICE	FEE per SERVICE	REVENUE
Oral	40	166	6.5	1079	5	EC$ 5395
F. Sterilization	28	58	1	58	*	0
Condom	10	41	72	2952	.25	738
Injection	10	41	2	82	10	820
IUD	6	12	1	12	20	240
Vaginal Methods	3	12	2	24	5	120
NFP	3	12	1	12	0	0
Subtotal		342				7313
Annual Examination			1	342	15	5130
						EC$12443
						US$ 4609

YEAR 2 Revenue Projection (High Utilization Scenario)

Oral	166	13	2158	5	10790
F. Sterilization	58	1	58	*	0
Condom	41	144	5904	.25	1476
Injection	41	4	164	10	1640
IUD	13	1	13	20	260
Vaginal methods	12	4	48	5	240
NFP	12	1	12	0	0
Subtotal	343				14,406
Annual Examination			413	10	6,195
					EC$20,601
					US$ 7,630

* Female sterilization acceptors to be referred to other providers.

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TABLE 7
YEAR 1 Revenue Projection (Moderate Utilization Scenario)

METHOD	PCT.	303 ACCEPTORS	UNITS/ ACC.	UNITS of SERVICE	FEE per SERVICE	REVENUE
Oral	40	122	6.5	793	5	EC$ 3900
F. Sterilization	14	42	1	42	*	0
Condom	10	30	72	2160	.25	540
Injection	10	30	2	60	10	600
IUD	3	9	1	9	20	180
Vaginal methods	3	9	2	18	5	90
NFP	3	9	1	9	0	0
Subtotal	100	251				5,310
Annual Visits			1	251	15	3,765
Total						EC$ 9,075
						US$ 3,361

YEAR 2 (Moderate Scenario)

Oral	122	13	1586	5	7930
F. Sterilization	43	1	43	*	0
Condom	30	144	4320	.25	1080
Injection	30	4	120	10	1200
IUD	9	1	9	20	180
Vaginal methods	9	4	36	5	180
NFP	9	1	9	0	0
Subtotal					10,570
Annual Visits			303	15	4,545
Total					EC$15,115
					US$ 5,598

* Female sterilization acceptors to be referred.

TABLE 8
YEAR 1 Revenue Projection (Low Utilization Scenario)

METHOD	PCT.	193 ACCEPTORS	UNITS/ ACC.	UNITS of SERVICE	FEE per SERVICE	REVENUE
Oral	40	78	6.5	507	5	EC$ 2535
F. Sterilization	28	27	1	27	*	0
Condom	10	19	72	1368	.25	342
Injection	10	19	2	38	10	380
IUD	6	6	1	6	20	120
Vaginal methods	3	6	2	12	5	60
NFP	3	6	1	6	0	0
Subtotal		161				3,437
Annual Visits				161	15	2415
Total						EC$ 5,852 US$ 2,167

YEAR 2 (Low Utilization Scenario)

Oral		78	13	1014	5	5070
F. Sterilization		26	1	26	*	0
Condom		19	144	2736	.25	684
Injection		19	4	76	10	760
IUD		6	1	6	20	120
Vaginal methods		6	4	24	5	96
NPF		6	1	6	0	0
Subtotal		160				6,730
Annual Visits				193	15	2895
Total						EC$9,625 US$3,565

* Female sterilization acceptors to be referred.

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Assuming that the revenue projections for Year 2 will remain unchanged for subsequent years[3] the following is the level of support beyond acceptor fees necessary to sustain the clinics:

	High	Medium	Low
Revenue	US$ 7,500	US$ 5,500	US$ 3,500
Expense	18,000	18,000	18,000
Deficit	(10,500)	(12,500)	(14,500)

For the moderate scenario, a shortfall of $12,500 would require support. There are several alternatives for managing this shortfall. In order to completely cover these costs with patient fees. In the moderate utilization scenario, fees would have to be tripled. Although fees could probably be further increased (25%-75%), a much higher increase would probably not be competitive. (The relationship between increases in fees and client utilization should be a subject for an Operations Research study). In other countries, large firms have been very willing to support these costs since they acknowledge this as a small investment compared to the return on their investment of a healthier and happier work force, enhanced worker productivity, reduced absenteeism, reduced turnover, and reduced retraining costs. In Barbados where there are several larger employers, it should be feasible to identify a firm or firms that would be interested in such an arrangement. In St. Lucia, Belle Fashions has expressed an interest in supporting a clinic and Castries Apparel may also be willing. The Commercial Technical Allied Workers Union has also expressed interest. In St. Vincent the Director of the Employers Federation has indicated their interest in supporting the recurrent costs of a clinic for the employees of Camden Park. Although some of these smaller firms have expressed interest in supporting a clinic, it must be assumed that their participation would be at a reduced level. Costs could be covered by obtaining a level of support of $22 per employee or $40 per acceptor on an annual basis. This would be a comparatively small amount for the associated benefits that the clinic would provide. Another alternative may be a cost sharing plan between the employers and the unions, although union financial resources are also limited.

The alternative of combining day care services for employees' children with family planning services has been suggested as an opportunity for generating revenue. Although when surveying employers, the interest in this service has been mixed, it does appear to be a viable alternative and should be included when market research for the family planning clinics is conducted. Cost sharing with a canteen serving refreshments has also been mentioned previously as a possibility. Another opportunity could be obtaining the physician coverage from a volunteer, yielding a savings of nearly EC$5,000 per year.

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[3] If estimated contraceptive prevalence and method mix remain stable, the only acceptor revenue projections that may change are for IUD acceptors and sterilization acceptors.

Family planning service initiatives have been most successful, financially, in developing countries in which several conditions have been present: a well developed for-profit private sector; large numbers of female employees; high pregnancy related fringe benefit costs to the employer; an existing employee health service infrastructure to which family planning services can be added. To various degrees, these conditions are not present in the Eastern Caribbean, however, other factors mitigate their absence and militate in favor of the provision of services.

Although the private sector is growing, it is not well developed, particularly in the smaller islands. This reduces opportunities for working with large employers in general and, in particular, large employers of women of reproductive age. Opportunities to obtain economies of scale are reduced, development costs and other fixed costs are distributed over fewer clients, thereby increasing cost per acceptor and cost per couple year of protection. In spite of these apparent problems, they are reduced in the Eastern Caribbean by the existence of industrial estates at which as many as twenty firms may be doing business. Several industrial estates mentioned in the discussion employ more than 500 and up to almost 2,000 women of childbearing age. These are substantial target populations, even if not overwhelming, and their existence coupled with the interest in providing family planning does minimize the issue of the critical mass of potential contraceptors.

The problem then becomes the identification of a sustaining organization among the several actors in family planning and at the industrial parks. Although the absence of large numbers of women in one firm can be mitigated by the existence of industrial estates, in order for the privatization of family planning services to be successful a vehicle must be identified for expanding or maintaining the level of family planning services achieved under the project without additional inputs from the project or AID after project completion. When, as is more usual, private sector family planning services are implemented within one specific firm, such a commitment to future support is a prerequisite for project implementation. Although there are some examples of large and willing firms in the EC (e.g. Belle Fashions, Dennery Industrial Park, St. Lucia; Castries Apparel, Bissee Industrial Park, St. Lucia), alternative sustaining organizations have to must be identified in situations in which no single firm is dominant, even though willing, in a given industrial estate. Although not all possible sites (e.g. Grenada and Barbados) have been sufficiently researched, several possible sustaining organizations have expressed their interest in addition to those above, namely the Employees Federation in St. Lucia and the Industrial Development Corporation in Barbados. Based on these positive responses to preliminary overtures, it should be feasible to arrange an agreement with a sustaining organization at each potential site.

Frequently one of the most apparent incentives to the sustaining organization for implementing work-based family planning is the high cost of pregnancy related fringe benefits, particularly maternity leave. Although employers do acknowledge the substantial cost of these fringe benefits, in most, if not all, the EC countries both employers and workers are mandated by law to contribute to national insurance schemes (NIS) that automatically cover the cost of maternity leave. Therefore, any anticipated savings from a decrease in cash maternity leave benefits would not be realized by the firm but by the NIS. This substantially reduces the financial benefits to employers accruing from family planning services.

Nonetheless, due to the costs indirectly associated with absent for maternity or parenting responsibilities, employee turnover, retra and reduced productivity as well as the social benefits to the worker his/her family of an improved standard of living and greater reprodu freedom, employers in the EC have consistently expressed a strong int in making family planning services available for their workers. Ther the existence of NIS does not appear to pose a major obstacle to implementation of work-based services.

Due to the relatively small scale of the EC industrial sector correspondingly small size of the firms, few firms have employee h services or clinics on site. In cases in other regions where there onsite employee health services with facilities, equipment, and perso it is relatively simple and cost effective to add family planning to services provided. In the absence thereof, additional development are incurred for facilities and equipment, and recurrent costs suc personnel costs are not easily allocated to other activities. This re in increased costs per acceptor or per couple year of protection (CY $37,719 in subproject cost divided by 2,376 acceptors = $15.87 acceptor; $37,719 in subproject cost divided by 3,564 CYP = $10.58 per

Regarded in this fashion, however, these figures are misleading. the purpose of the private sector component of the project is, first initiate and then to transfer responsibility for the delivery of f planning services to the participating firm or organization, the pr is, virtually by definition, costly in the short run. The most expe development years are subsidized and then the operation is transferre private responsibility.

Indeed, since these development activities are expected to yie return of additional CYP over a ten or twenty year period, these could justifiably be amortized over that period.

Year	CYP	AID Cost
1	1,188	21,050
2	2,376	16,669
3	2,376	0
4	2,376	0
5	2,376	0
6	2,376	0
7	2,376	0
8	2,376	0
9	2,376	0
10	2,376	0
	22,572	$37,719

This demonstrates that using the medium projections scenario acceptors) amortizing the development costs over a ten year period direct cost of each AID supported project per CYP would be $1.67.

Table 9 illustrates that at first glance the level of total AID investment for this component per CYP appears high, US$104 over the two year life of the subproject. However, due to the very nature of the project this is misleading. The project is essentially supporting the development costs for a service provision capability that should endure for the life of the firm or at least ten or twenty years. Therefore it is reasonable to amortize the costs over a ten or twenty year period.

The table illustrates that the AID support, amortized over a ten year period, would yield a cost per CYP of $16. Similarly the cost to the sustaining organization that will bear the recurrent costs is US$8.55 per CYP. The total (AID and sustaining organization) cost would be US$24.50. Note however that these calculations do not account for potential fee revenue generated from clients via the sale of services and contraceptives. This source of revenue will further reduce the cost to the sustaining organization and the net cost per CYP. Moreover other possible revenue generating activities, e.g. union contributions and revenue from other contemplated services such as day care, would further reduce these costs.

The more important criterion will be the service load (acceptors) that the private sector takes on and continues to support upon termination of project support. At the project's end, the sustaining organization will completely support program activities for the indefinite future.

The conclusion is that for-profit organizations recognize the value of accessible family planning services and are willing to participate in a demonstration activity that has recognized and accepted continuation costs even before the expected results of the demonstration are realized. However, without the subsidization of development costs it is unlikely that a sufficiently large and willing firm could be identified to undertake these substantial development costs themselves without support.

TABLE 9

AMORTIZATION OF DEVELOPMENT COSTS

YEAR	1 CYP	2 CUM. CYP	3 CUM. AID COST	4 AID COST/ CUM CYP (3/2)	5 SUSTAINING ORGZN. COST	6 CUM. SUSTAINING ORGZN.	7 CUM. SUSTAINIING ORGZN. COST (6/2)	8 TOTAL COST/CYP (4 + 7)
1	1125	1125	$175,000	$156	0	0	0	156
2	2250	3375	350,000	104	0	0	0	104
3	2250	5625	350,000	62	17,805	17,805	3.16	65
4	2250	7875	350,000	44	19,051	36,856	4.68	49
5	2250	10,125	350,000	35	20,385	57,241	5.65	41
6	2250	12,375	350,000	28	21,812	79,053	6.39	34
7	2250	14,625	350,000	24	23,335	102,388	7.00	31
8	2250	16,875	350,000	21	24,968	127,356	7.58	29
9	2250	19,125	350,000	18	26,716	154,072	8.06	26
10	2250	21,375	350,000	16	28,586	182,658	8.55	24.50
	21,375	21,375	350,000	16	182,658	182,658	8.55	24.50

FINANCIAL ANNEX

	ACTIVITY	REQUIREMENT	COST PER UNIT	TOTAL COST
Management Assistance				
1	Assessment of management needs	1 pm TA	15,000	15,000
2	Training and TA Year 1 (2 weeks mgt training)	0.5 pm TA	15,000	7,500
3	Year 2&3, (1 week training/review)	0.5 pm TA	15,000	7,500
4	Direct TA to FPAs year 1	0.5 pm/yr for each of 8 FPAs total 4 pm/yr	15,000	60,000
5	Year 2&3	0.25 pm/yr for each of 8 FPAs total 4pm	15,000	60,000
6	Annual 1 week training and prog review travel/perdiem	30 persons per year 3 years	$1,000 per person/wk	90,000
7	Special training	20 persons 2 weeks	$1,000 per person/wk	40,000
8	Baseline study	1 pm TA	15,000	15,000
9	Rapid Survey method	1 pm TA	15,000	15,000
10	CFPA salaries & travel for CEO & project coordinator			163,000
Management Information System				
11	MIS System Develop/ training	6 pm TA	15,000	90,000
12	General Computer training	20 persons 4 weeks	$500/wk	40,000

	ACTIVITY	REQUIREMENT	COST PER UNIT	TOTAL COST
13	Training of staff managers, etc	System training 20 staff/1 week	$1,000/per person/wk	20,000
14	Computer systems, IBM XT or AT level, printer, software, supplies, hard disk etc.	8 - CFPA,BFPA & FPAs	10,000	70,000
	Revenue Generation			
15	Revenue generation	5 pm TA	15,000	75,000
16	Training	10 people 2 weeks	1,000/wk	20,000
17	CFPA salary and travel			42,000
	Commodity Logistics			
18	Commodity logistics	3 pm TA	15,000	45,000
19	Commodities	(AID/W contraceptives)		150,000
	Information, Education and Communications			
20	IE&C Campaigns, production & materials			263,000
21	Seminars, mailings, and FPA training in managing local IE&C activities	regional and in each program country		82,000
22	Promotional market material			16,000

	ACTIVITY	REQUIREMENT	COST PER UNIT	TOTAL COST
23	CFPA salary and travel for training staff			93,500
	Private Sector Programs			
24	Design/evaluation of Private sector clinics	8 pm TA	15,000	120,000
25	Private Sector management training for clinic staff	2 pm TA	15,000	30,000
26	Equipment	5 projects	15,000	75,000
27	Construction/renovation	5 projects	25,000	125,000
28	Personnel travel	BFPA and CFPA management counterparts	10,000	20,000
29	Clinic staff support	5 clinics	20,000	100,000
	Training			
30	CFPA training staff and travel			108,500
31	CFPA Training costs			80,800
	Grant Administration			
32	CFPA office staff			149,000
33	CFPA Operating Expenses			207,200
34	RDO/C Project Management			300,000
35	SOMARC Project			50,000
36	Contingencies			155,000
	TOTAL AMENDMENT COST			3,000,000

ACTIVITIES MATRIX
(Numbers refer to items in Financial Annex)

	IE&C	MANAGEMENT ASSISTANCE				PVT. SCT.	FP TRAINING	TOTAL
		Mgt. Impr	MIS	Rev. Gen.	Com. Log.			
CFPA								
Tech Asst	22: 16,000 20: 263,000					28: 20,000 29: 100,000		399,000
Training	21: 82,000	6: 90,000 7: 40,000	12: 40,000 13: 20,000	16: 20,000			31: 80,800	372,800
Construction						27: 125,000		125,000
Tech Staff & Trvl	23: 93,500			17: 42,000			30: 108,500	244,000
Grant Admin (10,32,33)[1]								10: 163,000 32: 149,000 33: 207,200
TA Contract								
Tech Asst		1: 15,000 4: 60,000 5: 60,000 8: 15,000 9: 15,000	11: 90,000	15: 75,000	18: 45,000	24: 120,000		495,000
Training		2: 7,500 3: 7,500				25: 30,000		45,000
Equipment			14: 70,000			26: 75,000		145,000
AID Direct								
SOMARC[2]								35: 50,000
RDO/C Project Mgt[3]								34: 300,000
Commodities					19: 150,000			150,000
Contingency								36: 155,000
TOTALS[4]	454,500	310,000	220,000	137,000	195,000	470,000	189,300	3,000,000

1 Includes CEO & Project Coordinator salaries and travel; office staff and operating expenses not directly attributable to specific line items.

2 Buy-in for contraceptive services outside of this scope of work for contraceptive social marketing services delivery.

3 Project Management by RDO/C

4 Grant administration costs (10, 32, 33 & 34: $792,000), SOMARC buy in (35: $50.000) and Contingency costs (36: $182,200) must be added to horizontal axis totals to arrive at $3 million; these costs are included in vertical axis figures, however.

INITIAL ENVIRONMENTAL EXAMINATION No. 2

Project Location	:	Caribbean Regional
Project Title	:	Population and Development (538-0039)
Funding (LOP)	:	$7,666,000
Life of Project	:	8 years 5 months
IEE Prepared by	:	Elizabeth B. Warfield Project Development Officer
Date	:	June 1987
Environmental Action	:	The purpose of this amendment is to increase the impact and sustainability of family planning programs in the Eastern Caribbean. This will be accomplished through establishment of an appropriate policy environment, greater use of private sector delivery mechanisms, improved management and efficiency of private voluntary and public sector organizations and development of a regional institutional capability to provide technical and managerial support to family planning institutions. A minor amount of renovation and/or construction of private sector clinics is expected to occur under this project. These facilities, which are contained within existing industrial estates, are not expected to have significant environmental impact. Based on the above findings, a negative determination is appropriate.
Concurrence	:	Alfred Bisset Acting Director, USAID, Regional Development Office/Caribbean
Date	:	6/26/87

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STATE 177435

ACTION AID-1 INFO AMB DCM CHRON 3

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CN: 18644
CHRG: AID
DIST: AID

AIDAC

10 JUN 1987

E.O. 12356: N/A
TAGS:
SUBJECT: IEE - POPULATION AND DEVELOPMENT AMENDMENT (538-0039)

REF: BRIDGETOWN 4658

LAC CHIEF ENVIRONMENTAL OFFICER HESTER APPROVES NEGATIVE DETERMINATION FOR SUBJECT INITIAL ENVIRONMENTAL EXAMINATION. IEE NUMBER IS 87-19 AND IS DATED JUNE 8, 1987. COPY BEING POUCHED TO MISSION. WEITEHEAD
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#7435

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ACTION: AID
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Drafted
06/15/87
Noted
6/10/87

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