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**EVALUATION OF THE JAMAICA  
POPULATION AND FAMILY PLANNING  
SERVICES PROJECT  
(Project No. 532-0069)**

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## Glossary

ACOSTRAD	Association for the Control of Sexually Transmitted Diseases
AFRC	Adolescent Fertility Resource Center
A.I.D.	U.S. Agency for International Development
AIDS	Acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
CBD	Community based distribution
CDC	Centers for Disease Control (U.S. Public Health Service)
CDC	Commercial distribution of contraceptives
CPS	Contraceptive Prevalence Survey
CPT	Contraceptive Procurement Tables
CRS	Contraceptive retail sales
CYP	Couple year of protection
FY	Fiscal year
GOJ	Government of Jamaica
HPN	Health, population, and nutrition
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JFPA	Jamaica Family Planning Association
JHU/PCS	Johns Hopkins University/Population Communication Services (project)
LAC	Latin America and the Caribbean
MCH	Maternal and child health
MOE	Ministry of Education
MOH	Ministry of Health

MIS	Management information system
MWRA	Married women of reproductive age
MYCD	Ministry of Youth and Community Development
NEET	Now Entering Education for Tomorrow (YWCA project)
NFPB	National Family Planning Board
NPA	National Planning Agency
PHC	Primary health care
PIOJ	Planning Institute of Jamaica
PIO/T	Project Implementation Order/Technician
PPCC	Population Policy Coordinating Committee
POPTECH	Population Technical Assistance Project
PLO	Parish Liaison Officer
PRICOR	Primary Health Care Organization Research (project)
SMO	Senior medical officer
STATIN	Statistical Institute
TFR	Total fertility rate
TIPPS	Technical Information on Population for the Private Sector (project)
USAID	U.S. Agency for International Development (Mission)
UWI	University of the West Indies
UNFPA	United Nations Population Fund
VSC	Voluntary surgical contraception
WaR	Women at risk (of pregnancy)
YWCA	Young Women's Christian Association

## Project Identification Data

1. Country: Jamaica
2. Project Title: Population and Family Planning Services
3. Project Number: 532-0069
4. Project Dates:
  - a. First Project Agreement: March 31, 1982
  - b. Final Obligation Date: FY 91
  - c. Most recent Project Assistance  
Completion Date: March 31, 1991
5. Project Funding:
  - a. USAID Bilateral Funding (grant and/or loan) US \$10,711,000
  - b. Host Country Counterpart Funds 16,422,000

Total	US	\$27,133,000
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6. Mode of Implementation: Host Country
7. Responsible Mission Officials:
  - a. Mission Director: William Joslin
  - b. Project Officers: Rebecca Cohn/Grace-Ann Grey
8. Previous Evaluation: September/November 1985

## Executive Summary

### Introduction

The Population and Family Planning Services Project of Jamaica, 1982 to 1986, later extended to 1991, has as its overall goal the improvement of the health and the social and economic welfare of the Jamaican population through significantly reducing the birth rate. To attain this overall goal, the project seeks to assist the Government of Jamaica's (GOJ) efforts to expand the coverage and increase the quality and effectiveness of contraceptive delivery systems.

Project objectives are to strengthen and expand family planning services, expand the family planning motivational and informational network, and improve population data collection and analysis systems. In 1986, Project Amendment No. 3 refocused the project's emphasis on three areas: 1) continuing support for the provision of family planning education and services; 2) the voluntary surgical contraceptive program; and 3) the commercial distribution of contraceptives (CDC) program.

The present evaluation of the project was to concentrate on these new areas of focus. Recommendations were to be made for the remaining project period and actions were to be proposed for future directions of assistance by USAID to the Jamaica family planning program.

### The Jamaica Family Planning Program

#### Strengths

- From 1983 to 1989, contraceptive prevalence rose from 51.4 percent of women currently in union aged 15 to 49 to 54.6 percent.
- Family planning knowledge of at least one effective method is universal in Jamaica.
- Over 70 percent of all women aged 15 to 49 have used a method of contraception at some time.
- The total fertility rate has fallen from 3.5 in 1983 to 2.9 in 1989.
- Age-specific fertility has fallen for each age group from 1983 to 1989.

#### Areas of Concern

- Thirty-seven percent of women have at least one birth while still in their teen years. Ever use of contraception is lowest for the 15 to 19 age group; overall, the median age of first use is 19 years.
- More than half of the births which occurred in a five year period were mistimed with nearly 30 percent unplanned and the remainder unwanted.

- One-third of women currently in union are at risk of getting pregnant due to their non-use of contraception.
- IUD use declined from 4 percent in 1975 to 2 percent in 1989 while withdrawal increased slightly. Sterilized women have on average at least one child more than non-sterilized women.
- Contraceptive use varies among the 15 parishes of Jamaica. The unmet need for contraception is over 20 percent in 3 parishes and less than 15 percent in 7.

## **Project Implementation**

The project has made strides toward reaching its overall goal of significantly reducing fertility in Jamaica; for example, contraceptive prevalence has increased and both age-specific and total fertility rates have declined through the efforts of the project.

### **Clinical Services**

The quality of family planning services provided through Ministry of Health (MOH) health centers as well as the National Family Planning Board (NFPB) and Jamaica Family Planning Association (JFPA) clinics is high. In addition, the countrywide network of MOH health centers provides easy access to most women for family planning services and it is in these centers that most women in Jamaica receive their contraceptives.

Referral systems for IUD insertion and VSC, however, are less than optimum. In addition, more training of nurses to insert IUDs and motivation of them concerning the method are necessary.

### **Voluntary Surgical Contraception (VSC) Program**

The VSC program now has a system to ensure voluntary and informed consent, and informed consent is a standard practice of the MOH and the NFPB.

Shortfalls have occurred in the planned number of VSC procedures because of staff and material shortages as well as a lack of interest in VSC by the Ministry of Health and the NFPB.

Jamaican women who have chosen sterilization are generally older and have more children than their cohorts who have not chosen VSC. This implies the need to either refocus the program on cohorts of women somewhat younger than the groups now accepting, to place emphasis on longer-term methods that are already available such as the IUD, (but are not popular at this time), or to introduce a new method, such as NORPLANT®.

### **Commodities**

Overall, forecasting of commodity needs is running smoothly, but because forecasting is done by USAID with technical assistance from the Centers for Disease Control without formally including the NFPB, the technical sustainability for this function is not instilled in the NFPB.

### Commercial Distribution of Contraceptives (CDC) Program

There are very favorable findings with regard to the CDC program: there is virtually universal brand recognition for both program products -- Perle oral contraceptives and Panther condoms; products are being distributed nationwide; the highest share of the market for pills and condoms belong to Perle and Panther; the major share in national prevalence of oral contraceptive and condom use (46.6 percent of oral contraceptive usage and 39.6 percent of condom usage) is supplied by Perle and Panther; and there is an increasing awareness among the general population as to the role of condoms in prevention of AIDS.

At the same time, other findings highlight some deficiencies in program management and strategy as well as in those areas that are necessary to an understanding of market forces. For example, the project management structure of the NFPB inhibits flexible, timely responses to events/changes in the marketplace. In addition, there is no regular strategic planning, thereby diminishing CDC's potential to take advantage of its position in the marketplace by introducing a new product and recovering costs. The resolution of such issues may be necessary to realizing the long-term sustainability of program efforts.

### Adolescent Program

Thus far the adolescent program has proved to be of some value in that, for example, the programs of the Ministry of Education and the Ministry of Youth and Community Development are able to influence large numbers of young people through their nationwide programs. In addition, the Operation Friendship programs have been effectively recruiting contraceptors through a well-designed rural contraceptive delivery system.

On the other hand, the overall subproject strategy used by the project was not well designed. The management demands of so many subprojects were not anticipated when the project was designed. Some subprojects provided only IEC and there were limited linkages in many of the subprojects between IEC and services. The subproject component contributed a very small proportion to total contraceptives delivered in the project. The subproject strategy was a very expensive means to gain support of local organizations and to stimulate their action.

In addition, family life education has not been integrated into the school system of the country even though significant inputs were provided to the Ministry of Education. An opportunity to reach the majority of the youth population was lost.

The thrust of the early 1980s toward specially focused adolescent programs has now been considerably reduced. Continuing subproject efforts to reach adolescents are concentrating on working with youth within the broader setting of the family and the community, rather than in an isolated fashion. The NFPB states, however, that an adolescent focus is maintained in IEC activities and in the activities of the Parish Liaison Officers.

### IEC and Training

USAID assistance has helped to finance a field network of Parish Liaison Officers in each parish and four regional officers for supervision, which will provide a good base for organizing needed informational and motivational efforts. In addition, the

IEC Department of the NFPB is just beginning to mount a major program with World Bank and UNFPA assistance.

### **Program Management**

The roles and functions of the various organizations involved in family planning in Jamaica since 1970 have changed considerably. For example, family planning service delivery is clearly now a MOH function.

Both Jamaican government agencies and USAID/Kingston share the responsibility for the lack of progress made in the management of the national family planning effort: 1) the institutional insularity of the NFPB technical units has decreased their effectiveness in designing and implementing NFPB activities; 2) the problems that the MOH and NFPB have had in cooperating with each other have wasted both human and material resources that could have been put to better use in advancing the family planning effort; 3) the lack of strategic planning by the NFPB is partly responsible for the present slow and gradual increase in the contraceptive prevalence rate; 4) some aspects of the project and management actions that are being done by USAID are more appropriately the responsibility of the project (thus fostering a dependence of the NFPB on USAID); and 5) earlier recognition of potential problems and actions taken to forestall them by USAID may have facilitated project implementation and increased the potential for technical and financial sustainability.

### **Technical Assistance**

The total expenditure on technical assistance for a project of this size with so many subprojects and different activities was inadequate. Areas in which more technical assistance could have been useful to plan and help in the implementation of activities would have been the CDC program, the Adolescent Fertility Resource Center, the VSC program, and to advise on project sustainability issues. The reluctance of the NFPB to use technical assistance and the limited size of funds allocated for technical assistance in the USAID budget may account for its little use.

### **Sustainability**

The major issue in regard to sustainability of the project centers on contraceptive commodity procurement when donor funds are no longer available. In this context, the pricing structure for contraceptives provided through the CDC program does not cover even the manufacturing cost of the contraceptives. Contraceptives are either received free in clinics or a small donation is given. In neither case would the funds generated constitute cost-recovery. Under conditions of free or close-to-free family planning services available throughout the country, there is little reason for believing that private sector initiatives to provide family planning can be expanded.

## **Major Recommendations for the Jamaica Family Planning Program for the Remaining Project Period**

1. The NFPB should review its institutional goals and structure taking into account the changing nature and needs of the family planning program of Jamaica.

2. Because of the wide distribution of MOH health centers, family planning clinics of the NFPB and JFPA should be encouraged not to duplicate services in areas where MOH health centers are available. Family planning clinics should supplement the services offered by MOH health centers, e.g., offering services in the evenings or on weekends when government centers are closed.
3. Program strategies to reach targeted prevalence goals should be planned jointly by the technical staff of the NFPB and MOH. As a planning tool the TARGET SETTING MODEL computer program, which uses prevalence targets for each method and takes into account the age structure and proximate determinants of fertility, should be used.
4. A training program for service providers in inserting Copper T 380 IUDs should be undertaken and followed by an education/motivation campaign aimed at both the providers and the clients.
5. The MOH and the NFPB should ensure that a full-time obstetrics and gynecology specialist is appointed to head up the VSC program in the Secondary Health Care directorate. The model of the family planning coordinator situated in the maternal and child health unit who helps in the implementation of the family planning activities of the primary health care program should be used.
6. A program of market and consumer research should be undertaken during the next 12 months to help the CDC program develop a business strategy. This research should include at least a consumer intercept survey for development of CDC consumer profiles and a retail audit. Based on this business strategy, a price increase for both Perle and Panther should be implemented. From the preliminary data analyzed during the evaluation, a minimum of 100 percent increase should be considered.
7. The Ministry of Education should be encouraged to revive its family life education program. The implementation difficulties experienced by this program reflect some fundamental problems in the attitudes of teachers, and perhaps in the attitudes of the school system itself, to sexuality and reproduction. An influential and formative institution such as the Ministry of Education needs to address these problems.

## Future Directions

The Jamaica family planning program has some challenging years ahead. As a mature program it must keep the momentum of the present effort going, refine its program strategies to motivate those segments of the population now not contracepting, ensure the appropriateness of the method mix and help women switch methods when needed, and make the program cost-effective and financially sustainable.

Recommendation: USAID/Kingston should continue a program of assistance to the Jamaican family planning program at the end of the current project.

A major portion of USAID project funds are for the purchase of contraceptive commodities. If the Jamaica family planning program is to become sustainable in commodity procurement, a planned takeover of the commodities purchasing function must be worked out.

**Recommendation:** In a future project, USAID should provide funds for contraceptive commodities on a decreasing scale with the GOJ financing the residual. Over a five-year period, USAID would decrease its funding by 25 percent each year with the GOJ increasing its funding by the same amount each year. By year five, the GOJ would be responsible for all contraceptive commodities.

**Recommendation:** The MOH and NFPB should consider how to recover costs of contraceptives provided to clients using their facilities. A fee-for-service or fee-for-commodity system should be considered. USAID's planned project in the area of health care financing may assist in exploring how costs could be recovered.

A more aggressive marketing of contraceptives through the commercial sector could also start to recover costs. How this could be done either within the CDC program or outside of it needs to be considered. The following options are proposed:

- Policy and operational responsibilities for CDC remain within the NFPB, but the management structure is reorganized to facilitate the active marketing of contraceptives; USAID would provide contraceptives as above and would supply technical assistance and share fifty-fifty costs of marketing activities for two years.

- NFPB retains policy approval of CDC strategy, but operational responsibilities would move into the commercial sector; USAID would provide contraceptives as above, technical assistance, and full funding of marketing support activities for two years.

- NFPB relinquishes its role in marketing contraceptives and negotiates a "deal" with contraceptive manufacturers for their sales and distribution in the Jamaican market of one or more high quality, low-priced contraceptives at no long-term cost to donor/government agencies.

**Recommendation:** The for-profit sector may offer another avenue to reduce the burden to donor/government agencies in the cost of contraceptives and their provision. An assessment should be undertaken of the private/commercial sector potential in provision of family planning services.

**Recommendation:** Family life education projects focusing on youth should continue to receive attention. However, except for the Ministry of Education (MOE) program, USAID assistance should be through the ongoing programs of the NFPB. A new project with the MOE should be considered, taking into account technical and financial sustainability issues.

**Recommendation:** The technical assistance requirements of a mature family planning program are different from the needs of programs just beginning or expanding. During the next project, technical assistance should be provided to help the NFPB and MOH tackle some of the emerging problem areas in family planning programming, such as technical and financial sustainability, accessing the private sector's potential for providing services, and planning for the introduction of new contraceptive methods.

# 1. Introduction

## 1.1 The Evaluation

The Jamaica National Family Planning Board (NFPB) and USAID/Kingston requested the Population Technical Assistance Project (POPTECH) to undertake an evaluation of the Jamaica Population and Family Planning Project concentrating on the project from 1986 to the present. (The original project was for four years, 1982 to 1986, and was subsequently amended in 1986 for five more years with a new completion date of March 31, 1991.) The evaluation team was to give special attention to voluntary surgical contraception (VSC), Ministry of Health (MOH) clinics, adolescent fertility, and the commercial distribution of contraceptives (CDC) program. Besides ascertaining the achievement of the program, the evaluation team was asked to recommend actions to be taken in the remaining life of the project, and propose, as appropriate, future directions for assistance by USAID to the Jamaican family planning program. The scope of work for the evaluation, the evaluation methodology, and the team's composition are given in Appendix A.

## 1.2 Project Design

### 1.2.1 Project Goals and Objectives

The overall goal of the project is to improve the health and the social and economic welfare of the Jamaican population by significantly reducing the birth rate: the crude birth rate was to be reduced from 27 per 1,000 in 1980 to 20 per 1,000 by 1990.

To attain this overall goal, the project seeks to assist the Government of Jamaica's (GOJ) efforts to expand the coverage and increase the quality and effectiveness of contraceptive delivery systems. Project objectives are to strengthen and expand family planning services, expand the family planning motivational and informational network, and improve population data collection and analysis systems. A specific target over the original four-year period was to increase contraceptive prevalence of women in union from 58 percent in 1980 to 70 percent in 1986; this target date was later extended to 1990.

The project's overall demographic goal as set forth in the Project Paper was based on 1978 contraceptive prevalence figures that were inflated.<sup>1</sup> Thus, the project rested on a false premise: that contraceptive prevalence only had to be increased by 12 points to make the target of 70 percent.

A second false premise involved the notion that contraceptive prevalence could be raised as quickly as the project designers assumed. By 1982, the Jamaican family planning program was already a mature one and large increases in prevalence had been seen in the 1970s. These increases, however, were realized with a population which saw the need to contracept and sought services through the program. The situation of the 1980s was different: a good percentage of this "ready" population was already being served and the population group that was left were the more hard to reach. Growth in prevalence in this situation is much more difficult to achieve and the anticipation that 70 percent prevalence could be reached in four years, or even 10 years with the project amendment's extension of the project, was unrealistic.

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<sup>1</sup>Survey of Contraceptive Use, Department of Sociology, University of the West Indies, Mona, 1979.

Current projections calculated by A.I.D.'s Family Planning Logistics Management Project show that Jamaica's contraceptive prevalence at the turn of the century will be about 63 percent, if current trends in method choice continue (see Section 2.1).

### **1.2.2 Project Activities**

The Project Paper put forward three major areas of activities to achieve the project goal: 1) strengthening and expanding service delivery systems; 2) development of a population policy and plan and institutionalizing a policy, planning, and monitoring apparatus; and 3) expanding family planning motivational and educational networks.

The project was to strengthen service delivery by the provision of technical assistance to improve the management effectiveness of the NFPB, the MOH, and other agencies. In addition, the project was to provide technical assistance in the design and development of specific programs such as VSC, adolescent fertility, male motivation; training of all MOH primary health care workers in contraceptive technology and family planning recruitment, counseling, and follow-up. The project was also to support the expansion of family planning education, counseling and services through special projects with other government and non-governmental entities, and was to provide contraceptive supplies and equipment, including supplies and logistical support to the NFPB.

Policy implementation activities were to include budgetary support to the National Planning Agency (NPA) and Department of Statistics (STATIN) and to create population units; technical assistance to support the Population Policy Coordinating Committee (PPCC) and the demographic studies program of the University of the West Indies (UWI); and budgetary support to carry out fertility related research at UWI and to improve the national vital registration system of the Registrar General's Department. Family planning motivational and educational activities were to include support for research on socio-cultural determinants of fertility; training of health workers and others in counseling; mass media programming; expansion of community outreach through specialized programs; development and dissemination of client-oriented educational materials; and seminars and short-term training for school teachers and principals, social workers, and others in similar professions.

A series of project reviews of these three project areas was held in 1985 that resulted in some project activities being discontinued, either because their targets had been met or because they exhibited poor performance. These reviews formed the basis for the 1986 Project Amendment No. 3 which focused on three areas: 1) continuing support for the provision of family planning education and services; 2) the VSC program; and 3) the CDC program. Various organizations, through subprojects, were to receive assistance in family planning education and service support: the NFPB, MOH, Ministry of Youth and Community Development, Ministry of Education, the Jamaican Family Planning Association (JFPA), Operation Friendship, and the Roman Catholic Family Life Center. The project was to provide funding to allow the NFPB, MOH and the JFPA to expand VSC services, including a male vasectomy program. Lastly, the NFPB was to expand its CDC activities through the introduction of new contraceptive products, as well as financing the costs of contraceptives.

### **1.2.3 Appropriateness of Project Activities**

The strategy to provide contraceptives through the NFPB for distribution to MOH facilities and through commercial channels was well conceived; the NFPB has a good system for commodity distribution.

Using a subproject approach in the design of activities in policy development, statistics, training, and information, education, and communication (IEC) was appropriate for some types of activities. Although sustainability was not an issue explicitly dealt with in the project

design, institutional development, an important aspect of sustainability, has always been a goal of A.I.D. It was anticipated, therefore, that some subprojects would be finite in nature; once accomplished, the implementing unit would be strengthened and would incorporate the supported activities into its ongoing program. Subprojects to strengthen organizations in policy development, statistics and demographic research, and training have shown that this strategy was well conceived.

On the other hand, there were some types of subprojects for which this approach may not have been as appropriate, particularly in IEC development and adolescent fertility activities. In these cases, instead of choosing organizations and strengthening them so that an implementing capacity would remain in the organizations once the project was done, subproject efforts focused on service provision to particular target groups. It is a doubly hard task to build capacity in an organization and to deliver services. In addition, the strategy for working with adolescents centered, in some cases, on using adolescents as the agents of change. Institutionalizing training and counseling skills within this group is naturally lost as they move out of their adolescent years. (Section 8 of this report provides a full discussion of some of the difficulties the adolescent subprojects have experienced.)

## **2. Present Status of Jamaica's Family Planning Program**

## 2. Present Status of Jamaica's Family Planning Program

### 2.1 Contraceptive Prevalence and Fertility Levels

Jamaica's family planning program is one of the most successful programs in the world as measured in terms of trends in contraceptive prevalence and reduction in fertility. In terms of prevalence, it has moved in a 35-year period from an emergent level (less than 8 percent contraceptive prevalence), to a mature level (over 45 percent).<sup>2</sup> In the mid-1950s, contraceptive prevalence was about 5 percent of women currently in union. Prevalence rose dramatically to 32 percent in the early 1970s and by the 1980s was well established in the 50 to 55 percent range.

Table 1

Trends in Contraceptive Prevalence in Jamaica, 1956 - 1989

	1956 Survey ever use	1971/72 FMS	1975/76 WFS	1979 CPS	1983 CPS	1989 CPS
Sterilization: Female	0.8	14.4	21.0	17.1	21.0	24.9
Sterilization: Male	0.0	0.0	0.0	0.0	0.0	0.0
Oral Pill	0.0	29.9	31.0	42.2	38.0	35.7
Injectable	0.0	0.0	16.0	19.8	15.0	13.9
IUD	0.0	14.0	5.0	3.3	4.0	1.5
Condom	10.2	22.0	17.0	12.5	15.0	15.8
Vaginal Methods	28.3	9.5	4.0	1.8	2.0	1.5
Rhythm	2.4	N/A	1.0	0.6	2.0	1.8
Withdrawal	46.5	5.1	4.0	2.7	4.0	4.4
Abstinence	6.3	N/A	1.0	N/A	N/A	0.0
Douche	5.5	N/A	0.0	N/A	N/A	0.0
Other or not stated	0.0	5.1	0.0	0.0	0.0	0.5
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>Clinic &amp; Supply Method</b>	<b>39.4</b>	<b>89.8</b>	<b>94.0</b>	<b>93.3</b>	<b>95.0</b>	<b>93.3</b>
<b>% using any method</b>	<b>~ 5</b>	<b>32</b>	<b>41</b>	<b>57</b>	<b>53</b>	<b>56</b>

Source: Robert E. Lightbourne, *Recent Demographic Trends in Jamaica*, Office of Health, Nutrition and Population, USAID/Jamaica, Draft Final Report - 24 January 1990, p. 361, Table 3-3013.

<sup>2</sup>These classifications are taken from "Moving into the Twenty-First Century: Principles for the Nineties," Family Planning Services Division, Office of Population, A.I.D., April 10, 1989.

Fertility levels have decreased dramatically in the last 30 to 35 years. In 1960, the total fertility rate was about 6.3 births per woman; in 1975 it was about 4.5; 1983, 3.5; and in 1989 it is estimated to have been 2.9. Age-specific fertility has also decreased in all age groups.

Table 2

**Age-Specific Fertility Rates by Maternal Age and  
Total Fertility Rate (TFR) 1975-76 Jamaica Fertility Survey,  
1983 Jamaica CPS, 1989 Jamaica CPS  
(All Women Aged 15-49)**

Age-Specific Fertility Rate			
Age Group	1975*	1983**	1989***
15-19	137	122	100
20-24	234	190	161
25-29	207	150	130
30-34	155	110	93
35-39	101	73	59
40-44	54	40	31
45-49	9	8	5
<b>Total Fertility Rate (TFR)</b>	<b>4.5</b>	<b>3.5</b>	<b>2.9</b>

\* Calculated for years 1973-1975

\*\* Calculated for years 1981-1983

\*\*\* Calculated for years 1986-1988

Source: Carmen McFarlane and Charles Warren. 1989 Jamaica Contraceptive Prevalence Survey. Final Report. December 1989 (draft).

If the fertility levels of the 1950s and early 1960s had prevailed with no emigration of Jamaicans to the United States, Canada and Europe, Jamaica's population would have risen from 1.6 million in 1960 to 4.08 million in 1985, to about 7.6 million in 2000.<sup>3</sup> Instead, population growth during the 1960 to 1985 period was 690,000. Fertility decline during this period accounted for about 430,000 averted births.

## 2.2 Strategy of Jamaica's Family Planning Program

The GOJ has achieved this reduction in births through a well-designed, four-pronged strategy for family planning service provision: a clinic-based program with referrals

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<sup>3</sup>Robert E. Lightbourne. Recent Demographic Trends in Jamaica. Office of Health, Nutrition and Population, USAID Mission, Kingston, Jamaica. Draft final report, 24 January 1990.

for particular contraceptive services, a commercial distribution of contraceptives program, a hospital-based post-partum program, and special programs for selected target audiences, in particular, adolescents.

The clinic-based program, which provides services free (though token donations are now being solicited in some facilities), is intended to serve that portion of the population who are not able to afford private clinics or contraceptives. There are 358 MOH multi-purpose health facilities distributed throughout the country providing family planning and other services and referring clients, as necessary, to more specialized MOH or other facilities for provision of clinical methods, e.g., IUD insertion or sterilization. The NFPB has three clinics and the Jamaica Family Planning Association has two clinics providing specialized family planning services.

The CDC program, which distributes contraceptive pills and condoms through a network of pharmacies and other types of commercial outlets throughout the country, is intended to serve that portion of the population who can afford to buy contraceptives, but at a reduced price.

The hospital-based post-partum program takes advantage of the very high percentage of hospital deliveries in the country. The 1989 Contraceptive Prevalence Survey (CPS) found that about 77 percent of all births are in hospitals. Counseling on the various methods and provision of contraceptives including sterilization are done at this time.

Special programs in the area of adolescent fertility, focussing on education and motivation and services, have been identified as a priority area of concern. The Young Adult Reproductive Health Survey 1987 found that the average age of first intercourse for males is 14.3 years and for females, 16.9 years. Use of contraception at the time of first sexual intercourse was very low for the males, only 11 percent, and for the females, about 40 percent. These trends have been of great concern to policymakers in Jamaica and there has been a variety of education and service programs for the adolescent and young adult populations for some time.

To date, service delivery for family planning in the private sector has been limited. The 1989 CPS found that private doctors/clinics and private hospitals provided about 11 percent of all sterilizations and about 4 percent of other methods, primarily IUD insertions. With USAID assistance, the JFPA is working with the organized sector in selected areas to make contraceptives available in the workplace. Although this is not a major area for program activities at this time, the potential for more involvement in the private sector is discussed later in this report.

## 2.3 Results of the 1989 CPS

The recently completed CPS highlights many of the accomplishments that have resulted from the above strategy:

### **Biological determinants**

- Breastfeeding duration is increasing; in 1975-6 mean duration was 8.2 months; in 1989 it was 12.6 months.
- Unsusceptibility to pregnancy due to either amenorrhea or abstinence is 9 months, on average.

### **Spacing norms**

- Women desire relatively long birth intervals: 40 percent desire an interval of between 3 and 4 years and 31 percent desire an interval greater than 4 years.

### **Desire for children**

- The desired family size is small; the 15 to 19 age group desired a family size that averaged 2.2 children, while the 45 to 49 age group desired one that averaged 3 children.

### **Knowledge and practice of contraception**

- Nearly 100 percent of Jamaican women know of at least one effective family planning method, irrespective of age, education, or urban/rural residency.
- Over 70 percent of all women age 15 to 49 have used a method of contraception at some time.
- Contraceptive use has increased from 1983 to 1989 -- from 51 percent to 55 percent of women currently in union. Contraceptive use increased for all age groups between 1975 and 1983. Between 1983 and 1989 the only major change was the increase in use for the 15 to 19 age group.
- Age at first use of contraception has declined over the past twenty years.
- Urban/rural differences do not have an impact on contraceptive use; rural use was slightly higher than urban.

### **Method mix**

- Method mix did not change from 1975 to 1989; the most prevalent methods used in Jamaica are the pill, followed by female sterilization, condom, and injection.
- Female sterilization was the most prevalent method used by legally married women, followed by the pill and injection. Women currently in common-law and visiting-partner relationships were most likely to use the pill.
- Between ages 15 to 19 and 30 to 34, the pill is the most prevalent method used, followed by condom and injection; after age 35, it is female sterilization. Use of injection is moderately high for ages 20 to 34, and use of withdrawal is moderately high for ages 15 to 19.

### **Source of supply**

- The clinic/health center was the principal source for the pill, injection and IUD and over three-fourths of those who used the clinic/health center (the primary or very important secondary source for all methods) received counseling.
- Another important source of the pill was the pharmacy; it was the principal source for the condom. Condoms were also obtained from clinic/health centers and supermarket/shops.

### **Quality of service**

- Over 90 percent of the women currently using a temporary method of family planning were satisfied with the services they have received at all locations.

## 2.4 Successful Program Efforts

Although a causal link cannot always be made between programmatic efforts and actual outcomes, some program efforts seem to have made an important difference in the achievement of the family planning results listed above. These efforts are listed below and will be explored more fully in ensuing sections of this report.

1. Contraceptives have been made easily accessible to meet client demand in both the urban and rural areas. This provision of contraceptives at clinic/health centers, pharmacies, and other commercial outlets has been critical in the acceptance of the various methods of family planning. USAID's and the United Nations Population Fund's (UNFPA) provision of contraceptives to the NFPB and NFPB's distribution of these commodities to service outlets has greatly contributed to the success of the Jamaica family planning program.
2. The IEC efforts of the NFPB and MOH, as illustrated by the two-child family and promotion of breastfeeding, have been effective: family size norms are decreasing and the period of breastfeeding is increasing.
3. The equipment, training, and funds for provision of VSC, provided by various donor agencies, have made VSC a safe and popular method of contraception.
4. The high level of training and commitment of Jamaican health personnel has engendered trust in women seeking help to limit their family size.

## 2.5 Projections for the 1990s

The success of the family planning program is tempered with the realization of the NFPB and donor agencies that the program, now a mature one, must maintain the momentum in the provision of services already being offered. In addition, it must begin to target population groups and vary the method mix if the goal to reach replacement level fertility by the end of the century is to be realized.

The projected method mix of the program for the next ten years has been calculated based on projections utilizing the TARGET SETTING MODEL<sup>4</sup> and using method mix targets for the year 2000 based on past performance of the program and its current status.<sup>5</sup> See Table 3 (see next page).

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<sup>4</sup>This model was developed by The Population Council and The Futures Group.

<sup>5</sup>This projection was prepared by Mario Jaramillo and Luigi Jaramillo of the International Science and Technology Institute as part of A.I.D.'s Family Planning Logistics Management Project.

Table 3

**Jamaica: Method Mix in 1985 and Targets to 2000:  
Target Setting Model**

	1985	1990	1995	2000
<b>Pill</b>	37.50	35.70	35.70	35.70
<b>IUD</b>	3.90	2.90	2.90	2.90
<b>Female Sterilization</b>	21.20	25.18	26.59	28.00
<b>Male Sterilization</b>	0.00	0.00	0.00	0.00
<b>Injectable</b>	14.80	14.00	14.00	14.00
<b>Other</b>	5.90	4.49	3.45	2.40
<b>Condom</b>	14.80	15.73	15.36	15.00
<b>Vaginal Tablets</b>	1.90	2.00	2.00	2.00

Source: *Jamaica: Family Planning Projections, 1985-2000*, Family Planning Logistics Management Project, October 1989.

With these projections of method mix, and taking into account the percentage of women of reproductive age and duration of postpartum infecundability until the year 2000, contraceptive prevalence at the turn of the century will be about 63 percent (see Table 4). This will not achieve the goal of replacement level fertility.

Table 4

**Jamaica: Projected Contraceptive Prevalence  
1985-2000: Target Setting Model**

Year	Percent MWRA Using	Number Using (Thousands)
1985	53.0	243.4
1986	53.6	253.5
1987	54.3	263.4
1988	54.9	273.1
1989	55.6	282.9
1990	56.2	292.9
1991	56.9	303.0
1992	57.5	313.0
1993	58.2	323.2
1994	58.8	333.7
1995	59.5	344.6
1996	60.1	355.8
1997	60.8	367.3
1998	61.4	379.2
1999	62.1	391.7
2000	62.7	404.9

Source: *Jamaica: Family Planning Projections, 1985-2000*, Family Planning Logistics Management Project, October 1989.

## **2.6 Areas in Which Improvement Can Be Made**

The CPS indicates areas in the family planning program in which improvements can be made that would further increase contraceptive prevalence:

### **Targeting adolescents**

- Fifty-three percent of women age 15 to 19 have had sexual intercourse.
- Ever use of contraception was lowest for the 15 to 19 age group; overall, the median age of first use was 19 years.
- Although only 2 percent of women had a birth before the age of 15, 37 percent had at least one child while still in their teen years. The mean age of women at first birth is declining.
- The largest percent of women in all age groups who were pregnant at the time of the survey were in the 15 to 19 age group (14.6 percent).

### **Better counseling/education on methods**

- More than half of the births that occurred in the five years before the survey were mistimed, with nearly 30 percent unplanned and the remainder unwanted.
- Only 20 percent of women had accurate knowledge of the fertile period.

### **Targeting high risk women**

- One-third of women currently in union are at high risk of getting pregnant due to their non-use of contraception. Of these women who are not using a contraceptive, but had used the pill in the past, the reasons for stopping use of the pill were related to health and unwanted side effects.
- Sixteen percent of all women in Jamaica had an unmet need for contraception. These are women who are noncontracepting, fecund, sexually active, and who are not currently pregnant or desiring to become pregnant.
- Sixty-four percent of women in most need of family planning services have used contraception at some time and 58 percent desire to use contraception now or in the future.

### **Stressing more effective methods**

- Use of the IUD declined from 4 percent in 1975 to 2 percent in 1989. Use of withdrawal increased slightly over the period, from 1 percent to 2 percent.
- In each age group, sterilized women have, on average, at least one child more than non-sterilized women. About 32 percent of women who have been sterilized have never used any other method of contraception before the operation.
- For women who currently want no more children, one-third state that they are interested in sterilization. This demand is especially high for women who have post-secondary education or who have 6 or more children. For women who currently want more children, the future demand for sterilization is even higher, 37 percent.

### **Targeting population groups in the various parishes**

- Contraceptive use varies among the 15 parishes of Jamaica. It is very low in 2 parishes (Kingston, 42 percent; St. James, 47 percent), but use is over 60 percent in 4 parishes (Trelawny, Hanover, St. Thomas, and St. Elizabeth). Use of female sterilization is relatively low in Westmoreland, St. James, Portland, and St. Andrew when compared to St. Thomas, Trelawny, and St. Mary. Use of condoms is low in Kingston, St. Thomas, St. Mary, and Clarendon relative to other parishes. Use of injection is low in Kingston, St. Mary, and St. Ann compared with relatively high use in Portland, Westmoreland, St. Thomas, Trelawny, and Hanover.

Specific program-related recommendations requiring action by the GOJ, NFPB and the MOH, as well as those which are project related and with implications for USAID action, are made throughout this report. Recommendations for USAID action are highlighted.

### 3. Summary of Project Outputs and Inputs

#### 3.1 Project Outputs

The number of service delivery points in which family planning is being offered throughout the country is meeting the planned expectation. In terms of VSC, there has been a significant shortfall in actual procedures done in comparison to the number planned. The CDC program has provided a significant portion of the contraceptive supplies to the population as seen in the estimated couple years of protection (CYP) that it has achieved. Training, both overseas and local, has been at the level expected, and most of the persons who participated in overseas training programs have continued to work in family planning upon their return to Jamaica.

Table 5 summarizes the main project outputs based on the expected targets in the Project Paper. In some cases, it was difficult to ascertain if outputs had been achieved because of the changing targets with the extension of the project from 1986 to 1991. (The outputs for the various adolescent and IEC subprojects are provided in Section 8.)

**Table 5**  
**Major Project Outputs**

Output	Planned	Actual
<b>Provision of Family Planning Services:</b>		
<b>MOH facilities</b>	364	358
<b>VSC services</b>	by 1985 8,000/yr	35,783 procedures for '82-'88 averaged 4,500/yr
<b>CDC services</b>	414,398* CYP	286,157 CYP
<b>Training: (trainees)</b>		
<b>Overseas</b>	26	31**
<b>Local</b>	12,013***	11,815

Source: *Semi-annual Review*, April 1, 1989 - September 30, 1989

\* Project Paper target

\*\* Cumulative since 1983 to December 1990

\*\*\*Planned project of local training up to March 31, 1990

### 3.2 Project Inputs

Total project inputs planned for the ten-year project period are US\$ 27,133,000, with about two-thirds of the funds coming from the GOJ, and one-third from USAID. Table 6 provides a summary of the planned total budget of the project.

**Table 6**  
**Source and Area of Funding**  
**for the Population and Family Planning**  
**Services Project**  
**(US \$000)**

Government of Jamaica	MOH	NFPB	Other Gov & Private Agencies
Salaries & Emoluments	3,155	4,328	1,078
Travel & Subsistence	830	499	456
Supplies & Materials	816	605	460
Rental	786	410	59
Public Utility Services	500	321	70
Other Operational & Technical Services	320	738	153
Subsidies		351	
Equipment		297	53
Other		137	
<b>USAID</b>			
US Personnel Services	427		
Overseas Training	170		
Supplies & Equipment	2,340		
Other Costs	4,016		
<b>Total</b>	<b>6,953*</b>	<b>6,407</b>	<b>7,686</b>
		<b>2,329</b>	

\*Excludes \$3,758,000 for centrally funded procured contraceptive commodities.

Project inputs from USAID can be categorized into five different areas: technical assistance, overseas training, supplies and equipment, contraceptive commodities, and subproject costs/local activities (see Table 7A). The percentage of the USAID budget for these categories is 2 percent for overseas training, 4 percent for technical assistance, 22 percent for supplies and equipment, 31 percent for contraceptives, and 41 percent for subprojects.

Clearly, this has been a supply-oriented project. The amount of funds provided for local activities has also been very high (see Table 7B). In contrast, both the funds allocated for, and the use of, technical assistance have been fairly limited, primarily due to a reluctance on the part of the NFPB to utilize technical assistance.

Table 7A

**Population and Family Planning Services Project:  
Project Budget as of 12/31/89**

<b>Project Element</b>	<b>Obligation</b>	<b>Committed</b>	<b>Disbursement</b>	<b>Uniquely Obligated</b>
Technical Assistance	377,000	284,375	131,765	245,235
Overseas Training	155,000	147,364	147,364	7,636
Supplies & Equipment	2,080,000	1,925,191	1,644,262	435,738
Sub-Projects & Local Activities	3,861,000	3,628,264	3,186,802	524,198
<b>Sub-Total</b>	<b>6,473,000</b>	<b>5,985,194</b>	<b>5,110,193</b>	<b>1,212,807</b>
Contraceptive Commodities	2,938,000*	2,938,000	2,712,000**	226,000
<b>Sub-Total</b>	<b>2,938,000</b>	<b>2,938,000</b>	<b>2,712,000</b>	<b>226,000</b>
<b>Total</b>	<b>9,411,000</b>	<b>8,923,194</b>	<b>7,822,193</b>	<b>1,438,807</b>

Source: USAID/Jamaica, Comprehensive Pipeline Report by Project as of 12/31/89.

\* Allotment Transfer

\*\* A.I.D. PAIS Report, Centrally Funded Contraceptives as of 9/30/89.

Table 7B

**Budget of Local - Other Costs**  
**Project Implementation Letter No. 108**  
**Activities Financed by USAID/Jamaica Project 532-0069**  
**(In U.S. Dollars)**

Activity	Earmarked Level to Date	Established Disbursements*
<b>A. NFPB</b>		
1. NFPB Training	83,886	71,105
2. NFPB Exec. Salary Subsidies	18,800	18,765
3. Male Motivation Activity	30,193	30,193
4. Training Staff	41,700	31,391
5. Adol. Fertility Resource Center	253,121	219,969
6. Management Services	8,100	8,021
7. Management Seminar	6,600	6,536
8. Short Course/Pop. Seminar	13,769	13,769
9. Victoria Jubilee Hospital	34,559	28,892
10. Vol. Surgical Contraception	523,268	413,268
11. Natural Family Planning Clinic	5,000	5,000
12. Evaluation & Research	129,552	60,562
<b>B. MOH</b>		
1. Teen Scene	29,500	29,169
2. Training Activities	10,000	5,111
3. ACOSTRAD	140,000	108,942
4. Government Laboratory	6,810	4,959
<b>C. Ministry of Youth &amp; Community Development</b>	<b>395,229</b>	<b>294,290</b>
<b>D. Ministry of Agriculture</b>	<b>26,000</b>	<b>25,359</b>
<b>E. PIOJ</b>	<b>25,000</b>	<b>22,786</b>
<b>F. STATIN</b>	<b>223,632</b>	<b>132,228</b>
<b>G. Registrar General Dept.</b>	<b>35,540</b>	<b>35,540</b>
<b>H. JFPA</b>	<b>264,713</b>	<b>183,399</b>
<b>I. Operation Friendship</b>	<b>613,695</b>	<b>514,263</b>
<b>J. YWCA</b>	<b>38,148</b>	<b>38,147</b>
<b>K. UWI Department of Statistics</b>	<b>85,000</b>	<b>84,717</b>
<b>L. Ministry of Education</b>	<b>100,000</b>	<b>82,443</b>
<b>M. Roman Catholic Family Life Education</b>	<b>73,900</b>	<b>15,477</b>
<b>N. Mass Media Advertising Campaign</b>	<b>206,857</b>	<b>118,624</b>
<b>O. Family Planning Liaison Officers</b>	<b>140,733</b>	<b>107,678</b>
<b>P. Education Family Planning Materials</b>	<b>72,850</b>	<b>67,029</b>
<b>Q. Commer. Distrib. Contraceptives</b>	<b>0</b>	<b>0</b>
<b>R. Contingency</b>	<b>224,845</b>	<b>0</b>
<b>Total</b>	<b>3,861,000</b>	<b>2,847,672</b>

\*As of NFPB's reimbursement request #68 to March 1989.

## **4. Family Planning Clinic Services**

### **4.1 Strategy of the Clinical Service Program**

As stated previously, the overall objective of the clinical service program of the family planning program is to serve that portion of the population most in need of services at either a low cost or free. Family planning services, considered by the GOJ to be an integral part of maternal and child health (MCH) care, are integrated into the MOH primary health care program which provides primary health care through 358 health centers throughout the country. Sterilization services are a part of its secondary health care program which includes hospital and other tertiary care.

Jamaica is divided into 4 administrative areas, 13 parishes, and 47 health districts. Ideally, each health district is to serve about 20,000 people through three types of health centers: Type I health centers provide basic MCH and first aid and are staffed by a trained midwife and two or more community health aides who have been given a few weeks of training in basic health care in order to do routine home visiting and monitor the health status of women, their young children, and persons who are chronically ill. Type II centers offer a greater variety of services and are staffed by a public health nurse, a registered nurse, and a public health inspector; medical officers or nurse practitioners visit these centers periodically to provide services. Type III and IV centers have more staff and provide more services; they are staffed by a full-time medical officer and/or a nurse practitioner and clerical staff. The differences between Types III and IV are minor; Type IV serves as the parish headquarters, and here are based the most senior health personnel. Each of the centers is linked organizationally by a patient-referral system and by regularly scheduled visits by staff from Type III centers to Type II, and from Type II to Type I to provide supervision, conduct clinics, and perform administrative work.

In addition to the 358 health centers providing family planning services and referral as part of their regular MCH services, there are two family planning clinics operated by the JFPA. One clinic is located in St. Ann's Bay (on the northern coast of the island), and the other is in Kingston, the capital city; both provide all family planning services, including sterilizations. The NFPB also maintains three family planning clinics, one in May Pen, Clarendon Parish; one in Portmore, St. Catherine Parish; and one in Kingston. These clinics provide all services except sterilization.

### **4.2 Implementation of the Family Planning Program**

Attendance records at the MOH health centers and the clinics operated by the JFPA and the NFPB for 1988 show a total of 302,534 visits. New acceptors totalled 44,866 for the year and revisits were 257,668. The MOH centers constituted the greatest number of visits, followed by the JFPA clinics and then the NFPB clinics (see Table 8, next page).

Table 8

**Attendance by Program Outlet  
by Type of Visit, 1988**

Program Outlet	Total	Type of Visit	
		First	Revisit
Independent FP Center	41,913	3,770	38,143
NFPB Centers	9,584	1,190	8,394
MOH Centers	251,432	42,571	208,861
<b>Total</b>	<b>302,929</b>	<b>47,531</b>	<b>255,398</b>

Source: Statistical report, NFPB, 1988, Table A.

The geographical spread of these visits throughout the country and the trend from 1987 to 1989 show both the volume of family planning visits and their stable nature, though there is some reduction in the number of visits since 1987 (see Table 9).

Table 9

**Family Planning Visits by Parish  
1987-1989**

Parish	1987	1988	1989
Total	334,706	302,534	286,661
Kingston - St. Andrew	112,438	91,974	82,293
St. Thomas	14,940	12,684	11,454
Portland	12,866	11,361	10,860
St. Mary	14,282	13,125	12,500
St. Ann	14,108	13,953	14,029
Trelawny	9,775	10,450	10,297
St. James	20,315	21,920	20,021
Hanover	13,242	11,838	11,082
Westmoreland	18,655	16,622	14,992
St. Elizabeth	20,619	20,186	20,829
Manchester	16,850	18,585	17,752
Clarendon	28,097	25,400	21,738
St. Catherine	38,519	34,436	38,814

Source: 1988 and 1989 figures from summary report of MOH/Jamaica - MCSRS; 1987 figures extrapolated from 1988 figures (Table 3).

## 4.2.1 MOH Health Centers

**Numbers of Family Planning Visits.** Since family planning is provided as part of an integrated service in the MOH health centers, it is important to see how family planning visits compare with visits to the health centers for other reasons (see Table 10, below).

**Table 10**

**Total Visits and Percentage of  
Each Service to Health Centers, 1988 and 1989**

Year	Total Visits	Antenatal	Postnatal	Child Health	Family Planning	Curative	Dental
1988	1,980,349	147,270 7.4%	70,101 3.5%	349,757 17.7%	302,534 5.3%	981,763 49.6%	128,924 6.5%
1989	1,977,058	157,127 7.9%	79,505 4.0%	367,320 18.6%	286,661 14.5%	911,942 46.1%	174,503 8.8%

Source: Summary report of MOH/Jamaica, 1988 and 1989.

For 1989, family planning visits constituted 14.5 percent of all visits. Fifty percent of visits to health centers were made for curative care. The almost universal attendance by women for antenatal care (the 1989 CPS found that 98 percent of all women who had a successful pregnancy over the past five years received antenatal care) and the large number of women returning to the centers for postnatal care provide opportune times to counsel on family planning. Indeed, this is being done, particularly for postnatal visits. About 61 percent of women attending postnatal services at MOH facilities in 1988 and 1989 accepted a family planning method (see Table 11).

**Table 11**

**No. and Percent of Mothers Receiving Postnatal Services  
Who Accept a Family Planning Method  
1988 and 1989**

Parish	1988		1989	
	Number	Percent	Number	Percent
Total	20,818	60.7	23,845	61.2
Kingston - St. Andrew	4,372	65.2	5,437	65.6
St. Thomas	1,123	75.1	1,151	72.0
Portland	892	66.0	1,141	66.8
St. Mary	832	47.8	868	46.3
St. Ann	860	34.4	1,183	41.5
Trelawny	1,184	77.3	1,101	73.2
St. James	1,255	42.4	1,470	45.1
Hanover	945	72.7	888	65.1
Westmoreland	1,324	61.1	1,472	59.5
St. Elizabeth	1,372	64.7	1,543	68.2
Manchester	1,692	70.9	1,768	69.8
Clarendon	1,599	59.1	1,695	56.8
St. Catherine	3,368	63.3	4,128	66.2

Source: Summary report of MOH/Jamaica MCSRS, 1988, 1989 (Table 8).

**Numbers of New Acceptors vs. Revisits.** It is important to distinguish between new acceptors and revisits in order to ascertain if the program is really acquiring new entrants, or whether it is mainly a resupply program. The definition for new acceptor is somewhat problematic: besides counting new entrants (persons who have never accepted a method before), it also includes women accepting a method after giving birth even if they have used contraception in the past for spacing, as well as women who switch from one method to another. Also, it is not clear what constitutes revisits. Women may return to a health center just for resupply of pills (a maximum of a three-month supply is given out at most health centers). If she is seen by a health worker, it is counted as a revisit; if she gets her supplies through a clerk, it is not necessarily being counted as a revisit. This problem may be resolved with the introduction of the new appointment/dropout register (see MIS section that follows). See Table 12 (below) for attendance at family planning clinics by type of visit.

Table 12

**Attendance at Family Planning Clinics  
by Sex and Visit Type, 1989  
and Comparison with 1988 Attendance**

Parish	Females		Males		New Acceptors		Revisits	
	Number	%	Number	%	Number	'89 % of '88 Total	Number	'89 % of '88 Total
<b>Total</b>	251,264	87.7	35,397	12.3	50,935	117.4	235,726	94.5
<b>Kingston - St. Andrew</b>	74,320	90.3	7,973	9.7	16,143	124.8	66,150	91.5
<b>St. Thomas</b>	10,729	93.7	725	6.3	1,976	118.7	9,478	89.9
<b>Portland</b>	9,250	85.2	1,610	14.8	1,293	109.1	9,567	95.3
<b>St. Mary</b>	10,415	83.3	2,085	16.7	1,977	86.5	10,523	97.1
<b>St. Ann</b>	12,607	89.9	1,422	10.1	3,330	124.1	10,699	94.9
<b>Trclawny</b>	8,708	84.6	1,589	15.4	2,694	130.9	7,603	92.9
<b>St. James</b>	16,504	82.4	3,517	17.6	3,265	120.2	16,756	88.9
<b>Hanover</b>	9,230	83.3	1,852	16.7	1,378	99.2	9,704	96.0
<b>Westmoreland</b>	12,646	84.4	2,346	15.6	2,208	102.2	12,784	88.5
<b>St. Elizabeth</b>	17,220	82.7	3,609	17.3	3,481	119.7	17,348	100.4
<b>Manchester</b>	16,145	90.9	1,607	9.1	3,195	97.3	14,557	95.6
<b>Clarendon</b>	18,310	84.2	3,428	15.8	3,563	108.5	18,175	82.4
<b>St. Catherine</b>	35,180	90.6	3,634	9.4	6,432	132.8	32,382	113.8

Source: 1989 figures from summary report of MOH/Jamaica.

**Types of Contraceptives Used.** Types of contraceptives chosen by new acceptors for 1989 are found in Table 13 (below). Pills, injections, and condoms are the preferred methods, in that order.

**Table 13**  
**Family Planning Commodities Distributed through**  
**MOH Service Delivery Points and Sterilization Referral by Parish**  
**1989**

Parish	Pill Cycles	Injections	IUDs	Condoms	Koramex	Spermicides	Ster. Referral
<b>Total</b>	288,891	113,684	1,883	1,278,012	2,933	5,216	6,061
Kingston - St. Andrew	76,251	34,309	693	362,187	904	2,464	1,319
St. Thomas	13,309	5,079	14	34,998	329	45	51
Portland	9,778	5,185	30	39,352	29	31	516
St. Mary	11,690	4,064	442	70,192	18	62	226
St. Ann	14,247	4,966	351	41,855	85	520	448
Trclawny	9,486	3,981	29	42,453	84	97	1,133
St. James	21,156	5,505	50	98,350	481	308	123
Hanover	11,185	3,648	12	46,710	55	35	34
Westmoreland	16,931	6,006	57	60,053	39	77	143
St. Elizabeth	22,681	8,206	29	121,400	173	72	1,266
Manchester	19,351	7,121	25	71,517	124	487	224
Clarendon	23,306	8,072	57	144,965	78	674	253
St. Catherine	39,520	17,542	94	143,980	534	344	325

Source: 1989 figures from summary report of MOH/Jamaica/MCSRS, 1989 (Table 19).

**Quality of Services.** One indicator of quality of care in the Jamaica family planning program is the sheer numbers of clients accepting family planning through clinics and the volume of new family planning acceptors being served at each clinic. There has been no recent IEC campaign promoting family planning services (e.g., the location of where to get services or the type of method), thus promotion of methods and knowledge of the service sites is coming from interpersonal communication among acceptors and potential acceptors: the satisfied user is the best advertisement for a family planning program. As referred to previously, 90 percent of women using family planning services are satisfied with them. Further, clinic accessibility is high; therefore, a clinic not providing quality services will soon be bypassed for one that is. This attests to the high level of competence and dedication of the service providers.

The Statistical Report of the NFPB lists the number of new acceptors by each of the 358 health centers in the country. It would be useful, at some stage, to select a sample of clinics to study, stratified by number of new acceptors, to ascertain whether acceptor rates reflect service delivery problems. A study of clinic productivity was undertaken in 1985 with the assistance of the Primary Health Care Organizations Research Project (PRICOR) and changes in clinic management are being tried in a few locations near Montego Bay. The results of that field study, and possibly another clinic survey/patient flow analysis concentrating on family planning may be useful in determining how services could be enhanced, particularly in those clinics showing poor acceptance figures.

Table 14

**Distribution of Centers Reporting  
Family Planning Activities by  
Number of New Acceptors, 1988**

<b>Number of New Acceptors</b>	<b>Number of Centers</b>
Under 20	78
20-39	42
40-59	43
60-79	35
80-99	22
100-119	23
120-139	11
140-159	12
160-179	10
180-199	16
200-219	6
220-239	7
240 and over	45
Total	350

Source: Statistical report, NFPB, 1989, Table E.

The evaluation team visited a few clinics of each type, and although it was not known whether these clinics were representative, the quality of family planning services being offered seemed high. Observations in the clinics pointed out a number of problems, however, that, if not confined to just these clinics, would be a cause of a concern:

- Written guidelines on appropriate family planning methods according to the client profile were not available. There were no written procedures on what to do in the event of method problems or how to assess for method changes.
- Clinic personnel were not using maximum/minimum stock level indicators for resupply of commodities.
- Expired contraceptive stock was being stored and used.
- Oral contraceptives were seriously low at one clinic.
- There was no progestin-only oral contraceptive being offered in MOH health centers, where referrals are being made for post-partum women.
- IUD insertions were not being encouraged by the service providers, possibly due to their own misconceptions about IUDs and the lack of insertion training.

**Referrals.** With regard to IUD insertion, there does not seem to be a system that is used to refer patients who would be good candidates for the IUD. This may be due to 1) a lack of knowledge of who locally in the health care system can do the procedure, and 2) the lack of enthusiasm for the method by the service provider.

With regard to sterilization referrals, although referrals are recorded at the health centers, there is no way to match referrals with actual sterilizations performed. Furthermore, there is no follow-up by the health center to see if the procedure is actually performed. In 1989, for example, 6,061 persons were referred for sterilization and 1,851 interval procedures were performed. Unfortunately, there is at present no system to match those referred with those who were sterilized (see Section 5.3.7).

**Clinic Education/Counseling.** There are no recent materials or teaching aids available in the clinics for promoting family planning. There are, however, various posters for family planning displayed throughout the clinics. There are also stickers on the walls with family planning slogans.

Each patient is counselled individually, but according to the personnel interviewed, there is not enough time to counsel properly.

**Monitoring and Supervision.** There is an organized system of supervision with a regional supervisor in charge of the Level III zonal supervisors. The zonal supervisors use their own private vehicles or public transport to visit health centers and are reimbursed after expenses are incurred. They develop monthly itineraries based on the needs of the zones. There is a checklist for supervision, but it was not available to the evaluation team. There is no formal reporting system of supervision activities.

Rather than providing monitoring of the quality of services, the supervision visits have become more of a personnel backup system, with zonal supervisors serving as replacements for personnel who are absent from the clinics. Although such a backup system is excellent to ensure that services are provided, the quality of services needs to be monitored periodically.

**Human Resources.** Although no analysis of actual vacancies of trained personnel has been undertaken, the human resource situation in the health system in Jamaica is very poor. Starting from a position of strength, with extremely competent and dedicated medical personnel, the various cadres of health care workers have been severely depleted through emigration to the U.S., Canada, and Europe. Secondary health care in the hospitals has been the most severely affected by this attrition, but it has also affected primary health care provision.

In terms of MOH supervision, there are two persons with direct responsibility for family planning, the Senior Medical Officer for MCH and the Family Planning Coordinator. This last position is a secondment of an NFPB staff member to the MOH. This allows the NFPB to have a direct input into MOH service delivery and gives the Family Planning Coordinator executive power in the MOH.<sup>6</sup>

**Management Information System (MIS).** The MOH has developed a good MIS for its PHC program, which includes family planning. Every month each health center tabulates, from printed tally sheets which provide services performed daily in the center, the number of actions the center has performed over the month. These data are sent to the MOH and entered into a computer. Quarterly printouts are issued soon after data inputting; for example, the annual statistics for 1988 were issued by February 15, 1989. The family planning data are provided to the Research

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<sup>6</sup>Under the direction of the Chief Medical Officer and the Executive Director, NFPB, the Family Planning Coordinator liaises or works in collaboration with the Principal Medical Officer/PHC, the Senior Medical Officer/MCH, and the Medical Director, NFPB. She also collaborates with any other agent or agency involved in family planning programs or activities, e.g., Principal Medical Officer/Senior Medical Officer, Secondary Care of the MOH, the World Bank Project Manager, etc.

and Statistics Department of the NFPB and data from other health centers (private, hospitals, etc.) not included in the printout are added. The NFPB issues a yearly Statistical Report.

There have been some difficulties in the system. In the design of the summary form, the MOH did not consult with the NFPB and some information on the summary form in connection with postnatal family planning acceptance may not be recorded properly. This situation has been brought to the attention of the MOH and it is anticipated that training in filling out the form will take place to correct the form's deficiency.

It is not clear just how the data collected through the health information system are used for program management by the MOH, although copies of the computer printouts are provided to each parish as a guide for program planning. Targets for the next year's performance are then set based on the previous year's results. In any case, the completeness of the system in terms of capturing data from all service delivery points makes it a useful instrument to describe the progress of the PHC program.

The MOH has also recognized that the medical records system cannot easily be used to identify promptly dropouts from the family planning program. The present system being used does not routinely provide valuable information that managers could use for monitoring, strategic decision-making, planning or evaluating. It has, therefore, recently developed an appointment/dropout register for use in health facilities. The register utilizes a system of assigning each acceptor or user a unique identification number and records the acceptor's basic information, including age, parity, and method chosen. Family planning appointments are kept in this registry. Scanning the column for the current month reveals who has not kept an appointment and the information on the opposing page provides sufficient information to initiate follow-up visits. This system will help in the development of a profile of women using health centers for family planning. Also, the information on age and parity is critical for determining method appropriateness. Once this register is fully field-tested and revised, if necessary, it could provide health centers with their own management tool for family planning service delivery.

#### **4.2.2 Jamaican Family Planning Association (JFPA)**

The JFPA offers a wide variety of contraceptive methods to clients in its two clinics. In the clinic visited in St. Ann's Bay, all methods were displayed in the waiting room and listed in the consultation room. Female sterilizations are also performed in the clinic. Family planning supplies are ordered systematically at the end of year and are based on a three-year plan developed according to the budget allocated by the International Planned Parenthood Federation (IPPF). Consumption of contraceptives are based on distribution figures.

**Clinic Education/Counseling.** One-to-one counseling is provided at the clinics on a daily basis. Clinic nurses have a clear understanding of the need to match patients with particular methods depending on patient profiles.

**Outreach.** The JFPA has 13 outreach workers giving free contraceptives to clients in rural communities in St. Ann's and Trelawny. There is one supervisor for the outreach workers. They have achieved good continuation rates: 78,008 clients were continuing acceptors in 1989, 4,977 of which were new acceptors. The outreach workers provide a report of activities monthly when they receive their salaries. They are supplied with contraceptives twice a month. The JFPA is highly active with community organizations and is well supported by the community, a reflection of satisfaction with the services offered.

In addition, a private sector program of the JFPA works with factories and hotels in the nearby areas. One person is designated as a distributor and does counseling as well.

**Referrals.** Referrals for tubal ligation are excellent since they are done in the same facility.

The St. Ann's Bay clinic has begun a program in which current patients are asked to bring in three friends in order to increase the number of new clients. Local companies donate items that are used as prizes for those who bring in these friends.

IUDs are also inserted in the clinic and the facility is selling IUDs to private physicians in the community. The IUD has been a popular method in this area and there has been no decline in acceptance.

**Human Resources.** The clinics are well staffed; staff include medical officers who perform sterilizations.

**MIS.** The clinics provide their client data to the NFPB.

#### 4.2.3 **National Family Planning Board Clinics**

These clinics offer all contraceptive methods with the exception of sterilization; referrals for sterilization are made to Victoria Jubilee Hospital. There was no evidence of written protocols or guidelines to assist in matching clients to different methods. The number of clients for exclusively family planning clinics appears small. For one clinic, there were only 182 new acceptors for 1988. In the same clinic, however, 50 IUDs were inserted during 1988.

**Clinic Education/Counseling.** In one clinic visited, there was considerable activity in education and counseling of specific target groups, such as adolescents from nearby schools and factory workers and community groups. There were materials available in the waiting rooms, but there were no signs identifying the clinic as a provider of family planning services.

**Outreach.** There are many activities supported by the clinics to promote outreach. Programs to increase new client participation are carried out through health fairs, school educational sessions, teen mother centers, churches, and "client appreciation days," during which small gifts are distributed. The Parish Liaison Officer (see Section 9.1 for a full description of this position), when active, can assist in transportation and the promotion of these activities by helping in their arrangement and in counseling sessions.

**Referral.** The clinics provide referral forms to patients so that the hospital accepting a client for sterilization will know the source of referral.

**Human Resources.** The clinics are staffed by midwives.

**Monitoring/Supervision.** Since there are only three NFPB clinics, the Nursing Supervisor of the NFPB is able to carry out visits to the clinics on a weekly basis.

**MIS.** The clinics complete a printed monthly report form which is sent to the NFPB. The form includes data on total number of clients seen, number of new clients, number of revisits, number of visits for counseling only, number of male visits for condoms, and number of new acceptors under 20 years. The form also breaks down clients by parity and age for each method.

#### 4.3 **Conclusions**

The quality of family planning services provided through MOH health centers as well as the NFPB and JFPA clinics is high. In addition, the countrywide network of MOH health

centers provides easy access to most women for family planning services and it is in these centers that most women in Jamaica receive their contraceptives. NFPB and JFPA clinics, at times, organize promotional events that bring clients into their clinics; these clinics also provide good counseling services to clients.

The health information system for PHC is excellent. Family planning information receives adequate attention. The ministry is developing a family planning register for clinic use that will be useful for management information needs at that level. The monthly report form of the NFPB clinics is excellent, giving breakdowns of acceptors by parity and age.

There are, however, some areas of concern:

- Because there is some reluctance on the part of service providers to insert the IUD, this method is declining in use.
- Both the rushed nature of the family planning counseling provided in MOH health centers and the lack of materials on family planning and teaching aids reduces the effectiveness of the counseling effort.
- Because most JFPA and NFPB clinics keep the same working hours as the MOH health centers there may be a duplication of services.
- Referrals are made for sterilization services to hospitals or private family planning clinics; however, there is no system to provide follow up information on whether the sterilization was performed or if there were any difficulties.
- A good supervision system is in place for the PHC program but, because of staff attrition, supervisors have at times become replacements for absent staff.

#### 4.4 Recommendations<sup>7</sup>

1. A clinic study/patient flow analysis concentrating on family planning should be undertaken before the next population project commences in order to ascertain specific areas needing attention in terms of service delivery. If requested by the NFPB or MOH, USAID should provide the technical and financial assistance for this study.
2. Just as the standards for VSC have been reviewed and revised (see Section 5.3.2), the standards for the other family planning methods are being reviewed to ensure that the latest information on them is being provided to the health worker. A copy of these standards should be provided to each health facility.
3. Because of the wide distribution of MOH health centers, the family planning clinics of the NFPB and JFPA should be encouraged not to duplicate services in areas where MOH health centers are available. Family planning clinics should supplement the services offered in MOH health centers; e.g., they could offer services in the evenings or on the weekends when MOH health centers are closed.

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<sup>7</sup>The recommendations given through Chapter 10 of this report are considered to be primarily of a short-term nature, with some continuing into the long term. Recommendations for USAID action are highlighted. The recommendations are also collected together as Appendix D.

4. It is important that the post-partum counseling opportunity is followed up with receipt of a method. Therefore, more attention should be given to IUD insertion and the provision of progestin-only contraceptives, such as Ovrette.
5. **A training program for service providers in inserting Copper T 380 IUDs should be undertaken, to be followed by an education/motivation campaign aimed at both the providers (to remove any reservations they may have on inserting the IUD) and the clients, targeting those most appropriate for this type of contraceptive. If requested by the NFPB or MOH, USAID should provide technical and financial assistance in undertaking this training program.**
6. To facilitate referrals, each health center that does not have staff who are able to insert IUDs or provide surgical contraceptive services should have a sign posted stating the nearest clinics where there are staff who can insert IUDs as well as the nearest facility for surgical contraception services. Information on clinic hours and the facility's address should also be included.
7. **To make better use of the waiting areas in all health centers, posters should be displayed illustrating the different methods of family planning with brief explanations of the method and with information on the ideal client profile. These method and client profile posters should be developed and field-tested with the participation of a population of waiting room clients to ensure that the messages are appropriate and the visual aids are understandable. If requested by the NFPB or MOH, USAID should provide technical and financial assistance for the development of these specific posters.**
8. Training of health personnel in counseling skills should form a part of all in-service training courses. In this way, special courses on counseling may not be necessary, and the importance that is placed on the most effective ways of communicating with clients would be constantly reinforced. Training should encourage service providers to acknowledge their own personal biases in method choices and to respect a client's choice.
9. Simple guidelines on counseling techniques that are effective in informing clients about all methods should be made available to all clinic staff.

## 5. Voluntary Surgical Contraception

## 5. Voluntary Surgical Contraception

### 5.1 Objective

The project set 8,000 voluntary sterilizations to be performed annually by 1985 at its objective in the area of VSC. The VSC section of Project Amendment Number 3 expanded the objective to assure the availability of quality VSC for both females and males. Quality enhancement of VSC was to include the upgrading of VSC counseling, surgical standards, and patient follow-up. Also, the waiting period for female procedures was to be reduced to approximately one month from the 1985 average of three.

### 5.2 Strategy

The MOH's secondary health care program through its hospitals with maternity services and other centers equipped for VSC were to perform sterilization procedures as a regular part of their surgical workload and, when required, on an overtime basis. This was to include both post-partum and interval sterilizations. Post-partum sterilizations were anticipated to be the most popular because women who have just delivered are more easily motivated and a large percentage of women deliver in hospitals.

The USAID and GOJ inputs that were planned to reach this objective include

- USAID-- J\$50.00<sup>8</sup> to reimburse clinics/clinical staff for each procedure undertaken
- Supplies and facility renovations
- Technical assistance as required
  
- GOJ -- Facility, personnel, and operational costs

### 5.3 Implementation

#### 5.3.1 Trends in Numbers of Procedures Performed

In the first few years of the project, the number of VSC clients increased: a 52 percent increase from 1982 to 1983, from 3,858 to 5,896. During the period 1983 to 1984, there was a further increase of 12 percent to 6,587 VSC procedures. If this trend had continued, the project's objective for VSC would have been achieved. Starting in 1985, however, the number of VSC procedures done in MOH and NFPB-supported facilities began to decrease. As of 1989, the number of VSC procedures performed under the national family planning program was 3,349. See Table 15 for the trend in female sterilization since 1980 and Table 16 for the percentage distribution between post-partum and interval sterilizations from 1985 to 1989.

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<sup>8</sup>J\$6.50 = \$US1.00

Table 15

Trend in Female Sterilization Since 1980

Year	No. Procedure	Percentage Change From Prev. Year
1980	2,814	
1981	3,062	8.8
1982	3,858	26.0
1983	5,896	52.2
1984	6,587	11.7
1985	5,397	18.1-
1986	5,045	6.5-
1987	4,365	13.5-
1988	4,635	6.0-
1989*	3,349	27.7-

\* Provisional figures

Table 16

Post-Partum and Interval Sterilization  
Performed from 1985 to 1989,  
Percentage Done by Year

Year	No. Post-Partum	Percent	No. Interval	Percent	Total
1985	2,978	56.5	2,294	43.5	5,272
1986	2,433	49.3	2,499	50.7	4,932
1987	2,349	54.5	1,965	45.5	4,314
1988	1,837	48.8	1,930	51.2	3,767
1989*	1,498	44.7	1,851	55.3	3,349

Source: Statistical reports, NFPB, 1985, 1986, 1987.

\* Provisional figures

### 5.3.2 Program and Societal Constraints

The beginning of this downward trend was first investigated in 1985 when the Association for Voluntary Surgical Contraception (AVSC) undertook an assessment of the VSC program. At that time, the program was carried out through 20 MOH hospitals and 2 JFPA clinics by about 60 physicians. AVSC's assessment found that increases in demand for VSC were substantial; it estimated that a minimum of an additional 16,290 procedures were necessary to meet just the current demand. This demand could not be met, however, due to the shortage of skilled nursing staff to provide adequate counseling and client recovery care; a shortage of supplies; the non-utilization of new VSC techniques; and the lack of adequate medical supervision, monitoring,

and medical screening. In addition, the national program did not have standard guidelines for VSC, a system to certify physicians for VSC, or the requirement to submit reports concerning complications or informed consent forms to the MOH or NFPB. To correct some of these deficiencies, it was recommended that all facilities be evaluated with the view to selecting 10 or 12 to be provided with special support, in terms of retraining of personnel and the provision of a different type of financial support by USAID in order to improve VSC performance.

The lack of a system to ensure voluntary and informed consent was of particular concern to USAID, and prompt actions were taken to deal with it. The payment system to reimburse institutions/service providers for VSC procedures performed was linked to the receipt of correctly completed standardized consent forms. This solution has achieved compliance.

Other possible constraints on the VSC program include the following: Sterilization clients must make up to three visits to the doctor/institution before the procedure is done -- the first visit for counseling, the second for an examination, and the third for the actual procedure. This number of visits would certainly inhibit all but the most motivated clients. In addition, in a few clinics visited, it was reported that at various times in the family planning program, transportation to the hospital was arranged for sterilization clients. These systems are no longer in place and clients must find their own way to the hospitals.

Further, sterilization may not be as culturally acceptable in Jamaica as in other societies, due primarily to marriage practices and the stability of unions. Women not in stable unions, even if they have many children, may not wish to be sterilized. They may anticipate having other children, if and when they enter into more stable unions. Although there is evidence in the 1989 CPS that sterilization is fairly widely accepted -- 92.4 percent of women who have been sterilized are satisfied with the operation, and 32.7 percent of women who want no more children, as well as 37.0 percent who do want more are interested in sterilization -- this possible cultural bias against sterilization may affect the way in which sterilization is viewed by service providers/referral agents and clients.

### 5.3.3 AVSC Technical Assistance

Most of the deficiencies noted in 1985 report discussed above, however, have remained to the present and staff shortages of nurses have been particularly severe in the past few years. It was not until the middle of 1987 that AVSC formally proposed technical assistance and other assistance to respond to some of the needs identified a year and a half earlier. Another AVSC assessment was done in the fall of 1987, reiterating the need for more attention to quality of VSC counseling, services, and supervision. In early 1988, a draft scope of work for technical assistance was drawn up. The initiation of AVSC assistance did not take place until March 1, 1989.

The AVSC assistance now under way has three objectives: 1) to improve the quality of the sterilization program through professional education, training of trainers, establishment of a medical supervision system, the review of equipment and facilities, and training of paramedical staff in counseling and provision of educational materials; 2) to improve access to sterilization services through improved clinic management/patient flow, review of the system of provider payments, and development of specific IEC messages for service sites providing sterilization services; and 3) to introduce vasectomy as a program method through the conduct of focus groups to learn about male attitudes and preferences with regard to services, train male educators for community outreach programs, review training requirements for physicians, and assess the need to develop specific vasectomy materials.

### **5.3.4 CPS Information on Method Acceptors**

The 1989 CPS provides a profile of women choosing voluntary surgical contraception: Women who have been sterilized are generally older (38 years) have more children (about five) and are less educated (63 percent have a primary education only) than non-sterilized women, who are younger (average age 28), with fewer children (about 2) and better educated. In each age group, sterilized women have an average of at least one more child than the non-sterilized. Thirty-two percent of women who have been sterilized had never used another method. Nearly three-fourths of the women who have been sterilized have received counseling prior to the operation. Ninety-two percent have been satisfied with the operation. For women who currently want no more children, one-third state they want to be sterilized. For women who want more children, about 37 percent want eventually to have the operation.

### **5.3.5 Quality of Services**

Throughout the period under review, consultant reports have noted concern about the quality of VSC services. There have been seven maternal deaths reported in connection with sterilization or aftercare in the last 15 years. In 1987, AVSC suggested that a seminar on VSC safety for physicians be held. At the seminar, needs were identified concerning the refinement of both post-partum minilaparotomy procedures (smaller incisions, low anesthesia dosage), and interval minilaparotomy procedures (using local anesthesia and sedation).

It has been only since the initiation of AVSC's assistance in 1989 that plans are being made to improve the quality of the sterilization program. For example, there is no procedures manual to be used by physicians when undertaking VSC procedures. Thus far, with AVSC's assistance, some progress has been made in the development a such a manual of standards; a draft norms manual was produced and reviewed by a committee of physicians in February 1990.

It is also planned that an assessment of VSC facilities will take place in early 1990. This is vital to the planning of any subsequent activities with regard to the need for equipment, training, etc. For example, post-partum sterilization has provided the greatest number of clients, since they are already in the hospital after delivery. However, the lack of nursing staff, particularly for aftercare in some facilities, along with the severe shortage of beds in many facilities, has caused a decrease in the number of post-partum sterilizations performed. Victoria Jubilee Hospital in Kingston, which has a well-established post-partum program, had to stop its VSC program for just these reasons. (With AVSC funding of two nurses and the MOH funding of other positions, this program is about to be revived.) After reviewing the needs of the various facilities in Jamaica, it may be possible to develop solutions to the particular circumstances in each facility.

### **5.3.6 Training**

For many years, the Department of Gynecology and Obstetrics of the University of the West Indies has had an active family planning unit and a training program in sterilization. The technique taught in the university program is laparoscopy sterilization. The preferred method of the MOH and AVSC, however, is minilaparotomy. Although some physicians are proficient in both methods, physicians not familiar with the minilaparotomy technique and new physicians entering the service need to learn this procedure. At the present time, there are not enough patients to undertake a major minilaparotomy training program, unless Victoria Jubilee Hospital with its large maternity section could be used.

### **5.3.7 Education, Counseling, and Referral Services**

Public education. There has been no public education campaign for VSC. Although promotional/informational materials on all methods of family planning are not plentiful in Jamaica,

VSC seems to be particularly deficient in this area. For example, in the 1990 calendar issued by the NFPB, all methods are named but only the contraceptive pill, Perle, and the condom, Panther, are advertised. In the calendar's chart that provides the facts about various methods and information on advantages, possible problems, and warning signals, tubal ligation and vasectomy are not included.

**Post-partum counseling.** Post-partum counseling is an established program in Jamaican hospitals. Since a large percentage of births takes place in MOH facilities, these facilities provide a significant, receptive audience for family planning messages, including sterilization. For example, at the Victoria Jubilee Hospital in Kingston, with approximately 30 percent of all hospital births in the country (about 12,200 out of 42,300 births a year), has had a post-partum counseling program for many years. However, due to the severe shortage of nurses, this program is now carried out by one post-partum nurse/counsellor rather than six.

In terms of counseling for sterilization, the MOH has set down some very general guidelines that a counsellor may follow: a sterilization procedure may be performed 1) for specified medical reasons as determined by the physician, 2) on women over the age of 25 years who have indicated that they have completed their family, and 3) on women with three or more children. Whether these guidelines are followed and whether certain methods are promoted over others is not easy to determine without studying the views of the counsellors with regard to the various methods of family planning and how they actually counsel clients. A senior medical officer involved in family planning offered the view that at the third birth the woman should be given an IUD and only with the fourth birth would sterilization be appropriate. If the goal of the family planning program is to have women accept VSC at lower levels of parity -- i.e., after the third birth -- attitudes that view sterilization as only appropriate after the fourth birth will limit the effectiveness of this method in reducing fertility rates. As noted in the profile of women accepting VSC (see Section 5.3.4), the procedure is done primarily on higher parity women; thus, the impact of the procedure on reducing potential births is diminished.

**Referrals for interval sterilizations.** Referrals for interval sterilization are not linked with actual procedures undertaken. Therefore, it is impossible with the present data to know if those referred (number of referrals in standard reports) are actually the ones who are being sterilized. No standardized referral form identifying the source of the referral is being used to identify sterilization clients.

As in the case of post-partum counseling, the views of health workers in the Types I to III clinics on family planning methods are not known. Their own biases concerning VSC may affect whom they refer for the service.

**MIS.** There is no formal reporting of the number of sterilization procedures performed through the Secondary Health Program Directorate of the MOH. Although this situation is being investigated, more attention needs to be given to standardized recording of all procedures and linking these reports to the present health information system of PHC. The NFPB only knows of the number of sterilizations that are performed in the country through the submission of client consent forms.

**Private sector.** The number of procedures done by private physicians is not known. The 1989 CPS found that most sterilizations are done in public hospitals (88 percent). Private hospitals (7.2 percent) and private doctors/clinics (4.2 percent) constitute a small but potentially important future source.

**Physical and human resources.** Because sterilization procedures have been performed in Jamaica for some time, hospital facilities are in place and there are physicians trained to perform the surgery. It is possible, however, that equipment may be needed in the hospitals for the surgery. The physical assessment planned for later this year will address this issue.

The AVSC project called for a person responsible for sterilization to be identified in the MOH who would carry out the tasks required with assistance from a AVSC adviser. The MOH identified a physician who, however, could not be released from present duties to take on this task. The medical director of the NFPB was subsequently identified as the person responsible for sterilization. Although this solution has facilitated project activities thus far, the designation of a lead person for sterilization who cannot devote full time to establishing the system for sterilization nationwide, and who is not working directly in the MOH, may be problematic over the long term. Since the MOH is in charge of the hospitals where the procedures are taking place, it will be difficult for someone not working in the MOH to supervise this vital component of the contraceptive delivery system.

As stated above, USAID provides a cash payment (J\$50) to the providers of VSC services for each procedure undertaken. Even though the amount is quite small when divided, at times, four ways -- between the physician, anesthetist, nurse and helpers -- if enough procedures are done in a day, the payments become meaningful. The portion of funds allocated to a nurse allows the hospital to hire a nurse to assist in VSC procedures. With the shortage of nursing staff, this may be the only way to motivate nurses to assist in these procedures.

The MOH has decided that the cash payments should no longer be paid to individuals, but should go to the institution where the procedure is done. The reason for this change is the realization that sterilization should not be considered an extra duty of hospital staff. Also, the issue of payment for providing services has been a constant source of worry for the MOH and NFPB -- the providers always want more and delays in payments act as disincentives. There is the fear, however, that if the providers do not get some payment, since it is now considered a part of their entitlement, they will not perform the procedure. The institutional payment may still be used for hiring nursing staff on a per-session basis if the regular nurses are not available.

## 5.4 Conclusions

A concern early on in this project was the lack of a system to ensure voluntary and informed consent. A payment system to reimburse institutions/service providers for VSC procedures performed was linked to the receipt of correctly completed standardized consent forms. This solution has worked: informed consent is now a standard practice of the MOH and the NFPB.

The client profile of the sterilization acceptor shows that women who have chosen this method are generally older and have more children than their cohorts who have not chosen VSC. This implies the need to either refocus the program on cohorts of women somewhat younger than the groups now accepting, to place emphasis on longer-term methods that are already available such as the IUD, (but are not popular at this time), or to introduce a new method, such as Norplant.

The potential for establishing a VSC program in Jamaica is excellent. However, without priority being given to it by the MOH and NFPB and a physician put in charge who can work full time to organize and "breathe life" into the existing structure, the efforts being made in revising norms, etc., will not realize their full potential to establish a complete and functioning VSC referral system in the country.

## **5.5 Recommendations**

1. **The MOH and NFPB should ensure that a full-time obstetrics and gynecology specialist is appointed to head up the VSC program in the Secondary Health Care directorate. The model of the Family Planning Coordinator in the MCH unit to help in the implementation of family planning through the primary health care program should be used (see Section 4.2.1).**
2. **The NFPB should provide more information on VSC to both the service provider in health centers (to educate and motivate them on the procedure) and to potential clients.**
3. **A system for collecting information on all VSC procedures both from public and private institutions should be instituted and linked with the already established PHC health information system's reporting on family planning. Sources of referral should be included in this new system. If requested by the NFPB or MOH, USAID should provide assistance in helping to establish this system.**
4. **Institutional incentives should remain for VSC at the same rate for the short term. However, once a national system is operating under the MOH, consideration should be given to discontinuing the institutional incentive program, since the program would then be fully integrated into the MOH service system. USAID assistance should be continued for the short term.**
5. **USAID assistance through AVSC should continue during the project period to help the MOH and NFPB implement the required changes. Further technical assistance from AVSC may be necessary at the end of the present project, and USAID should provide this assistance if necessary.**

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## 6. Commodities and Logistics

## 6. Commodities and Logistics

USAID provides the NFPB with IUDs, contraceptive pills, and condoms. The private IPPF-affiliated program of the Jamaican Family Planning Association orders some commodities from IPPF. The injectable Depo-Provera is provided by UNFPA, while smaller quantities of miscellaneous lesser methods are obtained from a variety of sources. The NFPB provides the necessary administrative and support services to all participating programs in order to ensure that the procurement, importation, and distribution of commodities, as well as the financial management of the project funds, are carried out.

### 6.1 Procurement of Commodities

#### 6.1.1 Forecasting

Forecasting has been done on an annual basis by the USAID Health and Population Assistant with technical assistance from the U.S. Centers for Disease Control. Estimates of need are based on figures of monthly distribution of commodities leaving the warehouse. A yearly distribution figure is calculated and used as estimated yearly consumption. The forecasting is calculated using a computerized program developed by the Centers for Disease Control and a copy of this program has been installed on the USAID mission computer. Contraceptive Procurement Tables (CPT) are prepared using two historical years of data and projections are automatically produced for the following three years. Other good data, however, such as warehouse distribution records, new and continuing user data from the MOH and NFPB, and survey data, have not been taken fully into account in forecasting contraceptives.

#### 1990 CPTs

For the MOH clinic-based program, an additional 1,493,000 52 mm non-colored Sultan condoms will be needed for 1990. This is based on a 5 percent annual increase in condom use from 1988's actual distribution records and the warehouse stock cards' beginning-of-the-year stock level figure.

Lo-feminol, the MOH clinic-based oral contraceptive, will not need additional stock in 1990, since distribution in 1989 was lower than expected at only a 4.03 percent increase. This is significantly lower than the projected 10 percent increase for 1989. There are 107,000 cycles of Lo-feminol shipped but not yet received for 1990.

Fewer than 400 Copper T 380 IUD insertions were performed last year out of a total of 941 Copper T 380's that were distributed during 1989. There are 3,489 Copper T IUDs that expired in April 1989 in the MOH warehouse. One thousand Copper T 380 IUDs have been ordered for 1990 in view of planned training and promotion of this method in the near future.

The NFPB's CDC program condom, Panther, has only an estimated two months supply on hand. An estimated 2,873,000 units needs to be ordered for 1990, representing a 15 percent increase in sales over the previous year.

## **6.1.2 Ordering of Commodities**

Once forecasting is completed, an order cable is sent to Washington by the USAID to initiate production and shipping. The order cable includes the financial requirements using the project funds and a shipping schedule. Ordered quantities are sometimes changed according to the production capacity in Washington; however, the adjusted order is often not known until it is cleared from customs and boxes are opened in Jamaica.

In addition, orders are sometimes late. For example, in January 1989, an order was made for 57,600 units of Conceptrol; it was just airshipped in January 1990. A.I.D./Washington had taken immediate action, however, when notified of the problem and airshipped Conceptrol that arrived in country within ten days of notification of the problem.

The shipping schedule is worked out between the NFPB, the CDC program, and USAID. The shipping schedule is developed by taking into consideration number of months of stock on hand, and dividing estimated needs by storage capacity at the central warehouse. There has been a computerized shipping document developed in Washington called NEWVERN which assists in tracking the status of an order. Orders are marked planned, shipped, or received and are used by USAID to track shipments identified by the order cable number.

The MOH orders limited quantities of oral contraceptives and Depo-Provera on an ad hoc basis. Quantities purchased depend largely on funds available. The NFPB is not an active participant in the ordering process, especially in the monitoring of funds allocated for the purchase of commodities. As stated above, the JFPA orders commodities directly from A.I.D./Washington and IPPF. At the end of the year, estimated monthly consumption and estimations for the next year's order are made. The JFPA works on a five-year plan and has had no serious stock-outs.

## **6.1.3 Importation**

Once a shipment arrives at the port, the shipper notifies USAID and the NFPB. Official documents are requested in the original order cable specifications. The documents are included in the shipment and are sent to the NFPB and USAID in order to start the process of clearing the goods through customs. Under normal circumstances, commodities are cleared and delivered to the warehouse in approximately two weeks. Lead time from the time an order is cabled to the actual receipt of goods to the consignee is estimated at two months for Jamaica, if the product is available. If there are problems with documents, the NFPB assumes responsibility for payment of storage fees at the port until goods can be cleared. The NFPB also clears commodities for the JFPA.

There have been some problems with the importation of commodities when proper documentation was not received by either the NFPB or USAID. For example, in August 1989, 1,104,000 Sultan condoms arrived at the port without proper documentation. USAID assisted the NFPB in finding immediate alternatives to releasing the goods from customs. However, these commodities have remained at the port to date.

There have also been instances when the NFPB has received an incorrect shipment; e.g., at one point, a shipment of 516,000 Sultan condoms was shipped instead of the requested Panther condom.

## **6.1.4 Storage and Distribution**

All commodities for the NFPB are stored at the MOH central warehouse in Kingston. Other medical supplies are also kept at this location. The warehouse has adequate space; pallets, racks, and shelves are in sufficient quantities; and there is adequate lighting,

ventilation, and security. Stock cards are updated regularly. Three NFPB vehicles deliver requested supplies on a weekly basis. The first-in first-out method is used in filling orders from the field.

Storage conditions at the service delivery points for the MOH on the average hold three months worth of stock. Field visits revealed that there were no problems with storage of goods. The majority of clinics keep an up-to-date logbook on commodities received.

Training in supply management and refresher courses have been undertaken and a manual was developed and distributed to all participants. This training and manual have been important in ensuring the high quality of supply management.

At the same time, in reference to the above-noted expiration of some IUDs, actions have not been taken promptly to collect and destroy these expired commodities. Further, there is a large stock of Copper T 200B IUDs in the field without a marked expiration date. (USAID no longer provides this item and recommends utilization of the Copper T 380 exclusively.)

There is also no system for tracking individual clinic order forms from the warehouse once the commodities have gone out on delivery to verify when incorrect orders are filled. For example, one clinic received 60 vials of Depo-Provera instead of the requested 600; correcting the order was difficult.

The JFPA has its main warehouse located in St. Ann's Bay. The conditions at the warehouse are excellent and stock cards are current and correct. Expiration dates are clearly marked on each commodity carton. Distribution is done on a monthly basis for the outreach program.

All commodities for NFPB's CDC program are stored in the MOH central warehouse. NFPB personnel monitor this stock. All repackaging is done in the warehouse where space can be limited for this activity when large shipments arrive. Once repackaging is completed, the contraceptives are transferred to the distributor for the CDC program products, Grace Kennedy, Ltd.

## 6.2 Conclusions

Overall, forecasting of commodity needs is running smoothly, but because forecasting is done by USAID with technical assistance from the Centers for Disease Control without formally including the NFPB, the technical sustainability for this function is not instilled in the NFPB.

There are no major problems due to ordering; however, forecasting of certain commodities has been poorly done based on the chronic stock-outs of Depo-Provera (supplied by UNFPA), and difficulties of stock levels of IUDs.

Under normal circumstances, when commodities arrive at the port they are delivered to the central warehouse in a timely manner. When a problem does arise in clearing commodities from the port, however, there is no official line of command. Responsibility appears to fall on USAID whereas it should lie within the province of the NFPB.

Although warehousing and distribution procedures work well, there are problems with collecting and destroying out-of-date stock regularly (e.g., the MOH's 3,489 Copper T IUDs that expired in April 1989 are still waiting to be destroyed), there is no clear written guidance readily accessible on expired IUDs, and there is no system for tracking individual clinic order forms from the warehouse once the commodities have gone out on delivery.

### 6.3 Recommendations

1. The NFPB should play a more active role in the forecasting, ordering, importation, and warehousing of commodities. The following actions would further this more active role:
  - Counterpart(s) from the NFPB responsible for commodity forecasting and clearance should be appointed.
  - The computerized CPT program developed by CDC should be installed in one of the three computers at the NFPB. Formal training using the CPT computer program should be carried out.
  - The NFPB should develop a yearly workplan with a timeline for forecasting, ordering, and distribution of supplies. Responsible personnel should be indicated for each task with dates to submit progress reports towards accomplishing this workplan. Such a workplan would ensure that in an emergency stock-out situation the ordering process would be a smooth one, with available funds being immediately accessible.
  - A system regulating the procurement of each method should be designed on the basis of consumption patterns related to actual distribution.
  - The warehouse manager should devise a system to ensure that orders are correctly filled out for field deliveries. This check would enable the manager to easily trace an order that was incorrectly filled and send the balance of supplies needed as soon as possible.
  - Although field personnel are trained to always keep at least two months stock on hand when ordering for the next re-supply, this is not always the case and the NFPB should reinforce this practice.
  - Refresher workshops should be held once a year to update field personnel on new contraceptives, assist in the development of new maximum/minimum levels of stock, and correct misconceptions about expired products.
  - The NEWVERN shipping schedule should be verified quarterly to see if action is taken on all requested commodities. If a commodity does not appear to have been ordered two months after sending the cable, then Washington should be notified.
  - The supply management training manual developed by the MOH should be updated and printed for general distribution. Every clinic should have a copy for reference use.
2. Special double-checking of commodities should be carried out in Washington before they are shipped.
3. The 1,104,000 Sultan condoms at the port should be randomly tested because they have remained at the port for over five months in less than optimal storage conditions.

## 7. Commercial Distribution of Contraceptives (CDC) Program

### 7.1 Program Purpose

The purpose of the CDC program is threefold: 1) to make available low-priced contraceptives through commercial sector channels to lower-income couples who do not choose to use the MOH clinic system for their contraceptive supplies, 2) to assist in expanding national contraceptive prevalence from 50 percent to 70 percent, and 3) to generate sufficient sales revenues to ensure program sustainability once donor support has ended.

### 7.2 Strategy

The CDC program has no current written strategy, neither an annual marketing plan nor any other strategic statement. The strategy implied by present action appears to be to 1) make the current products almost universally price-accessible, and 2) make these products geographically accessible to everyone in the country. The possible introduction of new products in the future is also sometimes mentioned as a means of increasing program revenues.

CDC program staff include a Marketing Officer who is responsible for preparing marketing plans for the introduction of new products, forecasting sales and revenues, directing the activities of the field staff, coordinating packaging services, monitoring the activities of the distribution network, monitoring trends in the marketplace, developing a monthly distribution report, liaising with NFPB warehouse staff in regard to product stocks, and liaising with other NFPB technical areas such as IEC and training. The Marketing Officer is assisted by two Assistant Marketing Officers whose responsibilities are to work with the Marketing Officer in planning marketing strategies and developing short- and long-term objectives for the CDC program, to maintain regular contact with the distribution chain, to promote CDC products to the trade, to identify new outlets for CDC products, to ensure that retail outlets are well stocked, to distribute point-of-sale promotional materials to retail outlets, to monitor sales, and to gather marketing intelligence in the field.

At present, the NFPB is developing what is called a Five-Year Plan. A draft of this plan was made available to the evaluation team. Each staff member responsible for a technical area developed and presented a proposed plan for his/her area. The CDC portion of the plan included 1) a general projection of sales for Perle and Panther; 2) a projected budget with line items for advertising, research, public relations activities, incentives to sales staff, trade promotions, packaging, and printing; and 3) a general statement of the desire to introduce new products to the CDC product line. No rationale for each budget line item is included, nor is a target market for new products identified. (The Marketing Officer states that the market research data necessary to identify potential new target segments of the population are not available.) There is no specific pricing recommendation for current or new products in the plan beyond the general opinion that new products should be priced above Perle and Panther but below commercial levels. Products suggested for introduction into the CDC line include Lo-feminol, the low dose pill distributed free through MOH clinics (which by agreement between A.I.D./Washington and the manufacturer Wyeth Pharmaceuticals cannot be sold by a social marketing program anywhere in the world), a nonoxynol-nine condom, and a spermicidal jelly available through PROFAMILIA in Colombia.

This draft submission does not constitute a strategic plan for the CDC program. Instead, a marketing strategy should include the objectives of the program; a statement of

quantifiable goals for the program, including but not limited to sales goals; the description of a specifically defined target market for each product; an analysis of the competitive environment; and a strategy for the advertising, promotion, research, distribution, and public relations activities required to reach the targeted market segments successfully.

Although the Marketing Officer clearly states the importance of strategic planning to the possible future success of the NFPB as a whole, there is no current written strategy to give direction to the marketing management framework for the CDC program. (The last written marketing plan appears to have been one developed for proposed new product introduction in mid-1987.)

This lack of a strategy within the CDC program is variously attributed to the low status of strategic planning within the overall institutional "culture" of the NFPB, the absence of donor funds to support the implementation of any such strategy, and the futility of developing a strategic plan for one technical area of the NFPB when no mechanism exists for ensuring necessary coordination with and operational support from the other technical areas within the NFPB.

## 7.3 Implementation

### 7.3.1 Management and Marketing

Since 1978, the first year of the NFPB's full management and financial responsibility for the CDC program, the program has been housed in the offices of the NFPB and staffed by civil service employees hired for CDC management and marketing positions. Distribution of products through commercial sector channels has been accomplished through an agreement between the NFPB and Grace Kennedy, Ltd., the country's largest distributor of foodstuffs and other products. Contracts with two other firms, McCann/Erikson and Dunlop Corbin Compton, have been undertaken from time to time for advertising and promotional support.

It has been the advice of a variety of technical assistance consultants over the past eight years that CDC program performance and financing could be significantly enhanced by placing the responsibility for the marketing function -- with policy approval retained by the NFPB -- directly within the commercial sector. This advice was given for the following reasons: 1) The commercial sector can offer salaries sufficient to attract (and keep) long-term, top-notch marketing managers. Civil service pay grades, in contrast, are not sufficiently competitive. 2) The management systems of commercial sector firms are designed to allow for quick response to changes and demands in the marketplace. 3) Commercial sector responsibility for CDC marketing staff would save the NFPB the costs of those salaries and allowances. 4) The commercial sector is accustomed to the information-based strategic planning needed for maximally successful marketing to targeted segments of the population.

The USAID/Kingston mission, consequently, incorporated into its "Project Paper, Population and Family Planning Services (Amendment 3), 1986" the stipulation that further assistance to the CDC program -- beyond continuation of contraceptives supply -- would depend on NFPB's first having restructured the CDC program "so that its daily operations are directed by professional marketing management personnel."

In both April 1986 and October 1987, the Executive Director of the NFPB formally requested significant financial and technical assistance from USAID for the introduction of new contraceptive products into the CDC product line and for maintenance-level support for the current products, Perle and Panther. In the absence of any CDC program management restructuring, that assistance was not given.

The management structure of the CDC program continues today much as it has since 1978. Although a recent reorganization of the NFPB as a whole has placed the CDC unit directly under the Executive Director rather than under the supervision of the Deputy Executive Director as before, the Marketing Officer -- the chief technical staff member of the CDC unit -- is not on a level with the directors of the NFPB's other technical areas such as IEC, Projects and Research, Statistical Services, Service Delivery, and the like. This arrangement implies that the NFPB does not perceive the activities of the CDC program to be as important to its work as the activities of the other technical areas.

It appears, additionally, that approvals for CDC operations are required and must be sought on an activity-by-activity basis during the course of the year. Indeed, an annual budget committed to the CDC program does not exist. As the Marketing Officer identifies any new activity necessary to support CDC sales activities, he must make a request to the Executive Director for funding as well as for approval for implementation.

An Example of Marketing Difficulties. Recent program experience in attempting to advertise the Panther condom serves as an example of the difficulties in which a marketing program finds itself when managed within this type of framework.

In the late spring of 1989, commercial distributors of various condom brands began to advertise their products in the mass media. The CDC Marketing Officer decided that it was important to freshen consumer awareness of the Panther brand at this time so as not to lose possible new condom users and to take advantage of the general interest in condoms being stirred by the advertising of other brands. He therefore requested approval from the Executive Director for a budget for advertising Panther in the mass media. Approval was given, and the Marketing Officer proceeded to brief a local advertising agency for development of the campaign.

The agency developed its ideas and drew up a sample of proposed advertisements, which were then passed to the MOH for approval. The advertisements were targeted to lower income consumers -- the target market for the CDC program -- and featured men discussing among themselves the benefits of condom use (protection from pregnancy and protection from sexually transmitted diseases). To reach this targeted group effectively, the advertisements used dialogue in dialect. After deliberation, the MOH responded in writing, stating 1) that since condoms are pharmaceutical products only standard English may be used in advertising copy, and 2) that after any mention of the protection afforded by condoms, the phrase "if used correctly," must be added. Such changes would diminish significantly the communications effectiveness of the messages. Lower-income male consumers speaking together in standard English and adding the somewhat stilted phrase "if used correctly" to their advice to friends would violate the basic rules of effective message development and execution. In any event, the written response from the MOH was received at the NFPB and put into the file. The Marketing Officer was not notified of the receipt of the response and only later discovered the letter in the file. By this time, the new Board of Directors of the NFPB had been named and a new Publicity Committee of the Board had been put into place. Consequently, the Marketing Officer was required to submit the advertising copy for internal NFPB review and currently awaits the next meeting of this committee. It is now at least seven months after the event in the marketplace that triggered the Marketing Officer's request for funding to advertise Panther, and the approval process still continues. No marketing entity can operate effectively when it cannot respond with flexibility and timeliness to changes in the marketplace, nor can its marketing activities be effective when they are consistently controlled by non-marketing considerations.

### 7.3.2 MIS

In the absence of an annual marketing strategy, the basis for CDC program management is currently furnished by an annual sales forecast for Perle and Panther developed by

the Marketing Officer. Program performance is measured against the degree of success in meeting these sales goals.

The MIS consists primarily of monthly sales reports generated by Grace Kennedy, Ltd., the distribution agent. Totals by product are given for sales to 190 pharmacies, 40 to 50 wholesalers, and 4 or 5 cash-and-carry stores. This report is supplemented by the reports of the two CDC Assistant Marketing Officers on their sales to a relatively small number of minor shops not served by the Grace Kennedy, Ltd. system. Total sales by parish or total sales by outlet type are not a part of the report.

### **7.3.3 Product**

The CDC product line today contains the same two products introduced at project launch in the 1970s: Perle oral contraceptives and Panther condoms. Panther is the trade name registered in Jamaica for an uncolored, lubricated, 52mm condom manufactured by Ansell. The inner, sealed wrap features the Panther logo. The condoms are packaged in boxes of three, as are most condoms sold in the commercial sector. A cardboard wall dispenser is available for retail display and storage. Perle is sold in a one-cycle pack as well as a box of three cycles. A cardboard "pop-up" box which holds a quantity of either one-cycle or three-cycle packages is also available for retail counter display.

Each of these products has achieved virtually universal brand recognition to the extent that Perle and Panther are reportedly frequently used as generic names for their respective contraceptive methods. Data from the 1989 CPS as well as trade reports indicate that both products currently have high rates of satisfaction among targeted consumers. There does not seem to be any strong feeling among the trade that the products' low prices generate among targeted consumers perceptions of low product quality.

Perle is the trade name registered in Jamaica for Noriday 1 + 50, a product of Syntex Pharmaceuticals. Unlike the oral contraceptive (Lo-feminol) most frequently given to MOH clinic family planning clients, it is a "standard dose" pill. At some time during the past two years, a representative of the U.S. Centers for Disease Control commodity logistics staff indicated to the NFPB that A.I.D. will be "phasing out" Noriday from the list of commodities it makes available as part of its family planning assistance. Since that time, the NFPB has invested no funds in promoting Perle.

Jamaican law, as is the case in most countries, prohibits the sale of a pharmaceutical product under a trade name previously used for a different chemical formulation. In other words, a low dose oral contraceptive cannot be sold as Perle. It does not appear that either A.I.D. or the NFPB has assessed the potential impact of the "phase out" of Noriday -- and therefore Perle -- on the CDC program and its clients or has yet begun to develop a marketing strategy for dealing with this reported eventuality.

### **7.3.4 Pricing**

The current retail prices of CDC products are J\$ 1.00/ single cycle of Perle, J\$ 2.70/3-pack of Perle, and J\$ 0.60/ 3-pack of Panther.<sup>9</sup> Table 17 illustrates the current price structure.

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<sup>9</sup>J\$6.50 = \$US1.00

Table 17

Current Price Structure of CDC Products  
J\$

	Perle	Panther
NFPB Price to Grace Kennedy	5.37/dozen (+68%)	14.76/dozen (+30%)
Grace Kennedy Price to Wholesaler	wholesaler not used	19.19/gross (+20%)
Wholesaler Price to Retailer	9.02/dozen (+33%)	23.04/gross (+25%)
Retailer Price to Consumer	12.00/dozen (1.00/cycle)	28.80/gross (.60/3-pak)

Appropriateness of Product Prices. Since the initiation of product sales in the mid-1970s, there have been only two increases in the prices of Perle and Panther:

Price to the Consumer

	Single Cycle Perle	Single Condom Panther
1976 (Original Price)	J\$ 0.30	J\$ 0.05
1981	0.50	0.10
1985 (To Present)	1.00	0.20

During this same 14-year period, the effect of inflation and currency devaluation has been such that today's price of a single cycle of Perle translated into 1976 J\$ would be J\$ 0.125, and the price of a single Panther in 1976 J\$ would be J\$0.025. In other words, in constant dollars today's price to the consumer is one-half the original price for both Perle and Panther.

The reason given by NFPB staff for the negligible number and amount of price increases of CDC products over time is that the program's primary purpose is to make contraceptives available at a price affordable to lower-income couples. It appears that the current prices, however, make the CDC products accessible even to the poorest 10 percent of the general population.

Table 18, which follows, is a duplication of Table 3.1 from the Statistical Institute of Jamaica's "Survey of Living Conditions," July 1989. Table 19 is an extrapolation of those data to demonstrate household consumption by consumption deciles as well as the percentage of total

household consumption represented by the cost of an annual supply of Panther condoms at current prices.<sup>10</sup>

**Table 18**  
**Distribution of Consumption by Per Capita Consumption Deciles**  
**July 1989**

Decile	Share of National Consumption %	Mean per Capita Consumption (J\$)
1 *	2.89	1,056
2	3.22	1,786
3	4.21	2,359
4	5.35	2,976
5	6.43	3,615
6	7.86	4,348
7	9.64	5,397
8	12.29	6,855
9	17.11	9,535
10 **	32.00	17,892
Jamaica	100.00	5,581

\* Lowest  
\*\* Highest

**Table 19**  
**Percentage of Household/Consumption Represented by**  
**One-year Supply of Panther Condoms at Current Price**

Decile	(Per Capita Consumption x 4) Mean Per Household (4-Person) Consumption (J\$)	Percentage of Household Consumption Represented by One- Year Supply of Panther Condoms (J\$28.80)
1	4,224	0.68
2	7,144	0.40
3	9,436	0.31
4	11,904	0.24
5	14,460	0.20
6	17,392	0.17
7	21,588	0.13
8	27,420	0.11
9	38,140	0.01
10	71,586	0.04

<sup>10</sup>A four-person household was used in the extrapolation of Table 18 since the Survey of Living Conditions indicates that mean household size varies from 3.9 persons to 4.6. A one-year supply of Panther condoms is estimated to be 144 condoms at J\$ 0.20 each or J\$28.80 per year. Panther condoms are used instead of Perle oral contraceptives because a year's supply of Panther condoms is more expensive than a year's supply of Perle -- 13 cycles at J\$ 1.00 per cycle, or J\$ 13.00 per year.

Contraceptive social marketing programs like the CDC program are not designed to deliver services to the poorest of the poor. They are designed instead to reach lower-income couples who can afford to pay some price for their contraceptives but for whom the regular commercial price is out of reach. Using that definition, it is likely that the most appropriate targets for the CDC program are represented by consumption deciles 4, 5, 6, and 7. The poorest of these, decile 4, are using only 0.24 percent of their annual household consumption when they purchase a year's supply of Panther condoms at the current price. A rule of thumb frequently used by contraceptive social marketers in other countries is that an annual cost of contraceptives which represents 2 percent or less of household income is affordable to the social marketing program's targeted consumers. It appears, therefore, that there is considerable room for change in the current prices of Perle and Panther before either product is beyond the reach of the CDC's target consumers.

**Price of Program Products vs. Commercial Products.** The price position of both Perle and Panther within the commercial market is shown in Table 20 (see below). The goal of contraceptive social marketing programs in a number of other countries in the Caribbean and elsewhere is to be able to offer a contraceptive product that is half the cost of other contraceptive brands in the commercial market. As Table 4 shows, the current price of Perle is only 9.2 percent of Ovral, the lowest-priced commercial brand. The current price of Panther is only 12.0 percent of its lowest-priced competitor.

**Impact of Prices on Program Sustainability.** A purpose frequently stated by NFPB staff and management for the CDC program is to generate sufficient revenues through the sale of products in an effort to make a meaningful contribution to overall NFPB program sustainability. Table 21 demonstrates the price to the consumer for Perle and Panther that is necessary to "break even" on the cost of product and projected cost of sales/marketing support (see Table 21 below). It should be noted that the current price to the consumer for Perle and Panther does not cover even A.I.D.'s cost of product (which is probably the lowest available worldwide due to the volume purchased) and the estimated cost of shipping.

**Incentives to Retailers.** In a contraceptive delivery system, like the CDC program, that relies on the goodwill and interest of pharmacists and other retailers to ensure that products reach consumers, it is generally considered essential to provide a sufficient profit motive to the retail trade to maintain its enthusiasm for promoting and recommending the product to consumers. Consequently, the CDC distribution system provides retailers with at least the percentage margins and mark-ups that are standard for the Jamaican market. Because of the low consumer price of the CDC products, however, the dollar amount realized by the retailer on the sale of a CDC product is quite low. The chart below gives a brief view of the gross profit opportunity for the retailer per single cycle of oral contraceptive sold.

	Unit Price to Retailer	Mark-up	to Consumer	Gross Profit per Unit
Perle	J\$ 0.75	33%	1.00	0.25
Ovral	8.68	25%	10.85	2.17
Nordette	9.98	25%	12.48	2.50
Ortho 1/35	19.08	25%	23.85	4.77
Trinordial	13.08	25%	16.35	3.27

In summary, a pharmacist must sell 9 cycles of Perle to earn a dollar amount equal to that earned with the sale of a single cycle of the lowest-priced competitive brand.

Table 20

Prices for Oral Contraceptives and Condoms  
in Three Outlets, January 1990

Outlet # 1 - Mall Pharmacy

Outlet # 2 - York Pharmacy

Outlet # 3 - Nelson's Drug Store/Cross Roads Market

Oral Contraceptives	Price per Cycle (J\$)		
	Outlet #1	Outlet #2	Outlet #3
Perle-1	1.00	1.00	1.65
Perle-3	2.70	2.70	2.70
Ovral	10.85	10.84	11.50
Trinordial	16.35	16.31	
Microgynon			
Nordette	11.80		12.48
Neogynon Ed	21.30	20.28	20.28
Neogynon	19.75	18.62	18.46
Eugynon Ed	21.95	20.75	
Microgynon 30	19.80	19.79	19.79
Logynon Ed	24.75	24.75	23.30
Logynon	21.95	21.94	21.05
Ortho 1/35	23.85	23.83	23.83
Ortho 1/50	23.15	32.15	32.15
Ortho 7/7/7	23.45		22.43
Microgynon 30 ed		21.05	21.05
Eugynon			19.05
Condoms	Price per 3-pack (J\$)		
	Outlet #1	Outlet #2	Outlet #3
Panther	0.60	0.60	0.60
Rough Rider	7.50	8.50	7.00
Lifestyles/Stimula	7.50		
Studded Mates	7.50		
Durex Fetherlite		7.40	
Durex Gossamer		6.50	
Durex Nu-Form		7.60	7.55
Durex Arouser		9.90	
Durex Fiesta		9.90	9.46
Mates			5.00
Power Play			8.40
Kiss of Mint			8.40
Erotic			8.40
Bareback			8.40

Table 21

**Cost of Sales of Panther Condom and  
Perle Contraceptive Pill  
January 1990  
SJ6.50 = \$US 1.00**

Category	SJ Panther	SJ Perle
CIF Cost of Product	.37*	2.00**
Duty	assumed duty free import	
Unit Package	141.70/3000 units 1000 boxes	.20 (3-cycle pak)
	.05	.03
Prorated Cost of Retail Display Package	1.14/72 units .02	1.18/36 cycle .03
Prorated Cost of Shipping Package	5.14/1440 units 10 gross	5.14/864 boxes
	<u>.004</u>	<u>.006</u>
	<u>.444</u>	<u>2.336</u>
Advertising***	.21	.21
Promotion (POP, detailing materials users inserts)***	.06	.06
Research***	<u>.08</u> <u>.79</u>	<u>.08</u> <u>2.69</u>
Distributor's mark-up	(30%) 1.03	(68%) 4.52
Wholesaler's mark-up	(20%) 1.23	included in above
Retailer's mark-up	(25%) 1.54	(33%) 6.01
Price to Consumer for Break Even	1.54/condom	6.01/cycle

- \* US\$.056 (US\$.047[cost of product] x 1.2 [insurance and shipping]) x 6.5=J\$.37
- \*\* US\$.307 (US\$.256[cost of product] x 1.2 [insurance and shipping]) x 6.5=J\$2.00
- \*\*\* Prorated on the basis of annual sales of 2,500,000 units Panther and 570,000 cycles Perle (3,070,000 units).  
Annual budget of
 

(US 100,000 Maintenance Adv.)	650,000
(US 40,000 Market/Operations Research)	260,000
(US 30,000 Promotion)	195,000

While Grace Kennedy, Ltd., and owners of larger, more upscale pharmacies express a positive commitment to sales of Perle and Panther "for the good of the country" regardless of the low profit per unit potential, it may be incorrect to assume that smaller retailers can afford such a display of public spirit.

### 7.3.5 Distribution and Sales

As stated above, CDC program products are distributed through the nationwide network of Grace Kennedy, Ltd. Figure 1 illustrates the CDC product distribution structure. Upon receipt in Jamaica from A.I.D./Washington, CDC commodities are stored in the NFPB warehouse where NFPB contract workers package the unit products in the appropriate consumer packs and retailer cartons. When Grace Kennedy, Ltd., requests the transfer of a designated quantity to its warehouse, NFPB staff transfer the packaged goods to Grace Kennedy, Ltd. Grace Kennedy, Ltd., in turn, sells the product directly to all 190 pharmacies in the country, to 40 to 50 wholesalers, to 4 or 5 cash-and-carry stores (large wholesale outlets), and to the Jamaica Defense Force. Wholesalers resell the products to van drivers (individual entrepreneurs who drive a regular route through the countryside and sell products of various kinds to the shops along their way), and directly to shops. Each wholesaler may sell directly to as many as 200 to 300 shops.

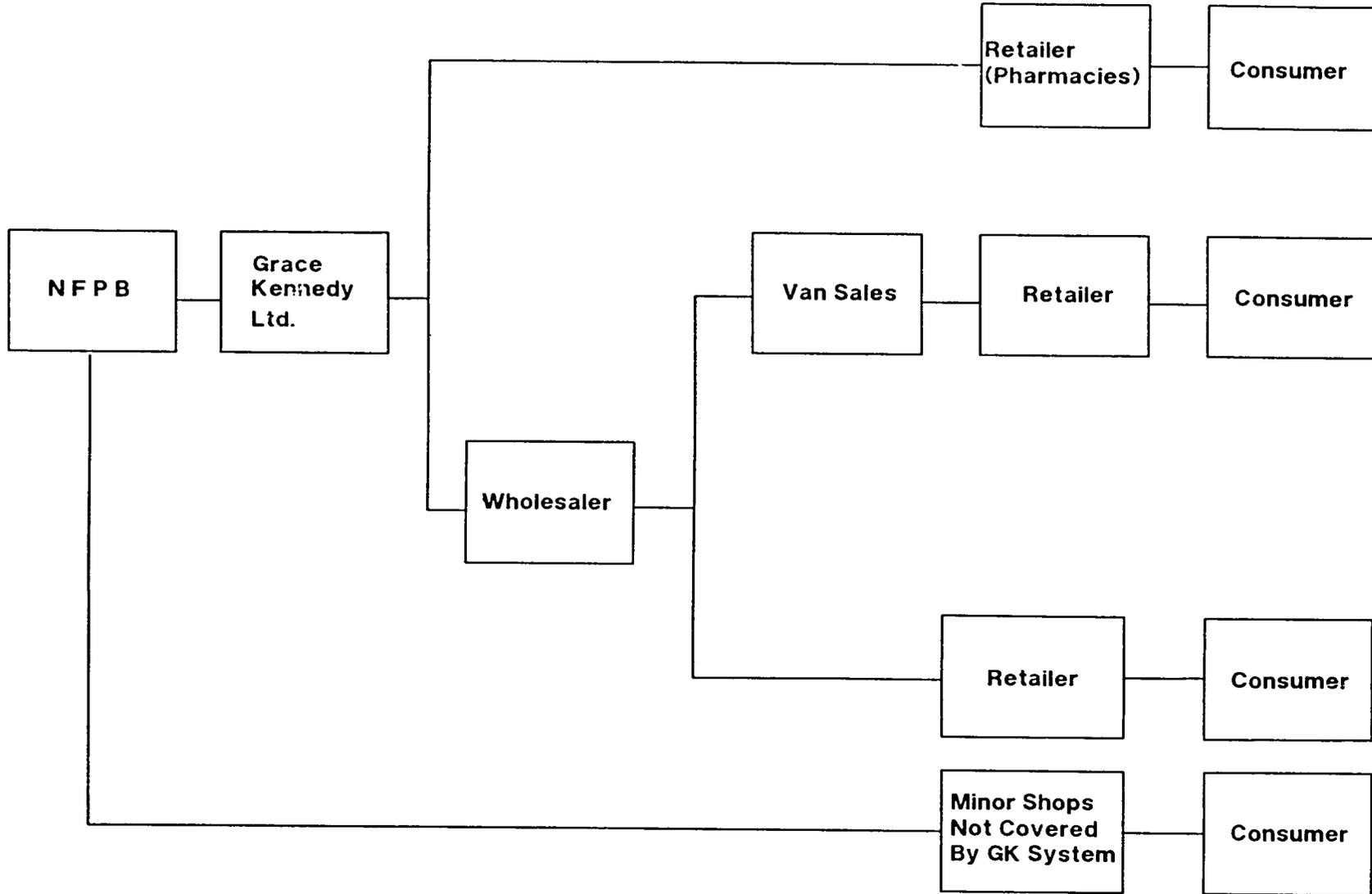
This system is supplemented to a small degree by the CDC program's two Assistant Marketing Officers who distribute products as required to smaller shops which for any reason are not served by the Grace Kennedy, Ltd., network.

**Geographic Coverage.** It is generally believed that this system makes both Perle and Panther geographically accessible to the whole population. Verification of this belief, however, is somewhat difficult to obtain since reliable distribution records extend only down to the wholesaler and pharmacy levels. (It has proved impossible over a number of years to elicit accurate sales and outlet information from van drivers, and wholesalers often sell on a cash basis and do not keep records of all shop owners who come to their depots to buy goods.) It is also difficult to ascertain more exactly the geographic coverage of this distribution system because sales and distribution data generated by Grace Kennedy, Ltd., and totaled by the CDC staff are not routinely subtotaled by parish or by outlet type.

The following facts are, however, known:

- Perle is sold only to pharmacy outlets with the possible exception of four or five major supermarkets.
- Panther is sold to all pharmacies and shops within the distribution system who request the product. This includes grocery shops, grocery-bar combinations, pharmacies, and some supermarkets.
- Grace Kennedy, Ltd.'s 40 to 50 wholesaler accounts are most likely serving 200 to 300 shops each, a total of perhaps 8,000 non-pharmacy outlets throughout the country. This is an average of at least one non-pharmacy outlet per 288 people.
- All 190 pharmacy outlets in the country are reached by this system. Approximately 80 of these pharmacies are in the Kingston metropolitan area where one quarter of the nation's population resides.

**Figure 1**  
**CDC Distribution Structure**



- Approximately 65 percent of all sales of Perle and Panther occur in the Kingston metropolitan area. The highest volume sales of CDC products occur in the Kingston metropolitan area followed by St. Catherine parish -- both areas with large urban populations.
- The lowest volume sales of CDC products occur in the parishes of St. Thomas and Portland, which are deeply rural areas.

**Comparative Sales Data.** The overall effectiveness of the CDC/Grace Kennedy, Ltd., distribution system is apparent from a comparison of Perle and Panther sales data with contraceptive prevalence data from the 1989 Contraceptive Prevalence Survey.

Table 22 presents annual sales and rates of growth for Perle and Panther.

Table 22

Perle and Panther Distribution  
through CDC Program

Year	Perle Single Cycles	% Incr/Decr Over Prev. Year	Panther Single Condoms	% Incr/Decr Over Prev. Year
1978*	175,572		801,648	
1979	220,548	25.0	885,168	10.4
1980	259,848	17.8	948,816	7.2
1981	305,148	17.4	1,045,872	10.2
1982	307,404	0.7	1,110,986	6.2
1983	345,152	12.3	990,789	10.8-
1984	432,516	25.3	1,454,968	46.8
1985**	434,292	0.4	1,382,400	5.0-
1986	451,140	3.9	1,545,408	11.8
1987	462,284	2.5	1,669,320	8.0
1988	515,584	11.5	1,731,096	3.7
1989	515,412	0.3-	2,139,118	23.6

\* Source for 1978-1984: Schellstede, 1985.

\*\* Source for 1985-1989: NFPB, Marketing Officer.

Table 23 demonstrates the number of women at risk (WaR) -- that is, the number of women within the fertile age groups of 15 to 49 who are currently in union, as defined by the CPS -- and the number of those WaR who are current users of oral contraceptives and of condoms (see next page).

In 1989, the year of the CPS data collection, 515,412 cycles of Perle oral contraceptive were distributed by the CDC program. Since 13 cycles of oral contraceptives represent one couple year of protection (CYP), 1989 sales of Perle equal 39,647 CYP -- the equivalent of contraceptive protection for 39,647 WaR. When this number is compared with the total number of WaR currently using oral contraceptives (85,018 from Table 23), it can be seen

Table 23

**Number of WaR and Number of WaR Currently Using Oral Contraceptive and Condoms**

<u>Females within the fertile ages:*</u>			
15-19	134,500		
20-24	131,600		
25-29	115,900		
30-34	92,400		
35-39	68,000		
40-44	51,800		
45-49	42,800		
	<hr/>		
	637,000		
 <u>Percentage in union**</u>		<u>Number of Women at Risk (WaR)</u>	
15-19	33.4		44,923
20-24	72.0		94,752
25-29	83.0		96,197
30-34	82.2		75,953
35-39	79.4		53,992
40-44	77.3		40,041
45-49	70.4		30,131
	<hr/>		435,989
 <u>Percentage of WaR Currently Using Ocs**</u>		<u>Number of WaR Currently Using Ocs</u>	
	19.5		85,018
 <u>Percentage of WaR Currently Using Condoms**</u>		<u>Number of WaR Currently Using Condoms</u>	
	8.6		37,495

\* Source: Composition of the Population by Age and Sex 1980-2015-Medium Projection, Moderate Fertility Decline, Medium Emigration (for yr. 1990), Table 14, Demographic Statistics 1987, Statistical Institute of Jamaica.

\*\* Source: 1989 CPS.

**Sales of Oral Contraceptives.** The recent CPS indicates that approximately 30 percent of all WaR using oral contraceptives report obtaining their pills from pharmacies. Since Perle is sold only in pharmacies and since sales of strictly commercial brands are not high, one would expect that the percentage of CYP provided by sales of Perle (46.6 percent as calculated above) would roughly coincide with the percentage of women reporting obtaining their pills from pharmacies (about 30 percent). The 50 percent difference between the two -- especially since it is sales of Perle that is reported higher -- is puzzling and not currently explained.

The CPS question that generated the 30 percent "from pharmacies" response is #423, asked of all current users of non-permanent contraceptives and categorized by method: "Where do you/your partner get your family planning supplies"? This question clearly implies "Where do you generally get your supplies"? and thereby eliminates as an explanation of the apparent discrepancy the possibility that the source of only the last cycle used was a pharmacy. A range of representatives from the commercial sector -- major distribution firms to individual pharmacists -- do not believe that any large volume purchases of Perle are being made for export. They indicate that their distribution and sales records show no such large amounts moving to individual accounts. One interesting observation made by a pharmacist, however, is that young Jamaican emigrants do sometimes buy a year's supply of Perle apparently for their future personal use when they return for holidays and family visits. This behavior is not surprising when one takes into account the fact that a year's supply of Perle costs J\$ 13.00 (US\$ 2.00) while a year's supply of oral contraceptives in the U.S. costs approximately US\$ 156.00. There is no information available as to the extent of this practice. The extent to which method and source switching or method discontinuation among contraceptors, and specifically among purchasers of Perle, may account for a discrepancy of this size is not clear. No consumer profile data for users of Perle are available to help in answering this question.

**Sales of Condoms.** In 1989, 2,139,120 units of the Panther condom were distributed by the CDC program. Since many contraceptive social marketing programs around the world use 144 condoms as the equivalent of a couple year of contraceptive protection, that figure is used in this analysis. Sales of Panther in 1989, therefore, represent 14,855 CYP. When this number is compared with the total number of WaR currently using condoms (37,495 from Table 23), it can be stated that approximately 36.5 percent of all condom use in Jamaica is being supplied by the CDC program. This, too, is one of the highest percentage contributions to national prevalence of condom use by a social marketing program anywhere in the world.

**Cost per CYP.** Table 24 shows the cost per couple year of contraceptive protection provided by sales of the CDC products. This estimation of total CDC program cost is an admittedly rough one. Overhead and costs of administration and technical assistance, for example, are not included. Product costs are figured at the exchange rate of J\$6.50 to US\$1.00. This estimate should, however, provide some insight into the comparative cost effectiveness of the CDC program as a delivery channel for family planning services.

While A.I.D./Washington policymakers consider a cost per CYP below US\$5.00 to be good, it should be noted that the cost per CYP of the CDC program -- even without any advertising and research -- has been increasing each year since 1985. In other words, the cost of sales has been increasing at a greater rate than sales. The self-enforced low price of the products, which has limited revenues returned to the program, has also contributed to this phenomenon.

**Rate of Sales Growth.** Although the 1989 contribution to overall pill and condom usage by the CDC program's products is quite high, the rate of sales growth over the past five years has slowed considerably. This is especially true for sales of Perle. Since 1985, the rate of sales growth has been less than 5 percent per year -- indeed, there was a slight decline in sales in 1989 -- with the exception of 1988. The Marketing Officer accounts for the unusually high growth of sales in 1988 by pointing to the fact that stocks of Perle were depleted in late 1987 and for a

Table 24

(J\$)

Cost per Couple Year of Contraceptive Protection through the CDC Program

Year	Product <sup>(a)</sup>	Advertising <sup>(b)</sup>	Research <sup>(b)</sup>	Packaging <sup>(b)</sup>	Printing <sup>(b)</sup>	Salary & Allowance <sup>(b)</sup>	Miscellaneous <sup>(b)</sup>	Total Costs	Revenues Returned To NFPB	Cost Less Revenues	Total CYP <sup>(c)</sup>	Cost/CYP
1985	1,144,985	0	0	20,840	77,051	78,358	27,400	1,348,634	336,042	1,012,592	43,007	23.54 (US\$3.62)
1986	1,222,819	0	0	21,000	159,792	86,221	35,400	1,525,232	360,289	1,164,943	45,435	25.64 (US\$3.95)
1987	1,279,217	0	0	22,423	131,195	97,837	35,986	1,566,658	337,977	1,188,681	47,152	25.21 (US\$3.88)
1988	1,386,782	0	0	21,089	182,713	135,345	78,399	1,804,328	408,161	1,396,167	51,682	27.01 (US\$4.16)
1989 <sup>(d)</sup>	1,511,147	0	0	26,086	228,996	157,839	46,144	1,970,212	449,907	1,520,305	54,502	27.89 (US\$4.29)

- (a) Condoms Sold x US\$.047 + Cycles sold x US\$.256 x J\$6.50 (=US\$1)  
J\$.1025/condom (14.76 gross)+  
J\$.4475/cycle (5.37/dozen)
- (b) Source: NFPB, Marketing Officer
- (c) Cycles Sold - 13 +  
Condoms Sold - 144
- (d) Provisional

time the distribution chain suffered a stock outage. (The stock outage was caused by a delay in A.I.D./Washington negotiations of a new contract for supply of oral contraceptives with the U.S. manufacturer.) In the early months of 1988, sales of Perle were quite high as the distribution system restocked the pipeline.

Slowed rates of growth in sales of Perle may perhaps be partially accounted for by 1) the relatively high rate of pill prevalence (almost 20 percent of WaR) that already exists in the country, 2) the desirable changes occurring in age distribution (decreasing numbers of females moving into the prime pill-using ages of 20 to 29) as the country's 20-year history of growing contraceptive prevalence makes its impact felt, 3) emigration of young adults, and 4) lack of any advertising/communication promoting the use of oral contraceptives, and Perle specifically. A further cause of slowed sales growth for Perle is suggested by CPS data which indicate that a core of eligible women either discontinue pill use or fail to initiate pill use because of their apprehensions concerning real or imagined side effects of the pill. No data relating to the characteristics of Perle consumers and non-consumers are available from the CDC to help in analyzing this critical program area.

Most striking in an examination of sales of Panther over the past five years is the wide variation from year to year in rates of sales growth (or decline). This phenomenon is largely unexplained. The Marketing Officer suggests that a portion of the larger than usual increase in Panther sales in 1986 may be attributed to the initiation of AIDS publicity in the previous year. Half of the rather high increase in 1989 is similarly attributed by the Marketing Officer to increased awareness of the role of condoms in AIDS prevention. In 1988, the decreased sales was due to the change over in packaging and the inability to delivery the product.

Overall, there is virtually no sales or consumer information available that would allow program management to understand adequately for future planning and implementation strategy development what is happening -- and why -- in the marketplace with its own or other contraceptive products.

### 7.3.6 Advertising and Promotion

There has been no advertising support for either Perle or Panther since 1985. The last major advertising campaign undertaken by the NFPB took place in 1985. This campaign used the message "Two is better than too many" (a family-size message) and included no method-specific and no Perle and Panther brand-specific mentions.

There have been no outlet identification window stickers, signs, or other point-of-sale identification materials produced since prior to 1985. There have been no supplies of such materials to distribute to retailers during the last four or five years.

Promotions to the trade have been limited to volume price discounts to wholesalers and bonus goods to pharmacists (e.g., one free for each 10 purchased).

Consumer promotions since 1985 have consisted of small, full-color folders produced in 1989 for both Perle and Panther which discuss correct use, contraindications, and the benefits of family planning. These folders were given to retailers for distribution to consumers. Approximately 50,000 folders were printed and distributed to retailers.

In summary, there has been little if any public communication/identification of outlets where the CDC products are available, the prices at which the products are sold, or the benefits of using these specific methods or brands. With such an obvious lack of marketing support for product sales, it is difficult to explain how Perle and Panther sales have achieved any increases over the past five years. Factors inherent in the marketing environment that may account at least

partially for continuing sales despite this lack of advertising and promotion include the following: 1) the level of geographic and outlet availability of the products is high, 2) word-of-mouth recommendation among friends and family may be unusually strong in this market, 3) there has been in the past a strong, independent demand for family planning goods and services among a large segment of the Jamaican population, 4) Perle and Panther may have been mentioned by name to contraceptive acceptors in MOH clinics, 5) the price, once discovered by the consumer, is affordable even to the very poor. There are no program data available which might help to shed light on this issue.

### **7.3.7 Research**

The last market research undertaken for the CDC program occurred in 1984 when the A.I.D./Washington centrally funded Social Marketing for Change (SOMARC) project provided money for a series of focus group discussions among men and women from the target market and for in-depth interviews with selected pharmacists and physicians.

The strategic and operational hardships caused by the lack of current market and consumer information have been cited throughout this discussion of the present status of CDC operations.

## **7.4 Conclusions**

There are very favorable findings with regard to the CDC program: there is virtually universal brand recognition for both program products -- Perle oral contraceptives and Panther condoms; products are being distributed nationwide; the highest share of the market for pills and condoms belong to Perle and Panther; the major share in national prevalence of oral contraceptive and condom use (46.6 percent of oral contraceptive usage and 39.6 percent of condom usage) is supplied by Perle and Panther; and there is an increasing awareness among the general population as to the role of condoms in prevention of AIDS.

At the same time, other findings highlight some deficiencies in program management and strategy as well as in those areas that are necessary to an understanding of market forces:

- The project management structure of the NFPB inhibits flexible, timely responses to events/changes in the marketplace.
- The lack of regular strategic planning (including both marketing and business planning) inhibits the development of an aggressive CDC program. Added to this is a lack of a complete MIS for regular monitoring.
- The CDC program does not specify its target market sufficiently.
- There is an absence of market and consumer research data that are necessary for informed decision-making and planning.
- There is a declining rate of sales growth for Perle oral contraceptive.
- The questionable long-term availability of Noriday and the therefore questionable long-term availability of the Perle brand may significantly affect the long-term strategy for the CDC program.
- There has been a lack of targeted brand and method advertising/communications for both Perle and Panther.

The prices to the consumer for both Perle and Panther are extremely low.

The resolution of these issues may be necessary in order to realize the long-term sustainability of program efforts.

## 7.5 Recommendations

1. **A program of market and consumer research should be undertaken during the next 12 months. This research should include at least a consumer intercept survey for development of CDC consumer profiles and a retail audit. This research is necessary to USAID/Kingston for use in the design of its possible new family planning project and to the CDC program for developing a current operational strategy. If requested by the NFPB, USAID should provide technical and financial assistance to undertake this research activity.**
2. With information currently available, CDC staff should develop an annual marketing and business strategy for program activities. Such a strategy should provide the framework and direction for program efforts during the coming year as well as a management tool for measuring program accomplishments. This strategy should include a specifically stated target market for each product sold or proposed to be sold by the CDC. Pricing and marketing activities suggested for each product should be consistent with the target market as defined.
3. Based on the business strategy developed in No. 2 above, a price increase for both Perle and Panther should be implemented; a minimum 100 percent increase should be considered.
4. The NFPB should ascertain the future availability of Noriday 1+50 from A.I.D./Washington. If the product will not be readily available over the long term, the NFPB should begin immediately to formulate a strategy for coping with this eventuality. (This might include such things as independent procurement of Noriday 1+50, introduction of a low-dose oral contraceptive with a Perle related name – such as Perle LD, Lo-Perle, or the like – to retain consumer loyalty and brand recognition built up by Perle, etc.) USAID/Kingston should facilitate the NFPB in clarifying this matter.
5. CDC staff, working with Grace Kennedy, Ltd., should design and implement an improved sales reporting system that includes at least the following for both Perle and Panther on a monthly basis: sales (dollar and unit) by parish, sales (dollar and unit) by outlet type (including, if possible, totals sold to each van driver, pharmacist, wholesaler, cash-and-carry store), and a monthly total of products sold to each individual Grace Kennedy, Ltd.-serviced outlet. With this refined sales reporting system, CDC management would know more clearly in what parts of the country Perle and Panther are best received by consumers, trends in purchasing patterns, what kinds of outlets are most successful in selling the products, which pharmacies or other major outlets sell the most products and therefore deserve special recognition or follow-up, where product sales need special promotional support in order to grow, and the like. If requested by the NFPB, USAID should provide technical assistance to assist CDC to undertake this task.

## 8. Programs Focusing on Adolescents

### 8.1 Adolescent Programs

#### 8.1.1 Perceived Need for the Programs

From the project's inception in 1982, the need to place special emphasis on reaching sexually active adolescents, including males, with family planning services was apparent:

- The greatest declines in fertility since the 1960s had been among the older age groups, particularly among women aged 30 to 39 years.
- There had been a decline in the fertility rate of adolescents (ages 15 to 19) from 149 per 1,000 in 1963 to 130 per 1,000 in 1978, but this latter rate still represented one of the highest in the Latin American/Caribbean region.
- Over two-thirds of all Jamaican women were reported to have their first pregnancy under age 20, and women who had children at an early age tended to have significantly larger families than those who postponed their first pregnancies to a later age.
- There were widely held cultural beliefs contributing to the high fertility rate among adolescent women; e.g., it was considered necessary for a young girl to have a child to prove her fecundity.

Although MOH clinics were identified as an appropriate delivery system for family planning services, a need also was seen for specially tailored family planning programs for adolescents, particularly for young males. A variety of approaches were proposed, including outreach programs and community distribution of contraceptives, educational efforts, and indirect impact activities such as improvement in economic levels, educational attainment, social status, and health care.

#### 8.1.2 Project Activities

The main activities related to adolescents carried out through the project have been the following:

**The Male Responsibility Program.** This NFPB program received USAID funding between 1982 and 1986. The program undertook some family life education and motivational programs for schoolboys and other young males, although activities with adolescents were not the main objectives of this program. The program was terminated in 1988 because of budget constraints, and the NFPB Board of Directors indicated that the new island-wide network of Parish Liaison Officers (see Section 9.1) would be responsible for these activities.

**The Adolescent Fertility Resource Center (AFRC).** The AFRC was fully supported by USAID from 1981, when it was established, to 1986, when it was expected to be assumed as a full responsibility of the NFPB. However, as a transition measure it was further supported by USAID as a subproject between 1986 and 1989. In 1989, the NFPB still found itself unable to assume the funding for this center; it was decided that its functions would be integrated into the IEC division and the AFRC ceased to exist as a separate entity.

During its existence, the AFRC functioned as

- an information-gathering and dissemination center for projects and programs servicing adolescents;
- an advisory and technical assistance center for youth agencies with family life and family planning programs; and
- an organizer of motivational and training activities including discussion programs and workshops.

There was no final evaluation of the roles played by AFRC or of any future directions to be continued once it was within the IEC division. Several subproject directors have noted a current lack of national information resources for youth programs, however, and the Ministry of Youth and Community Development (MYCD) in particular notes that it receives many requests from schools and community groups for training and technical advice which it seeks to satisfy even though this is not its primary task.

The Ministry of Education Family Life Education Program. This program of the Ministry of Education (MOE) was supported from 1982 to 1986, with a further extension for one year to March 1987. MOE staff state that some aspects of the Family Life Education Program still are continuing in the schools.

During the existence of this program, training in family life education was given to approximately 2,700 teachers from 790 schools. This represented a coverage of 85 percent of all government primary, all-age, secondary and high schools in Jamaica. Family life education curricula and teaching resource materials were produced and some modest efforts at radio and television programs for teaching purposes were undertaken. The teaching materials, however, reportedly minimized sexuality and fertility limitation issues. In addition, family life education was not systematically incorporated into the teaching system of all participating schools. Reports of the director of this subproject suggested that the Family Life Education Program was not strongly adopted or supported at the policy levels of the MOE.

MYCD Family Life/Family Planning Education Project. This project was established by the MYCD in 1982. A one-year renewal of the project was signed in February 1987, and a three-year project was signed in February 1988. The main objective was to provide family life education and contraceptive delivery to young people in government residential and training institutions and in youth clubs.

It was planned that one national coordinator and three (later increased to four) nurse-counselors would develop island-wide counseling and contraceptive distribution programs in collaboration with family life educators and/or other staff members in government institutions such as 37 Children's Homes, 19 Places of Safety, 4 Industrial Training Centers, and 4 Parish Youth Centers.

Similar programs also were to be developed with 1300 plus youth clubs (66,000 members), identifying volunteer youth counselors (peer counselors) to work along with the program and undertake contraceptive distribution.

The nurse-counselors have been spread very thinly in their coverage of the entire island. In many cases, the expected counterpart staff such as family life educators or counseling staff in the target institutions have not been in place. There also have been changes in the youth organization framework. For example, the number of active youth clubs currently is estimated at slightly over 500, as compared with the 1300 or so included in the original project document.

An extension of the subproject from 1988 emphasized consolidation of youth activities, expansion to community activities, training of community volunteers for teen-age pregnancy concerns, and creation of parish-level coordinating committees.

NEET (Now Entering Education for Tomorrow). This was a program of education and activities for 12 to 19 year olds run by the Young Women's Christian Association (YWCA) and its branches throughout Jamaica. This program was funded from 1982 to 1986 when the subproject agreement came to an end and was not renewed. (This program still is being undertaken by the YWCA, however, with support provided by the World YWCA.) The program linked family life/sex education and contraceptive delivery services with health screening and with recreational and training activities. Target groups included over 400 12 to 19 year old girls in three YWCA Teen Clubs in selected secondary schools, and other teenage members of the YWCA, with similar services also being provided to pupils in some additional secondary schools.

The project enjoyed modest success, mainly in its school program, with 315 new family planning acceptors being recruited over the first two years of the program and with a total of 841 persons benefiting from the health services offered. Contraceptive distribution was not allowed in schools, however, and other objectives such as peer counseling, parent involvement, and the establishment of a strong fertility education and personal development curriculum in the target schools, were not achieved.

Teen-Scene. This was a walk-in health care, recreational, vocational training, and family planning and counseling center for teenagers in one Kingston neighborhood, which was sponsored by the MOH from 1983 to 1986. The subproject established a center in an inner-city neighborhood in Kingston, with plans for a community clinic with a doctor and full-time nurse/midwife to deliver family planning and medical services, a vocational training and income-generating program, and continuing education and recreational activities, as well as peer counseling both in the center and as family planning outreach in the community. Difficulties were experienced in staffing, including the difficulty in recruiting health personnel, and there was no full-time manager for the center. Use of the center remained low, and over a seven-month period in 1985 only 19 new family planning acceptors were recruited, even though health personnel were in place by then. Difficulties also were experienced with regard to the security of the premises, which were burglarized and vandalized.

Moderately successful programs were developed in home economics and income-generating activities; peer counseling, which attracted some enthusiastic volunteers; and continuing education, which was the most popular single activity. It was finally decided, however, that the results attained through the center did not justify continuing funding.

A similar MOH youth program funded by the World Health Organization currently is being operated in Catherine Hall, Montego Bay. It is located in a regular health center but undertakes special youth-oriented activities and offers peer counseling.

Youth Associates and Community-Based Distribution of Contraceptives Project. Both of these programs have been run by the Jamaica Family Planning Association. Youth Associates is a "youth-to-youth" outreach program of peer counseling and contraceptive distribution in the parishes of St. Ann and Trelawny which was first begun in 1979 and operated under USAID project funding between 1982 and 1984.

Since 1982, there also has been a Community-Based Distribution of Contraceptives USAID-funded project in which adult outreach workers visit eight rural communities in St. Ann and Trelawny to motivate and recruit contraceptors. Condoms and oral contraceptives are supplied, and referrals are made for injectables, IUDs, and VSC. Since the end of the Youth Associates program, outreach workers also contact Youth Groups and individual adolescents.

Between 1988 to 1991 this subproject was modified and expanded to reach 18 communities in all, on a phased basis.

**The Operation Friendship Family Life and Family Planning Education Program and Parenting and Health Services for Families.** Operation Friendship is a well-established social services agency in West Kingston, which offers health, education, and vocational training services to the community. This agency also now offers health and family planning outreach services in Portmore, St. Catherine, a large new housing settlement area with inadequate social services; and Cascade, Portland, an isolated and inaccessible rural area.

Up to 1987, the USAID funding for Operation Friendship supported health and family planning services for adolescents in West Kingston and the entire Mobile Clinic outreach program in Portmore. Since 1988 this subproject has expanded to include adults up to age 35 as well as adolescents, and is emphasizing family planning for all ages, parental inputs into sex education, and pre-puberty family life education as well as its former work with adolescents. The aim is both to follow up former teenage clients as they become young adults and responsible parents, and to approach family planning in a holistic manner through work with the entire family.

**Roman Catholic Family Life Center, Family Life Education Project.** This small subproject undertakes activities to address family life education and sexuality within the Roman Catholic tradition. Educational programs are conducted with 8 to 12 year olds mainly in Catholic schools on puberty and sexual and general health. With 15 to 16 year olds, also in a few selected schools, educational sessions are presented on adolescence and other topics. The center also provides marriage guidance sessions for adults, marriage enrichment programs, and trains family life educators and Billings Method advisors. Training programs are offered to health and other personnel and to couples on the Billings Method. One nurse-counselor is Director of the Family Life Center, and there is one teaching assistant. The program occasionally offers sessions in rural schools, but it is mainly concentrated in Kingston and the Portmore region. See Table 25 for outputs by major subproject (see next pages).

## 8.2 **Management and Continuing Program Efforts**

The management and coordination of this variety of subprojects called for a substantial monitoring effort on the part of the NFPB. Standardized reporting systems and workable disbursement arrangements were difficult to implement. The NFPB has commendably managed this diverse operation to meet the relatively rigid accounting and management requirements of USAID funding. Currently, all the posts of the Project Management division of the NFPB are vacant, however, and another staff member is acting as Director of Projects in addition to his substantive responsibilities.

The thrust of the early 1980s towards specially focussed adolescent programs has now been considerably reduced. Although the AFRC has ceased to function, the NFPB states that an adolescent focus is maintained in IEC activities and in the Parish Liaison Officers' activities. Of the subprojects still active, however, both Operation Friendship and JFPA have substantially broadened the scope of their programs to move towards a more all-inclusive, community-oriented approach. This does not exclude attention to teenagers, but it is not as singularly focused as in earlier programs. These organizations state that they see the need to work with youth within the broader setting of the family and the community, rather than in an isolated fashion.

The MYCD, while retaining its responsibilities for youth programs, currently is emphasizing community education and involvement of local community leaders as a way of ensuring some amount of sustainability for the program. Activities reported over the past year reflect almost exclusively such community meetings and activities, with only limited reports of specialized youth activities.

**Table 25**  
**Adolescent Subproject Outputs, Calendar Year 1989**

Name of Subproject	Scope and Coverage	Target Groups	Services Offered	Motivation/ Education: Persons Contacted	New Female Acceptors	Acceptors < age 20	Continuing Acceptors	Contraceptives Distributed		
								Pill	Condom	Spermicidal
Operation Friendship "Parenting & Health Services for Families" 1988 - 1991	Three Communities: -1 urban low-income -1 peri-urban "dormitory" -1 rural mountain	Population aged 17- 35, especially parents; children aged 8 - 12	Health Care Services, Family Life Educators (FLE), Outreach Workers, Community-based Contraceptive Delivery (not in urban community), Training for FLE	Kingston 21,596	7,361	2,596		Pill	Condom	Spermicidal
				Portmore 6,704						
				Cascade 6,681	1,419	312		17,133	82,942	280
				Total 34,981	11,277	3,805		8,292	27,455	181
				33 parent-education workshops, with 604 participants				1,405	13,361	125
				(Referrals: Sterilization 7 Injections 1,522 IUD 6 Most referrals come from Kingston).				<u>26,830</u>	<u>123,758</u>	<u>586</u>
JFPA; "Community Based Distribution of Contraceptives" 1988 - 1991	13 districts in 2 parishes	Population aged 15 - 44	Individual & Group Counselling, door- to-door contracts, clinical referrals	19,267 (Referrals: Sterilization 113 Injection 72 IUD 30 Diaphragm 3)	3,244	580	6,732 (to Sept 1989)	Pill 31,211	Condom 78,865	Spermicidal 558
MYCD: "Family" Life/Family Planning Education" 1988-1989	Island-wide 70 communities	Existing MYCD youth groups and youth institution, also community members	FLE, Contraceptive Distribution, Training of Family Life Educators and Volunteer Counsellors	Community FLE Sessions: 729 attended by 25,120 persons. 31 Parent Ed. Workshops, attended by 1,343 Participants. Nurse Counsellors: 808 young people counselled.				Pill 16,963	Condom 112,327	

## Subproject Outputs, Calendar Year 1989

Name of Sub-Project	Scope and Coverage	Target Groups	Services Offered	Motivation/ Education/ Persons Contacted	New Female Acceptors	Acceptors < age 20	Continuing Acceptors	Contraceptives Distributed
MYCD: "Family Life/ Family Planning Education" (Continued)				Meetings of Volunteer Counsellors: 21 attended by <u>215 volunteers</u> Training: 81 Peer Couns- ellors/Volunteer Counsellors, 37 SDC workers for FLE activities, 34 Community Volunteers Summer Camps: 2, with 158 participants				
Roman Catholic Family Life Center: "Family Life Education Project"	5-10 schools in Kingston area, occasional extensions to rural schools. Urban community.	Pre-teens, adolescents, parents, NFP trainers, couples.	FLE in schools, (plus health screening in some schools), training of Billings Method teachers, NFP to couples, marriage preparation and marriage enrichment.	180 FLE sessions in 5 schools. Approx. 650 children. Occasional sessions in other schools, youth groups, approx. 300 participants. Training program for 6 NFP teachers.				Natural Family Planning (NFP) Acceptors: 26 couples

Only the Roman Catholic Family Life Center retains its emphasis on activities in selected schools, as well as on youth camps and other similar activities. This is, however, a very small program.

The MOE reports that although funding for the Family Life Education Program ended over two years ago, some family life education activities are continuing in the schools though family life education has not become part of the system-wide curriculum. There appears to be a potential for resuscitation of the program if governmental policy developments occur. In the now defunct program, however, official support at senior policy levels in the MOE was reported to be "not dynamic." The work of gaining acceptance for and incorporation of family life education into the school curriculum was reported to be left solely to the project team and not considered a responsibility of the MOE regular staff. Family life education also was reported to be not institutionalized in the Teacher Education Colleges, being offered only as an optional subject in some colleges or only for home economics specialists in others. Efforts to link family life education training with other existing in-service training programs for teachers also were reported to have been rebuffed by decision makers. With these realities in mind, it is perhaps not surprising that teachers have been uncomfortable with the prospect of teaching family life education.

It may also be noted that the new Parish Liaison Officers are undertaking some adolescent outreach programs and are even undertaking some family life education in schools.

### **8.3 Issues**

Some of the adolescent programs described above have suffered from an ambivalence about youthful sexuality and from a reluctance to promote family planning and more particularly contraceptive distribution. Thus, the YWCA NEET program and the MOE were both hesitant in the implementation of their programs. In her final report on the MOE program, its director wrote that a major constraint was that teachers were uncomfortable with teaching about sexual issues. Some of the reasons she suggested were lingering prudishness or a view of sexuality as a "secret" outside the realm of discussion; reservations by teachers about their own life styles; and inability to cope with topics relating to sexuality and human reproduction, especially when teaching students of the opposite sex.

The MOH has also expressed concerns over community distribution of contraceptives without adequate medical supervision, and both the MYCD and JFPA have sought to introduce safeguards and to give additional training to their community-based workers in light of these concerns.

### **8.4 Impact of the Programs**

From an analysis of community-based contraceptive delivery initiatives (see Table 26), it may be concluded that their impact is limited. The value of these efforts, however, needs to be assessed further because community-based workers insist that they encounter large numbers of young mothers who are using no contraceptive method and who need face-to-face motivation.

**Table 26**

**Contraceptives Distributed, Calendar Year 1989**

	<b>Orals (cycles)</b>	<b>Condoms (pieces)</b>	<b>Spermicidal (Tubes)</b>
<b>JFPA</b>	31,211	78,865	558
<b>Operation Friendship</b>	26,830	123,758	586
<b>MYCD</b>	9,693	64,187	-
<b>Subproject Subtotal</b>	67,734 7.8%	266,810 4.6%	1,144
<b>Clinic Subtotal</b>	284,900 32.8%	3,450,000 58.9%	
<b>CDC Subtotal</b>	515,412 59.4%	2,139,120 36.5%	
<b>Total</b>	868,046 100%	5,855,930 100%	

The involvement of youth counselors is exciting for participants, often provides a springboard for community leadership or job opportunities in family life education, and lends dynamism to the motivation/education thrust. On the other hand, there is a high attrition rate among counselors, and the counseling itself does not appear to have any strong effects on levels of contraceptive knowledge. A 1988 review of peer counseling programs revealed little difference in levels of reproductive knowledge among adolescents who had been exposed to peer counseling as compared with a control group. The explanation was that the emphasis in such adolescent programs was on personal outreach and counseling and on help in decision-making, rather than on effective transmission of reproductive knowledge.

It appears that the programs of the MOE and the MYCD are valuable because they each encompass nationwide networks which influence large numbers of young people. In addition, the MYCD is diversifying its activities to mobilize community interest and community support, with the aim of using this network of community activities to maintain some aspects of its program if USAID funding is no longer available.

The programs of Operation Friendship and the JFPA demonstrate differing models of in-depth community work, the former based on the provision of health, education and counseling services and the latter based on individual face-to-face community outreach, each promoting family planning access and acceptance. The Operation Friendship programs are more effective in recruiting contraceptors. Its rural contraceptive delivery system, based on a community resident who makes contraceptives available from her home, is a more efficient model than the mobile community distribution of the JFPA.

Programs have learned from each other. For example, Operation Friendship has served as a service delivery model for other small groups, while the MYCD program uses many of the educational materials developed by the MOE.

Overall, the subprojects seem to have a good sustainability potential. Among the private voluntary groups, the YWCA NEET program has demonstrated its ability to survive even though USAID support ended several years ago. Operation Friendship also has alternative resources, although without USAID support this organization would not be able to maintain its present programs at the same level.

Some of the experience gained from the activities of the Adolescent Fertility Resource Center and the Male Responsibility Program could be applied in future IEC activities even though, these two programs are no longer functional.

## 8.5 Conclusions

Thus far the adolescent program has proved to be of some value in that, for example, the programs of the MOE and the MYCD are potentially able to influence large numbers of young people through their nationwide networks and the Operation Friendship programs have been effectively recruiting contraceptors through a well-designed rural contraceptive delivery system. In addition, some of the experience gained from the activities of the Adolescent Fertility Resource Center and the Male Responsibility Program could be applied in future IEC activities and, overall, many of the subprojects seem to have a good sustainability potential.

On the other hand, the overall subproject strategy used by the project was not well designed. The 1983 Year 1 Evaluation of the project noted that the subproject emphases were deemed appropriate "for diversifying contraceptive distribution systems and for broadening the focus of population activities. However, subproject diversity...strains NFPB resources" and it was recommended that "caution [be observed] in the number and variety of additional subprojects undertaken."<sup>11</sup> Throughout the project's life, this strain has had an effect on the management of the subprojects. Some subprojects provided only IEC and there were limited linkages in many of the subprojects between IEC and services. These subprojects distributed a very small proportion of the total contraceptives delivered in the project. In the case of JFPA's Community-Based Distribution of Contraceptives Program in which service provision was the prime objective, the cost per user was exceptionally high. The subproject strategy was a very expensive means to gain support of local organizations and to stimulate their action.

In addition, the reluctance of the MOE to make family life education part of the nationwide school curriculum seriously hampers efforts to reach adolescents.

## 8.6 Recommendations

1. The Jamaica national family planning program should continue to support motivation and education programs in youth organizations. These need to be systematized, however, with good quality motivation/education skills and a dynamic audio-visual program.
2. The IEC Division of the NFPB and the Parish Liaison Officers should develop overall responsibility for monitoring and cooperating with these programs.

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<sup>11</sup>Hermione McKenzie and Amy Lee. *Final Report, Year 1 Evaluation, Population and Family Planning Services Project (532-0069) 1982 - 1986, October 31, 1983.*

3. **The MOE should be encouraged to revive its family life education program. The implementation difficulties encountered in this program reflect some fundamental problems in the attitudes of teachers, and perhaps in the attitudes of the school system itself, to sexuality and reproduction. These problems need to be addressed in such an influential and formative institution as the MOE. If requested by the NFPB and MOE, USAID should provide technical assistance for those areas in the MOE's Family Life Education Program that require strengthening.**

## 9. IEC and Training

The objective of the IEC Department of the NFPB is to promote motivational family planning and family life education programs designed to bring about acceptance of new fertility norms and desired fertility behavior, thereby facilitating the development of responsible persons and a stable family life. The IEC Department includes training to support IEC efforts. IEC efforts to promote the two-child family and breastfeeding are examples of recent campaigns that have been successfully (see Section 2.3).

### 9.1 Implementation and Strategy of IEC Activities

Staff shortages at NFPB headquarters have recently posed a constraint for IEC and training activities. However, with the implementation of a World Bank IEC project, advertisements have been placed to fill needed positions and a full work program for 1990 has been drawn up.

The IEC program under this project will continue to emphasize the two-child family and will also focus on the provision of information about different contraceptive methods, their side effects and advantages and disadvantages, and face-to-face counseling and communication. The audiences targeted for primary attention are adolescents, males of all ages, women in the 20 to 29 age group, discontinued contraceptive users, females with two or more children, and post-partum women. The 1989 CPS reconfirmed that many of these target groups were the appropriate audiences for IEC work.

USAID assistance has helped to finance a field network of IEC Parish Liaison Officers (PLO) in each parish and four regional officers for supervision (mainly salary support and vehicles to the PLOs). The primary work of these officers (probably better named, Population Information Officers) is to develop and initiate a plan for IEC at the parish level; to assist local communities to identify their family planning needs and developing plans and organizing programs to deal with them; to develop and co-ordinate family life and family planning education programs; and to liaise with other agencies to promote and implement population and family planning programs. The activities undertaken by PLOs are scheduled on a travel calendar which is provided to regional supervisors. The role of the Parish Liaison Officer was viewed as very important by policymakers in the MOH in the furthering family planning counseling and information dissemination. However, there has been no concerted effort by the MOH and NFPB to establish an institutional role for the PLO within the MOH health center system. Also, without the NFPB headquarters support that is necessary to carry out these functions and liaise with the MOH, some of these Parish Liaison Officers lack the direction needed to carry out their role adequately. With the hoped-for early recruitment of an IEC field supervisor and the start-up of World Bank-financed IEC activities, the role of the Parish Liaison Officers may be better understood and their activities more effectively implemented.

### 9.2 Future Directions

An IEC working paper, produced through a World Bank consultancy, may form the basis for much of the future direction of the IEC and training work of the NFPB. The direction for IEC suggested in the paper was to build upon the already existing IEC project that uses a counselor prototype named "Marge Roper" to answer questions about personal sexual problems through a telephone and mail service and to some extent through in-school sessions. The idea would be to use this image of a trusted counselor, who inspires confidence and who is credible, for family planning counseling, nationwide. If this idea is accepted, a comprehensive training and media plan would need to be developed. Also, the roles of the Parish Liaison Officers and MOH

health center staff would need to be clarified. The working paper offers various alternative ideas on how a nationwide Marge Roper program could be organized.

A comprehensive national strategy using Marge Roper and her counseling/advice as a focal point would offer an alternative to the present subproject strategy for much of the IEC program which has been limited in effectiveness and sustainability. The potential effectiveness of the proposed strategy is that it will use already existing positions -- the Parish Liaison Officers and, presumably, health center staff -- to provide the counseling and act as Marge Ropers. This means that counseling and services will be closely linked through the MOH and NFPB. Also, training in counseling and family planning, etc., will have a limited focus, rather than as it is now with the attempt to train a large variety of different groups. The potential for sustainability will also be greater since the staff are either already in position or there will be sanctioned posts for IEC. IEC efforts can also be better developed. Since Marge Roper started off as an advise counselor for telephone and mail services, efforts in these mediums could be expanded. Others could be added: a Marge Roper newspaper column and billboards telling where one can meet her, as well as providing her address and phone number. Messages given out to different age groups could become more standardized through training and public information aspects of the program, e.g., the IEC program could develop letters or provide commentary on the most-asked questions by women and men in different age groups.

The involvement of the World Bank and UNFPA in the IEC efforts of the NFPB and PPCC is substantial. The proposed NFPB 1990 budget for IEC alone is about US\$ 753,000. With this program just getting under way, and the potential of the Marge Roper concept that is being adopted to form the basis of a comprehensive IEC program, there seems to be little need for other donors to become heavily involved in IEC and training activities.

### 9.3 Conclusions

USAID assistance has helped to finance a field network of IEC Parish Liaison Officers in each parish and four regional officers for supervision. This parish-based IEC program for the NFPB was needed; however, as yet it has not met its full potential due to lack of NFPB leadership personnel and the establishment of linkage with the MOH health center services. The IEC Department of the NFPB is just beginning to mount a major program with World Bank and UNFPA assistance. This major funding and the potential offered by the "Marge Roper" prototypical counselor concept will provide a means for the PLOs to develop their program in cooperation with the MOH. At this time the World Bank and UNFPA funding seems to preclude the need for other donors to become heavily involved in IEC and training activities.

### 9.4 Recommendation

1. **With the amount of funds and donor involvement in the IEC Department planned for the next few years, USAID should not fund new IEC initiatives (ones that are not already committed or in the pipeline) until decisions on the future IEC strategy are made by the NFPB.**

## 10. Project Management

### 10.1 National Family Planning Board (NFPB)

The NFPB, a statutory body of the MOH, is empowered under the National Family Planning Act of 1970 to

- 1) Prepare, carry out, and promote the carrying out of family and population planning programs in Jamaica and to act as the principal agency of government for the allocation of financial assistance or grants to other bodies or persons engaged in the field of family and population planning in Jamaica.
- 2) Coordinate and, where it thinks necessary, direct the work of other bodies or persons in the field of family planning and population planning in order to ensure an effective and economical national effort.
- 3) Undertake and promote research, and disseminate information in relation to family and population planning.
- 4) Arrange and participate in national and international courses, seminars and conference in relation to family planning.
- 5) Provide for sex education and encourage the development thereof.
- 6) Collaborate with other bodies and persons in the preparation and carrying out of family life programs.
- 7) Operate and collaborate with government and other bodies in operating clinics and other institutions concerned with maternity and child welfare and family and population planning.

#### 10.1.1 Policy Development and Overall Leadership

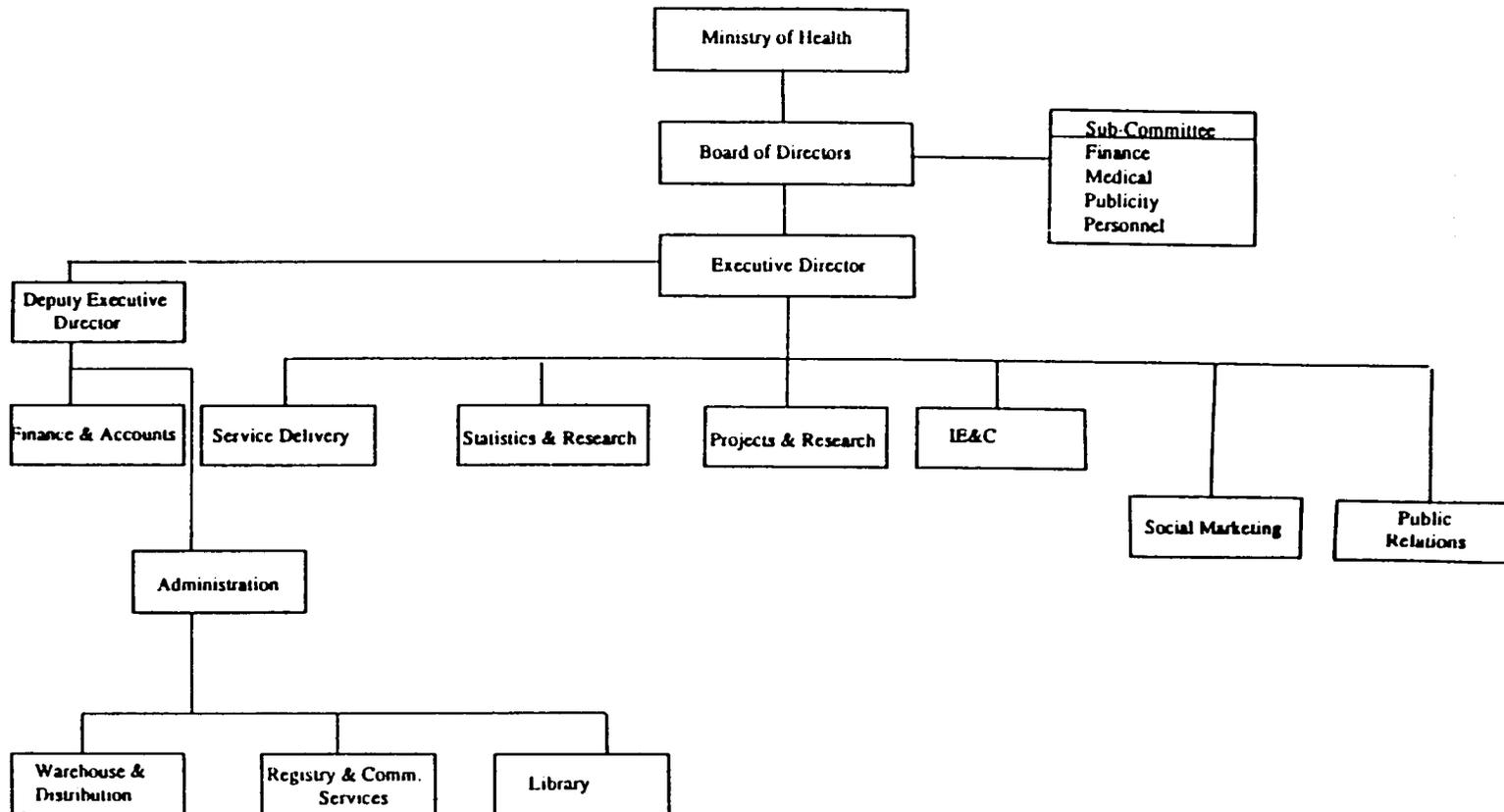
The Board of Directors and Chairman of the Board are appointed by the Minister of Health. With the recent change of governments (February 1989) a new Chairman has been appointed and the Board of Directors is not yet fully constituted. Thus, there has been a hiatus in policy development and overall leadership for some time.

Four subcommittees provide advice to the NFPB. At times the infrequent meetings of the committees have caused delays in implementation of NFPB activities. (See Section 7.3.1 for a description of the marketing initiative that was delayed in part due to the infrequent meetings of one of the subcommittees.)

The NFPB is run by an Executive Director who has direct control over all technical aspects of the program. The Deputy Executive Director has direct control over the finance and accounting of the NFPB and administration. Administration includes the important function of warehousing and distribution of commodities.

The technical areas include four directorates -- IEC, Projects and Research, Statistical Services, and Service Delivery, and two units of a lower status -- Social Marketing (CDC program) and Public Relations. See the organization chart, Figure 2, below.

**Figure 2**  
**National Family Planning Board**  
**Organization Chart**



Source: Based on Operational Chart of NFPB, July 1985 and discussions with senior NFPB staff.

### **10.1.2 Staffing**

There are staffing shortages in almost all directorates and units of the NFPB. The Projects and Research Directorate does not have a full-time director and the marketing officer of CDC is sharing his time between positions. Of the seven staff positions in the Projects and Research Directorate, five are vacant. There is only a clerical officer and secretary. Two project officers, one research officer, one clerical officer, and one secretary would need to be recruited to constitute the full complement of staff for this directorate.

The IEC Directorate is also understaffed compared to the planned staffing positions that are proposed in the NFPB/World Bank Project discussed in Section 9.2. These positions are being advertised at the present time.

The CDC program is in the process of recruiting for one Assistant Marketing Officer. The position of Public Relations Officer is vacant and has been for some time.

In the field, there are staff at the three clinics operated by the NFPB working under the supervision of the Service Delivery Directorate, and Parish Liaison Officers in most of the parishes working under the supervision of the IEC Directorate.

These staff shortages have had a negative effect on staff morale -- a perhaps unavoidable consequence when few staff are required to do the work of many.

In addition, at the present time, while the NFPB's new building is being constructed, the staff have been required to move offices. Not all support apparatus, e.g., files, copying facilities, etc., have been moved to the new location, thus causing an understandable dysfunction of the organization's operations. This will be rectified once the NFPB moves into its new offices.

### **10.1.3 Linkages among Directorates**

Linkages between organizational units within the NFPB seem lacking. Each unit has its separate program and there appears to be little effort made to coordinate activities, either at headquarters or in the field, between NFPB clinic staff and Parish Liaison Officers. While clinic staff and PLOs may cooperate on selected promotional, IEC, or counseling activities, it is not part of a joint program between the two groups. This may be due to the fact that the lines of authority/supervision for these staffs are different.

The linkages among three NFPB organizational units -- IEC, Social Marketing, and Public Relations -- are very weak. Each formulates its own workplan and each executes its program completely independent of the others. Although the Executive Director supervises the work of each unit, the lack of joint planning among units with very similar mandates causes, in the first instance, inefficiencies in the use of resources, and in the last, less effective programs.

### **10.1.4 Use of Data for Planning**

The Statistical Services Directorate is a supporting unit which provides data on the overall program. Its yearly Statistical Report may be one of the best such documents produced by a family planning agency. It gives much of the information needed to assess program strengths and weakness, and therefore should be of vital use in all planning by other units of the NFPB. There was little evidence, however, that NFPB planning was done based on the data generated by this directorate.

It is unclear how much importance the NFPB and its technical units place on data. In 1985, for example, the operational chart of the NFPB included a Planning and Evaluation

Officer. Also, the Projects and Research Directorate presumably did some research when it was fully staffed. Even the NFPB's sponsoring of the various contraceptive prevalence surveys testifies to its acknowledgement of the need for data. On the other hand, data-based planning is not well developed in determining the NFPB's priorities or the activities of the technical units. For example, one of the objectives of NFPB's new Five-Year Plan is to raise the contraceptive prevalence rate from its present 54.6 percent to 70 percent by 1995. As noted in Section 2, Table 4, based on the current trends in contraceptive acceptance, prevalence at the turn of the century will be only be 62.7 percent. Even if new contraceptive technologies are introduced and the number of sterilizations are increased, it is very doubtful that these programs can be implemented quickly enough to bring about the contraceptive prevalence rates at the level targeted by 1995.

## 10.2 Ministry of Health

As discussed in Section 4 of this report, the MOH is the major provider of family planning services. Although family planning services are provided by the JFPA and the NFPB through a number of clinics, the multitude of MOH service delivery sites and the quantities of contraceptives delivered through these sites testifies to the soundness of the decision to integrate family planning services within the MOH's program. This does not mean, however, that no problems exist in the MOH's delivery of family planning services. The lack of trained staff to provide services affect family planning services as well as the other PHC and secondary health care programs of the MOH. It may be difficult to overcome this particular constraint within the MOH's program, but it may be possible to overcome other problems, mainly those concerning communications and forming linkages with the work of the NFPB.

There are problems in communication between the MOH and the NFPB at all levels -- at the top management level, at the directorate level, and in the field. This may be due to the lack of sufficient personnel in key positions. This poor communication has caused difficulties in planning for the various aspects of the family planning program. The periodic meetings between the NFPB management and the MOH may be sufficient for the exchange of information and to reach consensus on particular policy or operational issues, but they do not foster joint planning, which is needed for the effective implementation of the family planning program. There are seldom meetings between the parallel operational units of the MOH and NFPB. In the field, no structure exists for communication between the Parish Liaison Officers and their MOH counterparts. Some improvements have been evidenced in the linkage between the MOH and the NFPB with the secondment of an NFPB officer to the MOH to act as family planning coordinator in the PHC program. A similar secondment has not occurred in the secondary health care program, however.

## 10.3 Population Policy Coordinating Committee (PPCC) of the Planning Institute of Jamaica (PIOJ)

The Population Policy Coordinating Committee of the PIOJ is an advisory board to the Minister of Development, Planning and Production. Its purpose, among others, is to advise agencies of government on the formulation and coordination of population policy, to monitor the population policy and to recommend changes and adjustments to the policy when necessary, to ensure consistency in the activities of the different agencies involved in population, and to stimulate broad dissemination of information on all aspects of population. Committee membership includes the NFPB and the MOH. The PPCC has a subcommittee on IEC which is receiving funds through a World Bank project. Coordination between this subcommittee and the IEC Directorate of the NFPB is close since both units are being supported by the World Bank project.

#### **10.4**            **USAID/Kingston**

The overall responsibility for managing the family planning portfolio in Jamaica rests with the Office of Health, Nutrition and Population (HPN) of the USAID mission in Kingston. USAID management of this project has been unusual in that a national program officer who had once worked for the NFPB is the person in charge of the day-to-day monitoring of the project. This officer is fully knowledgeable about the project and is able to use her knowledge of the project to take actions on behalf of the project. This has had both positive and negative consequences. On the positive side, there has generally been a good working relationship between the HPN office and the NFPB, even when there may have been differences of opinion on issues between the senior management of USAID and the NFPB. On the other hand, because the HPN officer is so familiar with the procedures and program of the NFPB, it has at times been easier for the NFPB and USAID to rely on the HPN officer to undertake an action, even though it was the responsibility of the NFPB -- for example, forecasting of contraceptive needs has remained an activity of USAID.

At a more general level, some of the issues brought out in this evaluation report are not new. Sustainability, for example, has not received attention until almost the end of the project when the consequences of the project's ending without a strategy for government takeover of contraceptive purchasing became fully evident. The need to review the institutional role and function of the NFPB in relation to the MOH, the JFPA, and the PPCC should have been recognized some time ago, and action taken by the HPN office to offer assistance.

#### **10.5**            **Conclusions**

The roles and functions of the various organizations involved in family planning in Jamaica since 1970 have changed considerably. Family planning service delivery is clearly now an MOH function. Coordination of population-related activities is shared to some extent between the PIOJ and the NFPB. IEC activities are split between PIOJ and NFPB. The advocacy role for family planning has shifted from the NFPB to the PPCC. Although NFPB has sponsored research (e.g., the CPS), STATIN, with assistance from USAID, has become the main demographic research institute.

Both Jamaican government agencies and USAID/Kingston have contributed to some of the issues that exist with respect to the national family planning effort: the institutional insularity of the NFPB technical units has decreased their effectiveness in designing and implementing NFPB activities; the problems that the MOH and NFPB have had in cooperating with each other have wasted both human and material resources that could have been put to better use in advancing the family planning effort; the lack of strategic planning by the NFPB is partly responsible for the present slow and gradual increase in the contraceptive prevalence rate; some aspects of the project and management actions that are being done by USAID are more appropriately the responsibility of the project (thus fostering a dependence of the NFPB on USAID); and an earlier recognition of potential problems and actions taken to forestall them by USAID may have facilitated project implementation and increased the potential for technical and financial sustainability.

#### **10.6**            **Recommendations**

1. The NFPB should review its institutional goals and structure taking into account the changing nature and needs of the population and family planning program of Jamaica.

- a) This should be the primary agenda item for the March 1990 retreat of the NFPB, which should include both Board of Directors members and technical staff.
  - b) An organizational management expert with skills in working with institutions to define goals and functions should assist the NFPB in this process. Consideration should be given to having this expert facilitate the discussion of this agenda item at the March retreat. If requested by the NFPB, USAID should provide assistance for this expert.
2. The development of any new long-range plan for family planning should be based on expected prevalence targets for each method. The TARGET SETTING MODEL computer program that uses prevalence targets for each method and takes into account the age structure and proximate determinants of fertility should be used. If requested by the NFPB, USAID technical assistance to install this user-friendly computer program at the NFPB should be given.
  3. Program strategies to reach targeted prevalence goals should be planned jointly by the technical staff of the NFPB and the MOH. At the same time that decisions are being made on targets for various contraceptive methods, the implications for service delivery should be reviewed by the MOH and program strategies explored to reach those targets. Data from the Statistical Reports of the NFPB, the MOH health information data from both PHC and Secondary Health Care, as well as 1989 CPS data should be used. The NFPB would assemble the data and would prepare, with the concurrence of MOH officials, an agenda for a two-day retreat of technical staff of the NFPB and MOH to develop program strategies. If requested by the NFPB, USAID financial assistance for this action should be given.
  4. USAID should hand over all contraceptive forecasting and other project-related responsibilities that are legitimately a part of the duties of the NFPB in implementing the project.

## 11. Lessons Learned

The following lessons learned may be useful for other family planning projects and for reassessing the various aspects of the Jamaican family planning program.

1. Careful brand naming and promotion of contraceptives can perform a significant motivational function: e.g., the Perle oral contraceptive and the Panther condom have become, to a large extent, the generic name for the pill and condom in Jamaica. Such brand recognition is an enormous asset to a family planning program and can play a major role in promoting family planning.
2. As family planning programs mature, the roles of those organizations that have been the leaders in the promotion and provision of family planning services change. How these organizations accept the new roles given them determines their future utility to the family planning program and whether the program will reach its ultimate goal of replacement-level fertility.
3. The general rule that successful social marketing programs are those that escape from the bureaucratic constraints of government by staying as close as possible to the commercial sector, may have been broken in the case of Jamaica. The CDC program functions within a heavily bureaucratic governmental environment and its sales of contraceptives are remarkable. However, the only rules known to foster sustainability -- to make a social marketing program a marketing program that recovers cost -- are those found in the marketplace.
4. The valuing of staff performance, no matter what level, is a major factor in increasing program output. For example, it is just possible that the most vital three people in the family planning program of Jamaica are the drivers who deliver commodities to the 358 health facilities around the country on a routine basis.
5. High standards for training nurse-midwives and physicians have produced well-trained health personnel, who engender trust in women seeking help to limit their family size. With the problems created by high rates of staff attrition, particularly among nurses, innovative courses and training schemes need to be developed to ensure high quality of service and to keep the trust of the women.

## **12. Major Conclusions and Recommended Future Directions**

## 12. Major Conclusions and Recommended Future Directions

### 12.1 Major Conclusions

1. The project has made strides toward reaching its overall goal of significantly reducing fertility in Jamaica; e.g., contraceptive prevalence has increased and both age-specific and total fertility rates have declined through the efforts of the project.
2. The project has distributed contraceptive commodities provided by USAID very effectively. USAID's commodity support has been critical to the achievements made in the family planning program. In terms of cost-effectiveness, this input has been the most cost-effective of all the USAID inputs.
3. Clinical services for family planning are widely available and of good quality at MOH health centers. Oral contraceptives and condoms are provided in these facilities more than IUDs. IUD insertion and VSC procedures are referred, though the referral system is not as effective as is desirable. There are a number of single-purpose family planning clinics in a few local areas run by NFPB and JFPA. These clinics provide good services and counseling and are used as referral points for IUD and for VSC in the case of JFPA clinics. For oral contraceptives and condoms these clinics are duplicative of MOH health centers.
4. While the proportion of women who have accepted VSC is quite high in comparison to other methods, the expectation of the project that the yearly number of procedures would increase over its life was not realized. This was due to both program and non-program factors. The lack of nursing staff to assist in operations and the overburdened hospital facilities did not permit more procedures to be done. There also has been little attention given to improving the VSC program in the MOH and NFPB until very recently. Vasectomy is still a rare procedure.
5. The present CDC program is one of the most successful such programs in the world. However, it has not used the opportunity available to it to increase its market further, add new products to it, or explore ways to recover costs.
6. The overall subproject strategy used by the project was not well designed. The strategy strained the management capability of the NFPB. In addition, some subprojects provided only IEC and there were limited linkages in many of the subprojects between IEC and services. The subproject component contributed a very small proportion to total contraceptives delivered in the project. In one case where service provision was the prime objective, the cost per user was exceptionally high. The subproject strategy was a very expensive means to gain the support of local organizations and to stimulate their action.
7. The thrust of the early 1980s toward specially focussed adolescent programs now has almost disappeared. Of the subprojects still active, both Operation Friendship and JFPA have substantially broadened the scope of their programs toward a more all-inclusive, community-oriented approach. This does not exclude attention to adolescents, but the approach used is not as singularly focussed as that used in earlier programs. The explanation of these organizations for this change in focus

is that they see the need to work with youth within the broad setting of the family and the community, rather than in an isolated fashion.

8. The priority of the project to work with adolescents was correctly placed. With a large percent of the youth population enrolled in schools, the subproject with the Ministry of Education to integrate family life education into the school curriculum had great potential. Although progress was made in the development of materials and curricula and the training of some teachers, the great potential for the subproject was not realized. The Ministry of Education has not taken the project over and continued the integration process in a systematic way that would ensure that family life education becomes a subject that is taught by trained teachers at the primary and secondary school levels.
9. The total expenditure on technical assistance for a project of this size with so many subprojects and different activities was inadequate. Areas in which more technical assistance could have been useful to plan and help in the implementation of activities would have been the CDC program, the Adolescent Fertility Resource Center, VSC program, and to advise on project sustainability issues. The reluctance of the NFPB to use technical assistance and the limited size of funds allocated for technical assistance in the USAID budget may account for its underutilization.
10. The major issue in regard to sustainability of the project centers on contraceptive commodity procurement when donor funds are no longer available. In this context, the pricing structure for contraceptives provided through the CDC program does not cover even the manufacturing cost of the contraceptives. Contraceptives are received free in clinics or a small donation is given. In neither case would the funds generated constitute cost-recovery. Under conditions of free or close-to-free family planning services available throughout the country, there is little reason to believe that private sector initiatives to provide family planning can be expanded.
11. Strategic planning and the use of data for planning is rarely undertaken at the NFPB. This has resulted in less effective programs in some cases, and a lack of vision with regard to where the NFPB should be going in the future.
12. The history of relations between the MOH and the NFPB has not always been good. The responsibility for the family planning service function has been disputed for some time. It is clear that this function is an MOH responsibility. One of the main responsibilities of the NFPB, among others, is to facilitate the MOH's delivery of this service. Although more cooperation and collaboration has started at the headquarters level of the PHC program, linkages are missing between the two programs at the secondary health care program level and in the field. While Parish Liaison Officers are working in the field, there is at present, no system for coordinating their activities with MOH health centers. While Parish Liaison Officers are working in the field, there is at present, no system for coordinating their activities with MOH health centers.

## 12.2 Recommended Future Directions

### 12.2.1 **General**

The past success of Jamaica's family planning program is tempered by the realization of the NFPB and donor agencies that there are new challenges to be met in the 1990s, which need to be overcome if the program is to reach replacement level fertility by the end of the century.

The challenge of the Jamaican family planning program in the 1990s is to

- 1) keep the momentum that has brought the program to the present level;
- 2) refine program strategies to meet the unmet needs of the "hard to reach" groups with information and services, such as adolescents;
- 3) assess the appropriateness of method mix for women in different age categories and at different parity levels to ensure their methods are safe and effective and then take action to help women change methods as appropriate; and,
- 4) make the program cost effective and financially sustainable.

The specific recommendations for program actions and USAID support to be acted upon during the present project (532-0069) have been noted throughout the report and are listed in Appendix D. The implementation of these recommendations will go a long way in meeting the technical challenges of the Jamaica Family Planning Program. However, the overarching challenge for the 1990s is achieving financial sustainability of the program. The GOJ and USAID will need to work together to find ways to accomplish this objective.

Recommendation:

**USAID/Kingston should continue a program of assistance to the Jamaican family planning program at the end of the current project.**

### 12.2.2 Sustainability in Contraceptive Commodities

A major portion of project funds are for the purchase of contraceptive commodities. It is unclear how the Government of Jamaica will assume procurement of these commodities after USAID assistance has ended. There is no plan for increased government participation in the supply of public sector commodities over time.

Recommendation:

**In a future project after March 1991, USAID should provide funds for contraceptive commodities on a decreasing scale with the Government of Jamaica complementing the funds to cover contraceptive requirements. For year one, USAID would finance all contraceptives; year two, USAID 75 percent and GOJ 25 percent; year 3, USAID 50 percent GOJ 50 percent; year four, USAID 25 percent GOJ 75 percent; year five, GOJ would finance all contraceptives. USAID should provide technical assistance to help plan for the phasing out of financial assistance for contraceptives and for the procurement of them.**

The Jamaica family planning program must also be made cost-effective and financially sustainable. It is only fairly recently that the issue of financial sustainability of the family planning program has become important. The Project Paper, for example, did not deal with the issue of the supply of contraceptives and how they would be paid for in the future. This issue has become problematic as the requirement for contraceptives by developing countries grows and donors are not able to meet all country needs. Buying of contraceptives is even more difficult to resolve since many governments, such as GOJ, cannot afford to use scarce capital to buy contraceptives. The MOH is already hard pressed to purchase needed supplies and drugs for its health system.

**Recommendation:**

Although some attempts have been made by the NFPB at cost recovery of contraceptives, the issue of financial sustainability for contraceptives should be placed at the top of the agenda in designing future family planning program activities. USAID should provide technical assistance to the NFPB on cost-recovery and "fee for service" schemes. In addition, USAID's planned project in the area of health care financing should include contraceptives in its scope of work.

**12.2.3 Training in Contraceptive Methods**

As noted elsewhere in this report, longer-term contraceptive methods are not receiving adequate attention. Besides the initiation of a training program for IUD insertion, training of physicians and nurses for minilaparotomy sterilization is needed. While the present AVSC project will provide assistance in sterilization training, more will be required under a new project.

**Recommendation:**

A training program for post-partum sterilization and IUD insertion should be considered in the new project. The Victoria Jubilee Hospital with the large maternity ward would be the preferred venue for initiating a large training effort. This training program could also be the vehicle for the introduction of NORPLANT<sup>®</sup>, if and when a decision is made to introduce this method into the program.

**12.2.4 CDC Program**

The CDC program is not fully conversant with the culture and techniques of the marketplace. Expertise in this area is essential to ensure flexible and timely responses to changes/events in the marketplace and to ensure that the program's marketing activities are sustainable and not overwhelmed by non-marketing considerations.

**Recommendation:**

The management structure of the CDC program should be changed in the new project to allow it to work in and meet the challenges of the marketplace. There are a number of management structures that would make this possible:

- Option 1. Policy and operational responsibility for the CDC program could remain within the NFPB but with a management structure reorganization that would facilitate CDC's ability to operate and make decisions on the basis of marketing considerations and consumer needs. Such a reorganization would include at least the following: a marketing manager of at least the capability and professional experience of the current Marketing Officer, elevation of the marketing manager/officer position to the level of other division chiefs within the NFPB, annual approval of the CDC marketing strategy by the Board of Directors with no further need for activity by activity approvals during the course of the year, an annual CDC budget approved by the Board of Directors within which the marketing manager/director can make decisions as required by the demands of the marketplace during the course of the year, and elimination of the need for MOH approval of CDC advertising. (The NFPB as the family planning "arm" of the GOJ should certainly be able to ensure that CDC advertising does not conflict with the overall aims and general informational goals of the MOH in regards to family planning. Internal NFPB approval of CDC advertising should be on the policy or concept level, not on the level of execution of the concepts).

In this event, it is recommended that USAID/Kingston should supply contraceptive commodities to the CDC program as described above. Additionally, it is recommended that USAID should supply technical assistance to the NFPB in the development of marketing and business strategies for the CDC program and that USAID share with the NFPB on an equal basis during the first two years of any future new project the costs of marketing activities (such as advertising, promotion, and research) necessary to revitalize current CDC products or to introduce selected new CDC products. Short-term technical assistance in specific areas of program implementation (such as research design, development of advertising concepts, and the like) could be provided if needed. Such time-limited and cost-shared assistance should facilitate the NFPB's ability to develop and implement its contraceptive social marketing activities in the most sustainable and effective ways possible and encourage the NFPB to reinvest the revenues generated by CDC product sales in improving and maintaining CDC program activities.

- Option 2. The NFPB could retain annual policy approval of CDC strategy but operational responsibility is moved into the commercial sector (e.g., Grace Kennedy, Ltd. staff manage program operations and coordinate advertising and research support for program activities). In this event, it is recommended that USAID/Kingston should provide commodities as described above, technical assistance in developing marketing strategies and in selected implementation areas if needed, and full funding of marketing support activities (such as advertising, research, and promotion) for the first two years of any new USAID project. This time-limited assistance should provide the commercial entity with necessary help in developing a market for the low-priced contraceptives sufficient to support future marketing activities. Full funding of support activities is recommended over the first two-year period since NFPB and/or donor resources would not be required to finance the costs of salaries, allowances, and overheads. These costs would be covered by the commercial firm's margins as they are with all other commercially distributed products.

- Option 3. The social marketing of low-priced contraceptives could become a part of a new national effort to privatize as much as possible the delivery of family planning services. In other words, the NFPB could relinquish its role in marketing contraceptives, and a "deal" could be negotiated with contraceptive manufacturers for the sale and distribution in the Jamaican market of one or more high-quality, low-priced contraceptives at no long-term cost to donor/government agencies. (Such arrangements are now successfully implemented in the Dominican Republic and Indonesia, for example.) In this event, it is recommended that USAID/Kingston should fully fund marketing support activities (such as advertising, research, and promotion) for a three- to five-year period after which time the position of the low-priced commercial products should be well enough established among target consumers that continuing, long-term sales of the selected products would be commercially viable for the participating manufacturers. In this scenario, donor/government agencies would never have assumed the cost of the contraceptive commodities involved.

From the point of view of diminishing demands on donor/government resources for service delivery, long-term sustainability potential, and management flexibility for most effective contraceptive marketing, the third option -- privatization of the CDC program -- is ideal.

Should policy considerations or unwillingness of the commercial sector to participate so directly in the social marketing of contraceptives in Jamaica prevent implementation of the third option, either of the remaining two options is a workable alternative for achieving some level of enhanced performance and improved sustainability of the CDC program. (Each of these two management structure options is being implemented currently in at least one other contraceptive social marketing country program in the world). Unfailing effort on the part of the NFPB to provide timely and flexible policy and strategic approvals for the operational arm of CDC activities -- whether it remain in the NFPB or be placed in the commercial sector -- will be essential to the success of either of these two remaining options for management structure.

### 12.2.5 Adolescent Programs

Programs focusing on youth need to be strengthened. However, the extent to which USAID assistance should be aimed at specific programs needs to be determined before funds are programmed for youth-related subprojects in a new project.

As recommended for action under the present project, the MOE should be encouraged to revive its Family Life Education Program. The revitalization of this program may likely require more time and technical and financial assistance before family life education is fully a part of the MOE program.

#### Recommendation:

**Working with the MOE in consultation with the NFPB, USAID should determine the technical and financial assistance requirements necessary to revitalize the Family Life Education Program of the MOE. Technical and financial sustainability issues of institutionalized family life education within the MOE program should be a priority consideration in determining the level and kind of assistance that USAID may provide to the MOE in a new project.**

Concerning the Family Life/Family Planning Education Project of the MYCD, the focus on youth programs has diminished over the past year. The potential for long-term institutionalization of family life education into the MYCD program seems less than that for the MOE program. There are other resources, namely the Parish Liaison Officers, who may be able to provide information on family planning to local youth clubs of the MYCD on a sustained basis. Also, the new IEC strategy being developed as part of the World Bank project should incorporate youth groups in its strategy.

#### Recommendation:

**USAID assistance to the MYCD should be limited to interventions that are a part of other ongoing programs of the NFPB and not a separate subproject.**

### 12.2.6 Private Sector Focus

The family planning program has had limited experience in for-profit private sector activities: JFPA's outreach work to the organized employment sector on the north coast and its selling of IUDs to private physicians; the CDC program's involvement with Grace Kennedy, Ltd., in distributing contraceptives; and the NFPB's and JFPA's promotion of clinic days and their solicitation of contributions from local businessmen. The NFPB is a public institution and while it may wish to have more involvement in the for-profit private sector it just does not have the experience. The difficulties described earlier in the report with regard to the CDC program's attempt to compete in the private sector illustrate the difficulty that NFPB, or any governmental organization, will have in trying to become involved in the for-profit sector in family planning.

The options suggested above for making the CDC program more competitive should be the focus of the NFPB's attention in regard to for-profit family planning activities. There may, however, be some other opportunities in the for-profit sector that could be exploited for family planning:

**Medical detailing of IUDs to private physicians. The JFPA is doing this already; physicians are coming to them for their supplies of IUDs.**

- Linking of private medical practitioners to factories or other businesses to provide family planning services for a fee, paid for by the employer or the company health program. For example, a cost-benefit analysis of time away from work due to sickness related to pregnancy, and the cost of delivery and recovery, convinced a group of executives of small factories in St. Lucia that providing family planning for their workers would be less expensive than paying for health costs related to pregnancy and child birth. Enough factories had to band together to make it affordable to hire one nurse/midwife to serve the small work force of the individual factories. Although the number of factories with over 100 employees in Jamaica is small (about 30), this type of linkage between private practitioners and companies might work well in Jamaica.
- Part of the costs for providing family planning is for motivation work. On a small clinic basis, local Jamaican businessmen have provided prizes as rewards for people coming to the clinics. The businessmen's motivation for doing this may be civic responsibility, creating goodwill, and/or selling his business. The Johns Hopkins University/Population Communication Services Project (JHU/PCS) has shown that business contributions to promoting family planning campaigns can be substantial if businessmen are approached in the right way and if they get something tangible from their contribution. For example, in the Philippines, JHU/PCS paid two well-known young singers to promote a song about family planning and waiting until one is older before having children. The song became a hit. As part of the strategy, JHU/PCS went to businesses, such as Coca Cola and McDonald's, to ask them to support the music promotion in return for their products being advertised along with the music and the two singers. Signs and banners of the appearance of the two singers had the logos of the businesses' products on them. Although the music strategy was expensive, it was, in the end, made up through corporate contributions. The added significance of this strategy, particularly for countries with large youth populations, such as the Philippines or Jamaica, is that the music and advertising appeal to just that audience who needs to be convinced about family planning.

It is important to note that each of the above activities is self-financing. Although there may be up-front costs, once the activity is operational, it would be sustainable without donor or government funds.

#### Recommendation:

**USAID/Kingston should support the development of a national assessment of private/commercial sector potential in provision of family planning services and should consider – on the basis of the assessment – support for the development of a national "umbrella" strategy for the privatization of family planning services delivery in so far as is possible. (This strategy could include such things as TIPPS-type involvement of employers in providing family planning services to workers, commercialization of CDC program activities, elimination or reduction of monetary and tax constraints on the import and sale of contraceptive products, motivation of private sector physicians to promote and provide affordable family planning services, and many others.)**

#### **12.2.7 Technical Assistance**

The technical assistance requirements of a mature family planning program are different from the needs of programs just beginning or expanding. The cooperating agencies of the Office of Population are working in many countries that have high contraceptive prevalence and are now facing similar questions to the ones facing the Jamaican family planning program. Their experience during this final USAID-assisted population project in Jamaica would be important in

helping the NFPB identify critical interventions that need to be taken and offering advise on alternative actions that the NFPB can take to reach its demographic goal and to attain technical and financial program sustainability. Issues that may require technical assistance include financial sustainability, introduction of new contraceptive methods, private sector initiatives, and new counseling methodologies.

**Recommendation:**

**During the next project, a larger proportion of funds should be allocated for technical assistance to be provided by Cooperating Agencies.**

## **Appendices**

**Appendix A**

**Statement of Work  
and  
Evaluation Methodology**

**Appendix A**  
**Statement of Work**  
**and**  
**Evaluation Methodology**

**Responsibilities**

The Contractor shall provide the services of a Jamaican social scientist who shall participate as one member of a five person team who shall evaluate USAID/Kingston's Population and Family Planning Services Project.

The evaluation Team Leader, who is also provided by the Contractor with AID/W funds, shall be responsible for assigning specific tasks and responsibilities for each team member within the overall statement of work for the evaluation. The Jamaican team member shall report to the Team Leader who has the overall responsibility for preparation and submission of the Final Evaluation report to USAID/Kingston as detailed in the overall statement of work for the evaluations which follows.

**Statement of Work**

The evaluation report shall be organized in three sections: i) empirical findings, ii) conclusions (interpretations and judgement) that are based on the findings, and iii) recommendations in order of priority based on an assessment of the results of the evaluation exercise. The report should also provide lessons learned which emerged from the analysis.

**A. Findings and Conclusions**

The evaluation shall analytically address the following questions:

- i. What has been the performance of the family planning program over the period of the project, with specific attention to the sterilization, MOH clinic, adolescent fertility and CRS programs?
- ii. Has the Project accomplished its purpose as stated in the Log Frame:
  - A contraceptive prevalence rate of 70% in 1986;
  - A 50% increase in the number of new and continuing family planning acceptors by 1985;
  - A 25% increase in sales of contraceptives through the CDC program?If not, why not? Was the original purpose realistic? The evaluation will examine the validity of the assumptions on the original log frame.
- iii. Have the project outputs been achieved? If not, why not? Evaluate the relevance, effectiveness, efficiency, and impact of the Project outputs on achievement of the Project Purpose.
- iv. Determine the efficiency and effectiveness of Project inputs of technical assistance, training, commodities, and other costs.
- v. What are the lessons learned that emerged from the above analyses that USAID and the NFPB can apply to future programs and activities.

**B. Recommendations**

- i. From the above, what activities under the Project should be continued by the GOJ, USAID or other donor funding? What steps should be taken to ensure the sustainability of these activities?
- ii. What have been the major strengths and weaknesses of the Project? What should be done to resolve identified weaknesses within the time frame of the project?
- iii. What should be the role of AID in providing contraceptives for the family planning program? What steps should be taken by the GOJ regarding the long-term plan for financing the costs of contraceptives?
- iv. How effective have the Parish Liaison Officers been? How can their performance be strengthened?
- v. Who have been the Project's beneficiaries and participants? This information must be provided on a gender desegregated basis. If gender issues emerge from this analysis, they should be included in the conclusions and recommendations sections.
- vi. Provide recommendations to USAID and NFPB regarding the changes needed under the ongoing project and the potential areas of need for future USAID assistance to the national family planning program.

### **Evaluation Methodology**

The evaluation team met in Washington, D.C. in mid-January to be briefed by the LAC Bureau and the Office of Population. At that time the team reviewed the scope of work and developed an approach for the assignment and a tentative table of contents for the evaluation. The team had been provided with basic documentation on the evaluation prior to their Washington briefing.

The fieldwork of the evaluation began on January 22 in Kingston with a preliminary meeting with the some of the senior staff of the NFPB and later with the USAID. Another orientation meeting with USAID took place later in the first week and the team provided a more detailed table of contents for USAID's consideration. The next three weeks were spent in interviewing staff of the NFPB, the Ministry of Health, the Ministry of Education and others persons responsible for some of the main subprojects funded under the project. Field visits to MOH health centers, NFPB clinics and JFPA clinics were made as well as visits to pharmacies. Private sector businessmen were interviewed concerning the CDC part of the Project.

At the end of the second week two of the team members finished their part of the evaluation and left. The two other team members continued to collect data and interview contacts. A significant volume of demographic and project-related literature was made available to the team for their review.

The draft report was submitted to USAID on February 16, 1990 and a debriefing was held on February 22, 1990 with USAID and the Government of Jamaica.

See Appendix B for the persons interviewed during the evaluation and Appendix C for the list of documents reviewed.

#### **Composition of the Team**

The team was composed of four members:

John McWilliam	-	family planning services and demography (team leader)
Hermione McKenzie	-	adolescent programs
Maryanne Neill	-	contraceptive logistics
Betty Ravenholt	-	social marketing of contraceptives

## Appendix B

### List of Persons Contacted

## Appendix B

### List of Persons Contacted

#### USAID

Mr. William Joslin	Mission Director
Mr. Paul Crowe	Economist
Mrs. Rebecca Cohn	Director, Office of Health, Nutrition & Population
Mrs. Grace-Ann Grey	Project Officer, Health & Family Planning

#### NFPB

Mr. Alvin Rattray	Chairman of the Board
Mr. Newton Forbes	Executive Director
Mr. Lennox Deane	Deputy Executive Director
Dr. Olivia McDonald	Director, Services Delivery
Mrs. Ellen Radlein	Director, Statistical Services
Mrs. Betty Ramdon	Director, IEC and Training
Mr. Eric Douglas	Acting Director, Projects and Research;
	Marketing Officer
Mrs. Janet Davis	Training Officer
Mr. Dudley Isaacs	Assistant Marketing Officer
Mrs. Allen	Nursing Supervisor
Mrs. Dauban	Clinic Officer, May Penn
Mrs. Charmaine McCoy	Clinic Officer, Hunt's Bay
Ms. P. Johnson	Assistant Clinic Officer, Hunt's Bay
Mr. Leslie Williams-Watson	Southern Regional Supervisor of Parish Liaison
	Officers
Mrs. Olive Nixon-Williams	Parish Liaison Officer, Clarendon

#### MOH

Dr. Barry Wint	Chief Medical Officer
Dr. Dianna Ashley	Senior Medical Officer, Maternal and Child Health
Mrs. Beryl Chevannes	Family Planning Coordinator

#### CPS

Mrs. Carmen McFarlane	McFarlane Consultants
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#### Commercial Sector

Mr. Rupert Gallimore	Sales Manager, Grace Kennedy Ltd.
Mr. Gernu Beckford	Owner, Dunlop Corbin Compton Advertising
Mrs. Pam Beckford	Owner/Pharmacist, Mall Pharmacy
Pharmacist	York Pharmacy
Pharmacist	Nelson's Drug Store, Ltd.

#### Planning Institute of Jamaica

Mrs. Myrtle Hazle	Deputy Head, Manpower and Social Planning
Ms. Joyce Vincent	Health Desk Officer

Mr. Easton Williams  
Mrs. Carmen Miller

Head, Population Unit  
IEC Specialist

U.W.I. Fertility Management Unit

Dr. Hugh Wynter

Professor of Obstetrics and Gynecology

Operation Friendship

Mrs. Ruth Brown

Nurse/Coordinator

Ministry of Youth and Community Development (MYDC)

Mrs. Doris Watts

National Coordinator, Family Planning/Family Life  
Education Project

Roman Catholic Family Life Centre (RCFLC)

Miss Denise Kelly  
Mrs. Lola Rose

Director  
Assistant

Ministry of Education

Mrs. Monica Holness

Education Officer, Guidance and Counselling  
Section

## Appendix C

### List of Documents Reviewed

## Appendix C

### List of Documents Reviewed

- USAID/Kingston. Project Files, 532-0069. Commercial Distribution of Contraceptives.
- CDC. Draft Final Report, CPS, Jamaica, 1989.
- CDC. Final Report, CPS, Jamaica, 1989.
- Statistical Institute of Jamaica, The World Bank. Survey of Living Conditions, Jamaica, 1989.
- Howell, Betty Butler. A Report on Technical Assistance to Jamaica Contraceptive Retail Sales Program. May 25-June 7, 1980.
- Saunders, Susan and Ed. Lucaire. Trip Report. March 10-23, 1985.
- Howell, Betty Butler and Timothy, Seims. Technical Assistance to the Contraceptive Retail Sales Program. November 26 to December 7, 1979.
- Andreasen, Alan. Jamaica Trip Report. June 20-28, 1983.
- Schellstede, William. The Commercial Distribution of Contraceptives. November 14-30, 1985.
- Statistical Institute of Jamaica. Demographic Statistics. 1987.
- Loy, Nancy. Review of the Marketing Research for the CDC Project of the NFPB. March 1985.
- McKenzie, Hermione. *Women and the Family: Trends in Union Types in Jamaica, 1960-1982*.
- USAID/Kingston. Project Paper, Population and Family Planning Services (Amendment No. 1). 1986.
- National Family Planning Board. Young Adult Reproductive Health Survey. 1987.
- National Family Planning Board. Five Year Plan. 1990.
- Lightbourne, Robert E. *Recent Demographic Trends in Jamaica*. Office of Health, Nutrition and Population, USAID Mission, Kingston, Jamaica. January 24, 1990.
- Jamaica Population and Health Project: Implementation Volume*, World Bank. October 1987.
- Ministry of Health/Jamaica. Summary Report of Clinical Activities (New MCSR), 1988, 3 Quarters 1989 to September 1989.
- Family Planning Initiatives, New Project Description, Project Number 532-0163.
- Budget Local - Other Costs, Project Implementation Letter No. 108, Activities Financed by USAID/Jamaica Project 532-0069.
- USAID/Jamaica Comprehensive Pipeline by Project as of 12/31/89.
- Chevannes, Barry. *Report on a Study of Peer-Counselling in Jamaica*. April 1988.

- TIPPS. Jamaica Private Sector Family Planning Initiatives, Talking Points, January 19, 1990.
- Gomez, Fernando and Gary K. Stewart. Trip Report, Jamaica. AVSC. October 1-5, 1989.
- Donnelly, Thomas R. *Jamaica Family Planning Assessment/Review*. LAC/DR/EST, AID/W, October 9, 1985.
- Bouvier, Leon F. *A Review of the Population and Family Planning Services Project USAID/Jamaica*, POPTECH, ISTI, November 18, 1985.
- Project 532-0069 Director's Meetings, Jamaica Population and Family Planning Services, FY 86.
- Project Implementation Committee Meetings.
- Voluntary Surgical Contraceptives, FY 82.
- Jamaica Family Planning Association. FY 82. (Agreement, Correspondence, Reports, Baseline Survey).
- PIO/T 532-0069-3-20191/60217 (AVSC) file. FY 89.
- Marsh, Beverly. *A Peer Counselling Manual*, Department of Social and Preventive Medicine, University of the West Indies, June 1986.
- PHP (World Bank)/UNFPA Funded Local Training Plan, January-December 1990.
- Semi-Annual Review Loan and Grant Projects (October 1, 1987 to March 31, 1988).
- Semi-Annual Review Loan and Grant Projects (April 1, 1989 to September 30, 1989).
- "Basic Socioeconomic Data of Jamaica," Health Services Rationalization Project Proposal, August 1, 1989.
- National Family Planning Board. Statistical Reports. 1984-85; 1986; 1987; 1988.
- Family Planning Services Monthly Reporting Form.
- Men in Family Life: Male Education Field Manual* (prepared by Chris Plummer). August 1989.
- Hosein, Everold N., Orville Campbell, and Lorna Clarke. *A New IEC Program for the Jamaica National Family Planning Board*. October 11, 1989.
- Campbell, Campbell. Review of NFPB Audio-Visual Materials. October 1989.
- Clark, Lorna. IEC Management and Coordination Review. April 1989.
- National Family Planning Board, Draft Five-Year Plan, January 1990.
- Evering-Lawrence, Karlene. Baseline Survey of Cascade, Western Kingston, and Portmore, Operation Friendship. 1988.
- MacFarlane, Carmen and Charles Warren. 1989 Jamaica Contraceptive Prevalence Survey, Final Report. December 1989.
- McKenzie, Hermione and Amy Lee. *Population and Family Planning Services Project, 1982 -1986, Year I Evaluation Final Report*. October 1983.

Ministry of Education. Family Life Education Project Report, May 1983 to March 1987. December 1987.

Ministry of Education. Family Life Education Project, Source Book for Teachers. 1986.

Ministry of Education. Implementation of Family Life Education Curriculum, Teaching Materials and Strategies.

Siegel, Anita. *Evaluation of Operation Friendship Family Planning/Family Life Education*. USAID. February 1984.

### Training Materials

Report on Supervision Course 1, September 4-29, 1989.

Nurse-Trainers Course in Counselling and Clinical Skills, Course 1, November 7 to December 2, 1988.

Ministry of Health/Jamaica. Family Planning Programme Register Field Test Instruction Manual. September 20, 1989.

Programme Management Course 1, March 29 to April 11, October 30 to November 3, 1989. Population and Health Project, WB/MOH. Advanced Training in Fertility Management, Dept. of Ob-Gyn, University of the West Indies.

Report on Programme Management Course 1, March 29 to April 11, 1989.

Circular on Family Planning Supply Management Training Seminars. March 17, 1988.

Circular on Family Planning Training/MOH. July 27, 1988.

Supervision Course 1, September 4-29, 1989, Advanced Training and Research on Fertility Management Department of OB-Gyn, University of the West Indies.

Report on Clinical and Counselling Skills Course 1, October 2-27, 1989.

Desai, P. *Productivity of Primary Health Care Teams in Jamaica*. Dept of Social and Preventive Medicine, University of the West Indies. 1986.

**Appendix D**  
**Recommendations**

**Appendix D**  
**Recommendations**

**Recommendations for the Remainder of the Current Project**

**Family Planning Clinic Services**

1. **A clinic study/patient flow analysis concentrating on family planning should be undertaken before the next population project commences in order to ascertain specific areas needing attention in terms of service delivery. If requested by the NFPB or MOH, USAID should provide the technical and financial assistance for this study.**
2. Just as the standards for VSC have been reviewed and revised (see Section 5.3.2), the standards for the other family planning methods are being reviewed to ensure that the latest information on them is being provided to the health worker. A copy of these standards should be provided to each health facility.
3. Because of the wide distribution of MOH health centers, the family planning clinics of the NFPB and JFPA should be encouraged not to duplicate services in areas where MOH health centers are available. Family planning clinics should supplement the services offered in MOH health centers; e.g., they could offer services in the evenings or on the weekends when MOH health centers are closed.
4. It is important that the post-partum counseling opportunity is followed up with receipt of a method. Therefore, more attention should be given to IUD insertion and the provision of progestin-only contraceptives, such as Ovrette.
5. **A training program for service providers in inserting Copper T 380 IUDs should be undertaken, to be followed by an education/motivation campaign aimed at both the providers (to remove any reservations they may have on inserting the IUD) and the clients, targeting those most appropriate for this type of contraceptive. If requested by the NFPB or MOH, USAID should provide technical and financial assistance in undertaking this training program.**
6. To facilitate referrals, each health center that does not have staff who are able to insert IUDs or provide surgical contraceptive services should have a sign posted stating the nearest clinics where there are staff who can insert IUDs as well as the nearest facility for surgical contraception services. Information on clinic hours and the facility's address should also be included.
7. **To make better use of the waiting areas in all health centers, posters should be displayed illustrating the different methods of family planning with brief explanations of the method and with information on the ideal client profile. These method and client profile posters should be developed and field-tested with the participation of a population of waiting room clients to ensure that the messages are appropriate and the visual aids are understandable. If requested by the NFPB or MOH, USAID should provide technical and financial assistance for the development of these specific posters.**
8. Training of health personnel in counseling skills should form a part of all in-service training courses. In this way, special courses on counseling may not be necessary, and the importance that is placed on the most effective ways of communicating with clients would be constantly reinforced. Training should encourage service providers to acknowledge their own personal biases in method choices and to respect a client's choice.

9. Simple guidelines on counseling techniques that are effective in informing clients about all methods should be made available to all clinic staff.

### **Voluntary Surgical Contraception**

1. The MOH and NFPB should ensure that a full-time obstetrics and gynecology specialist is appointed to head up the VSC program in the Secondary Health Care directorate. The model of the Family Planning Coordinator in the MCH unit to help in the implementation of family planning through the primary health care program should be used (see Section 4.2.1).
2. The NFPB should provide more information on VSC to both the service provider in health centers (to educate and motivate them on the procedure) and to potential clients.
3. A system for collecting information on all VSC procedures both from public and private institutions should be instituted and linked with the already established PHC health information system's reporting on family planning. Sources of referral should be included in this new system. If requested by the NFPB or MOH, USAID should provide assistance in helping to establish this system.
4. Institutional incentives should remain for VSC at the same rate for the short term. However, once a national system is operating under the MOH, consideration should be given to discontinuing the institutional incentive program, since the program would then be fully integrated into the MOH service system. USAID assistance should be continued for the short term.
5. USAID assistance through AVSC should continue during the project period to help the MOH and NFPB implement the required changes. Further technical assistance from AVSC may be necessary at the end of the present project, and USAID should provide this assistance if necessary.

### **Commodities and Logistics**

1. The NFPB should play a more active role in the forecasting, ordering, importation, and warehousing of commodities. The following actions would further this more active role:
  - Counterpart(s) from the NFPB responsible for commodity forecasting and clearance should be appointed.
  - The computerized CPT program developed by CDC should be installed in one of the three computers at the NFPB. Formal training using the CPT computer program should be carried out.
  - The NFPB should develop a yearly workplan with a timeline for forecasting, ordering, and distribution of supplies. Responsible personnel should be indicated for each task with dates to submit progress reports towards accomplishing this workplan. Such a workplan would ensure that in an emergency stock-out situation the ordering process would be a smooth one, with available funds being immediately accessible.
  - A system regulating the procurement of each method should be designed on the basis of consumption patterns related to actual distribution.

- The warehouse manager should devise a system to ensure that orders are correctly filled out for field deliveries. This check would enable the manager to easily trace an order that was incorrectly filled and send the balance of supplies needed as soon as possible.
  - Although field personnel are trained to always keep at least two months stock on hand when ordering for the next re-supply, this is not always the case and the NFPB should reinforce this practice.
  - Refresher workshops should be held once a year to update field personnel on new contraceptives, assist in the development of new maximum/minimum levels of stock, and correct misconceptions about expired products.
  - The NEWVERN shipping schedule should be verified quarterly to see if action is taken on all requested commodities. If a commodity does not appear to have been ordered two months after sending the cable, then Washington should be notified.
  - The supply management training manual developed by the MOH should be updated and printed for general distribution. Every clinic should have a copy for reference use.
2. Special double-checking of commodities should be carried out in Washington before they are shipped.
  3. The 1,104,000 Sultan condoms at the port should be randomly tested because they have remained at the port for over five months in less than optimal storage conditions.

#### **Commercial Distribution of Contraceptives (CDC) Program**

1. A program of market and consumer research should be undertaken during the next 12 months. This research should include at least a consumer intercept survey for development of CDC consumer profiles and a retail audit. This research is necessary to USAID/Kingston for use in the design of its possible new family planning project and to the CDC program for developing a current operational strategy. If requested by the NFPB, USAID should provide technical and financial assistance to undertake this research activity.
2. With information currently available, CDC staff should develop an annual marketing and business strategy for program activities. Such a strategy should provide the framework and direction for program efforts during the coming year as well as a management tool for measuring program accomplishments. This strategy should include a specifically stated target market for each product sold or proposed to be sold by the CDC. Pricing and marketing activities suggested for each product should be consistent with the target market as defined.
3. Based on the business strategy developed in No. 2 above, a price increase for both Perle and Panther should be implemented; a minimum 100 percent increase should be considered.
4. The NFPB should ascertain the future availability of Noriday 1+50 from A.I.D./Washington. If the product will not be readily available over the long term, the NFPB should begin immediately to formulate a strategy for coping with this eventuality. (This might include such things as independent procurement of Noriday 1+50, introduction of a low-dose oral contraceptive with a Perle related name – such as Perle LD, Lo-Perle, or the like – to retain consumer loyalty and brand recognition built up by Perle, etc.) USAID/Kingston should facilitate the NFPB in clarifying this matter.

5. **CDC staff, working with Grace Kennedy, Ltd., should design and implement an improved sales reporting system that includes at least the following for both Perle and Panther on a monthly basis: sales (dollar and unit) by parish, sales (dollar and unit) by outlet type (including, if possible, totals sold to each van driver, pharmacy, wholesaler, cash-and-carry store), and a monthly total of products sold to each individual Grace Kennedy, Ltd.-serviced outlet. With this refined sales reporting system, CDC management would know more clearly in what parts of the country Perle and Panther are best received by consumers, trends in purchasing patterns, what kinds of outlets are most successful in selling the products, which pharmacies or other major outlets sell the most products and therefore deserve special recognition or follow-up, where product sales need special promotional support in order to grow, and the like. If requested by the NFPB, USAID should provide technical assistance to assist CDC to undertake this task.**

#### **Programs Focusing on Adolescents**

1. **The Jamaica national family planning program should continue to support motivation and education programs in youth organizations. These need to be systematized, however, with good quality motivation/education skills and a dynamic audio-visual program.**
2. **The IEC Division of the NFPB and the Parish Liaison Officers should develop overall responsibility for monitoring and cooperating with these programs.**
3. **The MOE should be encouraged to revive its family life education program. The implementation difficulties encountered in this program reflect some fundamental problems in the attitudes of teachers, and perhaps in the attitudes of the school system itself, to sexuality and reproduction. These problems need to be addressed in such an influential and formative institution as the MOE. If requested by the NFPB and MOE, USAID should provide technical assistance for those areas in the MOE's Family Life Education Program that require strengthening.**

#### **IEC and Training**

1. **With the amount of funds and donor involvement in the IEC Department planned for the next few years, USAID should not fund new IEC initiatives (ones that are not already committed or in the pipeline) until decisions on the future IEC strategy are made by the NFPB.**

#### **Project Management**

1. **The NFPB should review its institutional goals and structure taking into account the changing nature and needs of the population and family planning program of Jamaica.**
  - a) **This should be the primary agenda item for the March 1990 retreat of the NFPB, which should include both Board of Directors members and technical staff.**
  - b) **An organizational management expert with skills in working with institutions to define goals and functions should assist the NFPB in this process. Consideration should be given to having this expert facilitate the discussion of this agenda item at the March retreat. If requested by the NFPB, USAID should provide assistance for this expert.**

2. **The development of any new long-range plan for family planning should be based on expected prevalence targets for each method. The TARGET SETTING MODEL computer program that uses prevalence targets for each method and takes into account the age structure and proximate determinants of fertility should be used. If requested by the NFPB, USAID technical assistance to install this user-friendly computer program at the NFPB should be given.**
3. **Program strategies to reach targeted prevalence goals should be planned jointly by the technical staff of the NFPB and the MOH. At the same time that decisions are being made on targets for various contraceptive methods, the implications for service delivery should be reviewed by the MOH and program strategies explored to reach those targets. Data from the Statistical Reports of the NFPB, the MOH health information data from both PHC and Secondary Health Care, as well as 1989 CPS data should be used. The NFPB would assemble the data and would prepare, with the concurrence of MOH officials, an agenda for a two-day retreat of technical staff of the NFPB and MOH to develop program strategies. If requested by the NFPB, USAID financial assistance for this action should be given.**
4. **USAID should hand over all contraceptive forecasting and other project-related responsibilities that are legitimately a part of the duties of the NFPB in implementing the project.**

### Recommended Future Directions

#### General

1. **USAID/Kingston should continue a program of assistance to the Jamaican family planning program at the end of the current project.**

#### Sustainability in Contraceptive Commodities

1. **In a future project after March 1991, USAID should provide funds for contraceptive commodities on a decreasing scale with the Government of Jamaica complementing the funds to cover contraceptive requirements. For year one, USAID would finance all contraceptives; year two, USAID 75 percent and GOJ 25 percent; year 3, USAID 50 percent GOJ 50 percent; year four, USAID 25 percent GOJ 75 percent; year five, GOJ would finance all contraceptives. USAID should provide technical assistance to help plan for the phasing out of financial assistance for contraceptives and for the procurement of them.**
2. **Although some attempts have been made by the NFPB at cost recovery of contraceptives, the issue of financial sustainability for contraceptives should be placed at the top of the agenda in designing future family planning program activities. USAID should provide technical assistance to the NFPB on cost-recovery and "fee for service" schemes. In addition, USAID's planned project in the area of health care financing should include contraceptives in its scope of work.**

#### Training in Contraceptive Methods

1. **A training program for post-partum sterilization and IUD insertion should be considered in the new project. The Victoria Jubilee Hospital with the large maternity ward would be**

the preferred venue for initiating a large training effort. This training program could also be the vehicle for the introduction of NORPLANT<sup>®</sup>, if and when a decision is made to introduce this method into the program.

#### CDC Program

1. The management structure of the CDC program should be changed in the new project to allow it to work in and meet the challenges of the marketplace. There are a number of management structures that would make this possible:

- Option 1. Policy and operational responsibility for the CDC program could remain within the NFPB but with a management structure reorganization that would facilitate CDC's ability to operate and make decisions on the basis of marketing considerations and consumer needs. Such a reorganization would include at least the following: a marketing manager of at least the capability and professional experience of the current Marketing Officer, elevation of the marketing manager/officer position to the level of other division chiefs within the NFPB, annual approval of the CDC marketing strategy by the Board of Directors with no further need for activity by activity approvals during the course of the year, an annual CDC budget approved by the Board of Directors within which the marketing manager/director can make decisions as required by the demands of the marketplace during the course of the year, and elimination of the need for MOH approval of CDC advertising. (The NFPB as the family planning "arm" of the GOJ should certainly be able to ensure that CDC advertising does not conflict with the overall aims and general informational goals of the MOH in regards to family planning. Internal NFPB approval of CDC advertising should be on the policy or concept level, not on the level of execution of the concepts).

In this event, it is recommended that USAID/Kingston should supply contraceptive commodities to the CDC program as described above. Additionally, it is recommended that USAID should supply technical assistance to the NFPB in the development of marketing and business strategies for the CDC program and that USAID share with the NFPB on an equal basis during the first two years of any future new project the costs of marketing activities (such as advertising, promotion, and research) necessary to revitalize current CDC products or to introduce selected new CDC products. Short-term technical assistance in specific areas of program implementation (such as research design, development of advertising concepts, and the like) could be provided if needed. Such time-limited and cost-shared assistance should facilitate the NFPB's ability to develop and implement its contraceptive social marketing activities in the most sustainable and effective ways possible and encourage the NFPB to reinvest the revenues generated by CDC product sales in improving and maintaining CDC program activities.

- Option 2. The NFPB could retain annual policy approval of CDC strategy but operational responsibility is moved into the commercial sector (e.g., Grace Kennedy, Ltd. staff manage program operations and coordinate advertising and research support for program activities). In this event, it is recommended that USAID/Kingston should provide commodities as described above, technical assistance in developing marketing strategies and in selected implementation areas if needed, and full funding of marketing support activities (such as advertising, research, and promotion) for the first two years of any new USAID project. This time-limited assistance should provide the commercial entity with necessary help in

developing a market for the low-priced contraceptives sufficient to support future marketing activities. Full funding of support activities is recommended over the first two-year period since NFPB and/or donor resources would not be required to finance the costs of salaries, allowances, and overheads. These costs would be covered by the commercial firm's margins as they are with all other commercially distributed products.

- Option 3. The social marketing of low-priced contraceptives could become a part of a new national effort to privatize as much as possible the delivery of family planning services. In other words, the NFPB could relinquish its role in marketing contraceptives, and a "deal" could be negotiated with contraceptive manufacturers for the sale and distribution in the Jamaican market of one or more high-quality, low-priced contraceptives at no long-term cost to donor/government agencies. (Such arrangements are now successfully implemented in the Dominican Republic and Indonesia, for example.) In this event, it is recommended that USAID/Kingston should fully fund marketing support activities (such as advertising, research, and promotion) for a three- to five-year period after which time the position of the low-priced commercial products should be well enough established among target consumers that continuing, long-term sales of the selected products would be commercially viable for the participating manufacturers. In this scenario, donor/government agencies would never have assumed the cost of the contraceptive commodities involved.

#### Adolescent Programs

1. Working with the MOE in consultation with the NFPB, USAID should determine the technical and financial assistance requirements necessary to revitalize the Family Life Education Program of the MOE. Technical and financial sustainability issues of institutionalized family life education within the MOE program should be a priority consideration in determining the level and kind of assistance that USAID may provide to the MOE in a new project.
2. USAID assistance to the MYCD should be limited to interventions that are a part of other ongoing programs of the NFPB and not a separate subproject.

#### Private Sector Focus

1. USAID/Kingston should support the development of a national assessment of private/commercial sector potential in provision of family planning services and should consider -- on the basis of the assessment -- support for the development of a national "umbrella" strategy for the privatization of family planning services delivery in so far as is possible. (This strategy could include such things as TIPPS-type involvement of employers in providing family planning services to workers, commercialization of CDC program activities, elimination or reduction of monetary and tax constraints on the import and sale of contraceptive products, motivation of private sector physicians to promote and provide affordable family planning services, and many others.)

#### Technical Assistance

1. During the next project, a larger proportion of funds should be allocated for technical assistance to be provided by Cooperating Agencies.