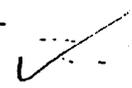


PD-ABE-217

BA 77407



AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A Add  
C Change  
D Delete

Amendment Number

DOCUMENT CODE

3

COUNTRY/ENTITY  
JAMAICA

3. PROJECT NUMBER  
332-0163

4. BUREAU/OFFICE

5. PROJECT TITLE (maximum 40 characters)

LAC

05

Family Planning Initiatives Project

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

7. ESTIMATED DATE OF OBLIGATION (Under 31 below, enter 1, 2, 3, or 4)

MM DD YY  
10 7 3 1981

A. Initial FY 911

B. Quarter 4

C. Final FY 92

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. LC	D. Total	E. FX	F. LC	G. Total
Approved Total	646	29	675	3,791	3,209	7,000
Grant	646	29	675	3,791	3,209	7,000
Loan						
Other						
U.S.						
Host Country					2,734	4,734
Other Donors						
TOTALS	646	29	675	3,791	5,943	9,734

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROXIMATE RELATIONSHIP	B. PRIMARY TECH. CODE	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
PN	400			7,000		7,000	
TOTALS				7,000		7,000	

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

440

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

1. Code 441 442 444

2. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To increase the effectiveness and sustainability of the national family planning system in preparation for USAID phaseout.

14. SCHEDULED EVALUATIONS

MM YY MM YY MM YY  
Interim 01 94 Final 10 96

15. SOURCE/ORIGIN OF GOODS AND SERVICES

100 341 Local X Other/Specify 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (Attach page 1 of 1 page PP Amendments)

USAID/Jamaica Controller has reviewed and concurs with the methods of implementation and financing included herein.

Marjorie Lewis  
Controller

17. APPROVED BY  
Signature: Robert S. Queener  
Title: Mission Director  
Date Signed: 07 23 91

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

## Table of Contents

	<u>Page</u>
Acronyms	i
List of Project Design Team	ii
I. Executive Summary	1
A. Summary of the Problem	1
B. Summary of the Project	1
II. Background and Problem	3
A. Country Setting	3
B. Statement of the Problem	5
III. Rationale and Strategy	6
A. National Development Goals and Population Growth	6
B. Access to Effective Family Planning	7
C. Strategy	9
IV. Project Description	10
A. Project Goal and Purpose	10
B. Project Accomplishments	10
C. Project Activities	11
1. Policy Framework	12
a. Policy Analysis	12
b. Operations Research & Surveys	13
c. Social Marketing	13
2. Sustainable Services	13
a. Public Sector	14
i. Contraceptive Supplies and Logistics	14
ii. Family Life Education	16
iii. Clinical Methods	17
b. Private Sector	18
i. CSM Program	18
ii. Private Providers	20
iii. Women's Center	21
3. NFPB Institutional Strengthening	21

	<u>Page</u>
V. Cost Estimates and Financial Plan	23
A. Summary Cost Estimate and Financial Plan	24
B. Costing of Project Outputs/Inputs	25
C. Projection of Expenditures by Fiscal Year	26
D. Methods of Implementation and Financing	27
E. GOJ Contributions	28
VI. Implementation Arrangements	29
A. Project Management Responsibilities and Organization	29
1. Steering Committee	29
2. Resident Advisor	29
3. USAID/Kingston Organizational Responsibility	30
4. Procurement	30
5. Training	31
6. Local Currency	31
7. Host Country Contribution	31
B. Implementation Plan	31
1. Policy Framework	31
a. Policy Analysis	32
b. Operations Research and Surveys	32
c. Social Marketing	32
2. Sustainable Services	33
a. Public Sector	33
i. Contraceptive Supplies and Logistics	33
- Contraceptive Forecasting	34
- Logistics MIS	34
- Autonomous Procurement	34
- Logistics Management	34
ii. Family Life Education	34
iii. Clinical Methods	34
b. Private Sector	37
i. CSM Program	37
ii. Private Providers	38
iii. Adolescent's Program	39
3. NFPB Institutional Strengthening	39
4. Implementation Plan	41
C. Procurement List	42
VII. Monitoring, Evaluation and Audit	43
A. Monitoring	43
B. Recipient Reporting Requirements	43
C. Evaluation	43
D. Audit	44

	<u>Page</u>
VIII. Summary of Analyses	45
A. Technical Analysis	45
B. Institutional and Administrative Analysis	48
C. Social Soundness Analysis	50
D. Economic and Financial Analysis	50
E. Environmental Analysis	52
IX. Conditions and Covenants	52
ANNEXES	
ANNEX A.	Logical Framework Matrix
ANNEX B.	PID Approval Cable
ANNEX C.	Statutory Checklist
ANNEX D.	Technical Analysis
ANNEX E.	Administrative and Institutional Analysis
ANNEX F.	Social Soundness Analysis
ANNEX G.1.	Economic Analysis
ANNEX G.2.	Financial Analysis
ANNEX H.	Environmental Threshold Decision
ANNEX I.	Letter of request from the GOJ
ANNEX J.	Letter from GOJ on Future Budgeting for Contraceptives
ANNEX K.	Local Production of Contraceptives
ANNEX L.	Basis for Contraceptive Financing Estimates
ANNEX M.	Waiver of Requirement for Host Country Funding of International Travel

Acronyms

AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AVSC	Association for Voluntary Surgical Contraception
CDC	Centers for Disease Control
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CPT	Contraceptive Procurement Table
CSM	Commercial Social Marketing
CYP	Couple-Year Protection
FPI	Family Planning Initiatives
FPLM	Family Planning Logistics Management
FPMD	Family Planning Management Development
GOJ	Government of Jamaica
GPA	Global Program on AIDS
HIV	Human Immuno-deficiency Virus
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
JFPA	Jamaica Family Planning Association
MCH	Maternal and Child Health
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
MSH	Management Sciences for Health
NFPB	National Family Planning Board
NPA	Non-project Assistance
OPTIONS	Options for Population Policy
OR	Operations Research
PACD	Project Assistance Completion Date
PC	Population Council
PIO/C	Project Implementation Order - Commodities
PIO/P	Project Implementation Order - Participant
PIO/T	Project Implementation Order - Training
POPTECH	Population Technical Assistance
RAPID	Resources for Awareness of Population Impacts on Development
SOMARC	Social Marketing of Contraceptives Project
STATIN	Statistical Institute of Jamaica
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Project Design Team

This Project Paper was developed by the following USAID/Jamaica staff:

Rebecca W. Cohn, Director, Office of Health, Nutrition and Population  
Grace-Ann Grey, Program Specialist, OHNP  
Louis Coronado, Project Development Officer

With the short-term consultancies of:

Janet Smith, Dual & Associates  
Betty Ravenholt, Futures Group  
Dayl Donaldson, Dual & Associates  
Maxine Wedderburn, Hope Enterprises  
Heather Royes, Independent Consultant

\*\*\*\*\*

The Project Paper was reviewed by:

Robert S. Queener, Mission Director, USAID/Jamaica  
Marilyn Zak, Deputy Director, USAID/Jamaica  
Marge Lewis, Controller  
Kathleen Davidson, Office of Economic and Private Enterprise  
Rosalee Henry, Office of Program and Project Development

- 1 -

## I. EXECUTIVE SUMMARY

### A. Summary of the Problem

Jamaica's national family planning program has been very successful, achieving in its 25 years of development a 55 percent contraceptive prevalence rate. Yet the program is largely a public sector program and is dependent for a significant portion of its funding on donors. The major donor, USAID, will phase out its assistance by 1998 with the completion of the Family Planning Initiatives Project (532- 0163).

To meet national development goals, a contraceptive prevalence rate (CPR) of 62 percent by 1998 has been set by the GOJ as the objective of the program. Given the current high level of contraceptive prevalence, additional gains are likely to come from potential user groups who are less committed and more resistant to family planning. Achieving expanded prevalence, therefore, poses a serious challenge to the program.

The Family Planning Initiatives (FPI) Project has been designed so that by the time USAID has phased out its assistance the national program will be performing at a level which is more effective and more sustainable. The activities included in the project will focus on effectiveness, for example, by improving the contraceptive method mix supplied by the public sector, and on sustainability, for example, by increasing the involvement of private sector physicians in family planning education, referral and service delivery.

### B. Summary of the Project

Over a seven-year period, the Project will assist a variety of organizations -- both public and private -- to expand effective and sustainable services. The National Family Planning Board (NFPB), the statutory body responsible for promotion and coordination of family planning services, will be the major counterpart. (The NFPB has been receiving substantial USAID funding for more than fifteen years, and therefore will be the organization most affected by the USAID phase-out.)

The major Project components are: Policy Framework, Sustainable Services (public and private) and Institutional Strengthening of the National Family Planning Board.

Policy Framework (\$1,010,000) - The need for expanded program effectiveness and sustainability after the phase-out of USAID funding support has raised important policy issues regarding financing of the family planning program and issues relating to program operations and effectiveness. This component will provide technical assistance for policy analyses; the development of marketing presentations and seminars for GOJ decision makers; surveys and research to assess program performance and assist program planning for improved effectiveness; and social marketing campaigns to increase new family planning acceptors and reduce program dropouts.

Sustainable Services (\$4,527,000) - This Project component addresses sustainable family planning services in both the public and private sectors. In the public sector, the principal activities are Contraceptive Supplies and Logistics, Clinical Methods and Family Life Education. The Contraceptive Supplies and Logistics element will provide contraceptives -- to the CSM project during the initial two years of the Project and to the public sector program on a 20% declining basis over a five year period. Contraceptive commodity support is designed to be completely phased out by Year Seven of the Project, 1997. To support the phase out at a technical level, extensive TA will be provided in autonomous procurement, contraceptive forecasting, and logistics. Achieving improved program effectiveness is the focus of the Clinical Methods activity of the Project. The high CPR in Jamaica includes a large number of pill users served by the public sector through its clinics and the CSM program through pharmacies. Many women are continuing with the pill (which is costly as a supply method and subject to user ineffectiveness) beyond the time when their age and parity suggest they should move to more effective (i.e. longer term) methods. This component of the Project will address the policy implications and implementation needs of an improved family planning method mix in Jamaica. From the policy perspective, the Project will support an active examination of the present method mix and the ideal future method mix, strategic planning necessary to achieve this mix, and development and dissemination of profiles of users of various methods. For implementation, the Project will support training in voluntary surgical contraception (VSC), IUD insertion, and counselling, and modest commodity support. While overtures will be made to private physicians to encourage their participation in provision of clinical services, the bulk of the Project's assistance in improving method mix effectiveness will go to the public sector family planning program. A final public sector activity of this component is institutionalizing Family Life Education in the Ministry of Education's schools. Technical assistance, training, and materials development and distribution will be provided if policy conditionality is fulfilled.

The private sector activities of this component include Contraceptive Social Marketing, Private Providers, and an Adolescent Program. The Contraceptive Social Marketing component will support marketing planning, advertising, promotion and public relation activities for the sale of CSM contraceptive products (condom and oral contraceptive) if the NFPB agrees to shift operational responsibility for the program to the commercial sector. The policy decision to commercialize the CSM program is a Condition Precedent for the disbursement of funds for CSM activities. Project support for marketing and promotion during the two- year transition period from NFPB to commercial operations will help ensure that any consumer "discomfort" during the shift is minimized and that contraceptive availability through the CSM project remains high. In addition, research and monitoring activities will be undertaken to ensure that any adverse impact on the CSM program is quickly recognized and addressed.

The Private Providers component of the Project focuses on the need to expand sustainable family planning services in the private sector. Jamaican families even in low-income groups are seeing private physicians, especially for "thorough checkups" and "serious illness." Private physicians are not using these opportunities to provide family planning counselling, referrals or

methods to their clients. Through public relations, training, and information, education and communication materials, the Jamaica Family Planning Association will work with private practitioners to increase their involvement in family planning services education, referral and delivery. Physician access to low-cost IUDs and injectables, may be a current constraint; consequently, this component of the Project may work with the JFPA to make low-cost clinical methods available to private practitioners.

To address a key target group, adolescents, the Project will provide a non-renewable grant to the Women's Center for an Adolescent Program to develop and implement school and community educational programs and establish an Adolescent Clinic to reach adolescents before the first pregnancy.

Institutional Strengthening of the National Family Planning Board (\$585,000) - Activities sponsored by the Project will assist the NFPB to take on a major advocacy role for population and family planning issues. Effective NFPB advocacy should ensure a flow of government and private funds adequate to support a strong, extended national family planning program. This activity will assist the NFPB to develop and implement an institutional strategic and marketing plan, a Management Information System, and a program of staff training to ensure it is properly equipped to assume the responsibilities commensurate with a vigorous and dynamic national family planning program.

## II. BACKGROUND AND PROBLEM

### A. Country Setting

The Government of Jamaica has been very successful in making family planning services widely available. Contraceptive prevalence has reached 55%, and services are well dispersed geographically. Knowledge of effective family planning methods is nearly universal, and over 70% of all women aged 15-49 years of age have used a method of family planning at some time. A broad range of methods is available to Jamaican couples, and voluntary surgical contraception (VSC), a highly effective method, is the second most prevalent method after the oral contraceptive pill. At 25 years of age, the program is also institutionally mature.

Against this positive picture, however, are concerns that the program has stalled. The 1989 Contraceptive Prevalence Survey (CPS) points to a number of areas in which program improvements to increase prevalence need to be made: strengthening the logistics system; in counseling; in disseminating information, education, and communication (IEC); and in reaching special target groups like at-risk women, adolescents, and lapsed users. The CPS profile of Jamaican women shows that 53% of the births that occurred in the five years preceding the CPS were mistimed, 18% were unwanted, and only the remaining 29% planned. The mean age of women at first birth is declining, and 37% of women gave birth during their teen years. One-third of women currently in union are at high risk of becoming pregnant due to non-use of contraception. Of these women who are not using a method now, but had used the pill previously, the reasons for stopping the pill had to do with concerns about health or side effects. Further growth in prevalence will depend on resolving these complex problems and resistances.

Another indication of a stalled program relates to the existing contraceptive method mix. In contrast to the trend in other mature programs (defined as those with CPR of over 50%), the Jamaican family planning program is not progressively improving the effectiveness of its method mix. The present method mix in Jamaica does not make maximal use of long-term, cost-effective methods, which are less expensive to provide over the long run and better suited to the needs of older, higher parity women.

The Jamaican method mix is heavily weighted to oral contraceptives. Of the overall contraceptive prevalence of 54.4%, the oral accounts for 19.5%. Female sterilization and the IUD together account for only 15% of program acceptors. By comparison, other mature national family planning programs with CPR over 55% tend to rely more on the two long-term methods. The Dominican Republic in 1986, with a CPR of 50%, had 30% prevalence in VSC and IUD. Colombia in 1986, with a prevalence of 63%, had 27% in these two methods.

Long-term methods are cost effective in two ways. First, as effective methods become a larger share of the national method mix, fertility targets become easier to achieve since fewer users are needed to achieve similar reductions in fertility. Second, long-term methods are cheaper to provide in terms of couple-years of protection (CYP). For example, using the costs of supplying oral contraceptives as a base of 100, with the cost of the method amortized over the duration of the protection it provides, the cost of providing protection through a VSC is 59, male VSC 44, and IUD 42. By the same token, the cost of condom protection is 179. Thus program sustainability over the long term will be enhanced by better method effectiveness.

The Contraceptive Social Marketing (CSM) program is based on contraceptives donated by USAID and sold for a fraction of their true cost. Although the CSM program continues to produce substantial CYP, the program is not exploiting its potential for increasing prevalence through dynamic use of effective mass media promotion and advertising. Such a campaign could help address and resolve misinformed fears of side effects and communicate the benefits to couples of using family planning. CSM products have not been advertised since 1985, except for a very small recent campaign carrying the protection message for the CSM condom. Furthermore, CSM products have not undergone periodic price increases, to keep up with inflation. There is some anecdotal evidence to suggest this has led to an erosion in perception of their quality and puts the products at a significant disadvantage when CSM program sustainability is considered.

Another characteristic of the Jamaican family planning program is its largely public sector base. The public sector accounts for the majority of service utilization. According to the 1989 CPS, the public sector served 65% of acceptors of all methods other than VSC and provided 88% of all surgical contraception procedures. Another 30% purchased contraceptives in stores and pharmacies, of which the subsidized CSM program accounts for a sizeable part of the pharmacy and store share. This shows the tremendous role the public sector is playing in the present delivery system.

The MOH has served Jamaica well to date in meeting the primary health care needs of families. This has been so much the case that the success of the public program, in maternal and child health (MCH) and family planning, may have dampened the development of these services in the private sector.

However, in recent years, funding of MOH programs has been level or declining; and during the 1980s there was a retrenchment of services. By 1988, a variety of MCH service visits were down by as much as 8-54%, with family planning declining 18%. Declines in MCH visits were probably the result of a combination of actual declines in services and consumer perceptions of declines in quality stemming from long waits, personnel shortages, and delay in special services like reading lab tests.

As a result, and for reasons associated with the type of medical care sought, Jamaican families of many income groups are seeking out private physicians. Surveys, both on the national level and among public clinic users, have documented the heavy use of private physicians for various health care needs. Private physicians are a largely untapped resource in conveying the family planning message to Jamaican couples.

#### B. Statement of the Problem

The challenges facing the Jamaica national family planning program are: an overdependence on USAID and other donor financing given the maturity of the program; the planned phaseout of donor financing (UNFPA, USAID) and the need to activate other means of financing the program; the need to restrain population growth and fertility to achieve national development goals within a fragile macroeconomic context; and the need to implement a cost-effective and efficient family planning program to conserve scarce financial and institutional resources.

Dependency on Donor Resources - Historically, USAID has been a major donor to the program. For the period 1982 to 1991, USAID assistance to the family planning sector has totalled US\$10.7 million. Governmental entities such as the NFPB have depended on this support; in 1989/1990, 37% of NFPB funding came from USAID. Family Planning Initiatives (532-0163), which will end in 1998, is planned to be USAID's last bilateral assistance in population and family planning in Jamaica. The UNFPA is likewise phasing down support for the injectable contraceptive, and similar to USAID, is concentrating scarce resources on newly emergent rather than mature family planning programs. In order to maintain the program, the GOJ must allocate additional resources to the program, involve the private sector to the maximum extent, and implement the program to maximize efficiency and effectiveness.

Scarce GOJ Resources - Accentuating the problem posed by the phase-out of USAID support is the general recognition that public sector resources are inadequate to meet the needs of most social programs. The macroeconomic picture presents a mixed picture. Debt service stands at approximately 31% of export earnings, and the Government of Jamaica (GOJ) is struggling to meet the conditions of the IMF-sponsored structural adjustment program. The world-wide recession is hurting tourism receipts; increased oil prices are requiring foreign exchange in an economy where the private commercial sector is being starved for foreign exchange. There are no immediate prospects for this macroeconomic picture to improve. However, decision makers must taken into account that containing population growth, and achieving replacement level fertility will facilitate achievement of the Government's macroeconomic objectives, and that the dollar invested in family planning programs generates high returns on the investment in saving other government outlays.

Controlling Population Growth through Family Planning - As part of the Five-Year Development Plan 1992- 1997, the GOJ has adopted the goal of increasing contraceptive prevalence from the present level of 55% to 62%. This has two implications: 1) present levels of service need to be sustained, meaning that the program will grow at the same rate that the population increases; and 2) the program will expand to reach the higher level of prevalence stated in the national goal.

Additional resources will be required by the national family planning program to meet the increased demand resulting from both population growth and increased prevalence. Gains in prevalence will have to be made from the pool of acceptors who are current non-users and may be resistant to contraceptive use because of fears of side effects or cultural patterns which associate economic support with children of a union. Thus the expansion of prevalence will be difficult to achieve.

As the strategy described below indicates, it is vital at this time to establish a dynamic program that can effectively address and resolve these barriers to increased prevalence. The strategy should incorporate as many sustainable elements as possible; limited public sector resources must be maximized; and the greatest levels of private sector involvement must be achieved.

### III. RATIONALE AND STRATEGY

The objective of the Project is to develop an effective, sustainable national family planning program before the termination of USAID assistance. This objective is based on the Project's two-part rationale -- 1) that Jamaica's family planning program is important to the country to reach national development goals; and 2) that Jamaican families need informed access to effective, voluntary family planning.

#### A. National Development Goals and Population Growth

National development goals take into account the ability of Jamaica to control its population growth. As early as 1986, the GOJ adopted as a goal the stabilization of the population at 3 million by the year 2000. Achievement of this goal required reduction of the total fertility rate (TFR) to 2.0 by 1980. This, however, was not achieved. In 1989, the CPS reported the TFR to be approximately 3.0.

Jamaica's 1990 population is estimated at 2,473,100. Population projections under various scenarios suggest the following alternatives for population growth. Under conditions of high fertility (where population growth achieves replacement levels, or TFR of 2.0, in 2010), the population in 2000 is expected to increase by 21.4% to the level of 3,002,583. By comparison, with moderate fertility (where population growth achieves a TFR of 2.0 in 2000), the population would grow 18.8% to 2,936,943 in the year 2000.

Further, a number of parameters related to fertility have shown small increases in recent years which gives rise to additional concern. These include the number of women in the childbearing years (ages 15 to 49 years) and the crude birth rate.

To the present, Jamaica has had the advantage of significant emigration which dampened population growth. In 1988, for example, out migration virtually equalled the natural increase in the population, accounting for nearly flat population growth in that year. Another way to illustrate the significance of migration is to compare the moderate fertility growth projection above with a scenario that also includes moderate emigration. Under these conditions the population is projected to be only 2,807,945 in 2000, representing a 13.5% increase, compared to 18.8% growth without emigration. There are concerns throughout the Caribbean, however, that the doors to population receiving countries may be closing. Therefore there is heightened pressure on Caribbean national family planning programs to maintain their population levels within acceptable bounds.

To summarize this demographic picture, fertility reduction from the high scenario to the moderate scenario averts about 63,000 births by 2000, with emigration assumptions held constant. This reduction in births reduces the population in Jamaica by about 2.5%, again with emigration assumptions constant.

Moderated fertility in Jamaica is important for several reasons. As described above, emigration may not be able to keep up with population growth, yielding a net positive population growth rate. Economic growth has been flat over the past two decades, producing negative real per capita growth. This has been a push for migration, with some of the migration amounting to a brain drain. The GOJ would like to lower unemployment rates which fluctuate but remain high for younger age groups and women. Global improvements in the standard of living will be difficult to achieve with the macroeconomic conditions of the present Jamaican economy; they will be nearly impossible with a growing population.

Another important consequence of population growth in Jamaica is environmental degradation. Concerns are growing about the negative impact of an increasing urban population, deterioration in sanitation infrastructure and water availability, agricultural cultivation of fragile hillside lands, and water pollution and marine environment destruction. Further growth in the Island's population will exacerbate damage to Jamaica's fragile environment.

To synchronize fertility with national development goals, the NFPB has set the following demographic goals: 1) to ensure that the population of Jamaica does not exceed three million by the year 2000; 2) to reduce the crude birth rate to 20 per 1,000 population by 1990; and 3) to achieve replacement level fertility, of two children per woman by the year 2000. It is estimated that a contraceptive prevalence rate of 62% will be required to achieve these goals.

#### B. Access to Effective Family Planning

The second rationale for the Project is to improve the effectiveness of the family planning services in Jamaica. Improving program effectiveness is essential to moving beyond the current plateau in contraceptive use and achieving the goal of 62 percent prevalence. This can be accomplished by increasing the effective use of all methods and by improving contraceptive method mix. Oral contraceptives are the most popular method among Jamaican women but discontinuation rates are also high largely because of perceived health problems and adverse side effects. Thus a critical feature of the

social marketing activity under the new Project will be qualitative research to assess client attitudes and beliefs, and development of an aggressive campaign to combat the myths and misperceptions about the pill. In addition, more proactive counseling of new and continuing users on the part of the MOH staff will direct women to the method most appropriate to their fertility desires.

While the 1989 Contraceptive Prevalence Survey showed that contraceptive use is quite high among Jamaican couples, it also showed that many women are using a method inappropriate to their fertility desires. Jamaican women desire relatively long birth intervals: 40 percent desired an interval between three and four years, and over 30 percent of the women wanted to wait at least four years. This would suggest that the IUD would be widely desired and used.

However, according to the survey, over half the women practicing contraception are using either the pill or the condom which are clearly not appropriate methods for women seeking to avoid another birth by three or more years. For this group of women the IUD may be a better choice, but less than three percent of contracepting women choose this method. Furthermore, IUD usage has actually decreased over the past decades according to the results of the 1977 and 1989 contraceptive surveys even though overall contraceptive prevalence has risen substantially. The lack of trained clinicians in IUD insertion is a major factor accounting for this decrease. The situation with respect to female sterilization is not so bleak; it is the second most popular method accounting for about twenty-five percent of current users.

A frequently cited obstacle to expanded use of long-term (clinical) methods is the instability of marital unions in Jamaica. If women want to bear a child by their next "baby father", they may not opt for voluntary surgical contraception (VSC). While it is true that women with multiple partners may not be good candidates for the IUD, new studies show this may not be true. There is a group of women for whom the IUD and VSC are appropriate (e.g. women in stable monogamous unions). Service providers need to be trained to identify and counsel these women about the benefits of the IUD and voluntary sterilization. This will be an important element of the clinical services component of the Project.

Clinical methods are not widely available throughout the family planning program; relatively few clinic staff in MOH outlets are knowledgeable or trained in IUD counseling and insertions, and there are few VSC facilities and few staff trained in the procedures. The recent evaluation of the current USAID bilateral family planning project noted that many of the service providers in the MOH clinics do not have the necessary training to insert IUDs, and there are reports of women waiting several months before being able to get a sterilization. Clearly there is an urgent need to expand the availability of IUDs and VSC throughout the family planning program. This means increased training of providers; more effective promotion of these clinical methods through the media and through the program; and more effective counseling of family planning clients to ensure that the most appropriate methods are offered to women.

The major focus of Project initiatives in clinical methods is the public sector. With its facilities and clinical training programs, the public sector

has a comparative advantage in offering these methods. But the public sector must become much more proactive in providing these methods, training appropriate service providers, promoting the benefits of these methods, and counseling women who want no more children or want long birth intervals to use IUDs or VSC. Through this Project, A.I.D. will provide technical and financial resources to the NFPB/MOH to undertake these activities.

### C. Strategy

Based on Mission guidance, the design addresses two main objectives--long-term sustainability and program effectiveness. "USAID has made a determination that this will be the final project in the Family Planning Sector" (PID Authorization, Action Memo, p. 1). Consequently, in planning for the program to operate without AID support by the end of the Project, the design has tried to ensure that gains in program effectiveness (provision of quality, appropriate services) are accomplished prior to phaseout.

Sustainability. The PP design follows the directions specified in the approved PID. The PID, and the Action Memo, indicates that the "purpose of the Project is ... to assist the Government of Jamaica in developing self financing, sustainable family planning services" (Action Memo, p.1). The Action Memo also calls for the GOJ to commit itself prior to commencement of the Project to assume full responsibility for financing of the family planning program by the Project's end. With respect to the commercial social marketing (CSM) program, the PID also mentions that this component will be supported by the Project only in the case "that the NFPB implements previous recommendations (to commercialize) which have been made with regard to the management and structure of the program" (p. 7).

Guaranteed Access. Since this is the USG's last assistance to the GOJ in population and family planning (the possibility of an emergency successor--or safety net activity--was eliminated in the Action Memo), the design has sought to assure that the system provides broad access and becomes maximally effective prior to phaseout. Therefore the Project design and earlier sustainability analyses have built in a mechanism by which those who cannot afford to pay are assured free services in the clinics. This provision is an insurance policy that consumers will always have a place to turn, regardless of what happens in the private sector.

Social Marketing--Sustainability and Effectiveness. Once steps are taken to provide services for the poor within the MOH system, the CSM program can be modified to increase sustainability and program effectiveness as directed in the PID: 1) to relieve the GOJ of the large foreign exchange requirement of purchasing CSM commodities for a subsidized program, and 2) to allow the CSM products to be aggressively supported and marketed to increase their effective use by consumers. The social marketing consumer, consumption deciles 4-7, will face gradual price increases for their CSM contraceptives over a two-year period. The poor, who belong in the public sector clinic system where they receive free products, are not affected by these increases. All consumers will profit from the mass media marketing program addressing side effects. The media campaign will support counselling in the clinics about proper oral contraceptive use and expected sequelae.

Public and Private Sector Program Effectiveness. In the public sector, clinical methods delivery and support will be a critical emphasis. The program presently relies too heavily on oral contraceptives. Older, high parity women have limited access to effective methods like the IUD and VSC which may be more suited to their needs. Further, in the private sector, a marketing program to private practitioners will seek to engage private physicians in family planning education, referral and service delivery, so that they reinforce the family planning message. As AID phases out donated contraceptives for the public sector, it will support strengthening the capacity of the GOJ to handle the technical issues related to contraceptive commodity forecasting, procurement and distribution.

#### IV. PROJECT DESCRIPTION

##### A. Project Goal and Purpose

The Project's goal is to maximize the quantity and quality of family planning services in Jamaica delivered by the public and private sectors to support national development goals related to population. Achievement of this goal will be measured by declines in the total fertility rate, increases in contraceptive prevalence, and declines in unmet need for appropriate family planning services, and increased participation of the private sector in family planning service delivery. The purpose is to increase program effectiveness and sustainability of the national family planning system in preparation for USAID phaseout. During the Project period, the system faces the ultimate challenge--making significant strides to increase prevalence and improve method mix while absorbing declines in donor funding.

##### B. Project Accomplishments

The delivery system projected to exist at the end of the Project will be one of strengthened programs functioning in both the public and private sectors. By the end of the Project, Jamaican families should be able to draw on better quality service programs, to draw on programs which are more stable due to greater self-sustainability, and should have increased choice and access through the opening up of private sector services. The Project's program effectiveness initiatives, designed to increase prevalence and optimal provision of long-term methods, and emphasize sustainability and private participation should result in a system with more diversification of use and a more effective (and cost-effective) method mix. Continuation rates will improve stemming from, first, the GSM marketing activities addressing fears of side effects, and, second, better support for clinical methods including counseling for them.

A number of conditions have been identified which will reflect achievement of the Project's purpose. National contraceptive prevalence should rise from 55% to 62% during the Project period. This will be a major accomplishment because the program has been stalled in prevalence for about the last ten years. These gains will come from aggressive promotion of the GSM program, improved support and access to clinical methods, and increased promotion and access to private services. The proportion of acceptors protected by VSC, IUD and injectable methods should increase from 42% to 49%, indicating improved system

support, and acceptor access, to clinical methods. Within the method mix, IUD use is expected to double and return to its 1975 level. The CSM program will provide consumers low-priced, aggressively marketed products, signalling that the CSM program has been transferred to the private sector and that those firms are actively supporting their products with advertising, training and detailing.

Jamaican opinion leaders and populace will be better informed and aware about the importance of family planning to women's health and to national development. This improved awareness will be generated mainly by the continuous, high visibility advocacy programs of the NFPB, reinforced by the CSM marketing, and mass media promotion about the role of private physicians in family planning.

Public sector contraceptive supplies will be continuously available without AID assistance. This condition indicates that AID funding has been supplanted by, ideally, GOJ funding, without disruption in supplies to consumers. The GOJ will have the ability and commitment to develop routine estimates and procure contraceptives and deliver them to service delivery outlets in a timely and efficient manner. Private entities and providers will be more actively involved in providing family planning education and services.

#### C. Project Activities

The activities have been designed to reflect the Project's purpose of increasing program effectiveness and sustainability of the Jamaican family planning system. Given that the public sector is presently the major provider of family planning services, and will remain so for the foreseeable future, particularly in counseling and in the delivery of clinical services, the majority of Project activities focus on that sector.

The major Project components are Policy Framework, Sustainable Services (public and private), and Institutional Strengthening. Activities targeted to the public sector include Institutional Strengthening at the NFPB; Policy Analysis and Research; Contraceptive Supplies and Logistics; Family Life Education activity with the Ministry of Education if policy conditionality is met; and Clinical Methods to assure that cost- and contraceptive-effective, long-term methods are available to Jamaican acceptors.

The Project will target activities to expand sustainable effective private sector family planning services. Although the public sector is and will remain the principal provider of services, Jamaican families do seek some health care through the private sector. Many families purchase contraceptive products in the pharmacies; to supplement counseling services available in the clinics, aggressive marketing of these products and media campaigns addressing side effects of these methods are needed. The CSM component will address the sustainability and effectiveness of this program, if earlier caveats regarding AID assistance are fulfilled.

Further, Jamaican families see private physicians for some of their health needs. When they do this, if the physician does not mention family planning, it is a lost opportunity to reinforce the family planning message. The Project component, Private Providers, provides for education and outreach to

physicians for family planning services in the private sector. Lastly, as a means to reach adolescents, a key group of hard-to-reach new acceptors, a Project component will be a sub-grant to the Women's Center, a PVO, to liaise with schools and school children to defer the first pregnancy.

1. Policy Framework (\$1,010,000)

This component of the Project will ensure that the appropriate policy framework and programs are in place within the Government of Jamaica to support sustainable family planning services, and that relevant data are available as a basis for policy decisions. This component has the following elements:

a. Policy Analyses - (Technical Assistance, seminars, training, local costs: \$195,000) The policy analysis component concentrates on enhancing the sustainability of the Jamaican family planning program and the importance of an active and sustainable family planning program for the health of Jamaican women and for achieving other national development goals. Seminars and presentations will be made to the highest level of decision makers in the GOJ to convincingly demonstrate that money invested in family planning services saves the government money in the long run. This support will include such things as development and preparation of necessary presentations, and "marketing" tools (e.g. a study of the economic and social costs of rearing a child). Analyses of population policies and program issues and an ongoing policy dialog with the GOJ will ensure that the family planning program's policies are appropriate and sustainable. Under this component, it is anticipated that two marketing presentations will be developed, three seminars conducted for decision makers including a national seminar on method mix and two policy analyses will be conducted.

Illustrative policy issues which this component could address include:

the willingness of the GOJ to see and support the private sector as an important partner in achieving the country's population goals;

the willingness of the GOJ to permit the private sector to become more actively involved in the provision of family planning services, such as the commercialization of CSM, and the more active participation of private physicians;

the willingness and need of the GOJ to commit financial resources to procuring public sector contraceptives as A.I.D. phases out;

the need to identify and minimize policy and regulatory barriers to the provision of family planning services including duties on importation of contraceptives, regulations on advertising and mass media communications campaigns;

the need to examine and revise policies of charging fees for using health and family planning services within the MOH system; and

the commitment to making service programs more effective, particularly with respect to minimizing policy barriers to a more active provision of long-term clinical methods, especially the IUD and VSC (e.g. allocation of operating room space and time to VSC).

While these are certainly not all the policy barriers facing the expansion of the family planning program in Jamaica, these have a direct bearing on the success of the Family Planning Initiatives Project. Thus these issues will be important for the National Family Planning Board to address in its role as family planning advocate.

b. Operations Research & Surveys - (Technical assistance, local costs, seminars: \$415,000)

This component will support operations research studies, contraceptive prevalence surveys (CPS) and the development of other research needed to evaluate and refine the family planning program's strategy.

Operations Research (OR) has proven to be an important tool for promoting changes in service delivery operations, procedures and operational policies. Potential OR topics that would be beneficial to the program include: alternative modes for delivering clinical family planning methods (like counseling) more effectively; changes in service delivery procedures to improve the effectiveness of all methods (e.g. reduce discontinuation rates); determining the appropriate pricing of services, and testing various cost recovery schemes. It is anticipated that three operations research studies will be supported by the Project.

An important element of policy analysis is reliable and current data on program performance, such as those obtained through Contraceptive Prevalence Surveys (CPSs). The most recent survey was conducted in 1989 and is providing baseline data for this project. The CPS will be the most comprehensive and reliable source on changes in prevalence and method mix, source of supply for the users, and improved program effectiveness. The CPS conducted under this project will have to pay particular attention to these three issues. Given the changes that the program will undergo, these data will be essential to monitor response of acceptors to program changes. Utilization and dissemination of the survey findings for policy making will be emphasized under this project. Over the life of the project two CPS studies are envisioned, one in early 1993 and one in early 1997.

c. Social Marketing - (Technical assistance, local costs: \$400,000)

In order to assist the public and service providers and consumers to accept and understand new thrusts in GOJ family planning service provision, the Project will support social marketing efforts to educate and motivate concerned persons. Examples include media campaigns to inform women of sources of family planning services; and method specific promotions or campaigns to educate and address fears and side effects of various family planning methods. Where appropriate this component can also support the collection of qualitative data from beneficiaries and providers to ensure that the social marketing activities achieve their objectives.

2. Sustainable Services (\$4,527,000)

This component of the Project addresses the sustainability of family planning services in both public and private sectors.

a. Public Sector - (\$2,975,000) - Project activities addressing the Public Sector are Contraceptive Supplies and Logistics, Family Life Education, and Clinical Methods.

i. Contraceptive Supplies and Logistics - (\$2,275,000)

o Contraceptive Supplies - (Technical assistance and commodities: \$1,810,000) - Virtually all of the contraceptives used in the national program are provided by donors, with A.I.D. being by far the largest supplier. A.I.D. supplies all condoms and IUDs and all but a few of the orals used in both the public sector and social marketing programs. In 1990 alone, A.I.D. supplied over \$560,000 worth of contraceptives. The only other contraceptive donor is the UNFPA which supplies the injectable. Since A.I.D. will gradually eliminate its support for contraceptives as part of the process of graduating Jamaica's family planning program, the program is left with two options for securing a stable source of contraceptive supplies: another donor or direct procurement by the GOJ. With the UNFPA also phasing-out its supply of injectables to the Jamaican family planning program, the uncertain long-term commitment of other bilateral or multi-lateral donors, the only viable long-term option is direct procurement by the GOJ with GOJ funds.

A.I.D. will phase-out its support for contraceptives to the Jamaican family planning project over the life of the Family Planning Initiatives Project. There are two schedules to this phase out: one for the social marketing component and one for the public sector NFPB/MOH program. Part of the rationale for moving the social marketing activity into the commercial sector is that a local distributor can assume responsibility for providing an adequate supply of contraceptives, so neither A.I.D. (or other donor), nor the GOJ will have to indefinitely supply subsidized commodities. But to minimize the disruption to the CSM clientele, the Project will continue to provide up to two years of contraceptive support (Condoms and Orals) to the social marketing program.

The contraceptive phase-out for the public sector program will take place over a five year period beginning in 1993. During this period, A.I.D. will gradually reduce its financial support for public sector condoms, orals and IUDs, while the GOJ increases its contribution commensurately. Assuming no other donor will shoulder the GOJ share, the contraceptive phase-out plan follows. It should be noted that this applies to A.I.D. financed commodities only and does not include those already financed by the GOJ (i.e. Ovral).

<u>Year</u>	<u>AID Contribution</u>	<u>GOJ Contribution</u>
1992	100%	0%
1993	80%	20%
1994	60%	40%
1995	40%	60%
1996	20%	80%
1997	0%	100%

With this schedule the GOJ will be fully responsible for procuring all condoms, oral contraceptives and IUDs used in the public sector program by the

time the project ends in 1998. The percentage figures refer to the proportion of the contraceptive requirements that each party will finance each year. For example, in (FY) 1992 AID will finance all public sector condom, oral and IUD needs; by (FY) 1996 A.I.D. will be financing only 20 percent of the commodity requirements and the GOJ 80 percent. The phase out schedule is gradual enough that the GOJ should have sufficient time to undertake the necessary budgetary allocation to ensure little disruption in availability of public sector contraceptives. Provided the CSM program goes completely commercial, the amount of GOJ financial resources needed to offset the A.I.D. phase out plan is \$1,737,113 over the seven years or an annual commitment of approximately \$375,000 by the end of the Project (1998), excluding any revenues earned if cost recovery is implemented in the public sector.

But if demand for contraceptives exceeds current expectations and projections, the phase out plan will have to be accelerated. For this reason generous assumptions have been used about the use of temporary methods and conservative estimates about how rapidly method mix can change to reflect a greater reliance on clinical methods. It is important to note that, while the overall level of contraceptive support is fixed, the actual annual allocation of funds for contraceptive procurement, will depend on the yearly Contraceptive Procurement Tables (CPTs) and the contract cycles of A.I.D.'s contraceptive suppliers.

Although A.I.D. will not be supplying the Jamaican family planning program with any donated contraceptives by the end of the project, A.I.D. will make, through this project, a significant investment in providing the GOJ with the institutional capability to handle contraceptive procurement. It is estimated that \$350,000 will be allocated to this task and contraceptive logistics management described below through buy-ins to S&T/POP projects.

Among the options available to the GOJ for contraceptive procurement are direct procurement, use of International Planned Parenthood Federation's crown agent, and negotiation with A.I.D. contraceptive suppliers to continue to provide public sector contraceptives at a concessional rate to the GOJ as A.I.D. phases out. Technical assistance from this component will assist the GOJ to assess and evaluate the most viable alternative procurement mechanism, with price, quality, and continuity of chemical formulation (i.e. pills) of utmost importance.

o Contraceptive Logistics - (Technical assistance, workshops and commodities: \$465,000) - In the past, estimation of the program's contraceptive requirements has been handled entirely by external consultants funded by A.I.D./Washington. This has created a dependency that is not beneficial to a program as mature as the Jamaican program. The NFPB, in conjunction with the MOH, has already begun to assume more responsibility for forecasting its contraceptive requirements. To date, the estimates of contraceptive requirements have been done for both the public sector program and the CSM program. However, once the CSM program is spun off into a commercial activity the whole set of CSM logistics tasks becomes the responsibility of the local distributor rather than the NFPB. This reduces the NFPB's responsibility in contraceptive forecasting, procurement and distribution and the amount of hard currency required to purchase contraceptives for the remaining public sector program. Early in the project the NFPB and the MOH should have the capacity

to project public sector contraceptive needs, including the financial and budgetary requirements, with sufficient lead time to allow for the purchase and delivery of commodities in a routine and timely manner.

A critical feature of the family planning phase-out is that the Jamaican program be able to handle, without A.I.D. assistance, the estimation and procurement of contraceptives on a timely basis. Unless the national family planning program has the institutional capacity to determine its commodity requirements, manage international procurement of its contraceptives, and effectively deliver commodities to all 360 plus outlets, the program's goal of reaching a 62 percent prevalence is unobtainable. Fortunately, by moving the CSM component of the national program into the strictly commercial sector the scale of the logistics needs of the remaining public sector program are more manageable. The assistance provided under this project component will be targeted to the public sector MOH and NFPB program.

Currently, capability within either the NFPB or the MOH to estimate future contraceptive requirements needed to meet existing needs and anticipated growth in the program is limited. However, the essential building blocks exist. The MOH has experience in estimating drug needs eighteen months into the future as this corresponds to the duration of their tenders for pharmaceutical supplies. And, most importantly, the basic information needed to estimate contraceptive requirements already exists through the monthly service statistics kept by the MOH and NFPB. However, because of the level of HIV/AIDS in Jamaica estimating condom requirements is particularly difficult, and will require an improved reporting and monitoring of condom distribution in the public sector service delivery system.

The logistics management system for contraceptives is basically sound. In general, the necessary supplies reach the MOH (and NFPB) clinics and there are few stock-outs at the clinic level due to faulty internal logistics distribution. Nevertheless, some targeted technical assistance and training would increase the efficiency of the public sector logistics system. Since the existing NFPB logistics vehicles will require replacement in the next several years, the Project provides funds to purchase four replacement vehicles thereby ensuring continuation of the current system.

ii. Family Life Education - (Technical assistance, training and local costs: \$250,000) - Assistance for the Ministry of Education's Family Life Education program is contingent upon the Ministry's adoption of certain policy reforms. The conditionality for this component results from USAID's experience in financing a FLE project under the previous bilateral Agreement, and an analysis of lessons learned which was recently completed. If the Ministry of Education takes the policy decisions to: 1) actively integrate the subject of Family Life Education into the curriculum, especially for Primary and All-Age schools, and institutionalize it as an examinable subject; 2) formalize FLE as a subject in teacher's colleges, making it compulsory and examinable; and 3) revises the methodology for communicating family planning and birth control concepts and messages in the FLE curriculum, the Project will support activities which will build on past experiences and emphasize the sustainability of FLE. These include the development of new attractive FLE books for primary and secondary students, reprinting of "Curriculum Guidelines" and "Teachers' Handbook, purchase of audiovisual materials for teachers colleges and secondary schools, training, and technical assistance.

iii. Clinical Methods - (Technical assistance, training and commodities: \$450,000) - The main thrust of public sector clinical methods is to assure that cost- and contraceptive- effective methods are widely available. The purpose of the clinical methods component is twofold--first to establish a process by which program leadership can systematically look at clinical methods and method mix improvement, and second, to provide funding and TA to implement changes recommended by that process in clinical service delivery. The national family planning program is concerned with expanding prevalence and issues of sustainability. Clinical methods are important, because they are highly effective in protecting the acceptor, they are cost-effective over the life of the method, and they are well-suited to the family planning needs of significant groups of limiters and spacers.

In Jamaica, clinical methods are not universally accessible at present. This is partly due to nuts-and-bolts issues like unavailability of trained staff, lack of counseling support, etc. However, these practical issues may hark back to a lack of a central mechanism concerned with these methods, their importance and planning for their delivery. A systematic look at method mix and clinical methods is needed, and issues in the delivery of clinical methods warrant careful examination. Through this Project component, the Medical Subcommittee of the NFPB will become an active leader of a process to address method mix and constraints to clinical methods service delivery. The Subcommittee exists now; however, it tends to play a reactive rather than a proactive role. Technical assistance and interagency commitment will be instrumental in reformulating the policy leadership function of this Subcommittee. The present composition of the Subcommittee is as follows: NFPB Chief Medical Officer, MOH-Principal Medical Officer for primary health care, MOH-Principal Nursing Officer, and MOH-Head of Pharmaceuticals Division. On an as-needed basis, the Director of the University of the West Indies-Fertility Management Unit takes part. If issues related to pharmaceuticals or medical practice are to be raised, representatives of the Jamaica Pharmaceuticals Association, Jamaica Medical Association or Jamaica Association of Ob-Gyns are invited to attend.

It is vital that the committee include representatives of all the actors who provide services and be under the proactive leadership of the NFPB. For its day-to-day work, the Committee may include senior medical representatives, but it should also be able to call upon top decision makers from time to time, for example, if issues like funding needs of programs in clinical methods arise. At present core membership would be NFPB, MOH, and the JFPA. Over time, private sector organizations like the Jamaica Association of General Practitioners may be added, as they get involved in service provision.

The Subcommittee will need to develop a collaborative approach among the various entities to implement the policy and planning steps. Thus, the process elements of developing this collaboration have to be addressed and time invested in them.

This component of the Project will provide technical assistance, training and commodities to increase the public sector's capability to provide clinical methods of family planning. With technical assistance, the first step in implementing this component is to identify the ideal method mix and to plan for its implementation. A national multi- year, possibly multi-sector, plan

will be formulated, with quantified goals for facilities, procedures (by type), and for allocating the distribution of trained providers. The planned method mix seminar in the Policy Framework component will be instrumental in this regard. Profiles of acceptors by method will be developed, referring to age and parity, for dissemination to all service points. These profiles must be linked to counseling training, to assure that acceptors are presented the methods in the context of a choice from a cafeteria of methods. Active multi-method counseling is a departure from the norm in Jamaica, where counseling has been described as virtually nonexistent, and where selection is based on acceptors asking for methods they have heard about on the outside. The component will provide clinical training for medical personnel and counselling training needed to achieve the method mix targets. For example, training for IUD insertion is particularly important, since lack of trained personnel has been suggested as a major contributing factor in the decline of this method. Achievements in shifting the contraceptive method mix can be monitored through the monthly MOH clinic report and the two Contraceptive Prevalence Surveys to be undertaken by the Project.

b. Private Sector (\$1,552,000)

Three activities will be undertaken: first changes in the sustainability and effectiveness of the social marketing program, second is work with private providers, and third is a small grant to the Women's Center for work with adolescents.

i. CSM Program - (Technical assistance, training and local costs: \$920,000)  
Part of the FPI Project's strategy to strengthen the NFPB's role in national advocacy of family planning and coordination of the national program is to identify ways of diminishing the NFPB's responsibility for direct implementation of services delivery programs. Additionally, it is part of the FPI Project strategy to identify and support ways in which private sector resources can be substituted for GOJ resources in funding existing and even expanded family planning services delivery.

Shifting the operational and commodity procurement responsibilities of the CSM contraceptive social marketing program from the NFPB into the commercial sector acknowledges the need for the NFPB to use its own resources maximally for advocacy and coordination of the national family planning effort as well as the economies/ efficiencies of operation which the commercial sector can offer the CSM program. These economies include procurement of contraceptives for the CSM program without use of NFPB or other GOJ funds as well as other in-kind contributions to program costs such as detailing to physicians and pharmacists, staff participation in marketing planning, promotions to the trade, public relations activities, and contributions to future advertising campaigns.

Under the policy guidance of the NFPB with input from USAID, agreement will be reached with local representatives of manufacturers for provision in the marketplace of contraceptives -- initially oral contraceptives and condoms -- which are price accessible to C and D class consumers, the traditional CSM target market. Provision of the products to the marketplace will be undertaken by the manufacturers and their representatives as a strictly commercial transaction.

Manufacturers are willing to lower their price to local distributors for selected contraceptive brands because they feel that the number of social marketing consumers in Jamaica is large enough to ensure that volume of sales will make up for this reduction in unit price. Social marketing consumers also represent a segment of the market never before reached by the commercial pharmaceutical sector; consequently social marketing contraceptive sales would be new and additional sales for the manufacturers and their distributors.

The agreements reached will be documented in Letters of Agreement between the NFPB and the relevant firms. (It may be that agreements with manufacturers for sale of low-priced contraceptives in additional categories -- such as IUDs and injectables -- are reached during the life of the Project. These products can be added to the program whenever such agreements are reached and documented in Letters of Agreement between the NFPB and the relevant commercial entities.)

Once agreements with commercial firms have been reached, a two-year, phased transition from NFPB to commercial operation will begin. During this period, USAID-supplied Perle and Panther will continue to be sold as usual by the NFPB; but the price of each product will be periodically raised to the price level at which the commercially provided products are being sold. Simultaneously during this two-year transition period, the commercially provided social marketing products will be introduced to the market and sold.

At the end of the two-year transition, USAID-supplied contraceptives will no longer be available for the CSM program. Commercially provided, low-priced contraceptives for the CSM target market will remain in the marketplace as the social marketing program's offerings.

A responsive monitoring system and program of market and consumer research will be critical to ensure that any adverse program impacts are quickly recognized and ameliorated. Accordingly, the Project will undertake a program of research to periodically assess the impact of CSM price increases on the sales of CSM products, and undertake activities to minimize any negative impact on the overall program.

The FPI Project will provide other significant support for CSM product sales during the two-year transition period (and to a lesser extent during Year 3 of the Project), if commercialized, in the form of 1) budgets for mass media advertising, promotions to the consumer and to the trade, training/seminars for physicians and pharmacists, public relations, and market research and 2) technical assistance in marketing management and planning. It is anticipated that participating commercial sector entities will make in-kind contributions in these same areas of support for product sales. These contributions will be documented in the firms' Letters of Agreement with the NFPB.

The level of CSM product support included in the FPI Project is critically important in the current family planning environment in Jamaica. The GOJ has set as its goal an increase in the rate of contraceptive prevalence from 55% to 62% over the next six years. Additionally, the most recent CPS and other research recently implemented indicate that potential users' frequently unfounded or misinformed fears of the health effects of contraception are a

principal barrier to increased use of contraceptives among Jamaican women. Communications, public relations, and promotional efforts can make a significant positive impact on this situation.

Advertising, promotional, and public relations support will also help ensure a smooth transition from public to private sector provision of social marketing products and minimize any possible negative impact on product sales and usage.

ii. Private Providers - (Technical assistance, commodities and local costs: \$382,000) The private providers activity is designed as a flexible vehicle to encourage the participation of private providers in education, referral and delivery of family planning services. The activity will forge direct links to private providers through public relations, mass media, and training.

The twin needs of sustainability and increased program effectiveness are the rationale for this component. At present, the national family planning program is largely a public sector one. The system will be stronger if it makes best use of private service providers, so that acceptors have more options for education and referral, and there are more avenues for the reinforcement of the family planning message. Jamaican families use public sector health services for many purposes, but they also turn to private providers for certain needs. The majority of women using public sector clinics, or their families, have also at some time seen a private physician. Many visit physicians for a thorough check-up, yet few report that the physician asked about their family planning needs. Private providers are not yet serving as a source of counseling and methods to women. Visits to private physicians are a great missed opportunity for reinforcing the family planning message and providing another avenue for referral and possible service delivery.

It is anticipated that Jamaica Family Planning Association, a PVO, will implement this component.

Because private providers are a largely untapped resource for family planning, it is useful now to begin to activate their participation. Years of public sector successes have formed attitudes of physicians and acceptors about the role of the private sector in family planning. Physicians may not be aware of the priority that women place on their reproductive health and contraceptive needs, nor of how physicians can counsel and care for women in this area. Women may also not be aware that private physicians can answer their questions and meet their family planning needs. Under the present Project, Population and Family Planning Services, a small survey of physicians was conducted to identify barriers and needs to increase private physician participation. The preliminary findings are that whereas private physicians are reluctant to become actively involved in providing family planning services, they are potential sources of family planning education and referral if properly sensitized. Family Planning Initiatives will follow up these findings, for example, public relations to physicians will be carried out about their vital role. Private providers will have access to training in family planning methods (both counselling and clinical methods application) and to IEC materials for use in private settings.

iii. Women's Center - (Commodities and local costs: \$250,000) The Project will make a sub-grant to the Women's Center for work with adolescents to delay the first pregnancy. The Women's Center, founded in 1977, has had a successful program to help school girls after their first pregnancy. The methodology is to identify young women who have become pregnant and who may leave school because of the pregnancy. The Women's Center works with these adolescents to keep up their studies and gives them practical skills to re-enter school after the baby's birth. Through the process of arranging for these adolescents to re-enter school, the Women's Center has developed excellent relations with the schools.

Based on these pre-existing relationships, the Women's Center will develop a pilot program in the Kingston area to work with younger adolescents to defer the first pregnancy. The program will 1) liaise with the schools to get their ideas about approaches, and to build relationships in support of the program; 2) work with PTAs, school nurses, etc. to solicit their involvement; 3) approach the Ministry of Education for permission to offer the services of program staff in Primary and All Age schools; and 4) offer a program to all Grade 7 students in New Secondary schools who did not gain entry into traditional high schools, and may be demoralized and open to early sexual experience and parenthood. Therefore, the program will seek to rebuild self image and redefine personal goals. Successful graduates of the Women's Center's established program will be used to the fullest in making presentations to this group.

The Women's Center will also conduct programs in the community with 10-13 year olds for "homework" evenings. During these periods of supervised study, it may be possible to bring up such topics as boy-girl relationships. Teachers from the relevant communities will be involved in these evenings on a part-time basis as will successful graduates. As part of the sub-grant, the Women's Center will also open an adolescent clinic on the grounds of the main center in Kingston. The spacious site has ample space for the clinic, and a simple, prefab building will be installed there.

### 3. NFPB Institutional Strengthening (\$585,000)

The issues of sustainable financing, private sector involvement, policy analysis and marketing are new areas to be addressed by the Family Planning Board. Assistance to the National Family Planning Board under the Family Planning Initiatives Project is designed to facilitate the NFPB's shift in its primary focus from that of implementation of sub-projects to one of advocacy of population and family planning issues and coordination of the national family planning program. For these new initiatives to succeed, the Board must recruit new staff, and develop existing staff who are capable of planning, managing and evaluating a different sort of family planning program, and carrying out a very different role for the Board itself. This component will ensure that the National Family Planning Board is able to serve as an advocate for family planning and to act as manager and coordinator of the national family planning program.

There are three major parts to this Project component: institutional development of the NFPB, development and implementation of a Management Information System, and training of NFPB staff.

o Institutional Development - (Technical assistance: \$255,000) Technical assistance will be provided to collaborate with NFPB in determining an institutional strategy for the Board and how best to implement it. A wide variety of technical assistance and training relevant to advocacy and coordination of a multi-participant national family planning program can be provided to the NFPB by the Project. Technical assistance will also be made available to assess the management and organizational capability of the organization to operate effectively, and to further develop the organization as required. To successfully implement the initiatives planned under the Project the NFPB will require an active, visible presence advocating the allocation of substantial resources and attention to family planning needs as well as creative, innovative leadership in the coordination of services delivery activities nationwide. At the same time, responsibility for implementation activities serves to divert NFPB attention and resources from its critically important advocacy/ leadership role for which no other Jamaican organization can effectively substitute. In addition, in the current environment of constrained resource availability, it is necessary to ensure that responsibility for services delivery is given to organizations with comparative advantages for those tasks and that unnecessary duplication of services delivery among organizations is eliminated wherever possible. These issues will be assessed and addressed under this component. Small scale feasibility studies can be supported by the Project to help the NFPB ascertain areas in which its implementation responsibilities can be transferred effectively to other institutions. For example, provision of family planning services at places of employment may be shifted to the Jamaica Family Planning Association where a nucleus of such services already exists. Operation of the NFPB's vertical clinics may be shifted to the existing MOH or JFPA clinic systems.

Simultaneous with the shift of services delivery implementation to other organizations, a systematic program of institutional development for the NFPB's increased advocacy/leadership role will begin.

o Management Information System - (Technical assistance, training and commodities: \$230,000) Once a strategic plan has been developed, the Project will provide technical assistance to the NFPB in its implementation. This assistance will include support in the development and use of a management information system (MIS) for monitoring the flow of services and the achievement of quantitative goals, forecasting commodity needs, procurement, quality control, and distribution flow; and set-up of cost-center budgeting systems. An appropriate management information system, particularly for collection of service statistics in both private and public sectors will be required for the NFPB to take policy decisions based on adequate information. The MIS will also be linked to the Policy Framework and Contraceptive Logistics Components to ensure that a comprehensive MIS is developed and implemented and the collected information is utilized for improved decision making. This component will finance required hardware and software, technical assistance for systems design, and training costs for staff.

o NFPB Training - (Training: \$100,000) Staff at headquarters will be provided with training and technical assistance in the areas of market research, marketing, cost recovery, private sector development, strategic planning and

other areas relevant to the new approaches of the program. This component will support training in the U.S. for selected NFPB managers and peer development through internships "matching" U.S. and NFPB professionals. Funds for the international air travel of participants are included.

V. COST ESTIMATES AND FINANCIAL PLAN

The total cost of the seven year Family Planning Initiatives Project is US\$9,734,000. Of this total, USAID will contribute US\$7,000,000, and the GOJ US\$2,734,000. Funds will be incrementally obligated, with an initial obligation of US\$675,000 in fiscal year 1991.

A. Summary Cost Estimate and Financial Plan

Table 1 gives the Summary Cost Estimate and Financial Plan broken down by inputs and financial sources.

B. Costing of Project Outputs/Inputs

Table 2 shows the total estimated costs by project output and disbursement category.

C. Projection of Expenditures by Fiscal Year

Table 3 shows a detailed estimate of project expenditures over the life of the project. These figures are broken down by disbursement category and source of funds for each project year.

D. Methods of Implementation and Financing

Table 4 shows the basic methods of implementation and financing for the USAID funded activities of the Project. The methods of financing do not deviate from AID's preferred methods.

E. GOJ Contributions

Table 5 provides a breakdown of the GOJ counterpart contribution to the Project. The GOJ budget consists of financing for contraceptive commodities, and the NFPB's administration and distribution costs for the public sector contraceptive commodities.

TABLE I  
SUMMARY COST ESTIMATE AND FINANCIAL PLAN  
(US\$000)

ELEMENTS		FX	AID	TOTAL	GOJ	TOTAL	
			LC		LC	FX	LC
<b>1. TECHNICAL ASSISTANCE</b>							
Short Term - US	42 pm	1045	-	1045	-	1045	0
Short Term - Local	59 pm	-	265	265	-	-	265
Long Term - Local	36 pm	-	180	180	-	-	180
		1045	445	1490	0	1045	445
<b>2. TRAINING</b>							
Local Workshops and Seminars	44	-	545	545	-	-	545
US Short-Term trainees	20	100	-	100	-	100	0
		100	545	645	0	100	545
<b>3. COMMODITIES</b>							
Contraceptives		1760	-	1760	1740	1760	1740
Others (vehicles, computers, medical)		347	-	347	-	347	0
		2107	0	2107	1740	2107	1740
<b>4. PRIVATE PROVIDERS AND ADOLESCENTS</b>							
Technical Assistance		50	25	75	-	50	25
Local Costs		-	500	500	-	-	500
		50	525	575	0	50	525
<b>5. LOCAL COSTS</b>							
		-	1305	1305	994	-	2299
<b>6. AUDITS AND EVALUATION</b>							
		175	75	250	-	175	75
<b>7. CONTINGENCY/INFLATION</b>							
		314	314	628	-	314	314
=====							
<b>GRAND TOTAL</b>		3791	3209	7000	2734	3791	5943

TABLE II  
COST OF PROJECT OUTPUTS/INPUTS  
(US\$000)

OUTPUTS	TECHNICAL ASSIST.		TRAINING		COMMODITIES		LOCAL COSTS		SUBTOTAL		GRAND TOTAL
	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	
1. Policy Analyses and Dissemination	120		75		-		-		195		195
2. Surveys	120		45		-		250		415		415
3. Social Marketing Campaigns	50		-		-		350		400		400
4. Contraceptive Procurement and Logistics System	350		75		1850	1740	-		2275	2734	5009
5. FLE Institutionalized	45		100		-		105		250		250
6. Method Mix Plan	50		-		-		-		50		50
7. Clinical Training	100		200		100		-		400		400
8. CSM Commercialized	300		20		-		600		920		920
9. Private Sector FP	75		-		7		300		382		382
10. Adolescent Program	-		-		50		200		250		250
11. NFPB MIS	100		30		100		-		230		230
12. NFPE Training and Organization	255		100		-		-		355		355
13. Evaluation and Audit	250										
<b>TOTAL</b>	<b>1815</b>		<b>645</b>		<b>2107</b>	<b>1740</b>	<b>1805</b>	<b>994</b>	<b>6372</b>	<b>2734</b>	<b>9106</b>
Contingency and Inflation	-		-		-		-		628		628
<b>GRAND TOTAL</b>	<b>1815</b>		<b>645</b>		<b>2107</b>	<b>1740</b>	<b>1805</b>	<b>994</b>	<b>7000</b>	<b>2734</b>	<b>9734</b>

TABLE III  
PROJECTION OF EXPENDITURES BY FINANCIAL YEAR  
(US\$000)

	FY91		FY92		FY93		FY94		FY95		FY96		FY97		FY98		TOTAL	
	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ	AID	GOJ
1. TECHNICAL ASSISTANCE	-	-	150	-	250	-	300	-	300	-	250	-	250	-	65	-	1565	0
2. TRAINING	-	-	75	-	125	-	150	-	125	-	100	-	50	-	20	-	645	0
3. COMMODITIES	-	-	646	55	693	119	315	190	352	272	101	363	-	367	-	374	2107	1740
4. LOCAL COSTS	-	-	200	142	300	142	400	142	400	142	300	142	100	142	105	142	1805	994
5. AUDITS AND EVALUATION	-	-	-	-	100	-	25	-	-	-	-	-	100	-	25	-	250	0
6. CONTINGENCY/INFLATION	-	-	-	-	100	-	100	-	100	-	150	-	150	-	28	-	628	0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>1071</b>	<b>197</b>	<b>1568</b>	<b>261</b>	<b>1290</b>	<b>332</b>	<b>1277</b>	<b>414</b>	<b>901</b>	<b>505</b>	<b>650</b>	<b>509</b>	<b>243</b>	<b>516</b>	<b>7000</b>	<b>2734</b>

Document TABLE III 6/18/91

TABLE 4  
METHODS OF IMPLEMENTATION AND FINANCING  
(\$000)

INPUT	METHOD OF IMPLEMENTATION	FINANCING	AMOUNT
TECHNICAL ASST.:			
-Long Term	H.C. Contract	Direct Reimb.	180
-Short Term Local	AID Direct Contract	Direct Payment	290
-Short Term - U.S.	AID Direct Contract/ buy-in	Direct Payment	1,095
TRAINING:			
-Local Seminars/ Workshops	H.C. Contract	Direct Reimb.	545
-US Training	PIO/P	Transfer of Funds	100
COMMODITIES:			
-US Commodities	AID Direct Contract/	Bank L. Com/ Direct Payment	290
-Contraceptive Commodities	AID Direct Contract	OYB Transfer	1,760
-Sub-Grant Commodities	Sub-grant	Advance Reimb.	57
LOCAL COSTS**	H.C. Contract	Direct Reimb.	1,305
Surveys			
Marketing			
Promotion			
Advertising			
PRIVATE PROVIDERS/ ADOLESCENTS*	Sub Grant*	Advance Reimb.	500
AUDITS/EVALUATIONS	AID Direct Contract	Direct Payment	250
CONTINGENCY/ INFLATION			<u>628</u>
TOTAL			7,000

\*Commodities will be included in sub-grants

\*\*Includes surveys, operating expenses, advertising, marketing, etc.

GOJ CONTRIBUTIONS  
NATIONAL FAMILY PLANNING BOARD  
PUBLIC SECTOR COMMODITIES  
(US\$)\*

ITEM	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	TOTAL
<b>A. ADMINISTRATION &amp; DISTRIBUTION</b>								
1. Permanent Staff	\$62,421	\$62,421	\$62,421	\$62,421	\$62,421	\$62,421	\$62,421	\$436,947
2. Temporary/Casual Labour	\$17,530	\$17,530	\$17,530	\$17,530	\$17,530	\$17,530	\$17,530	\$122,710
3. Subsistence/Other Travel	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$3,750	\$26,250
4. Rent	\$20,325	\$20,325	\$20,325	\$20,325	\$20,325	\$20,325	\$20,325	\$142,275
5. Public Utilities	\$3,238	\$3,238	\$3,238	\$3,238	\$3,238	\$3,238	\$3,238	\$22,666
6. Stationery	\$500	\$500	\$500	\$500	\$500	\$500	\$500	\$3,500
7. Petrol/Oil	\$8,536	\$8,536	\$8,536	\$8,536	\$8,536	\$8,536	\$8,536	\$59,752
8. Motor Vehicle Parts	\$200	\$200	\$200	\$200	\$200	\$200	\$200	\$1,400
9. Transport & Haulage	\$6,906	\$6,906	\$6,906	\$6,906	\$6,906	\$6,906	\$6,906	\$48,342
10. Insurance	\$3,313	\$3,313	\$3,313	\$3,313	\$3,313	\$3,313	\$3,313	\$23,191
11. Repair & Service: Facilities & Equipment	\$281	\$281	\$281	\$281	\$281	\$281	\$281	\$1,967
Vehicles	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$105,000
<b>SUB-TOTAL</b>	<b>\$142,000</b>	<b>\$994,000</b>						
<b>B. PUBLIC SECTOR COMMODITIES</b>	<b>\$55,000</b>	<b>\$119,000</b>	<b>\$190,000</b>	<b>\$272,000</b>	<b>\$363,000</b>	<b>\$367,000</b>	<b>\$374,000</b>	<b>\$1,740,000</b>
<b>TOTAL GOJ CONTRIBUTION</b>	<b>\$197,000</b>	<b>\$261,000</b>	<b>\$332,000</b>	<b>\$414,000</b>	<b>\$505,000</b>	<b>\$509,000</b>	<b>\$516,000</b>	<b>\$2,734,000</b>

## VI. IMPLEMENTATION ARRANGEMENTS

This chapter addresses the implementation arrangements necessary to conduct the Project. The first arrangements are those between the USG and the GOJ which adopt the Project and sustain its operations year by year. In the second section of this chapter, the implementation arrangements pertinent to each Project component are described.

### A. Project Management Responsibilities and Organization

Project Management/Implementation will be the responsibility of the National Family Planning Board (NFPB) for the Government of Jamaica through the existing Projects & Research Department. This Department will be headed by the NFPB's Director of Projects & Research with the support staff of two (2) Project Officers and one Secretary. The Director of Projects and Research will be responsible for the day to day administrative functions of the project for the GOJ, including documentation necessary for the purchase of commodities, contracting of technical assistance including Requests for Proposals and Scopes of Work, preparation of the quarterly reports to USAID, liaising with the NFPB accountants to ascertain that the financial and managerial reports are submitted to USAID on time, and liaising with the NFPB procurement officer in the timely forecasting, logistics management and clearing of project commodities. The Director of Projects & Research will also be responsible for providing assistance to subgrantees in project design and preparation, project approval (jointly with USAID), project monitoring, financial review and evaluation.

#### 1. Steering Committee

The current Sustainability Committee already constituted by the NFPB will continue to function as the Steering Committee for the Project. Representatives of this Committee include NFPB Chairman, Executive Director, Director of Projects and Research, Medical Director, Marketing Director, Ministry of Health, Planning Institute of Jamaica, USAID and UNFPA. The Steering Committee will meet quarterly to review the progress of the NFPB's program particularly as it relates to implementation and formulation of policies affecting the program and Project, the privatization of the Commercial Social Marketing Program, overall sustainability and financing of the national family planning program, and the role of the NFPB as advocate for family planning.

#### 2. Resident Advisor

The Project will finance the services of a Resident Advisor for a three year period. The Resident Advisor will be responsible for providing technical oversight of project activities. The Resident Advisor will be placed at the NFPB for the first three years of the Project when the bulk of the expert Technical Assistance will be provided and while the system is undergoing the most extensive change. The Resident Advisor will liaise with USAID and report to the Executive Director of the NFPB.

### 3. USAID/Kingston Organizational Responsibilities

The implementation responsibility with USAID will be held by the Office of Health/Nutrition and Population (OHNP). The USAID Project Officer will be a FSN Program Specialist, who will be responsible for preparing all earmarking and committing documentation, drafting of Project-related correspondence, preparing quarterly and semi-annual reports, and making all arrangements for foreign technical assistance and training. USAID will also review and approve all contracts and sub-grants to be funded by the Project. Mission support will be provided by other USAID offices as appropriate (i.e., to include Office of Economic and Private Enterprise, Office of Contract Management, Office of the Controller, and Office of Program and Project development).

### 4. Procurement

AID-funded commodities will be procured in accordance with AID and host country contracting procedures and requirements. Project procurement will be in accordance with A.I.D.'s Buy America policy. An assessment of NFPB's contracting capabilities will be completed and their capabilities certified as acceptable prior to NFPB undertaking contracting actions or awarding sub-grants. All commodities including vehicles (4 are planned for the Logistics component) will be U.S. source and origin except where U.S. sourced commodities cannot obtain local warranties and service (i.e. computers). Detailed procurement information will be provided to the National Family Planning Board as an attachment to implementation Letter No. 1, the text of which will also explain the application of AID requirements.

The NFPB, with the assistance of USAID, will be responsible for all local procurement under the project, whereas USAID will procure directly for U.S. commodities and technical assistance. Coordinators of sub-grants implemented through other agencies will assist the NFPB in carrying out procurement actions for their special projects including formulation of specifications and obtaining quotations from at least three suppliers for all local procurement.

The NFPB will arrange for port clearance of all imported commodities and for delivery of commodities to the sub-grantees.

All overseas procured commodities will be checked by the National Family Planning Board Storekeeper or Assistant Storekeeper on arrival at the NFPB stores, who will verify the amounts received against the prepared procurement (PIO/C or Contract Award) document and submit to USAID a Receipt of goods form within two days after arrival. In the case of large scale local procurement, copies of all quotations must be submitted to the NFPB and USAID.

Over the life of the project four vehicles, computer equipment, minilap kits and replacement equipment will be bought to enhance the delivery of contraceptives; to improve the contraceptive forecasting and logistics Management Information System; and the voluntary surgical contraception program of the NFPB. Also office and clinical equipment will be bought for the Women's Centre sub-project.

## 5. Training

As a significant step toward sustaining of the family planning program, training is an important component supported by this 1991 to 1998 project. This includes training in the areas of:

Contraceptive Forecasting, Logistics Management Information System, Autonomous Procurement, and Logistics Management for NFPB, MOH and JFPA personnel;

the use of clinical methods such as the VSC minilap procedure and IUD insertion for MOH, JFPA personnel and possibly for the private physicians; and

the strengthening of the full range of family planning services delivered by both the public and private sector providers especially in the area of effective counselling.

By the latest six months after the start of the project the NFPB will be responsible for submitting to USAID a two year training plan, and biannually thereafter.

## 6. Local Currency

The Project Agreement will specify the terms and conditions relating to the generation of local currency from the sale of oral contraceptives and condoms through the Contraceptive Social Marketing Program. These include: the revenues generated from the sale of Perle and Panther will be deposited into a separate bank account by the NFPB; the revenues will be used to further family planning objectives which are mutually agreed to by A.I.D. and NFPB; and that it will provide A.I.D. with written reports, statements of income and expenditures, including specific uses of the revenues, and any other information A.I.D. may reasonably request. The annual audit report to be submitted to A.I.D. by NFPB will include the CSM sales revenues income and expenditures, including the specific uses of the revenues.

## 7. Host Country Contribution

The Host Country Contribution consists of contraceptives commodities and non-A.I.D. financed operating costs of NFPB as outlined in Table 5. As A.I.D. will be receiving annual audited statements of NFPB, the operating costs will be easily identifiable. The NFPB records on contraceptive commodity procurement will also be available to verify the GOJ contribution to the Project.

## B. Implementation Plan

1. Policy Framework - This Project component implemented through a combination of international and local technical assistance will conduct policy analyses, policy and dissemination presentations and seminars, surveys and research, and social marketing campaigns.

a. Policy Analysis - It is anticipated that technical assistance through ST/POP's OPTIONS Project will assist the Board to identify the key policy obstacles which could be ameliorated through policy analyses and presentations and develop a workplan to address the obstacles. An important part of the policy analyses will be the development of presentation tools, using microcomputer graphics if appropriate, that can be used to inform policy makers and senior program officials of the consequences and program impact of the policy issue under study. For example, presentation tools such as TARGET and TARGET-COST can be adapted to the Jamaican context and used to illustrate the importance of involving the private sector in family planning, and the importance of increasing the use of effective methods of family planning. Transferring to the Board the capability to effectively use these policy tools will be an important output of the technical assistance.

It is anticipated that two full scale policy analyses and presentation activities will occur and these will focus on the twin objectives of this project. Because the issue of sustainability and increasing the role of the private sector is so central to the FPI project these substantive areas will be given priority consideration for early action. In addition, OPTIONS consultants, in collaboration with CDC staff who assisted with the 1989 CPS, will plan and assist with implementing a seminar with the NFPB and MOH to analyze the implications of various method mix trends using the 1989 CPS data and identify method mix targets for the national family planning program (see Clinical Methods section).

b. Operations Research and Surveys - Reliable and current data on family planning attitudes and practices are essential to sound program management. Therefore, two CPS studies will be conducted over the life of the FPI project. The first survey will be conducted in 1993 and the second in 1997. As with previous CPS surveys, these two will be the responsibility of the NFPB with technical assistance and training from CDC experts. In addition, a detailed plan for data analysis and dissemination will be developed at the outset of the CPS. Particular attention will be paid to analyzing data regarding service delivery performance, sustainability and effectiveness of the program to evaluate the effectiveness of the Project in accomplishing its objectives. It is anticipated that support for CDC's assistance will be handled on a cost sharing basis between S&T/POP and a buy-in to CDC under the Family Planning Logistics Management Project (See contraceptive Supply and Logistics section).

In the area of operations research, it is anticipated that the NFPB, the MOH and Population Council (PC) staff will identify several research topics consistent with the project's twin objectives. Examples of possible topics include: how to encourage the older and higher parity pill users to switch to a clinical method; and how to increase the use of the more effective clinical methods. It is anticipated that three operations research/program evaluations will be completed.

c. Social Marketing - The results of the CPS and operations research as well as MIS data will provide indications of where special marketing efforts are required to achieve the family planning program's objectives. For example, women may need information regarding sources of family planning services, both public and private, or clinical methods may require specific promotional

efforts in order to reach the method mix targets. Under this component, technical assistance will be provided to assist in the identification of social marketing topics, and local advertising/public relations firms contracted by NFPB to carry out at least two family planning social marketing campaigns.

## 2. Sustainable Services

- This component of the Project accounts for the bulk of Project resources, reflecting the primary purpose of developing and institutionalizing family planning services in both the Jamaican public and private sectors.

### a. PUBLIC SECTOR -

Activities include contraceptives supplies and logistics, a program of Family Life Education with the Ministry of Education, and clinical methods of family planning.

#### i. Contraceptive Supplies and Logistics

o Contraceptive Supplies - The Project will support two years of CSM commodities and public sector orals and condoms on a twenty percent declining basis over five years. Based on the Contraceptive Procurement Tables to be completed annually by NFPB and USAID, OYB transfers will be made from USAID/Jamaica to ST/POP for the required commodities. It is anticipated that a buy-in to ST/POP CDC or JSI (Family Planning Logistics Management Project - FPLM) contracts will provide technical assistance to NFPB in autonomous procurement to assure that adequate preparation is made for the NFPB to assume this function.

o Contraceptive Logistics - The contraceptive logistics component of the Family Planning Initiative Project covers four areas: contraceptive forecasting and needs estimation; logistics MIS; and strengthening contraceptive logistics management. This Project component will be implemented through a combination of short-term technical assistance and training to the appropriate staff at the NFPB and the MOH.

A buy-in to the centrally funded FPLM and/or CDC Agreements will provide technical assistance and training for this component as well as the technical assistance for contraceptive procurement.

Successful implementation of this Project component will depend on the collaboration of appropriate NFPB and MOH staff, with the Board taking the lead role since they continue to be responsible for the actual distribution (and procurement) of contraceptives.

Given the public sector contraceptive phase-out plan, which begins in 1993, it is critical that the assistance and training commence as soon as the project is signed, and that the bulk of the work be done within the first two years. Unless this happens the NFPB and the MOH will face major changes in source of contraceptive supplies without the technical capability to manage this shift. Furthermore, unless these areas are given serious attention and high priority by the senior management of the NFPB and the MOH the program could face

serious commodity shortfalls by 1995. Thus the key policy feature of this component will be to secure high level GOJ commitment to strengthening the institutional capacity for logistics management especially in the areas of contraceptive forecasting and procurement. One means that has been used in other countries (e.g. Bangladesh and Pakistan) is a workshop sponsored by the host country government on contraceptive requirements for the 1990s and their financial implications. This can be a good way of getting senior level GOJ policy makers to focus on the programmatic and financial implications of A.I.D.'s phase out of contraceptive support.

The first step in implementing the logistics component is the development of a strategic plan and an accompanying workplan which details all the activities envisioned. To help strengthen GOJ commitment to and responsibility for contraceptive supply and distribution, the MOH and NFPB should be active participants in the development of these plans. Wherever possible, appropriate MOH staff should be included in the logistics TA and training provided through FPLM. Anticipating the results of the logistics strategy and workplan the following activities are envisioned, but with the caveat that they are illustrative:

a. Contraceptive Forecasting:

1. identification of appropriate NFPB and MOH staff who should receive training in contraceptive estimation methodologies (YEAR 1);
2. two (2-3 week) training courses in contraceptive estimation for appropriate NFPB and MOH staff (YEARS 1, 2);
3. local NFPB/MOH staff to prepare 1992/93 Contraceptive Procurement Tables for A.I.D. under the general guidance of FPLM consultants;
4. workshop/seminar sponsored by the GOJ on the contraceptive requirements for the 1990s of the Jamaican family planning program (YEAR 1);\*\*7.
5. several short TA consultancies by FPLM staff to be done in conjunction with other logistics visits (YEARS 1&2).

b. Logistics MIS:

1. microcomputer equipment and training for the Statistics and Research Unit within the NFPB and the central warehouse;
2. technical assistance to link the central warehouse inventory system into the MIS;
3. technical assistance to ensure that clinic inventory data are included in the MIS; and
4. assistance to strengthen the reporting and tracking of public sector condom distribution.

c. Autonomous Procurement:

1. technical assistance and training in designing international tenders for contraceptives;
2. explore IPPF crown agent, a central purchasing facility, option for public sector procurement;
3. facilitate discussions with A.I.D.'s contraceptive suppliers;
4. ensure that there is a good link between the requirement estimation and procurement and ordering processes.

d. Logistics Management:

1. assistance in strengthening the port clearance process to avoid excessive delays between product arrival and clearance;
2. assistance in evaluating and improving the efficiency of the internal distribution of contraceptives;
3. assistance in improving the flow of commodities from central warehouse to clinics;
4. update supply manual and make it widely available;
5. provide refresher training in supply management to clinic staff;
6. assist MOH and NFPB to establish guidelines for the removal of expired stock from the system; and
7. procure four replacement vehicles for the internal distribution of contraceptives.

ii. Family Life Education - Provided the Ministry of Education fulfills the policy conditionalities outlined earlier in this paper, the Project will provide assistance to strengthen and institutionalize a program of Family Life Education in primary and secondary schools. It is anticipated that a subgrant will be awarded by NFPB to the MOE for this activity. Disbursement of funds will be based on written benchmarks to ensure that the policy agreements between NFPB and MOE are indeed implemented. In the event that the policy conditionality is not met, the funds allocated to Family Life Education will be jointly reprogrammed by USAID and NFPB for other Project activities.

iii. Clinical Methods - Work in clinical methods will be carried out through a combination of international TA, local TA, and funding for equipment and local training. It is anticipated that international TA will be obtained from the Association for Voluntary Surgical Contraception (AVSC), which will provide a policy consultant to the Medical Committee and various technical specialists for the clinical methods activities.

o Support to the Medical Committee. The buy-in to AVSC will provide a consultant to the Medical Committee knowledgeable about clinical methods, including female and male VSC, the IUD, NORPLANT and injectable contraception, to guide policy, to serve as a resource for technical issues, and to identify where specialized TA is required. Although this person will work through a series of short-term consultancies (conducted on a quarterly basis), continuity of the individual will be important because of the importance of relation building. The policy agenda facing the Medical Committee is large if a strategic approach is taken to move the national clinical methods program forward.

An early task, described above, is the Medical Committee's examination of the present method mix and evolution desired for the future. A complementary task can be added to the larger OPTIONS buy-in (to add senior demographer time from the Futures Group to the NFPB strengthening work) or to the larger FPLM buy-in (to add CDC demographer time to the commodities logistics work) for two weeks of on-site TA to manipulate the 1989 CPS data to answer Medical Committee questions on method mix.

o Clinical methods TA. It is envisioned that TA visits by AVSC staff or consultants may be needed approximately four times/year. These visits will be for two purposes: medical and programmatic site visits. Medical site visits will include (but not be limited to): assisting with ensuring adequate supervision of VSC services; assisting with surgical training or training of trainers; assisting with the clinical aspects of introducing a new technology (i.e. post-partum IUD); and responding to needs for medical oversight or support on an as-needed basis.

Programmatic site visits are expected to be of two kinds, 1) providing specialized expertise or support as requested, to be described below, and 2) regular visits for monitoring, planning and management purposes. Programmatic visits may be needed, for example, to establish a demonstration center for postpartum contraception (at Victoria-Jubilee); assisting with non-clinical training needs (e.g. counseling training; orientation of service staff to VSC services and/or post-partum program); and assisting with production of materials (e.g. for client education and/or training of service providers).

Funds have been provided to support the equivalent of the following annual in-country training.

o 3 week training and practicum for VSC (10 participants, public and private sectors),

o 5 day IUD insertion training and practicum (10 persons, public and private sectors),

o 2 one day workshops on all methods and VSC (80 participants, public and private),

o 2 two-day professional education meetings on VSC for health professionals (60 MD/RNs),

- o 1 three-day refresher training seminar for OR nurses (20 participants), and

- o 1 three-day meeting for VSC counseling (30 participants).

Funds are also included for adaptation of generic NORPLANT education and training materials in support of the UNFPA/Population Council pre-introduction trial of NORPLANT in Jamaica.

Given the level of sophistication in the Jamaican medical community, it is assumed that local technical trainers can be identified to work with AVSC consultants to develop the local capacity for clinical training. No VSC consumable supplies are planned for this activity because the World Bank Health Sector Loan has a large medical supplies line item. A small quantity of replacement equipment will be provided; in view of the Project's seven-year duration, replacement of worn out or lost items may be warranted in later years of the Project.

b. PRIVATE SECTOR

Activities include Contraceptive Social Marketing, Private Providers and Adolescent Program.

i. CSM Program - The Condition Precedent for USAID funding support to the CSM program is the NFPB's agreement to and initiation of the shift of daily operations of the CSM program to the commercial sector. Commodity support (i.e., USAID provision of Panther condoms and Pearle oral contraceptives) in any case will be limited to ensuring that product is available in-country for a period of two years from the date of signature of the Bilateral Agreement for the FPI Project. These commodities will be procured through an OYB transfer to ST/POP through AID/W's central contraceptive procurement mechanism.

If the Condition Precedent is fulfilled, USAID will finance selected local costs of the CSM program over a three-year period. The NFPB will, in turn, contract where necessary with local suppliers for these activities including production and placement of mass media advertising, promotions to the consumer and to the trade, training/seminars for physicians and pharmacists, public relations activities, and market research.

It is anticipated that expatriate technical assistance in marketing planning and marketing management will be provided during the first two years of the Project through the mechanism of a Mission buy-in to the AID centrally funded SOMARC contract. Technical assistance in the third year will be provided through a buy-in to a centrally funded contract, as yet unnamed. (The current SOMARC contract ends in the fall of 1993.)

Agreed upon, in-kind contributions to the program by participating commercial entities will be provided through the mechanism of Letters of Agreement signed between the NFPB and the respective firms. In-kind contributions may include such things as detailing of program products; participation in training, public relations, and promotional activities; sharing of market information; staff participation in marketing, planning and management; and future

contributions to product advertising budgets. Initial product price and conditions under which product price can be changed as well as level of sales reporting required will also form a part of these Letters of Agreement.

The Letters of Agreement between the NFPB and the participating commercial firms will also serve as the mechanism by which the NFPB describes and commits to the commercial sector its own contributions to the CSM program. The Letters of Agreement should contain at least the following: the level of funding by category available from the NFPB through its grant from USAID for support of CSM product sales (i.e. the annual budget available for advertising, promotions, etc.); the commitment to a timetable for response to and approval of the annual marketing plan (e.g. within 30 days of its presentation to the Advisory Committee); the timetable and process by which advertising messages and campaigns will be approved so that product sales are guaranteed effective and timely advertising support; and the commitment to include commercial participant representation in program planning and review.

The CSM program will be planned, coordinated, and monitored through two mechanisms: 1) a unified marketing plan which will be developed annually by the NFPB Marketing Director with input and collaboration from participating commercial entities; and 2) an NFPB Advisory Committee which will meet quarterly to review program progress. At one of the quarterly meetings each year, the marketing plan will be presented by the NFPB Marketing Director, along with a representative of each participating commercial entity, for approval by the Committee. At each of the remaining three quarterly meetings, the Marketing Director and at least one representative from each participating commercial entity will meet with the Advisory Committee to present a statement of program achievements for the previous quarter, identify any constraints or policy issues which need to be resolved by the group, and present an overview of the activities and goals for the next quarter. USAID may be an "observing member" of this committee if it so chooses. Coordination of social marketing activities and management of local contracts will be the responsibility of the NFPB Marketing Director.

ii. Private Providers- It is anticipated that the private provider program will be housed at the JFPA and implemented through a sub-grant agreement between NFPB and the JFPA over a three year period. The budget will provide for the private provider's PR and mass media activities, and administration. The sub-grant may also provide funds for JFPA to implement a low-cost methods program to facilitate private providers family planning service delivery.

For the private physician's activity, the mass media and public relations campaigns will be contracted by the JFPA to local marketing and advertising firms; these campaigns will be coordinated with related programs in CSM and the Social Marketing activities in the Policy Framework component. A cost-effective approach to private physician training is to include them in training carried out under the clinical methods component of the Project. When training sessions are planned, consideration should be given to charging fees to private physicians for the training. Minilap kits could be sold to participating physicians on a cost recovery basis as could IEC materials.

With respect to administration, the sub-grant will include a share of the Director's time to be devoted to the activity. The sub-grant will also pay administrative of the JFPA for supporting the activity, but will otherwise not support core costs of the JFPA's program. Local travel will be paid but vehicle purchase is not contemplated. The administrative budget will cover a full-time subproject manager, with a strong business background. This individual will help applicants develop their ideas into fundable proposals for self-sustaining services. Because of the importance of this function, a clause in the sub-grant will address the business qualifications of the administrator.

The JFPA is changing its operations from a regional to a national base. The organization can still profit from institutional strengthening, although significant funds are not available in the Project for this purpose. Two things are possible, however. First, plans are for the JFPA to be included in institutional strengthening activities at the NFPB, for example training to use the RAPID model or courses held at the NFPB in advocacy or marketing. Second a small line item is included for local TA, so that as the JFPA carries out the strategic workplan to be developed under Population and Family Planning Services in Summer, 1991, there will be a resource available to the JFPA to respond to questions, refine plans, and provide guidance. Higher visibility of JFPA activities will help it be sustainable and grow.

This component also includes funds for a buy-in to ST/POP's Family Planning Management Development (FPMD) Project to provide technical assistance for this activity. Because the activities in this component are diverse and innovative, the JFPA may not know how to get started. TA can help develop the workplan, laying out tasks, timing and responsible person; and develop administrative capacity and oversight, in terms of timely implementation, accounting, monitoring. FPMD support to the JFPA can be cost effective, since FPMD is also slated for involvement in the institutional strengthening of the NFPB (for example, for MIS, cost-centered budgeting, etc.) When FPMD consultants come to work with one group, progress at the other can be checked and input given. This will be a cost effective approach to these types of TA needs.

iii. Adolescent Program - Assistance to the Women's Center will be made through a sub-grant agreement between NFPB and the Women's Center over a three-year period. Although the sub-grant cannot support vehicles, travel allowance has been budgeted. A small line item is included for the acquisition and siting of a prefab building for establishment of an adolescent facility. The capital expense projected is reasonable in relation to the rest of the activity. However, if the capital expense were to be substantially greater than projected it would be necessary to reconsider it. The sub-grant is a one time only assistance from USAID. If the pilot program is successful, the Women's Center plans to seek other donor funding to sustain the activity and disseminate the new approach to other areas.

3. NFPB Institutional Strengthening - It is anticipated that technical assistance to the NFPB for development and monitoring of its institutional strategy, development of "marketing" and public relations tools, and institutional development of its advocacy function will be provided through a Mission buy-in to the centrally funded OPTIONS contract held by The Futures Group.

Technical assistance and support to the NFPB in management, cost-centered budgeting techniques, and establishment and maintenance of management information systems will be provided through a Mission buy-in to the Family Planning Management Development Project to Management Sciences for Health.

To ensure that the technical assistance provided through these two mechanisms (OPTIONS and FPMD) is maximally coordinated and mutually reinforcing, staff representatives from each of the two projects will collaborate in Jamaica with the NFPB on the development of an institutional needs assessment and workplan before initiation of any other technical assistance agendas.

Local costs of implementing the NFPB's advocacy/coordinating role will be provided by the Project. This support will include funds for the purchase of a personal computer system for use by NFPB staff in program management information collection and analysis as well as for purchase of special projection equipment necessary for NFPB presentations to high-level decision makers and influentials.

**IMPLEMENTATION PLAN**

FY 91    FY 92    FY 93    FY 94    FY 95    FY 96    FY 97    FY 98  
 -----JL5    OOOJFJFJFJL5    OOOJFJFJFJL5    OOOJFJFJFJL5    OOOJFJFJFJL5    OOOJFJFJFJL5    OOOJFJFJFJL5    OOOJFJFJFJL5

PROJ SECID 87/15/01  
 RFP Training Plan  
 Issues RFP Contracting Capabilities

**1. POLICY FRAMEWORK**

Prepare P10/P and Executive Report

a Policy Analysis  
 Policy Analysis Commission  
 Marketing Propositions Developed  
 Present for Decision Board  
 CMS contract and contract awarded  
 Select Bid Services

b Operations Research and Services  
 CMS Success Connection  
 Research needs identified  
 Research studies completed

c Social Marketing  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 Firm Selection and Contracted  
 Media Packages

**2. SUSTAINING SERVICES**

a Public Sector

i Contracting Services & Logistics  
 Prepare P10/P and Executive Report  
 Develop contracts  
 Contracting Services  
 Prepare CPMs  
 RFP Transfer to PDP  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

ii Contracting Services  
 Contracting Services  
 Prepare for Cont. Goods & Fin.  
 Prepare contracts  
 Develop Logistics RFP  
 Conduct procurement  
 Prepare RFP

iii Human Resource Development  
 Conduct research and  
 RFP program in place  
 Develop contracts  
 Develop contract agreements  
 Teacher training

iv Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

v Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

vi Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

vii Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

viii Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

ix Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

x Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

xi Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

xii Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

xiii Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

xiv Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

xv Contracting Services  
 Prepare P10/P & Executive Report  
 RFP for Social Marketing Firm  
 RFP Advertisement  
 RFP for CMS Cont. Financing  
 Identify autonomous procurement options

- ①
- ②
- ③
- ④
- ⑤
- ⑥
- ⑦
- ⑧
- ⑨
- ⑩

Procurement List

Private Providers

JFPA computer, software  
MAJ laser printer  
Furniture  
IEC materials for private providers

NEPB

MIS computer, software  
Presentation hardware

Commodities/Commodities Logistics

Contraceptives  
1 LMIS Computer  
2 Stockram Computer  
4 Logistics Vehicles

Clinical Methods

Replacement Equipment  
Minilap Kits

Women's Center

Office and Medical Equipment  
Pre-fab building

ELE

Educational and Audiovisual materials

VII. MONITORING, EVALUATION AND AUDIT

A. Monitoring

The USAID population project officer will be responsible for overall USAID monitoring of the Project. For day-to-day management and technical oversight of project activities, a resident advisor will be placed at the NFPB. This individual will be assigned for the first three years of the Project when the bulk of the export TA will be provided, and while the system is undergoing the most extensive change. The division of labor between the USAID project officer and the resident advisor can be illustrated as follows:

USAID project officer-financial monitoring/approvals; preparation of PIO/Ts, PIO/Cs, PIO/Ps; clearance of cables, memos, travel concurrences.

Resident Advisor - preparation of scopes of work; briefing and debriefing of TA consultants; preparation of quarterly and semi-annual review material, in conjunction with the USAID Project Officer; technical input to cables, memos, etc.; and collaboration with counterparts and TA consultants in the preparation, monitoring and revision of workplans.

B. Recipient Reporting Requirements

Sub-Grantees will provide (1) semi-annual implementation reports covering activities initiated or completed during the reporting period, major decisions/problems or developments, and plans for the next reporting period; (2) quarterly financial reports; (3) annual implementation plans, including annual budgets; and (4) a final report summarizing accomplishments.

C. Evaluation

Evaluations will be carried out at various stages of project implementation.

1993 - Contraceptive Prevalence Survey  
1994 - mid-Project evaluation  
1996 - in-depth Project evaluation  
1997 - Contraceptive prevalence survey.

The two contraceptive prevalence surveys carried out during the life of the project, one in 1993 and the other in 1997, will measure the achievement of project goals, including maintaining contraceptive prevalence rate at 55 percent, declines in the total fertility rate, declines in unmet need for appropriate family planning services, and increased participation of the private sector in family planning service education, referral and delivery.

Up-to-date data on utilization of family planning clinics, birth rates, sales of contraceptives, etc. will be readily available through the NFPB and MOH and other agency records and used to monitor program performance.

An overall project evaluation will be carried out between the 18th and 24th month of the project. It will be especially important that the evaluation assess the following:

- o progress in implementing user fees for family planning within the context of primary care user fees in the Ministry of Health;
- o impact on sales and client profiles of privatized CSM program;
- o potential and performance of private providers delivering family planning services;
- o whether sufficient improvements have been made to MOH pharmaceutical system to recommend combining it with NFPB for procurement and distribution of public sector family planning commodities;
- o performance of GOJ in allocating adequate budget for public sector family planning commodities; and
- o degree to which NFPB has assumed meaningful role as advocate and leader of national family planning program.

The evaluation will also investigate technical, administrative and managerial matters that have a bearing on the project.

In addition, a major in-depth impact evaluation will be carried out in Year 5 of the Project. The evaluation will assess the success of efforts to sustain and finance the program during the period of donor phaseout. Emphasis will be placed on lessons learned, what worked and did not work, to provide a "case study" for other countries which may be facing the same challenges as Jamaica and to allow for final mid-course correction of the Project's activities.

It is anticipated that the evaluations will be conducted by teams consisting of Jamaican and U.S. experts with Terms of Reference jointly agreed upon by USAID and NFPB.

#### D. Audit

The National Family Planning Board will be the GOJ implementing agent and will be responsible for all host country accounting and financial reporting and contracting for goods and services. USAID will make disbursements directly to NFPB based upon approved requests for advances of funds to meet local currency costs of goods and services included in the approved project budget. Such advances may not exceed 90 days estimated expenditure. Expenditures must be properly reported and documented to USAID on monthly financial reports in form and substance acceptable to AID before further advances are approved. Monthly financial reports to be submitted by NFPB to USAID with supporting documentation three weeks following the end of each month.

NFPB's accounts are audited annually by the Jamaican accounting firm of Horwarth & Horwarth. The scope of the NFPB's annual audits will be expanded to include the USAID Project, CSM sales revenue account, and GOJ expenditures to monitor host country contribution to the Project. Project funds may be used to offset the increased cost of the annual audit to cover these additional USAID requirements.

The NFPB is currently implementing the Population and Family Planning Services Project and their accounting and reporting capabilities were reviewed on several occasions by the Mission's Financial Analyst staff. Prior to NFPB undertaking any contracting actions, USAID will utilize the existing Mission IQC with Coopers and Lybrand to assess NFPB's host country contracting capability and certify that it is adequate.

#### VIII. SUMMARY OF ANALYSES

##### A. Technical Analysis

The technical analysis recommends that the Family Planning Initiatives Project take a four-pronged approach. First, strengthening through provision of training and special resource "tools" the leadership/advocacy capability of the national program. This ensures the long-term technical and financial sustainability of family planning services delivery. Second, shifting the logistics and financial burdens of contraceptive commodity procurement to the Government of Jamaica in planned stages while providing assistance in developing strategies for advantageous purchase. Third, improving--through user education and counseling and through provider training--the contraceptive method mix which provides both enhanced fertility-efficiency and cost-efficiency over time. Fourth and perhaps most importantly, developing substantive options for increased privatization of family planning services delivery which can, in the long term, diminish the technical and financial burden on the public sector.

In the current family planning environment in Jamaica, program and project sustainability is a pressing concern everywhere. Generally, sustainability is used to mean financial sustainability beyond complete dependence on donor or public sector resources. The technical sustainability of the national family planning program is, however, equally important to its financial sustainability. Financial resources without effective programs to implement are useless in achieving family planning goals. The National Family Planning Board will need to provide through its national leadership role in this new era the strategic planning, direction, coordination, and innovative thinking which will make possible the technical sustainability of the family planning program in Jamaica, as well as its financial sustainability. NFPB advocacy is critical to ensure maximal possible allocation of Government resources to family planning activities as well as maximal contributions from the private and commercial sectors to the costs of services delivery.

Options for privatization and cost recovery in efforts to achieve sustainability in family planning services occupy an important place in the Project strategy. There are four areas in the Jamaican environment in which increased use of the private sector's resources--including the consumer's resources--can enhance both the financial and technical sustainability of the national family planning program. These areas are 1) social marketing of contraceptives, 2) user fees in the public sector, 3) work-related provision of services, and 4) private physicians. In the short-term increased investments in both time and money may be required to advocate and implement the desired private sector participation; but these initial investments must always be seen in the context of their long-term sustainability pay-offs.

The present family planning delivery system is comprised of several service delivery channels which together deliver all family planning services in Jamaica. Family planning services have four components: education/awareness, counselling, commodities, and method application. The dissection of the service into its component parts is useful in the analysis of system changes, such as how to achieve increased privatization, increased prevalence and improved method effectiveness. Finally, the market for family planning can be segmented into three groups of consumers: 1) the safety net consumer, consumers in the lowest three consumption deciles, 2) the social marketing consumer in the fourth through seventh consumption deciles, and 3) the "commercial" high-end consumer in the top three deciles. Through an analysis of the current delivery channels for family planning services by component parts and consumer groups and a projection of the system at the end of the project, several conclusions can be made. By the end of the Project, the privatization initiatives, along with attention to better counselling for increased prevalence and optimal provision of long-term methods, should result in a system with more diversification of use and a more cost-effective method mix. There should be more delivery points, representing the public and private sectors, where some or all of the four component services may be obtained. The Ministry of Health will be providing education/awareness services to consumer in the lower two groups, the safety net and social marketing groups. The MOH will also be providing counselling to these groups. But as far as commodities are concerns, the MOH would be supplying free commodities only to the safety net group or possibly to first-time users. The CSM program would be a major provider of education and awareness, through a very active marketing effort. This would use method-specific advertising to provide information about use of methods, side effects and to counter rumor. The CSM program would provide commodities directly from the commercial manufacturer/distributor to the social marketing consumer wherever possible.

Increased private sector involvement in family planning service delivery will have the following ramifications for method mix: The MOH with its access to clinical facilities and trained personnel has a comparative advantage to deliver long-term clinical methods. Furthermore, given the product cost and cost of skilled delivery of these methods, it will be very difficult to make them price affordable to the national family planning program target market. Thus the private sector method mix in Jamaica will always emphasize supply methods.

Increased involvement of the private sector, however, can make a noticeable indirect contribution to improving the method mix. By replacing the public sector as the source of supply methods and services for many users, who are able to purchase them in the private sector, private sector involvement can "free up" at least a portion of public sector resources previously committed to serving supply users for application to expanded provision of longer-term methods to those who want them.

Work-based programs will continue to exist on a financially self supporting basis, and might offer more effective services. Education and counselling services through this mechanism will be targeted at the social marketing consumer and will be strengthened. Commodities and method application will be used by the top two groups, the commercial consumer and those in the social

marketing target groups. The social marketing consumer may also be more able to seek counselling and method application from General Practitioners, if these practitioners have become more actively involved by improving counselling to acceptors.

Social Marketing: Privatization of the CSM program is feasible in Jamaica. CSM programs are not intended to serve either the poorest of the poor or the very poor, but rather to make available price affordable products to lower income couples. Contraceptive manufacturers have provided price-affordable contraceptives to CSM programs in a number of countries. The willingness of contraceptive manufacturers to make products price-affordable to lower income groups along with the overall geographic accessibility of commercial distribution chain outlets (e.g. pharmacies, shops, markets, etc) clearly obviates the need for government and donor agencies to duplicate the services provided to this particular segment of the contraceptive market. In Jamaica, the commercial contraceptive market is immediately willing to make a high quality, reliable, low-dose oral contraceptive price-affordable to the lower income market. A survey of public sector clinic users concluded that many public sector users have the willingness and ability to pay for contraceptives. If a commercially available lower-priced oral contraceptive is introduced and marketed concurrently with the phase-out of Perle (especially if the price of Perle is increased incrementally during the transition), it should be possible to implement this shift without any significant negative impact on contraceptive prevalence. The NFPB will need to explore the commercial availability of a lower-priced condom for the program.

Public Sector Cost Recovery: In the public sector in the face of staffing and financing problems, facilities are turning to payment for services as a means to offer a better service. From anecdotal evidence, it appears that a diverse system of informal user fees already existing. In addition to these informal fees in primary care facilities, a formal system of fee collection is in place in Jamaican public hospitals. The survey of clinic attenders concludes that clinic users appear ready to pay for clinic services. On average, they indicated that \$15 was a reasonable charge for a visit and \$5 for a contraceptive. It is recommended that user fees for family planning services be instituted along with other primary health services when the Ministry of Health implements user fees in primary care. Fees for family planning should be waived for those who cannot afford to pay. Ideally, user fees should be implemented to allow facilities to keep some of the proceeds and free family planning commodities should only be provided to those who cannot afford to pay. Beyond the impact on revenues and expenditures, cost recovery should improve the quality of local services, improve the perception of quality and raise the personal value of public services to users, establish the ethic of paying for services, and move consumers to the private sector.

Private Practice Physicians: Private physicians are providers of health care for a significant proportion of Jamaican women. Although only 12% saw a physician for family planning, 67% of these women or their families have at some time been a client of a private physician. This suggests that physicians are not yet serving as a source of family planning counselling and methods to women. These visits are a great missed opportunity for the national family planning program to enlist physicians to participate in family planning service delivery. There are two primary issues involved in the potential

contribution of private practice physicians to the sustainability of the national family planning program: 1) their effectiveness in motivating women to accept and continue to use family planning methods and 2) the extent to which public sector consumers of family planning services will shift into the private sector. It is recommended that private physicians be trained to become more frequent and effective counsellors of clients about family planning needs and that activities be implemented to broaden the range of contraceptive methods available through private practitioners.

Work-Based Programs: Both JFPA and NFPB operate work-based family planning programs in private enterprises. Private entrepreneurs do not contribute to the operational cost of these programs (NFPB-37 firms; JFPA-58 firms). It is recommended that the present free programs become self-supporting, and that cost-benefit analysis be used as a tool to demonstrate to firms that convenient family planning services produce returns in terms of productivity to attract their financial support.

#### B. Institutional and Administrative Analysis

The twin objectives of the Project--to increase sustainability and program effectiveness of the national family planning program--place a special challenge before the organizations which are involved. This analysis underlines the difficulty of the challenge which faces the organizations. As the system seeks a new equilibrium, serving more acceptors more effectively, and without participation of a major donor, it is impossible to predict the exact direction of change. But the new Project has been designed to give the program its greatest chance for success as it moves toward fiscal and programmatic autonomy.

The NFPB, a statutory body, has the mandate for family planning advocacy and coordination, and for galvanizing other organizations which operate service programs. The national program needs a powerful advocacy organization as it seeks to make up funding lost in donor phaseout. More dynamic leadership needs to be invested in the program for its continued growth, for example to strengthen its promotion and delivery of cost- and contraceptive-effective, clinical methods. Much more noise--and convincing noise--is needed in Jamaica as the program seeks to reach the hard-to- reach acceptors who now need to be brought into the program. The NFPB has these advocacy functions in its mandate.

At present, however, the NFPB is an ineffective advocate organization, dividing its attention between advocacy and implementation. Given that the program needs a powerful advocating agent--and that there are other organizations with a comparative advantage to implement--it is recommended that the NFPB transfer its implementation roles to these other organizations.

First and foremost is the CSM program. It is recommended that the CSM program be put into the commercial sector, with the NFPB retaining a significant advocacy/coordination role. Governmental organizations have the responsibility to maintain systems of checks and balances, minimize risk, and maintain consensus. In contrast, the commercial sector has a strong marketing capacity to respond rapidly to changes in the marketplace and to take reasonable business risks. The new program should be aggressively managed,

with strong technical support of products and extensive advertising to the consumer about side effects and the personal value to the acceptor of family planning, to begin to reach hard-to-reach acceptors.

It is also recommended that the two single-purpose clinics be turned over to the MOH or the JFPA, and that the factory program be turned over to the JFPA. For the meanwhile, though, the distribution of contraceptives to clinics should be retained at the NFPB, and the logistics function strengthened (including forecasting, procurement and distribution), since the MOH distribution system is not sufficiently strong to take this over.

The MOH is the major provider of family planning services. However the program has hit a plateau. Improvements in program effectiveness are needed to achieve program growth. It is recommended that the Project work with the national program in three principal areas, 1) removal of policy barriers to program growth, 2) clinical methods delivery and counselling, and 3) dialogue with private service providers and enterprises to increase private provision of family planning services.

Further, the MOH is faced with funding and staff shortages. To address the sustainability issue in the MOH, it is recommended that fees for family planning services be adopted for those who can afford to pay, as part of the ongoing effort to implement user fees for primary health care services. It is not recommended that fees for family planning be implemented apart from other fees, but if other fees are instituted it would be appropriate for fees for family planning to be considered for the better-off users. Since this initiative applies to the health sector as a whole, FPI Project funds have not been allocated to this purpose.

The Ministry of Education has historically tried to develop family life education programs. However, resistance to introduction in the schools of material about family planning has held this process back. The Project will assist the MOE to introduce an examinable family life education curriculum at the level of the teacher's college, provided the curriculum is acceptable to the NFPB and that the curriculum is mandatory in the schools.

The JFPA is a private, voluntary organization, affiliated with IPPF, an international non-governmental donor. The JFPA is the appropriate implementing agent as steps are taken to realize the contribution of the private sector. It is recommended that it be the locus of the private physician/private sector seed grant component of the Project. This will strengthen the JFPA's linkage to private professional groups and private firms and to the NFPB/MOH, as they oversee evolution of standards of practice in private service provision.

The Women's Center is a local foundation whose program has historically sought to work with adolescents to delay the birth of their second child. Given the Women's Center's strong link to the public schools, it is recommended that a grant be made to the Women's Center to introduce a pilot program in selected schools designed to delay the first birth.

### C. Social Soundness Analysis

Although Jamaica has reached a mature stage in its family planning program, indications are that certain inherent problems will continue to stall the contraceptive prevalence rate. Problem areas include non-users of contraceptives who are at risk, inability of the public sector to expand its commodity distribution and counselling services, and the need for aggressive leadership and advocacy for family planning. Non-users who should be targeted include poor and rural women, teenagers, and young men who are sexually active. These groups have traditionally been the most difficult to reach due to cultural norms and socioeconomic factors.

Health care workers, especially nurse and midwives, play an important role in providing face-to-face communication and credible counsellors for the majority of users. Most private doctors in Jamaica leave family planning counseling and services to the public sector; and in turn, clients do not expect private doctors to deliver these services. Although it is financially feasible for many users of public health centers to pay fees and purchase commodities at a higher price, it is realistic to expect some market fall-out during the transition period of the Project.

The most difficult aspects for the Project will be those that pertain to the political will and commitment to support privatization of some aspects of the family planning program as the public views it as a successful Government effort. The Project should introduce change in ways designed to minimize program disruption and market these changes for maximal acceptability by the public and Government decision-makers.

### D. Economic and Financial Analysis

Economic Analysis: The benefit-cost analysis for the Project shows that the value of benefits from the implementation of the Project greatly exceeds the costs. This is demonstrated by the cost savings in averting births over the Project period and the couple-years of protection provided by Project commodities. The economic benefits of averting births can be roughly estimated to equal US\$344 million, far in excess of the US\$1.8 million in the Project budget for contraceptives. The analysis concludes that the Project interventions are cost effective in delivery family planning services to current users, increasing acceptance among non-users and that a "mix" of activities as proposed is likely to be more cost-effective than selection of components only to improve the cost-effectiveness of service delivery, or to reach non-users.

Financial Analysis: The financial analysis reviews information about trends and prospects for the Jamaican economy and in government financing for the health sector and family planning; GOJ policy regarding user fees and issues related to the Jamaican population's willingness and ability to pay proposed fees for family planning; descriptions of other donor inputs into family planning; estimates of recurrent costs associated with the family planning program and potential sources of financing; a description of the current public pharmaceutical system in Jamaica; and options for future procurement and distribution for the CSM program.

Significant increases in financing for the MOH over the next 10 years will be modest, perhaps up to 29% in real terms. Donor financing for the rehabilitation of public sector facilities will help with respect to upgrading physical infrastructure. While revenue from user fees may also raise the level of recurrent resources available to the MOH, there will be many claims on this revenue to cover variable inputs, such as drugs and contraceptives. Some current clinic users will shift to private sector sources of care, as has been the case of the past several years.

The analysis shows that the proposed level of MOH fees for family planning services would likely generate sufficient revenue to cover the cost of contraceptives currently provided by donors - even if a significant proportion of clinic attenders is exempted from payment. While user fees can potentially cover the costs of contraceptives currently provided, fees must be adjusted to reflect devaluations in the Jamaican dollar, and that irrespective of the administrative systems put in place for fee collection, NFPB is provided adequate funds in its budget for the purchase of public sector contraceptive requirements.

The analysis of NFPB recurrent costs shows that phasing out NGO sub-projects (completed March 1991) and a reorientation of the CSM program reduces the gap between income from Jamaican sources and financing requirements to about J\$2.0 in 1989/90, about 26% of NFPB income from all non-CSM sales and non-donor resources. This amount is roughly equal to the financial requirement estimated earlier for public sector contraceptives. Aside from increasing revenue from user fees for family planning services, the NFPB might also provide financing for contraceptives by reviewing their clinical programs and eliminating services which the NFPB cannot provide cost-effectively.

The NFPB has several advantages over the MOH regarding the procurement and distribution of contraceptives to public sector institutions. There may be longer run developments which would permit elimination of the parallel system of the NFPB without jeopardizing the supply of contraceptives including: responses of the MOH to the dismantling of JCTC, to proposals to privatize the provision of public sector pharmaceuticals, and to management improvements in the current system accompanying the provision of significant amounts of pharmaceuticals by the World Bank. The mid-term evaluation should review the decision to leave the procurement and distribution of public sector commodities with NFPB or whether sufficient MOH improvements have been made to warrant a combined system.

The financial analysis of the CSM programs shows that there are pros and cons associated with either the option of strengthening the CSM program within the NFPB or moving the program further in the commercial sector. It is clear that the future success of either option is more assured with a high level of NFPB/MOH support, and inputs of USAID technical and financial support. The design of a commercial approach should include elements to reduce anticipated downsides, as well as funds for monitoring the impact of this approach on contraceptive use, and the overall financial burden to the NFPB to provide contraceptives in public sector institutions. The mid-term evaluation for the Project should assist the NFPB in evaluating their experience with commercialization, if it is adopted.

E. Environmental Analysis

The environmental threshold decision for the Project dated June 4, 1991 is a categorical exclusion as set forth in Annex H.

IX. CONDITIONS AND COVENANTS

In addition to the Standard Conditions Precedent of a Statement of Authorized Representatives, the Grant Agreement will contain, in substance, the following conditions precedent and covenants:

Conditions Precedent:

(a) Before disbursement of grant funds for the Contraceptive Social Marketing component (except for the supply of contraceptives), the Grantee will submit to A.I.D., in writing, within 12 months of the signing of the agreement a policy decision, satisfactory to A.I.D., to commercialize the CSM program. If the Grantee decides not to commercialize the CSM program, A.I.D. may reprogram the amounts designated for the CSM component for other private sector family planning activities.

(b) Before disbursement of grant funds for the Ministry of Education Family Life Education program, the Grantee will submit to A.I.D., in writing, a policy commitment, satisfactory to A.I.D., that the MOE agrees:

- (1) to actively integrate the subject of FLE into the curriculum, especially for Primary and All-Age schools, and will institutionalize it as an examinable subject;
- (2) to formalize FLE as a compulsory and examinable subject in teacher's colleges; and
- (3) that the FLE program will contain family planning and birth control concepts and methodologies acceptable to the NFPB.

If this condition is not fulfilled within three years after signing of the Agreement, A.I.D. may reprogram the MOE/FLE program funds for other Project activities.

(c) Before disbursement of funds for the Clinical Methods component, the Grantee will appoint and have in place a full-time Family Planning Coordinator in the Ministry of Health. The Grantee will submit written confirmation of the appointment and placement of the Coordinator to A.I.D.

Covenants:

(a) The Grantee agrees to provide sufficient funds for public sector contraceptives in its annual budget. The Grantee agrees further to provide written evidence to A.I.D., on an annual basis, that this covenant has been satisfied.

(b) The Grantee agrees:

1. That it will maintain separate accounts for the receipt of all revenues generated under the Contraceptive Social Marketing (CSM) Program as mutually agreed by A.I.D. and NFPB;
2. That it will use the revenues generated under the CRS Program to further family planning objectives which are mutually agreed to by A.I.D. and NFPB;
3. That it will provide A.I.D. with written reports, statements of income and expenditures, including specific uses of the revenues, and such other information, audit reports or other accounting as A.I.D. may reasonably request;
4. That it will consult with A.I.D. concerning changes in the pricing of products in the Program; and
5. That it will consult with A.I.D. on the introduction of new products in the Program, and observe A.I.D.'s objection to the use of products that contravene A.I.D. family planning policies.

LOGICAL FRAMEWORK MATRIX

Narrative Summary	Indicators	Means of Verification	Assumptions
<p><b>PROJECT GOAL</b></p> <p>To maximize the quantity and quality of public and private family planning services to support national development goals related to population.</p>	<p>Decrease in total fertility rate, decrease in unmet need for appropriate family planning services, increased participation of the private sector in service delivery</p>	<p>Demographic surveys, service statistics</p>	<p>GOJ policies and programs will be supportive of Project activities</p> <p>Macro-economic stability</p>
<p><b>PROJECT PURPOSE</b></p>	<p><b>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED</b></p>	<p><b>MEANS OF VERIFICATION</b></p>	<p><b>ASSUMPTIONS</b></p>
<p>To increase program effectiveness and sustainability of the national family planning system in preparation for USAID phaseout.</p>	<p>Contraceptive prevalence increased to 62%.</p> <p>Proportion of Jamaican acceptors protected by clinical methods (VSC, IUD, injectables) increases from 42-44%.</p> <p>Commercial sector social marketing program serving acceptors with low-priced, aggressively marketed products.</p> <p>Jamaican opinion leaders and population better informed and aware about the importance of family planning to women's health and to national development.</p> <p>Public sector contraceptive supplies continually available without AID assistance.</p> <p>Private entities and providers more actively involved in providing family planning, education, referrals and services.</p>	<p>Demographic surveys, service statistics.</p> <p>CSH letter of agreement, annual reports and spot audits, CSH sales data.</p> <p>Media coverage, presentations, outside evaluation.</p> <p>Spot audits.</p> <p>Contraceptive Prevalence Survey</p> <p>Research Survey.</p>	<p>GOJ &amp; private sector will continue to finance and provide family planning services.</p> <p>No other donor willing to take over when AID phases-out</p> <p>Private sector policy barriers resolved.</p> <p>GOJ political commitment to FP can be galvanized.</p> <p>GOJ gives priority to allocating budget to purchase of contraceptives and VSC supplies</p> <p>GOJ routinely develops estimates, procures contraceptives and delivers them to service delivery outlets in a timely and efficient manner</p> <p>Private providers are willing and interested</p>

PROJECT OUTPUTS			
NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<b>OUTPUTS</b>			
<b>Policy Frameworks</b>			
Policy Analysis and Research.			
5 Seminars and presentations for GOJ policymakers.	Number of presentations and seminars to GOJ policymakers and public opinion leaders.	Reports, evaluation interviews, project files.	GOJ staff are interested and actively participate in policy analysis activities.
2 Contraceptive Prevalence Surveys conducted and results analyzed and disseminated.	Contraceptive Prevalence Surveys completed.	Study reports.	Relevant economic and financial data are available to construct the presentation models.
3 Operations research and other studies on sustainability and effectiveness completed.	Number of operations research/ other studies completed.	Study reports.	Adequately trained local staff to conduct surveys and research.
2 Social Marketing Campaigns.	Number of Social Marketing Campaigns.	Ads, media project records.	No socio-cultural and political barrier to conducting surveys or studies.
<b>Contraceptive Supplies &amp; Logistics</b>			
<b>Contraceptive Supplies</b>			
2 years of social marketing grants and condoms.	Amount of contraceptives supplied.	GOJ budget, USAID Procurement Records.	There are clients willing to use methods provided.
Contraceptive supplies (grants, condoms and IUD) for the public sector program.			The internal transportation and distribution infrastructure doesn't deteriorate significantly.
			Trained staff remain within the system.
<b>Contraceptive Logistics</b>			
10-20 NFPB and MOH staff trained in contraceptive forecasting requirements estimation.	Annual forecasts and contraceptive estimates prepared by the NFPB/MOH.	NFPB Records.	GOJ provides budget for contraceptives. There is no frequent turnover in staff.
A functioning MIS operation that provides service statistics and logistics information including distribution and inventory data.	Routine service statistics, and logistics reports. Routine inventory and distribution data.	Project Records and Reports.	NFPB designates staff responsible.
NFPB and MOH staff trained and capable of handling international tenders for contraceptive supplies.	GOJ Contraceptive Contracts in Place.	Spot Checks, NFPB Records.	Trained personnel remain in system.
Updated contraceptive supply manuals available.	No stock out or contraceptive shortages in clinics when there are stocks in the central warehouse.	Spot checks.	NFPB committed.
<b>Family Life Education</b>			
3 FLE policies adopted.	FLE mandatory in schools. FLE examinable subject. FLE curriculum appropriate.	NDE written policies.	NDE is willing to change FLE policy.
2 FLE books developed and published; guidelines reprinted.	Number of books. Number of guidelines.	Spot check.	FLE policies are adopted.
Teachers and teacher tutors trained in FLE.	Number of trainees. Number of FLE sessions conducted.	Project records.	FLE policies are adopted. Teachers feel comfortable teaching FLE.

55

ANNEX A  
LOGICAL FRAMEWORK MATRIX

- 3 -

<u>Clinical Methods</u>			
Method-mix plan developed and implemented.	Process established and functioning to examine and plan for method-mix evaluation. Increase in VSC share from 25% in 1990 - 29% by 1997. Increase in IUD share in method-mix from 2.7% 1990 to 4.3% by 1997. Clinical methods increase from 19% in 1987 to 25% by 1997.	Minutes of meetings, reports. CPS, service statistics.	That GDJ undertakes to look at method-mix. That policy process supports theoretical objectives. That multiple partner situation remains stable.
20 clinical methods and counselling workshops for medical personnel.	Practitioners and counselors trained.	Project records.	Participants are released for training.
Accepter profiles developed and disseminated.	Increase in appropriate clinical method acceptors.	Spot check, project records.	Adequate contraceptive supplies are available.
<u>Private Providers/PPGG</u>			
Private physician family planning education campaigns conducted.	Number of FP referrals from GP's.	Ads, tapes, scripts.	Appropriate campaign can be designed by local firm.
50 physicians trained in counselling and family planning.	Number of trainees. Increase in new and continuing acceptors.	Project records.	MSs are interesting in FP and take time.
IEC materials developed and provided to private providers.	Number and type of material developed and distributed to clients by private providers.	Brochures, posters.	Appropriate materials can be developed by local firm. Private sector is interested in involvement with provision of FP.
<u>CSM</u>			
Shift of CSM to commercial sector.	Letters of Agreement. Sales of products mktg. plan.	Retail audits. Sales reports.	GDJ adopts appropriate policy. Commercial sector willing and able to provide products at appropriate price.
Advertising, promotions and communications promoting methods and FP.	Appearance of ads, spots, and promotions. Increased consumer recall of CSM products.	Media checks, spot checks of outlets, market research.	NFPB implements promotion in a timely and effective manner.
Training of MSs, RIS.	Seminars detailing.	Project files, detailer's call reports.	Participants willing to be trained.
Market research studies.	Level of CSM sales, consumer satisfaction.	Results of studies.	Local firm capable of conducting relevant research.
<u>Women's Center</u>			
Adolescent clinic facility established.	1 clinic established.	Project records.	Adolescent clinic is feasible and cost effective.
Community and education programs conducted.	Number of programs conducted.	Project records.	Schools & communities give program access to adolescents.

56

<p>Institutional Strengthening</p> <hr/> <p>NFPB Institutional Strategy developed and implemented.</p> <p>MIS system in place.</p> <p>NFPB staff trained.</p> <p>INPUTS</p> <p>Long Term TA Short Term TA Commodities Training Local Costs</p> <p>Audits &amp; Evaluation</p> <hr/>	<p>Strategy document</p> <p>MIS reports generated.</p> <p>No. trained.</p> <p>See Budget in Section IV</p>	<p>Site visit</p> <p>Project record, site visits.</p> <p>Training, Reports.</p> <p>Project records.</p>	<p>NFPB adopts strategy NFPB assumes advocacy role.</p> <p>Data are available and staff trained.</p> <p>Staff are released for training.</p> <p>Inputs available on a timely basis.</p>
---	--	---	---

ACTION: AID-2 INFO: 1B DCM ECON -1-

ANNEX B  
PID APPROVAL CABLE

VZCZCKG0206  
PP RUEHIG  
DE RUEHC #0071/01 0800346  
ZNR UUUUU ZZE  
P 210342Z MAR 90  
FM SECSTATE WASHDC  
TO AMEMBASSY KINGSTON PRIORITY 6423  
BT  
UNCLAS SECTION 01 OF 03 STATE 090071

21-MAR-90 TOR: 12:06  
CN: 12907  
CERG: AID  
DIST: AID  
ADD:

**FILE**

**ACTION COPY**  
ACTION TAKEN

*Handwritten notes:*  
COP  
COPD

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: USAID/JAMAICA FY 1991/92 ACTION PLAN REVIEW

1. SUMMARY: THE FY 1991-1992 USAID/JAMAICA ACTION PLAN (AP) WAS REVIEWED TUESDAY, MARCH 6, 1990 IN MEETING CHAIRED BY THE ACTING ASSISTANT ADMINISTRATOR FOR LATIN AMERICA, FREDERICK W. SCIECK (A/AA/LAC). USAID/JAMAICA WAS REPRESENTED BY MISSION DIRECTOR WILLIAM JOSLIN, PROGRAM OFFICER NANCY HARDY, AND PROJECT DEVELOPMENT OFFICER DENISE ROLLINS. THE AAA/LAC COMMENDED THE MISSION FOR ITS EXCELLENT PROJECT IMPLEMENTATION PERFORMANCE DURING THE LAST TWO YEARS, PARTICULARLY NOTING THE OUTSTANDING ACCOMPLISHMENTS UNDER THE HURRICANE RECONSTRUCTION PROJECT. THIS CABLE SUMMARIZES THE ISSUES DISCUSSED AND THE DECISIONS OF THE ACTION PLAN REVIEW. A FULL DISCUSSION OF THE ISSUES IS CONTAINED IN THE ISSUES PAPERS PREPARED FOR THE REVIEW. THESE PAPERS ARE BEING HANDCARRIED TO THE MISSION BY THE USAID PARTICIPANTS.

2. FOLLOW-UP ACTIONS FROM FY 90-91 ACTION PLAN. IT WAS AGREED THAT USAID/JAMAICA HAS SUCCESSFULLY FOLLOWED-UP ON THE DECISIONS COMING OUT OF THE FY 90-91 ACTION PLAN

REVIEW WHICH WAS HELD IN APRIL 1989. THE AP REVIEW COMMITTEE REQUESTS THAT THE MISSION CONTINUE TO STRIVE TO REDUCE ITS MORTGAGE RATIO FROM THE CURRENT LEVEL OF ABOUT 3.6 TO BETWEEN 2.0 AND 2.5 TIMES THE ANNUAL OBLIGATION LEVEL OVER THE FY 90-92 PERIOD. ATTAINING THIS RATIO MAY ENTAIL NOT STARTING PROJECTS WITH LOW LEVELS OF FUNDING AND/OR DELAYING THE DEVELOPMENT OF NEW ACTIVITIES, AS APPROPRIATE. FACTORS THAT SHOULD BE BORNE IN MIND INCLUDE: THE POSSIBILITY OF DECLINING A.I.D. RESOURCES WHICH MAY LEAD TO DECLINING OYB LEVELS AND PROJECT EVALUATION OUTCOMES THAT COULD REVISE CERTAIN PROJECT LOPS DOWNWARDS.

3. FY 1991-1992 ACTION PLAN ISSUES AND DECISIONS. IT WAS AGREED THAT THE GOALS AND OBJECTIVES OUTLINED IN USAID/JAMAICA'S CDSS, WHICH WAS APPROVED IN MARCH 1988, REMAIN VALID AND APPROPRIATE. IN THIS CONTEXT, THE REVIEW FOCUSED ON THE FOLLOWING ISSUES.

DATE RECEIVED	<i>3/21</i>
ACTION OFFICE:	<i>OPD</i>
INFO TO:	
DIR ✓	ARDO
D/DIR ✓	OHNP
<i>RLA</i>	GEHR
GEPE	GAPD
OEEB	OCM
ENO	RHDDO
CONT	R.F.
DIST. <i>6</i>	
DUE BY	<i>3/23</i>
ACTION:	

*Handwritten note:* on 3/21/90

A. ISSUE NO. 1. SHOULD THE MISSION'S MACROECONOMIC POLICY DIALOGUE WITH THE GOJ BE MORE NARROWLY FOCUSED?

DECISION: IT WAS AGREED THAT SATISFACTORY IMPLEMENTATION OF THE STAND-BY AGREEMENT WITH THE INTERNATIONAL MONETARY FUND (IMF) IS JAMAICA'S TOP POLICY PRIORITY AND THE MISSION SHOULD SUPPORT THIS OBJECTIVE. AT THE SAME TIME, JAMAICA'S CURRENT FOREIGN EXCHANGE REGIME CONTINUES TO BE A CRITICAL CONCERN CONSTRAINING THE COUNTRY'S DEVELOPMENT AND THE ROLE OF THE PRIVATE SECTOR. THUS, THE MISSION'S POLICY DIALOGUE EFFORTS SHOULD EMPHASIZE MOVEMENT TOWARD A MARKET DETERMINED FOREIGN EXCHANGE RATE AND TO DEREGULATE PRIVATE SECTOR ACCESS TO FOREIGN EXCHANGE. THIS USAID POLICY DIALOGUE EMPHASIS, HOWEVER, SHOULD NOT EXCLUDE OTHER IMPORTANT POLICY REFORM ISSUES WHICH THE MISSION HAS BEEN PURSUING WITH THE GOJ, SUCH AS TAX REFORM, PRIVATIZATION, AND THE ROLE OF THE JAMAICA COMMODITY TRADING CORPORATION.

B. ISSUE NO. 2. WILL THE MISSION BE ABLE TO CONTINUE ITS DIVERSE PORTFOLIO, INCLUDING NEW STARTS, GIVEN THE SEVERE REDUCTIONS IN BOTH THE DA AND ESP ACCOUNTS DURING THE ACTION PLAN PERIOD? SHOULD PROPOSED NEW PROJECTS BE DELAYED OR SCALED BACK IN LINE WITH BUDGET REALITIES?

DECISION: IT WAS AGREED THAT THERE IS A NEED TO CARRY OUT A COMPREHENSIVE REVIEW OF THE OVERALL USAID/JAMAICA PROJECT PORTFOLIO TO DETERMINE WAYS TO FOCUS IT. THE

FIRST STAGE OF THAT PROCESS IS NOW UNDERWAY, WITH ORDERLY COMPLETION OF TWELVE PROJECTS WITHIN THE NEXT NINE MONTHS. BEYOND THIS, THE BEST WAY OF CARRYING OUT THIS REVIEW IS IN THE CONTEXT OF THE PORTFOLIO REVIEW, WHICH WILL COVER THE PERIOD ENDING SEPTEMBER 30, 1992. ACCORDINGLY, THE MISSION IS REQUESTED TO PREPARE, AS PART OF THAT REPORT, A SPECIAL ANALYSIS SHOWING ITS PLANS FOR CONSOLIDATING ITS PROGRAM PORTFOLIO. THIS ANALYSIS SHOULD CONSIDER THE PROJECTS' LOP, IMPLEMENTATION STATUS, DEOBLIGATION POSSIBILITIES, MORTGAGE SITUATION, THE EVOLVING REQUIREMENTS FOR INNOVATIVE ACTIVITIES SUCH AS THE CO-FINANCING SCHEME WITH THE JAPANESE GOVERNMENT, AND EXPECTED RESOURCE LEVELS AVAILABLE FOR JAMAICA.

C. ISSUE NO. 3. WHAT IS THE STATUS OF THE GOVERNMENT OF JAPAN'S INTEREST IN FUNDING THE PLANNED JOINT A.I.D.-OECF INFRASTRUCTURE ACTIVITY? WHAT FEASIBILITY WORK REMAINS TO BE COMPLETED BEFORE JAMAICA CAN PRESENT A FUNDING PACKAGE TO THE GOVERNMENT OF JAPAN? HOW MUCH IN NEW A.I.D. FUNDING IS REQUIRED TO COMPLETE THE

## FEASIBILITY STUDIES AND WHEN WILL THEY BE COMPLETED?

DECISION: IT WAS AGREED THAT THE PROPOSED CO-FINANCING ACTIVITY WITH THE JAPANESE GOVERNMENT IS AN INNOVATIVE AND IMPORTANT CONCEPT WHICH DESERVES PRIORITY CONSIDERATION AND SUPPORT. HOWEVER, THE DESIGN OF THE ACTIVITY IS NOT CONSIDERED TO BE ADVANCED ENOUGH AT THIS TIME TO ALLOW THE AUTHORIZATION OF A PROJECT. BASED ON CLARIFICATIONS PROVIDED BY THE USAID MISSION DIRECTOR, IT WAS DECIDED TO FOLLOW A PEASING PROCESS BASED ON THE PROGRESS IN CARRYING OUT THE FEASIBILITY STUDIES AND ON THE EXTENT OF THE JAPANESE COMMITMENT TO THE PROPOSAL (ACCORDING TO AMEMBASSY REPORTING, QUOTE THE GOJ HAS INDICATED IT IS WAITING FOR THE MISSION TO PUT FORWARD ITS FEASIBILITY STUDY SO IT CAN INITIATE ITS REVIEW OF THE PROJECT PROPOSAL UNQUOTE). THE MISSION, THEREFORE, SHOULD SUBMIT FOR AID/W REVIEW A CONCEPT PAPER ON THE PROPOSED ACTIVITY. THE CONCEPT PAPER SHOULD DESCRIBE: HOW THE MISSION PROPOSES TO WORK WITH THE JAPANESE, TAKING INTO ACCOUNT JAPANESE AID REGULATIONS AND PROCEDURES; THE STATUS OF THE FEASIBILITY STUDIES, ANY JAPANESE CONTRIBUTION TO THESE STUDIES; THE CONSTRUCTION TO BE UNDERTAKEN AND ITS COSTS; THE JAPANESE/GOVERNMENT OF JAMAICA COMMITMENT TO FINANCE PROJECT ACTIVITIES, THE RESPONSIBILITIES OF THE CONCERNED PARTIES IN UNDERTAKING THIS ACTIVITY; THE IMPLEMENTATION PLAN AND TIMEFRAME FOR THIS ACTIVITY AND THE FUNDING REQUIRED FROM A.I.D., THE

JAPANESE, AND THE JAMAICANS. THE IMPLEMENTATION PLAN SHOULD INDICATE HOW THE MISSION FORESEES DESIGN, TENDER DOCUMENT PREPARATION AND CONSTRUCTION SUPERVISION BEING CONTRACTED AND FUNDED, AND HOW THE DESIGN OF THE ACTIVITY WILL ENSURE EQUAL OPPORTUNITIES FOR POTENTIAL U.S. BIDDERS ON CONSTRUCTION WORK OR EQUIPMENT SUPPLY. A DECISION ON ADDITIONAL FINANCING FOR IMPLEMENTATION ACTIVITIES RESULTING FROM THE FEASIBILITY STUDIES AND RELATED ARRANGEMENTS WITH THE JAPANESE GOVERNMENT WILL BE MADE FOLLOWING THIS REVIEW. TO THE EXTENT THAT ADDITIONAL FUNDS ARE REQUIRED TO COMPLEMENT EXISTING RESOURCES FOR FEASIBILITY STUDIES, THESE SHOULD BE PROVIDED FROM PROGRAM DEVELOPMENT AND SUPPORT (PD AND S) ACTIVITIES OR FROM OTHER APPROPRIATE PROJECTS, SUCH AS THE TECHNICAL CONSULTATIONS AND TRAINING PROJECT AND/OR FROM LOCAL CURRENCY GENERATIONS.

D. ISSUE NO. 4. ARE THE POLICY OBJECTIVE(S) THE MISSION IS SEEKING IN PRODUCTION AND EMPLOYMENT XI AND THE POLICY PERFORMANCE PROGRAMS COMPATIBLE? SHOULD THE MISSION FOCUS ITS POLICY DIALOGUE EFFORTS ON A SINGLE ACTIVITY INSTEAD OF THE TWO PROPOSED?

DECISION: THE REVIEW CONCLUDED TO DEFER FURTHER CONSIDERATION OF THE POLICY PERFORMANCE PROJECT AS PROPOSED. HOWEVER, THE MISSION IS ENCOJRAGED TO DEVELOP AN ALTERNATIVE PROPOSAL BASED ON CURRENT UNDERSTANDING OF PERFORMANCE FUND GUIDANCE, SHOULD FUNDS BE AVAILABLE.

REGARDING THE PRODUCTION AND EMPLOYMENT ESF PROGRAM, THE REVIEW SUGGESTED, AS INDICATED ABOVE, THAT THE MISSION CONSIDER NARROWING THE POLICY DIALOGUE AGENDA TO EMPHASIZE A MARKET-DETERMINED EXCHANGE RATE, BUT NOT AT THE EXCLUSION OF OTHER POLICY ISSUES WHICH THE MISSION MAY BE ABLE TO PURSUE WITH THE GOJ. THE APPROPRIATENESS OF THE SPECIFIC REFORMS WILL BE FURTHER DISCUSSED WHEN THE MISSION SUBMITS THE FY 1990 ESF CONCEPT PAPER DESCRIBING USAID'S OVERALL POLICY DIALOGUE AGENDA.

E. ISSUE NO. 5. HOW CAN THE USG FOSTER A LARGER ROLE FOR THE PRIVATE SECTOR IN FOOD AID IMPORTS?

DECISION: IT WAS DECIDED THAT LAC AND FVA/PPP, WILL WORK CLOSELY WITH THE INTERAGENCY COMMITTEE ON FOOD AID (DCC) TO SUPPORT A MISSION PROPOSAL TO ALLOW THE JAMAICAN PRIVATE SECTOR TO PARTICIPATE IN THE P.L. 480 TITLE I PROGRAM. THE OBJECTIVE WOULD BE TO DEREGULATE AND REDUCE THE ROLE OF THE JAMAICA COMMODITY TRADING

COMPANY (JCTC) SO THAT THE PRIVATE SECTOR COULD PLAY A DIRECT ROLE IN THE IMPORTATION OF COMMODITIES PROVIDED UNDER BILATERAL AGREEMENTS. TO FACILITATE A.I.D.'S DISCUSSIONS WITH THE THE DCC, THE MISSION IS REQUESTED TO SUBMIT A PROPOSAL GIVING THE DETAILS OF THE PRIVATE SECTOR-ORIENTED PROGRAM, KEEPING IN MIND RISKS ASSOCIATED WITH PRIVATE SECTOR MONOPOLIES. THIS PROPOSAL SHOULD BE SUBMITTED NO LATER THAN THE END OF THE THIRD QUARTER OF FY 1990 TO ALLOW FOR A DECISION TO BE MADE ON THE FY 1991 PROGRAM.

4. NEW PROGRAM INITIATIVES

A. LAC/W REVIEWED USAID/JAMAICA'S NEW PROJECT DESCRIPTIONS (NPDS) AND COUNTRY TRAINING PLAN ON FEBRUARY 28. THE COUNTRY TRAINING PLAN IS APPROVED. FOR PROPOSED FY 90 PROJECTS, THE MISSION DIRECTOR IS AUTHORIZED TO APPROVE PROJECT PAPER SUPPLEMENTS (PPS) FOR THE CROP DIVERSIFICATION/IRRIGATION (532-2123) AND

'61'

THE UWI MANAGEMENT EDUCATION PHASE II (532-0129) PROJECTS. THE AP DECISION ON THE TECHNICAL SUPPORT FOR ESSENTIAL INFRASTRUCTURE PROJECT (532-0159) IS NOTED UNDER ISSUE NO. 3 OF THIS CABLE.

B. FOR PROPOSED FY 91 PROJECTS, THE MISSION DIRECTOR IS DELEGATED AUTHORITY TO APPROVE THE FAMILY PLANNING INITIATIVES (532-1063) AND THE INNER KINGSTON DEVELOPMENT - PHASE II (532-0151) PIDS. THE AGRICULTURAL LAND MARKETS (532-0167) PROJECT WILL BE DEFERRED TO FY 92. THE MISSION WILL SUBMIT FOR LAC/W REVIEW AND APPROVAL A PID FOR THE TOURISM SUPPORT (532-0166) PROJECT AND A CONCEPT PAPER FOR THE PRODUCTION AND EMPLOYMENT XI (532-0172) ESP PROGRAM. A POLICY PERFORMANCE PROJECT MAY BE SUBMITTED.

C. THE MISSION SHOULD INCLUDE IN THE FY 1992 ABS THE THREE PROJECTS PROPOSED FOR FY 92: PROTECTED AREAS RESOURCES CONSERVATION II (532-0149), RESOURCE MOBILIZATION FUND (532-0170), AND PRODUCTION AND EMPLOYMENT XII (532-0171), IN ADDITION TO THE AGRICULTURAL LAND MARKETS PROJECT.

5. OTHER CONCERNS AND CLARIFICATIONS.

A. RESOURCE REQUIREMENTS. THE MISSION SUBMITTED A COST REDUCTION PLAN WHICH IDENTIFIES A NUMBER OF LIMITED MEASURES IT IS PURSUING OR INTENDS TO PURSUE TO REDUCE COST DEMANDS. THE MISSION SHOULD IMPLEMENT THE MEASURES

PROPOSED IN THIS PLAN, INCLUDING THOSE MENTIONED AS BEING UNDER CONSIDERATION, SUCH AS CHARGING RUDO AND THE COMMISSARY FOR RENT.

B. PORTFOLIO MORTGAGE. THE MISSION WILL REVISE ITS MORTGAGE ANALYSIS, TRACK ITS PERFORMANCE, AND REPORT ITS STATUS AT THE FALL SAR REVIEW.

C. THE HOUSING INVESTMENT GUARANTEE PROGRAM (HIG). THE MISSION CONDUCTED A REVIEW OF THE JAMAICA HOUSING SECTOR PROGRAM IN LATE FEBRUARY 1990. AS A RESULT, THE MISSION DECIDED TO MODIFY THE SECTORAL APPROACH TAKEN IN HIG-13, AND USE THE REMAINING AUTHORIZATION (ABOUT DOLS. 4.75 MILLION) UNDER THE PROGRAM TO ADDRESS TWO KEY CONSTRAINTS AFFECTING THE PRIVATE SECTOR — LAND TITLING AND LAND SUBDIVISION AND DEVELOPMENT. THE MISSION ALSO DECIDED TO REEMPHASIZE THE PRIVATE SECTOR APPROACH AND SERVICED SITES PRODUCTION IN HIG-12. THE MISSION WILL PROCEED WITH THE DEVELOPMENT OF HIG-14 TO FOCUS ON WATER AND SEWERAGE SERVICE IMPROVEMENTS. THE MISSION'S APPROACH IN THE HOUSING SECTOR WAS ACCEPTED AS PROPOSED. THE MISSION WILL SUBMIT TO AID/W: (A) THE ANNUAL REVIEW OF PROGRAM ACTIVITIES FOR HIG-13, INCLUDING AN ANALYSIS OF POLICY GOALS; AND (B) CONDITIONS UNDER WHICH THE REMAINING DOLS. 4.75 MILLION UNDER HIG-013 WOULD BE BORROWED.

UNCLASSIFIED STATE 090071/03

-6-

ANNEX B  
PID APPROVAL CABLE

D. THE MISSION WILL UPDATE THE LOCAL CURRENCY  
UTILIZATION TABLES TO REFLECT FY 90 ESP. EAGLEBURGER  
BT  
#0071

NNNN

UNCLASSIFIED STATE 090071/03

63

**5C(2) - ASSISTANCE CHECKLIST**

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

**CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?**

**A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS**

Yes, A country Checklist was done for the 1991 Amendment to Prod. & Employ. X Program

**1. Host Country Development Efforts (FAA Sec. 601(a)):** Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

- a) No
- b) Especially if Contraceptive Social Marketing Program is privatized.
- c) No
- d) No
- e) No
- f) No

**2. U.S. Private Trade and Investment (FAA Sec. 601(b)):** Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. pharmaceutical firms may be contracted by GOJ for contraceptive supplies.

**3. Congressional Notification**

a. **General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A):** If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

Project was included in 1991 Congressional Presentation, page 194.

b. **Notice of new account obligation (FY 1991 Appropriations Act Sec. 514):** If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)):** If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. **Engineering and Financial Plans (FAA Sec. 611(a)):** Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

a) Yes  
b) ~~No~~

5. **Legislative Action (FAA Sec. 611(a)(2)):** If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. Water Resources (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

N/A

8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

9. Multiple Country Objectives (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

- a) No
- b) Especially if Contraceptive Social Marketing Program is privatized.
- c) No
- d) No
- e) No
- f) No

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. pharmaceutical firms may be contracted by GOJ for contraceptive supplies.

**11. Local Currencies**

**a. Recipient Contributions (FAA Secs. 612(b), 636(h)):** Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

It is planned that the GOJ will contribute approximately US\$2.7 million in local currency for contraceptive procurement and distribution costs.

**b. U.S.-Owned Currency (FAA Sec. 612(d)):** Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

**c. Separate Account (FY 1991 Appropriations Act Sec. 575).** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

- a) Yes
- b) The Project Agreement will state that an agreement will be reached with the Government.
- c) Agreement on monitoring responsibilities will be reached with the Government.

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

Yes.

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

Yes.

67-

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

Yes.

**12. Trade Restrictions**

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

No.

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No.

- 68 -

14. **Sahel Accounting (FAA Sec. 121(d)):** If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

N/A

15. **PVO Assistance**

a. **Auditing and registration (FY 1991 Appropriations Act Sec. 537):** If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

Yes. The Jamaican Family Planning Association is registered with USAID and steps are being taken to register the Women's Center.

b. **Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"):** If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

16. **Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)):** Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

N/A

17. **Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy):** Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the

Not at present.

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Women are the primary beneficiaries of the Project.

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No.

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No.

b. Will any funds be used to lobby for abortion?

No.

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

No.

**22. U.S.-Owned Foreign Currencies**

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

N/A

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

**23. Procurement**

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

U.S. small businesses may participate on a competitive basis.

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

Yes.

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

N/A

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible

N/A

under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No.

g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes.

Yes.

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes.

**j. Consulting services**  
(FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes.

**k. Metric conversion**  
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Not at present.

**l. Competitive Selection**  
Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

**24. Construction**

**a. Capital project (FAA Sec. 601(d)):** If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A

**b. Construction contract (FAA Sec. 611(c)):** If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A

**C. Large projects, Congressional approval (FAA Sec. 620(k)):**  
 If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

N/A

**25. U.S. Audit Rights (FAA Sec. 301(d)):** If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A

**26. Communist Assistance (FAA Sec. 620(h)).** Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

Yes.

**27. Narcotics**

**a. Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

N/A

**b. Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

N/A

28. Expropriation and Land Reform (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.
29. Police and Prisons (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.
30. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes.
31. Motor Vehicles (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.
32. Military Personnel (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.
33. Payment of U.N. Assessments (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes.
34. Multilateral Organization Lending (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.
35. Export of Nuclear Resources (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes.

75

36. Repression of Population (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

Yes.

37. Publicity or Propoganda (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?

No.

38. Marine Insurance (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?

Yes.

39. Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

No.

**B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

1. **Agricultural Exports (Bumpers Amendment) (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment):** If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

2. **Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"):** Will DA funds be used for tied aid credits?

N/A

3. **Appropriate Technology (FAA Sec. 107):** Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

4. **Indigenous Needs and Resources (FAA Sec. 281(b)):** Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

This activity fully recognizes needs and capacity of people of Jamaica.

**5. Economic Development (FAA Sec. 101(a)):** Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes.

**6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)):** Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

- a) N/A
- b) N/A
- c) The Project will assist the GOJ family planning program to become sustainable and less dependent on donor financing.
- d) Women will be the primary project beneficiaries.
- e) N/A

**7. Recipient Country Contribution (FAA Secs. 110, 124(d)):** Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes.

**8. Benefit to Poor Majority (FAA Sec. 128(b)):** If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes. The Project will ensure that family planning services are available to lowest income groups through public sector clinics.

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No.

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No.

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes.

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? No.

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No.

10. **Contract Awards (FAA Sec. 601(e)):** Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

11. **Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567):** What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

There are no funds set aside for these groups.

12. **Biological Diversity (FAA Sec. 119(g)):** Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

N/A

13. **Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):**

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes.

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent

N/A

- feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?
- |     |      |
|-----|------|
| 1)  | N/A  |
| 2)  | N/A  |
| 3)  | N/A  |
| 4)  | N/A  |
| 5)  | N/A  |
| 6)  | N/A  |
| 7)  | N/A  |
| 8)  | N/A  |
| 9)  | N/A  |
| 10) | N/A  |
| 11) | Yes. |
| 12) | N/A  |
| 13) | N/A  |

**c. Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

1) No.

2) No.

3) No.

4) No.

5) No.

6) No.

**d. Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

**e. Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

N/A

14. Energy (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks,

N/A

83

to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

18. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

1) N/A

2) N/A

3) The Project will assist the GOJ family planning program to become sustainable and less dependent on donor financing.

4) Women will be the primary project beneficiaries.

5) N/A

**20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):**

N/A

**a. Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

**b. Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

**c. Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

**21. Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of

Project will increase capability of the Ministry of Health Primary Care clinics to provide family planning services within overall context of integrated Maternal and Child Health Program.

86

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

81

c. research into, and evaluation of, economic development processes and techniques; N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness; N/A

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; N/A

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. N/A

24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A

98

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

N/A

2. Military Purposes (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. Commodity Grants/Separate Accounts (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

4. Generation and Use of Local Currencies (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?

5. Cash Transfer Requirements (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. Separate account: Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

81

b. Local currencies: Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. U.S. Government use of local currencies: Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. Congressional notice: Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

DRAFTER:GC/LP:EHonnold:4/11/91:2169J

90

- 1 -

## 1. INTRODUCTION

### New Era for Family Planning in Jamaica

A new era in family planning in Jamaica is beginning. The national program at 25 years of age is institutionally mature, and contraceptive prevalence has reached a level of 55 percent of women within the fertile ages who are currently in union. Aware of these accomplishments, donor agencies such as USAID are beginning to decrease their support of the Jamaican family planning program in favor of other countries whose family planning efforts are still nascent. In fact, USAID intends its proposed new Project (1991-1998) in family planning assistance to be its last.

At the same time, the macro-economic environment in Jamaica appears to be deteriorating. The financial and human resources available from Government of Jamaica allocations to the Ministry of Health and the National Family Planning Board for health and family planning services delivery are severely constrained. To hope to reach national development goals it is estimated that a contraceptive prevalence rate of at least 62 percent among a growing population of women within the reproductive ages will be required by the year 1998. According to data from the 1989 Contraceptive Prevalence Survey, potential new contraceptive acceptors are in large part a "hard core" of those actively choosing not to contracept -- because of fears of real or perceived side effects of contraceptive use or previous unhappy experience. In other words, the family planning motivation and service delivery task is expanding.

Faced by an expanding task and decreasing financial resources available from government and donors, the Ministry of Health (MOH) and the National Family Planning Board (NFPB) correctly see the issue of program sustainability as a major element in this new era. Exploration of strategies for the increased involvement of the private sector in all aspects of family planning services delivery has become a focus of organizational activity.

### Role of the NFPB in the New Era

In a family planning program environment where allocation of resources and their effective application is unusually important, it is critical that there be a compelling voice advocating the importance of family planning in all aspects of the national life. In other words, there must be a national advocate of family planning which keeps the program and its needs constantly before governmental decision makers, private sector influentials, service delivery agencies, and the general population. The role of the National Family Planning Board in the new era is the role of advocate.

91

- 2 -

Advocacy involves many tasks. Lobbying, personal and general public relations, education, and promotion are but a few. As all good teachers and salesmen know, advocacy requires continuing efforts -- often in the face of initial resistance -- before success is achieved.

Advocacy implies a position of leadership within the field. Strategic planning for the overall national family planning program, coordination of the activities of the many participants in services delivery, development of innovative approaches to reach targeted audiences, creative recruitment of resources from all possible sources, and resolution of constraints to effective program implementation are primary responsibilities of the National Family Planning Board in its national leadership role.

\ The role of leadership and advocacy which the Government of Jamaica has mandated for the National Family Planning Board is a full-time job for any institution. Indeed, times as critical to overall national program sustainability and continued success as these may require the Board to move fully into its role of leadership and advocacy and leave to other organizations which have different mandates the role of implementation of service delivery projects.

#### Sustainability of Family Planning Program

In the current family planning environment in Jamaica, program and project sustainability is a pressing concern everywhere. Generally, sustainability is used to mean financial sustainability beyond complete dependence on donor or public sector resources. The technical sustainability of the national family planning program is, however, equally important to its financial sustainability. Financial resources without effective programs to implement are useless in achieving family planning goals.

The National Family Planning Board provides through its national leadership role in this new era the strategic planning, direction, coordination, and innovative thinking which make possible the technical sustainability of the family planning program in Jamaica. Through the results of its advocacy role, however, the Board also makes major contributions to the financial sustainability of the overall national family planning program. Its advocacy ensures maximal possible allocation of Government resources to family planning activities as well as maximal contributions from the private and commercial sectors to the costs of services delivery.

The financial sustainability of the National Family Planning Board itself is a quite separate issue from the sustainability of the national family planning program. As the Board moves more fully into its mandated leadership/advocacy role, it may be forced to leave to other organizations with different

92'

- 3 -

family planning mandates project implementation activities, which might divert its time and effort from the critical leadership activities no other organization can fulfill. In other words, the Board may choose not to implement services delivery activities and, therefore, may not have a revenue generation capability of its own.

Such a state of affairs should not be seen as detrimental to the Board. The costs of effective NFPB leadership and advocacy will be more than repaid by the technical and financial sustainability gains it creates for the national program. Part of the advocacy task of the NFPB will be to ensure that this is clearly understood by policy makers and budget planners.

### Goals

A national family planning program -- no matter how dynamic -- can be effective only in so far as it has stated, quantified goals to give it direction and purpose. The scarcity of public and donor resources currently available to implement family planning programs, as well as the expanding nature of the national family planning task, require that all activities be "on target" toward achievement of the national goals. There is, in effect, no time or resources to waste in misdirected action.

This means, then, that national, long- and short-term goals must be set. Areas of the family planning environment for which quantified goals for future action may be set include dollar budget targets, service targets for both the private and public sectors, contraceptive method mix targets, prevalence targets, profiles of targeted contraceptive users, fertility rate targets, and growth rate targets.

A primary task of the National Family Planning Board as coordinator of the national family planning program is to work with all the relevant agencies in setting such goals for program performance. The efficiency of goal-directed program action is essential to ensure family planning sustainability -- both technical and financial.

### Unified Strategy and Workplan

Once goals are agreed upon and set, a unified strategy and workplan for reaching them can be developed. Such strategic planning and coordination of the family planning activities of all service providers -- both private and public sector -- is a critical part of the National Family Planning Board's leadership role.

The unified strategy should coordinate and integrate all family planning activities including those in advocacy, social marketing, public sector, and private sector; and it should show the relationship of all these activities toward accomplishment of

- 4 -

the stated long- and short-term goals. A workplan should be developed annually and distributed to all participants so that each will clearly see its organizational contribution to the overall effort and will understand its "bottom line" responsibility for effective performance in reaching those goals.

The kind of direction and coordination a written annual workplan for the national program creates 1) prevents unnecessary duplication of services delivery, misdirected services, inadequately supported services, and activities which do not contribute to the achievement of the agreed upon goals and 2) thereby ensures maximum program efficiency which is a major contributor to increased program sustainability.

#### Opportunities for Privatization in the Strategy for Program Sustainability

Options for privatization and cost recovery in efforts to achieve sustainability in family planning services delivery occupy an important place in present strategic thinking.

There appear to be four areas in the Jamaican environment in which increased use of the private sector's resources -- including the consumer's resources -- can enhance both the financial and technical sustainability of the national family planning program. These areas are 1) social marketing of contraceptives, 2) user fees in the public sector, 3) work-related provision of services, and 4) private physicians.

In the short term, increased investments in both time and money may be required to advocate and implement the desired private sector participation; but these initial investments must always be seen in the context of their long-term sustainability pay-offs.

#### Organization of this Report

The organization of this document is as follows. Section 2 describes the family planning environment in which any strategies for privatization must operate. This description includes the family planning service delivery system, its costs, and its present and future configurations. Section 3 examines privatization opportunities in the contraceptive social marketing program. Section 4 looks at cost recovery options in the public sector. Section 5 considers increased participation of private practice physicians in the family planning services delivery task, and Section 6 addresses privatization in work-based family planning.

Throughout these analyses, the roles of various actors such as the MOH, the NFPB, and the commercial sector are described. With this as background, Section 7 examines institutional development needs and tools required to meet those needs effectively. Summarizing the discussion, Section 8 presents an

94.

- 5 -

overview of the cost impact of the recommended privatization measures. Section 9 concludes the discussion.

- 95 -

- 6 -

## 2. THE JAMAICAN FAMILY PLANNING SERVICES DELIVERY SYSTEM

### 2.1 Public Sector Family Planning Costs

The Government of Jamaica has been very successful to date in making family planning services widely available. Contraceptive prevalence has reached 55 percent, and services are well dispersed geographically. Public sector services account for the majority of service utilization; according to the 1989 Contraceptive Prevalence Survey, public sector programs served 65 percent of acceptors. Another 30 percent of acceptors purchased contraceptives in stores and pharmacies. When it is considered that the subsidized social marketing program accounts for some sizeable portion of the pharmacy and store share, the proportion provided by the public sector becomes even higher. This shows the tremendous role the public sector is playing in the present delivery system.

USAID has traditionally been the major donor in population in Jamaica, providing on average \$1 million/year. Yet the maturity of the Jamaican program, in the face of the needs of programs in less developed countries, has led to a policy decision by USAID to gradually phase out population assistance to Jamaica. USAID's present population project, Population and Family Planning Services (532-0069) will be ending in 1992, and USAID is in the process of planning a new project, Family Planning Initiatives (532-0163), which will be the last US assistance in the sector. Family Planning Initiatives will run through 1998, and will incorporate declining levels of support, for example, in commodities provision. In view of this phase out of support, USAID is planning the new project to emphasize progressive improvements in sustainability of the national program, with more participation of private sector resources in financial support and service delivery.

#### Program Operations Costs

The gravity of the issue of sustainability is shown in Table 1. To illustrate the financial necessity of developing alternative strategies for financing and providing family planning services, rough estimates were made of additional budgetary funds required 1) to replace USAID funds and 2) to cover costs associated with increased population and higher prevalence. Specifically, the 1989/1990 budget of the NFPB would have to be increased by 55% to compensate for the expenditures currently covered with USAID funds. An additional 31% increase would be necessary to cover the costs associated with providing services to the increased number of women at risk who procure family planning services from the public sector by 1998. (This increase comes from the fact that as population grows, programs have to serve more women just to maintain

96

prevalence, in addition to the increases required to expand it.) In short, by 1998 the budget of the NFPB will have to increase by at least 86% in real terms to cover both the costs related to the phase out of USAID support and the costs related to an increase in the number of acceptors served by the public sector. A portion of this increase is of course due to increased service delivery costs at MOH clinics.

Table 1  
Public Sector Family Planning Costs

	1990 Current	1998	1998	1998
Prevalence Rate	55 %	62 %	62 %	62 %
Population WAR	436,000	611,600	611,660	611,600
# WAR using contraceptive services	239,800	379,200	379,200	379,200
% WAR using public sector for contraceptive services	65 %	65 %	17.5 %	37.3 %
# WAR using public sector for contraceptive services	155,870	246,480	66,075	141,640
Avg. \$ J/WAR Using public sector for contraceptive services	117 *	276 **	276 **	276**
\$ J required to serve	18,236,790	68,028,480	18,236,700	39,092,600 (18,236,790 adj. for inflation at rate of 10 %/year)

- \* World-wide average cost/new acceptor paid by A.I.D. = US \$ 17/new acceptor preliminary excluding cost of commodities (or \$ J117 where \$ J6.89 = US \$1.)
- \*\* Inflation at 10%/yr.

**Commodity Costs**

It is also important to look at contraceptive commodity costs since these are payable in foreign exchange. Table 2 shows the dollar value of commodities as the program presently uses them. In public sector clinics, condoms and oral contraceptives valued at \$92,000 are used each year. The social marketing program is a bigger consumer of foreign exchange; condoms for the program cost approximately \$100,000 per year, and oral contraceptives \$139,000. The total value of commodities which the national family planning program uses each year is \$332,533. In the course of this paper, changes in program implementation will be suggested which may decrease the burden on the public sector of these foreign exchange commodity costs.

Table 2  
Present Public Sector Commodity Use (1987)

% in Public Sector/CSM	Condoms	# Users	# Units	Units Cost*	Total Cost*
41.3	Condoms	8,517	851,700	.047*	\$40,030*
64.2	Pill cycles	30,021	390,273	.13	\$50,736
54.2	IUD	1,950	1,950	1.06	2,067
72.2	Injectables	16,803	67,212	NA	NA
Sub Total*					\$ 92,833

CSM

	Condoms		2,139,118	.047	\$ 100,539
	Pills		515,412	.27	\$139,161
Sub Total*					\$ 239,700
Total					\$ 332,533

\*US\$

**2.2 The Present Delivery System**

**Delivery Mechanisms**

The present system is comprised of several service delivery channels which together deliver all family planning services in Jamaica. For this analysis, we are defining the family

- 9 -

planning service as having four components:

- 1) education/awareness: information about methods, side effects, usage, etc. which can be conveyed through mass media, written materials, or individual/group contact,
- 2) counselling: interpersonal communication for the informed selection of a method, in which the acceptor is given information, to understand the pros and cons of methods given his/her situation, in a setting offering privacy and time for open exchange of fears, special needs, etc.
- 3) commodities: tangible consumables like oral contraceptives, condoms, vials of injectable contraceptives,
- 4) method 'application': the application or placement of a method such as insertion of an IUD or the surgical procedure of voluntary surgical contraception (VSC), which requires a skilled provider.

The dissection of the service into its component parts is useful in the analysis of system changes, such as how to achieve increased privatization, increased prevalence and improved method effectiveness. Not every delivery channel is equally suited to play a greater role in delivery of each of the component parts. So, if the system is to be analyzed from the perspective of where privatization options exist, where increased prevalence will come from and how to achieve a more effective method mix, the comparative advantage of the delivery channels to contribute to this must be identified. For example, counselling can only be provided in a service point which can offer face-to-face interaction; thus to whatever extent counselling will be important in the move toward increased prevalence and method effectiveness, these gains must come from the parts of the delivery system able to provide that service.

The delivery system, then, is comprised of a number of delivery channels for the four components of the family planning service. A final tool needed to describe the system is a segmentation of the market; not all consumers will use all parts of the system. For this analysis, we have envisioned three groups of consumers: 1) the safety net consumer, consumers in the lowest three consumption deciles, 2) the social marketing consumer in the fourth through seventh consumption deciles, and 3) the "commercial", high-end consumer in the top three deciles.

The present section addresses the current configuration of the system. The next section describes the system which should be in existence at the end of 1998 when the Family Planning Initiatives Project concludes. This end-of-project system would be created if steps are taken toward privatization and, at the same

99

time, attention is paid to achieving higher rates of continuation, leading to increased prevalence, and to delivery of cost-effective long-term methods. This section concludes with a brief discussion of the present national goals from the perspective of whether these support the evolution of the more sustainable end-of-project system.

Table 3 shows the present system as it delivers services -- education, counselling, commodities and method application -- through the delivery channels to the different groups of consumers. Seven types of service facilities are taking part in the delivery of services. These are the MOH; the contraceptive social marketing (CSM) system; the National Family Planning Board (NFPB); employers through work-based programs; the Jamaica Family Planning Association (JFPA); private physicians, both general practitioners (GPs) and specialist obstetrician-gynecologists; and commercial pharmacies. All seven play a part in delivering the four component parts of the family planning service.

Table 3  
Delivery Channels For Family Planning Services  
By Component Parts and Consumer Groups  
Present System

	Education/ Awareness	Counselling	Commodity	Method "Application"
MOH	1,2	1,2 <sup>a</sup>	1,2	1,2
NFPB		1,2	1,2	1,2
CSM			1,2	
Employer Provided	2 <sup>b</sup>	2	2,3	2,3
JFPA	1,2	1,2	1,2	1,2
Private MD				
GP		2		2
Specialist		3		3
Commercial Pharmacies			3 <sup>c</sup>	

Key to Consumer Groups:  
1) Safety net -- lowest 3 consumption deciles  
2) Social marketing -- 4-7 deciles  
3) Commercial consumer -- 8 - 10 deciles

- 11 -

<sup>a</sup>Constrained by staff time and training

<sup>b</sup>Constrained by employee access, time and training

<sup>c</sup>Also for group 2 IUD and injectables for application by MD.

At present, in view of the lack of method-specific advertising, the MOH is providing most of the education/awareness to the safety net and the social marketing consumer. The MOH is also providing counselling, but circumstances such as lack of staff time and lack of training in counselling (so that workers do not appear to be authority figures dictating to acceptors) are limiting the effectiveness of counselling in MOH clinics. MOH clinics are providing free commodities to anyone who requests them, thus subsidizing both the safety net and the social marketing consumer. Likewise, both groups use MOH facilities for method application.

The NFPB is operating two stand-alone clinics. Through them, the NFPB offers counselling, commodities and method application. The NFPB also subsidizes outreach programs, conducted by the JFPA, the Ministry of Youth and Community Development and Operation Friendship. These programs carry the family planning message to the community, provide supply methods to acceptors, and refer acceptors for clinical methods.

The social marketing system is making available oral contraceptives and condoms; thus it is providing commodities to both the lower groups of consumers. The mass media education/awareness role that the CSM program can serve is not being exploited at present.

Employment-based services are available to some consumers, in a variety of forms, including reimbursement by insurance companies. These programs provide education and counselling to acceptors in the social marketing target group, although counselling may be severely limited by its access to workers, and the time and training limitations of the service provider. Depending on the type of program, commodities and method application may also be available through these systems (the latter on a referral or reimbursement basis). Both the CSM and the commercial sector consumer might use work-based programs as a source for paid commodities and turn to work-based programs for method application where available.

The JFPA provides all four components of service to the safety net and social marketing consumers. Other private voluntary organizations do not make a measurable contribution to the service delivery system.

With respect to private physicians, specialist practitioners serve the commercial consumer, who can afford to pay standard consultation fees, while GPs serve some members of the social marketing group. Physicians are a source of counselling for their clients and handle method application for them, by inserting

101 -

IUDs or performing VSC procedures. Social marketing consumers may purchase prescription methods like an IUD or a bottle of injectable contraceptive at a commercial pharmacy for application by a private physician. For supply methods like the pill and condom, both social marketing and commercial consumers turn to pharmacies.

**Consumer Source of Commodities**

More detailed information on source of commodities for the consumer is shown in Table 4. This table shows the various methods and the facilities in the system which provide or sell them. For oral contraceptives, public sector clinics and hospitals, the JFPA and pharmacies are the sources. Condoms are available in these same facilities, as well as at stores and markets. Injectables and IUDs are available from the public sector, from the JFPA, from both specialist physicians and GPs, and from health maintenance organizations (HMOs). Also, these prescription contraceptives may be purchased from pharmacies and then "applied" by private providers. VSC services are available through public hospitals, the JFPA, and through private providers with access to surgical facilities. This table shows that commodities are widely available; the issue is whether commodities are priced so that they are affordable to social marketing consumers. It is hoped that during the implementation of Family Planning Initiatives, the CSM program will be able to make more methods available at affordable prices.

Table 4  
Source of Contraceptives in the Delivery System

Method	MOH Clinic	MOH/UWI Hospital	JFPA	Physician		Pharmacy	Store/ Mkt.	HMO
				Specialist	GP			
Oral Contraceptive	X	X	X			X		
Condom	X	X	X			X	X	
Injectables	X	X	X	X	X	X*		X
IUD	X	X	X	X	X	X*		X
VSC		X	X	X				X

\*With prescription from physician, for physician to provide.

**Provision of Methods by Sector**

Based on the results of the 1989 Contraceptive Prevalence Survey (CPS), it is possible to examine the present roles of the public and private systems in providing family planning. Table 5 shows the breakdown of services by sector. At present, the MOH

provides 88 percent of all VSC procedures, and private physicians and hospitals provide 11 percent. With respect to other methods, the public sector provides approximately 65 percent, pharmacies and stores 30 percent, and private physicians and facilities 4.1 percent. The public sector is clearly the major provider of family planning services, particularly given that the social marketing program, based on donated commodities, accounts for a sizeable portion of the pharmacy and store share.

Table 5  
Share of Present Services by Sector  
1989 Jamaica CPS

A. Users of Sterilization

Source	Total
Public Hospital	88.2
Private Hospital	7.2
Private Doctor/Clinic	4.2
Other	0.4
Total	100.0
No. of Cases	(569)

B. Users of Other Methods

Source	Total
Clinic/Health Centre	61.7
Public Hospital	2.2
Private Hospital	0.3
Private Doctor/Clinic	3.8
Supermarket/Shop	1.8
Pharmacy	28.3
Outreach Worker	0.5
Other	1.4
Total	100.0
No. of Cases	(1587)

Method Mix by Sector

Data from the CPS have been reanalyzed to determine the method mix of each of the major sectors, so that comparisons could be made in the types of services provided. Table 6 shows the present method mixes of the public and private sectors, and

103.

illustrates some important differences in them. The public sector method mix is comprised of 35 percent oral use, 33 percent VSC, 20 percent injection, 10 percent condom and 2 percent IUD. This illustrates the public sector's comparative strength in delivering long-term methods; 57% of the public sector's method mix is in VSC, injection and IUD.

Table 6  
Present Method Mix by Sector - 1989 Jamaica CPS

	Global	Public Sector		Private Sector		Unknown/Other		Total	
		N	%	N	%	N	%	N	%
Pill	19.5%	529	35	284	48	11	34	824	100
Injection	7.6%	305	20	23	4	3	9	331	100
IUD	1.5%	31	2	24	4	2	6	57	99
Condom	8.6%	147	10	196	33	14	43	357	100
VSC	13.6%	501	33	65	11	2	6	568	99
Other	3.8%	?	?	?	?	?	?	?	?
Total	54.6%	1513	100	592	100	32	100		

By comparison, the private sector method mix at present is almost totally based on supply methods. Nearly half of private sector services (including the social marketing program) are in orals (48 percent), and another 33 percent is in condoms. Only 11 percent of private sector services is in VSC, and 4 percent each is in injection and IUD.

### 2.3 End-of-Project Status Service Delivery System

By the end of the new Project, the privatization initiatives, along with attention to better counselling for increased prevalence and optimal provision of long-term methods, should result in a system with more diversification of use and a more cost-effective method mix. There should be more delivery points, representing the public and private sectors, where some or all of the four component services may be obtained.

Table 7 shows the delivery system, comprised of service channels and consumer groups, after implementation of the privatization strategy. Elements which have changed from the present system are shown in boxes. The Ministry of Health would be providing education/awareness services to consumers in the lower

704.

two groups, the safety net and social marketing groups. The MOH would also be providing counselling to these groups; the necessity of this is discussed further in Section 4.1.2. But as far as commodities are concerned, the MOH would be supplying free commodities only to the safety net group or possibly to first-time users. The NFPB would be a source of education/awareness. The NFPB's role would have metamorphosed into one of advocacy and coordination, and the NFPB would no longer be operating any direct service programs, including clinics, outreach or work-based programs.

Table 7  
Delivery Channels For Family Planning Services  
by Component Parts and Consumer Groups  
End-of-Project System

	Education/ Awareness	Counselling	Commodity	Method "Application"
MOH	1,2	1,2	1	1,2
NFPB	1,2,3			
CSM	1,2,3			
Employer Provided	2	2	2,3	2,3
JFPA	1,2	1,2	1,2	1,2
Private MD				
GP		2		2
Specialist		3		3
Commercial Pharmacies			3	

Key to Consumer Groups:

- 1) Safety net -- lowest 3 consumption deciles
- 2) Social marketing -- 4-7 deciles
- 3) Commercial consumer 8 -- 10 deciles

Note: Shading indicates components that are expected to change by end-of-period.

With respect to social marketing, the CSM program would be a major provider of education and awareness, through a very active marketing effort. This would use method-specific advertising to provide information about use of methods, side effects, and to counter rumor. The CSM program would provide commodities directly from the commercial manufacturer/distributor

105-

- 16 -

to the social marketing consumer wherever possible.

Increased private sector involvement in family planning service delivery has the following ramifications for method mix: The MOH with its access to clinical facilities and trained personnel has a comparative advantage to deliver long-term clinical methods. Furthermore, given the product cost and cost of skilled delivery of these methods, it will be very difficult to make them price affordable to the national family planning program target market. Thus the private sector method mix in Jamaica will always emphasize supply methods.

Increased involvement of the private sector, however, can make a noticeable indirect contribution to improving the method mix. By replacing the public sector as the source of supply methods and services for many users, who are able to purchase them in the private sector, private sector involvement can "free up" at least a portion of public sector resources previously committed to serving supply users for application to expanded provision of longer-term methods to those who want them.

Work-based programs would continue to exist on a financially self supporting basis, and might offer more effective services. Education and counselling services through this mechanism would be targeted at the social marketing consumer and would be strengthened. Commodities and method application (through work-based programs and through insurance reimbursement) would be used by the top two groups, the commercial consumer and those in the social marketing target group. The social marketing consumer may also be more able to seek counselling and method application from GPs, if these practitioners have become more actively involved by improving counselling to acceptors.

The JFPA continues to provide all four services as in the present system. For the commercial consumer, the system would remain unchanged.

#### 2.4 Government of Jamaica Objectives and the End-of-Project System

The Government of Jamaica's objectives for the national family planning program (as stated in USAID's Project Implementation Document) are as follows for the period 1990-1994:

- increased access to all family planning services including tubal ligation
- strengthened infrastructure through renovating, upgrading, and equipping primary health care centers
- increased number of services offered daily at health centers
- targeted services for groups such as working women,

- 106 -

- 17 -

- males, and adolescents
- expanded on-site services at work places particularly in industrial zones and rural areas
- expanded product line within the commercial distribution of contraceptives (CDC) program
- increased CDC product prices in order to facilitate the project's financial self sustainability
- increased provision of family planning services by employers to their employees
- financially sustainable national program by 1997 or at the latest 2000.

The program described by these objectives has important areas of commonality with that envisioned by the Assessment Team and other areas of difference. For example, the first objective is increased access to services including VSC; for the program to reach the next level of prevalence and improved method mix, this is vital. The objectives also address the critical area of price increases for the CDC program and financial sustainability is a major concern.

On the other hand, these objectives do not exploit the contribution which the private sector can make. It appears that the national program is still conceived as primarily a public sector program where only work-based family planning is in the private sector. By comparison, the privatization strategy calls for an increased role for the private sector in the CDC program, increased service delivery of counselling and clinical methods by private physicians and introduction of fee-for-service in public sector clinics. These steps will maximize the contribution which the private sector can make to the delivery of family planning services.

To be an effective management tool, the programmatic directions described above should be developed into a strategic plan. Quantified national objectives, derived from a consensus-building process, serve as a critical management tool. If the objectives which have been laid out above are described in quantitative terms, progress can be measured against them. It may also be useful to consider categories for goal setting most frequently used in other countries -- 1) national contraceptive prevalence, 2) method mix within the overall prevalence, 3) dollar budgets, 4) service targets for the public sector, 5) service targets for the private sector, 6) profiles of targeted potential contraceptive users, 7) fertility rate, and 8) growth rate.

It may also be useful to examine the assumptions underlying the objectives given above. Can program sustainability be achieved if the emphasis remains on increasing access through the public sector and strengthening infrastructure? Are working women in Jamaica an especially important group of unmet need, or do working women (as elsewhere in the world) better control their fertility since it ties in with their economic security? This

- 18 -

examination of assumptions may show where objectives are contradictory or complementary in guiding the program.

In developing the strategic plan, program objectives -- sustainability as well as others -- should be prioritized in relation to each other; and careful thought given to their selection and articulation. In order to have a cost- and implementation-efficient program, all objectives must be capable of accomplishment within one overall cohesive national program. The Assessment Team recommends therefore, that in developing the next annual work plan, the NFPB restate its long- and short-term objectives in quantified terms. It would be useful if this restatement included a brief rationale about the importance of each objective, identified the implementation agent, and specified a timeframe for accomplishment. Such a document is the firm foundation required for all strategic planning.

102

**3. PRIVATIZATION OPPORTUNITIES IN THE  
SOCIAL MARKETING OF CONTRACEPTIVES**

**3.1 Background**

The purpose of contraceptive social marketing (CSM) programs has been defined consistently by AID as provision through the commercial distribution system of contraceptives at a price affordable to lower income couples. It has not been the intention of AID that these social marketing programs should serve either the poorest of the poor or the very poor. These lowest segments within a country's economic structure are targeted and served free of charge or very nearly free by public sector clinics and hospitals and by rural outreach workers or community based distribution (CBD) agents.

It has been suggested that, in Jamaica, the lower income target for CSM programs is represented by the fourth, fifth, sixth, and seventh (4,5,6,7) consumption deciles as defined by the Statistical Institute of Jamaica (STATIN) (see Table 8).

Table 8  
Distribution of Consumption by Per Capita Deciles  
July 1989

Deciles	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

As the prevalence of contraceptive use and the value to the individual of contraceptives have broadened into lower income segments of society, the commercial pharmaceutical industry has

- 20 -

begun to see potential for their contraceptive products' sales to a much broader-based target market than previously enjoyed. The presence within contraceptive product lines of reliable, low-dose oral contraceptives which long ago paid return on the research and development investment required and which no longer represent a "cutting edge" technology (as tri-phasics, for example, do) offers contraceptive manufacturers the opportunity to make selected products price-affordable to this large, lower-income market segment.

Contraceptive manufacturers have adopted this market-expanding strategy successfully in a number of countries. For example, in the Dominican Republic, a leading manufacturer dropped the consumer price of one of its traditionally well-accepted oral contraceptives to one-half that of other brands on the market. Sales of that oral contraceptive increased by 500 percent within fifteen months. Market research indicated that approximately 65 percent of those purchasing this reduced-price product were within the targeted lower income groups and approximately 30 percent of those purchasing were first-time contraceptive acceptors.

The willingness of contraceptive manufacturers to make products price-affordable to lower income groups along with the overall geographic accessibility of commercial distribution chain outlets (e.g. pharmacies, shops, markets, etc.) clearly obviates the need for governments and donor agencies to duplicate the services provided to this particular segment of the contraceptive market.

### 3.2 Commercial Feasibility in Jamaica

The commercial pharmaceutical sector in Jamaica is quite active, although not particularly large. Approximately US\$18,000,000 in business is done annually. This includes medical supplies, over-the-counter preparations, ethical (or prescription) pharmaceuticals, and related raw products. There are seventeen to twenty large importers and stockists of drugs who compete for a share of this business.

Ethical pharmaceuticals such as oral contraceptives are assessed a 15 percent import duty and a 5 percent consumption tax. They are exempted from the 40 percent stamp duty which is assessed other types of pharmaceutical goods. In total, oral contraceptives are taxed at import at the rate of about 20 percent, while over-the-counter products are taxed at the rate of about 85 percent. Condoms are assessed duty as rubber goods at the rate of 60 percent. By and large, commercial importers of contraceptives do not feel that import duties are a significant constraint on the willingness of the commercial sector to import and distribute such products.

- 21 -

The cost of money and availability of foreign exchange, however, are seen as potential barriers to increased importation of contraceptive products. The recent floating of the Jamaican dollar to find its own level in the market is expected to resolve considerably this constraint.

In Jamaica, the commercial contraceptive market is immediately willing to make a high quality, reliable, low-dose oral contraceptive price-affordable to the lower income market. Schering AG may lower the consumer price of its Microgynon to US\$ 1.00 and market it under the name of Minigynon. The local representative of Schering, Lasco Distribution, has also indicated a willingness to detail this product to pharmacists and physicians and to implement training/promotional seminars for relevant audiences at no cost to the public sector.

That this price (US\$ 1.00/cycle) is affordable to the lower income CSM target group is suggested by the following. A rule of thumb frequently used by CSM practitioners in other countries is that an annual cost of contraceptives which represents two (2) percent or less of household income is affordable to the lower income target group. J\$ 78 per year's supply of oral contraceptives represents a maximum of less than seven-tenths of one percent to a minimum of less than four-tenths of one percent of annual household expenditure for the fourth, fifth, sixth, and seventh consumption decile target group cited above (see Table 9).

Table 9

Percentage of Household/Consumption Represented by  
One-year Supply of Oral Contraceptives  
at J\$ 6/Cycle

Deciles	(Per Capita Consumption x4) Mean Per Household (4 person) <sup>1</sup> Consumption (J\$)	Percentage of Household Consumption Represented by One-Year Supply of Oral Contraceptives (J\$ 78.00)
1*	4,224	1.84
2	7,144	1.09
3	9,436	.83
4	11,904	.66
5	14,460	.54
6	17,392	.45
7	21,588	.36
8	27,420	.28
9	38,140	.20
10**	71,586	.11

<sup>1</sup>A four-person household was used in the extrapolation of Table 9 since the *Survey of Living Conditions* indicates that mean household size varies from 3.9 to 4.6 persons.

\* Lowest

\*\* Highest

1111

- 22 -

The results of recent quantitative research are informative about price affordability and willingness to pay. USAID/Kingston has commissioned a survey of public sector clinic users, in order to profile these users and determine whether (and at what price level) they might be able to purchase contraceptives directly through the social marketing program. With respect to socioeconomic characteristics, the sample is surprisingly well educated. The women have on average attended to the secondary or all-age school level, with a median of 10 years of education. More than 50% are not employed; 14% are self employed, 23% are employed in the private sector, and 7% are employed in government. Nearly 50% of women report they cook with gas; the remainder use kerosene (25%), coal (18%), and wood (8%). Nearly half the sample lives with a partner (including 14% who are married) while the rest are living independently -- in visiting partner relationships (32%), are single (17%) or are widowed or divorced (1%).

From the survey it appears that many public sector users have the willingness and ability to pay. Users were asked what they thought was a reasonable price for contraceptives obtained from the clinic. The median value that respondents offered was Ja.\$5.00. Since this group includes the poorest of the poor, contraceptive prices for the social marketing consumers in this group could be pegged at higher levels. In terms of ability to pay, the survey showed that 71% of clinic users purchased bottled or boxed drinks in the past week, and that the median number purchased was two per week. This represents a disposable income for non-essential purchases well beyond the US\$ 1.00 proposed for a monthly cycle of oral contraceptives. The target group, therefore, appears to have the ability to pay a price which at least one pharmaceutical manufacturer and local distributor find commercially feasible for a selected contraceptive product.

The ability of target consumers to pay for contraceptives is also demonstrated by the experience of the Jamaican Family Planning Association. At their clinic in Kingston, the association regularly sells a single cycle of oral contraceptives for J\$3 and a three-pack of condoms for J\$3.

The willingness of the target group to pay this price (i.e. to value equally or more greatly a month's supply of contraceptives than soft drink purchases) is a measure of the effectiveness of past and present family planning IEC and advertising/communications activities in reaching, educating, and motivating them. In any event, future effective campaigns can have positive impact on willingness to pay by identifying for the target group the personal benefits and value of family planning acceptance.

712 -

**3.3 Recommended Strategy**

Four aspects of family planning service delivery have been identified: education/awareness, counseling, commodity provision, and -- in the case of some methods -- method "application." The commercial pharmaceutical sector and social marketing programs can contribute to service delivery through two of these areas: commodity provision and education/awareness programs. In other words, commercial/CSM activity can replace or at least supplement government's responsibility to lower income contraceptors in family planning service delivery in two of its four aspects.

The National Family Planning Board has hoped that -- in addition to contributing to contraceptive prevalence through the two service delivery areas identified above -- the Commercial Distribution of Contraceptives (CDC) program would contribute to the Board's overall sustainability goals through income generation. According to Table 10, however, the CDC price of an oral contraceptive, for example, which is required to reach the "break even" point must be at least J\$ 6/cycle. This price does not offer any savings to the targeted consumer over the commercial price proposed above, nor does it offer any "profit" to the NFPB. There seems to be, therefore, no compelling financial reason to maintain low-priced commodity provision by the CDC when such products could be available through the commercial sector.

Table 10

Cost of Sales of Panther Condom and  
Perle Contraceptive Pill  
January 1990  
J\$6.50 = \$US 1.00

Category	J\$ Panther	J\$ Perle
CIF Cost of Product	.37*	2.00**
Duty	assumed duty free import	
Unit Package	141.70/3000 units 1000 boxes .05	.20 (3-cycle pak) .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 <u>.004</u> <u>.444</u>	5.14/864 boxes <u>.006</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	1.03 (30%)	4.52 (68%)
Wholesaler's mark-up	1.23 (20%)	included in above
Retailer's mark-up	1.54 (25%)	6.01 (33%)
Price to Consumers for Break Even	1.54/condoms	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

Indeed, where the overall national policy is toward increased privatization of services and where there is no price or quality benefit to users for service provision through the public sector, it appears imperative to allow the private/commercial sector to replace public sector activities.

It is recommended, therefore, that the CDC program move immediately to rely on the commercial sector for distribution and sales of lower-priced commodities and education/awareness activities wherever possible.

### 3.3.1 Commodities

A low-dose oral contraceptive affordable to lower income consumers appears to be commercially feasible for Jamaica. (See above.) It is the recommendation of the Assessment Team that an agreement be reached with Lasco Distribution to import, distribute, and detail this product and that the CDC program phase out over the next one and a half to two years oral contraceptives from its product line.

The financial and privatization rationale for phasing out oral contraceptives from the CDC program outlined earlier is strengthened by two additional arguments. 1) The availability from AID of Noriday (Perle) is questionable beyond the next two years. 2) A low-dose oral contraceptive is thought to be more desirable in the Jamaican market than the standard-dose Noriday; and, in any event, the low-dose Norquest would be the only AID-

114

- 25 -

provided alternative to Noriday for the CDC program. Introduction of Norquest -- which has a different chemical formulation than Noriday -- would require use of a trade name other than Perle; consequently an investment in promotion and recognition of a new brand name will shortly be required regardless of the source -- whether AID or commercial manufacturer -- of the product.

If the commercially available lower-priced oral contraceptive is introduced and marketed concurrently with the phase-out of Perle (especially if the price of Perle is increased incrementally during the transition as recommended in the recent evaluation), it should be possible to implement this shift without any significant negative impact on contraceptive prevalence.

The Assessment Team further recommends that the commercial availability of a lower-priced condom be explored. This is the Team's preferred option if a commercial "deal" can be arranged. The local representative of Ansell condoms, Central Trading Company, should be approached as well as the corporate management of Ansell in the U.S. The fact that Ansell sells approximately 800 million condoms annually to AID may provide some leverage. Other manufacturers and local distributors should not be overlooked.

If a lower-priced condom cannot be negotiated with the commercial sector, the NFPB must develop a strategy for purchase of condoms for the CDC program. Beginning in Year 3 of the proposed new Project, USAID will diminish its contribution of commodities by 20 percent annually. Ansell has previously stated that it will sell the same condoms it supplies to AID to other governments and agencies at AID prices. The IPPF has established an independent commodity procurement group which acts as a broker for volume purchases of contraceptives from a variety of manufacturers and is therefore able to obtain quite low prices for its clients. (It is reported that, since it is not limited to U.S. manufacturers for procurement as is AID, the IPPF is able in many cases to offer lower-than-AID prices.) Both these purchase options should be examined.

Purchase options imply that a strategy for increasing the consumer price of Panther will be developed and implemented early in the new Project period so that revenues are generated and available for purchase of continuing CDC condom supplies. How to maintain the value of any such revenue reserve over time, in the face of relatively high inflation and periodic devaluation of the currency, is an issue which should be addressed in an overall business plan for the whole of the NFPB.

115

- 26 -

The Assessment Team wishes to stress that commodity purchase is a much less desirable option than more direct provision through the commercial sector. Operational involvement in commodity procurement, packaging, and distribution can only distract the resources of the NFPB from its important advocacy role.

With respect to demand for condoms, at present virtually all non-commercial sector condoms used for prevention of pregnancy or prevention of AIDS are brought in by the USAID family planning project. No condoms specifically for AIDS are brought in by the AIDS prevention program, but USAID/Kingston's AIDS activity will begin a mass media promotion of condoms as protection from AIDS in May, 1991.

In the Assessment, the Team did not specifically address growth in demand for condoms for the purposes of AIDS prevention. Rather, the Team looked at sustainability of the condom social marketing activity regardless of the ultimate use of the condoms. Further, since the Team was concerned with privatization and progressive improvement of method effectiveness, the Team did not project an enhanced role for the condom. The condom is among the poorer methods of preventing pregnancy, given its low user effectiveness and is relatively expensive. However, there is an implicit assumption that if the family planning program remains the major supplier of condoms, the program must be sensitive to increases in demand for condoms for AIDS and aware of new plans to promote the condom, so that commensurate supplies will be on hand. Another alternative which should be considered is for the AIDS program to obtain its own condoms.

It may be possible during the life of the Project that additional contraceptive methods (such as injectables and IUDs) become price accessible to the lower income target group through direct commercial sector participation as suggested for Microgynon/Minigynon. This has occurred, for example, in Indonesia. NFPB/CDC management should ensure that exploration of such opportunities is included in all future marketing planning.

Because of the current high costs of the implant -- which may become a long-term method suitable for use in the Jamaican family planning environment -- the Team does not feel that it represents, in the foreseeable future, a good opportunity for sales to the social marketing program's target consumers.

### 3.3.2 Education/Awareness

Education/awareness is the second of the two aspects of family planning service delivery to which the commercial pharmaceutical sector and social marketing programs can contribute.

- 116 -

- 27 -

Education/awareness activities can be reasonably expected to accomplish the following:

- Awareness within the trade (i.e. physicians, nurses, pharmacists, and other relevant retailers) of contraceptive methods, products, their correct use, their attributes, and the benefits of their use.
- Awareness within the trade of the importance and personal benefits of family planning acceptance to targeted consumers.
- Awareness among targeted consumers of contraceptive methods, products, their correct use, their attributes, and the benefits of their use.
- Awareness among targeted consumers of the importance and personal benefits of family planning acceptance to themselves.
- Awareness among targeted consumers of sources of contraceptive supply and of contraceptive prices.
- Awareness among targeted consumers of sources of additional information and counseling concerning contraceptive use and method selection.

There are several channels through which education/awareness activities can be implemented by the commercial/social marketing sector. These include detailing of pharmacists and physicians; seminars for physicians, pharmacists, nurses, and other relevant suppliers; consumer-oriented mass media; promotions to the distribution trade; promotions to consumers; and public relations events.

Effectively designed, skillfully implemented communications campaigns can contribute greatly to the individual consumer's understanding of the personal benefits to him/herself inherent in family planning practice. It is only a belief in the value of the product in his/her own life circumstances which will lead the targeted consumer to choose to buy and use it.

The Assessment Team highly recommends that a strong, renewed education/awareness effort which incorporates the best in communications and motivational techniques and which is implemented through all the channels listed above be undertaken as part of the new proposed Project. Such an effort will require a considerable investment in time and dollar resources. The private sector, however, can share in the cost of this program in the following ways:

- 28 -

- The local distributor of the proposed lower priced oral contraceptive will detail the product to pharmacists and physicians at no cost to the public sector.
- The local distributor of the proposed lower priced oral contraceptive has indicated a willingness to implement informational/training seminars on the method and product for relevant providers (such as nurses, retailers, physicians, and pharmacists) at no cost to the public sector.
- Corporate sponsorships can be sought for specific elements of the communications campaign. For example, if a radio "soap opera" on family planning issues is developed and aired, companies might be convinced to pay for air time or production costs in exchange for on-air mention of the company as a sponsor of the program.
- A consortium of local pharmaceutical distributors may be convinced to participate in the costs of method specific advertising of oral contraceptives since they are unable by law to advertise their products directly to consumers. Such generic advertising of methods in other social marketing countries has been shown to increase the level of sales of all oral contraceptives, not just the social marketing brand.

### 3.3.3 Counseling

Counseling, or face-to-face/personal selling, is not an aspect of family planning service delivery which the commercial/social marketing sector can provide. The commercial sector relies on mass media communications which by definition speak to groups within the marketplace. The advantage of the mass media is that they can communicate a chosen message quickly to a very large audience and can repeat that message regularly and frequently.

In sensitive areas like family planning and health, however, where the decision to accept and practice the promoted behavior is based on deeply held beliefs strongly influenced by such powerful factors as religion, family and cultural values, sexuality, and the like the mass media -- in order to be effective -- must be supported by "personal selling." Personal selling, or counseling, is the provision of information, motivation, and reinforcement on a one-to-one basis by a culturally credible individual (e.g. mother, friend, nurse/midwife, peer) in a way that is understood and accepted by the target consumer. Counseling for lower income social marketing target consumers must continue to be provided by the public sector.

- 29 -

**3.4      Role of the NFPB**

The elimination of commodity provision -- whether totally or in part -- from the CDC program does not eliminate the role of the NFPB in social marketing. In fact, the inclusion of multiple commercial sector entities in program activities requires the NFPB to accept and implement effectively the role of marketing coordinator and strategic planner.

The social marketing responsibilities of the NFPB would include at least the following:

- To develop with active participation and input from the relevant commercial entities the overall goals and strategy for the social marketing program.
- To develop with input from commercial sector program participants written annual marketing and business plans for social marketing products.
- To bring together on a regular basis the commercial sector entities and resources available to the CDC program for sharing of programmatic information, issues, and concerns.
- To coordinate the development and implementation of advertising/communications campaigns which support the marketing and sale of the social marketing program's methods/products.
- To develop and implement a plan for maximum financial support of the social marketing communications effort by the private sector.
- To monitor through market research the effectiveness of the social marketing effort in reaching targeted consumers with appropriate contraceptives.
- To compile and analyze sales and distribution data generated by participating commercial distribution agents.

It is further anticipated that the Marketing Division of the NFPB will be a primary resource to NFPB management in the development of a marketing/public relations strategy for the NFPB and for the national family planning program as a whole.

#### 4. COST RECOVERY OPTIONS IN THE PUBLIC SECTOR

##### 4.1 Ministry of Health

##### 4.1.1 Background

Jamaica has a distinguished history in the provision of maternal and child health (MCH) and family planning services, as evidenced by the low infant mortality rate of 13.2 /1000 in 1984 and the long life expectancy of 70 years. MCH and family planning services are provided through a network of 360 primary care facilities of various sizes distributed throughout the island. The public sector's success to date in this area has been highlighted by Prof. G. E. Cumper, who notes that while most health services are widely available in both the private and public sectors in Jamaica, MCH and surgery are less available at present in the private sector.

But in recent years, funding to the Ministry of Health has remained level, or decreased per capita given population increase. During the decade of the '80s, the Government of Jamaica (GOJ) attempted to hold funding for public sector health expenditures constant from year to year. By 1984-1985, increases in demand, coupled with management inefficiency in the face of level funding, brought the system to the verge of collapse. Funding authorization was increased somewhat to remedy the situation, but funds were not allocated accordingly. In 1987, funding was put back to the previous constant (see discussion in Cumper, GE; "Investment Climate in Private Health Care" (draft); Kingston, 1990).

The consequence of the 1980s funding crisis in health was a decline in services. The MOH was not able to sustain the previous level of operations; home visits were virtually eliminated, staff positions were not filled and clinic hours were reduced. By 1988, health care contacts in public facilities had declined by as much as 8-54 percent across various services, with family planning declining by 18 percent (Hospital Statistics, cited by Cumper, op. cit.). The decline in usage was probably the result of the combination of actual declines in service availability and consumer perceptions of declines in quality of services, stemming from long waits, and delay in special services like physician contact or the reading of lab results. Declines have occurred in virtually every category of personnel in the MOH, with particularly notable declines in registered nurses (40 percent); demand for Jamaican nurses abroad has resulted in tremendous shortages of this level of personnel.

In the meantime, Jamaicans are turning increasingly to the private sector and to payment for services. A 1987 study by MacFarlane and MacFarlane showed that only 9-20 percent of the

- 31 -

population used public sector facilities for their last illness. The balance sought services in the private sector (MacFarlane and MacFarlane, "Appraisal of and Analytic Report on a Survey of New Initiatives in Health Finance and Administration", Statistical Institute of Jamaica, 1989 cited in Maureen Lewis, "Government Policy and the Effectiveness of User Charges in Jamaican Hospitals"; the Urban Institute, 1989). Likewise, in 1986, according to MacFarlane and MacFarlane, for services to all age groups, the private sector saw nearly twice as many patients as the public sector (609 vs. 333 cited in Cumper, op. cit.)

In the public sector in the face of these problems of staffing and expenditure constraints, facilities are turning to payment for services as a means to offer a better service. From anecdotal evidence, it appears that a diverse system of informal user fees already exists. For example, fees for some special services, in some areas, provide facilities with a little working capital with which to pay overtime or replace out-of-stock, essential commodities. Furthermore, contributions are sought informally by some facilities for immunizations, diabetes test strips, and pregnancy test strips, and a token fee of ten cents may be charged for oral contraceptives. There is also a Ja. \$50 fee on the books for tubal ligation (at this writing, US \$7.00). This is supposed to be freely waived so that no one is turned away, however there have been a few instances where the fee was enforced and acceptors did not receive the service.

In addition to these informal fees, a formal system of fee collection is in place in Jamaican public hospitals. With the implementation in 1986 of policy changes allowing hospitals to keep a portion of their fee revenues, the system of collections has been substantially improved and revenues have grown. Hospital fee collections in 1986/1987 equalled between 5.7 and 27.4 percent of operating budgets (Lewis, op. cit.).

The recently completed survey of users of public sector facilities addressed family planning and facilities use. The sample comprised over 700 respondents, half using family planning and half not. Acceptors reported that they were using the pill (46%), injection (16%), VSC (5%), condom (4%), IUD (1%) and other methods (1%). This differs from the method mix in the population as a whole in the following ways. Fewer clinic users report having had a VSC, because women who have been sterilized do not make return family planning visits. More clinic users report using injection; this makes sense since the MOH is the primary provider of injection.

Method mix was also examined by age group. Even in the age group of women 30-34 years old, pill usage remained high, with more than a third of all acceptors using the pill. This age group reports having more than three children on average, suggesting that

121-

- 32 -

it may be important to move these acceptors to more cost- and method-effective contraceptives.

The large majority of the sample use MOH facilities for family planning (87%) with only 12% seeing private physicians for this services. Many clinic users (46%) report paying a small fee or donation for their clinic visit. These women also pay for services in another way: although they do not frequently use private doctors for family planning, two-thirds report that they or a family member see private doctors for other care.

Clinic users appear ready to pay for clinic services. The sample was asked what they considered to be reasonable charges for clinic visits and contraceptives. On average, they indicated that \$15.00 was a reasonable charge for a visit and \$5.00 for a contraceptive. Since this group of women includes the poorest of the poor, user fees for those who can afford to pay could be pegged at levels above these estimates.

Users have the ability to pay. The survey showed that 71% purchased bottled drinks or drink boxes in the last week, and the median number purchased was 2 drinks per week. Using this non-essential purchase as an indicator, it appears that monthly purchase of contraceptives under Ja\$10.00 would be affordable.

Thus the timing may be right for the adoption of user fees in the primary health care system. The Ministry of Health is in the process of developing a system of fee collection for a number of its primary care services. A proposal is being prepared which would institute fees for curative services, adult dental services and for a variety of public health inspections and certifications. Once a commitment is made to the adoption of user fees, considerable work on logistics is planned, given the number of facilities in the system, in which collections, accounting and security of funds would have to be assured.

#### 4.1.2 Recommended Strategy

The recommended strategy has four elements:

- 1) institute user fees for family planning services along with other primary health services, waive fees for those who cannot afford to pay;
- 2) implement user fees in a way which allows facilities to keep some of the proceeds;
- 3) provide free family planning commodities only to those who cannot afford to pay;
- 4) improve counselling in MOH facilities, so that use of

122

- 33 -

long-term methods, such as the IUD and voluntary surgical contraception (VSC) increases. These are more cost effective than supply methods like the oral and the condom.

The elements of the strategy will be reviewed in the paragraphs which follow, and the impact of the change on the public sector health system will then be described.

### Institute User Fees

It is recommended that user fees for family planning, for example in the form of per visit registration fees, be adopted, simultaneously with fees for other types of primary health care services. Fees should be collected from those who can afford to pay.

The importance of implementing fees for family planning services along with other fees stems from a number of factors. From an economic perspective, we do not want cross subsidization in the program, with family planning subsidizing other services. Further, the response elasticity of demand is an issue. The demand for curative care may be more inelastic so that families seek curative care regardless of fees. Therefore, a policy maker would want to implement fees for curative care first. However, if families are unconvinced about family planning (and the demand is relatively elastic), they may not continue to use these services once fees are adopted.

There may be a psychological phenomenon also. The consumer may perceive, whether warranted or not, that family planning services were not deemed by others to be as essential as other primary care services, if user fees were adopted for family planning only. Acceptors might choose to stop using the service rather than use it under these conditions. However, if fees went in for a basket of services, the policy change would be viewed by consumers in the light of all prices going up all the time. Family planning would be at no special disadvantage.

It is also vital that a user fee policy take into account ability to pay. The sentiment is strong in Jamaica that the public sector must always be a provider of last resort to those in the society who are too poor to pay. This is the safety net function of the public sector. One reason the hospital fee collection system has worked as well as it has is that a waiver system exists. For example, Food Aid recipients and pensioners are not required to pay, and it is incumbent on hospitals to waive fees for others who cannot pay, to assure that no one goes unserved. According to Lewis, there is room to refine the criteria for determining who can pay, to assure that those who can afford services do pay. It may be feasible, if work is done to refine the criteria and uniform

123

- 34 -

criteria are adopted, to use the same criteria in primary care facilities as in public hospitals.

There are many models for the implementation of fee for services, and the final model should be chosen through a consensual process of decision making. The draft MOH proposal for user fees at present does not call for fees for MCH and family planning services. This may go back to the traditional great importance, referred to earlier, which the GOJ puts on unlimited availability of these services. It may be possible, though, to break the MCH/Family Planning category of service down to determine whether some discrete services could be subjected to user charges. For example, given the difficulties in getting children immunized everywhere in the world, immunization may not lend itself to user fees. On the other hand, family planning may, and it may be possible to consider user fees for prenatal care as well. Lewis encountered anecdotal evidence from hospital administrators that consumers are using private physicians for prenatal care and then delivering in public hospitals.

#### Facilities Permitted to Keep Some Revenues

The user fee policy should allow institutions to keep some of the revenue raised. Some portion of fees raised could go to defray family planning program costs presently paid by the MOH (to cover supplies consumed or for contraceptives which they will now need to buy), but some portion should remain with the facility. The rationale for this recommendation is that the incentive value in hospital fee collections has to date come from the fact that funds which the facility was allowed to keep were supplementing public expenditures, not substituting for them. In public hospitals, a portion of the user fee has been kept for such vital functions as purchase of out-of-stock commodities or painting the facility. (It appears that the policy may be changing with respect to use of funds; it is reported that hospitals are now having to account for revenues received in their standard budgets.)

If user fees are fully applied to operational line items which are presently covered by public revenues, the incentive to the institution to collect the funds may be lost. The trade off is that to the extent that revenues are allowed to supplement present on-budget expenditures, there would be less reduction in total on-budget expenditure. If facilities can supplement inadequate recurrent budgets, improvements in program quality would result, in the sense that programs could offer a complete, basic service. (Note that the ability to offer a complete, basic service has been more of an issue for primary health care where the MOH has had to fund its own consumables, than for the family planning program which has historically been supplied by a major donor. Plans of the major donor to phase out could bring the same problem into

124

- 35 -

family planning services.) Decision makers will have to weigh these issues in determining a policy for retention of fees -- will facilities have an incentive to collect fees, must fees be used to defray ordinary operational costs, or will programs be able to retain fees to improve services?

The Assessment Team sees the retention of fees in facilities as important to securing their cooperation in fee collection. In addition it is vital that funds raised be linked to the provision of services in the allocation of national resources. This link is necessary if those funds are to ensure the continuation and improvement of family planning services, the rationale for adopting user fees in the first place. Sustaining and improving the national family planning program is less likely to occur if family planning user fees are turned over to the Consolidated Fund.

**Free Commodities Only to Those Who Cannot Afford to Pay**

At the present time, the public sector provides free commodities to anyone requesting them; the commodities themselves are supplied by USAID, with the exception of depo-provera provided by UNFPA. Since the commodity costs of a successful program are large, and will grow as the population increases and overall prevalence rises, the present dependence on donated commodities lessens the sustainability of the Jamaican program.

Implementation of a policy restricting free commodities to those who cannot pay, the waiver or safety net group, would greatly reduce the expense of commodities for the operation of public sector family planning services. If the public sector aims to serve the lowest three consumption deciles of Jamaican consumers with free commodities, and can move the fourth through seventh deciles to social marketing products, costs for commodities which must be paid in foreign exchange could be greatly reduced. In terms of the feasibility of requiring social marketing consumers to pay for commodities, note that the JFPA, which distributes the same commodities as the public sector (the Sultan condom and Lo-Femenol obtained through the International Planned Parenthood Federation-Western Hemisphere Region-IPPF/WHR) charges three times the present social marketing prices for condoms and oral contraceptives.

As with MOH user fees, numerous models can be envisaged for implementation of the restriction on free commodities. One is to adopt a policy by which consumers are referred to social marketing products unless they fall into the safety net group. Another would also provide commodities to first time users, on their first visit, to insure that first-time acceptors do not go away empty handed. After the initial supply, acceptors who could afford to pay would be steered to social marketing products.

125

- 36 -

Improve Counselling in MOH Facilities

The present method mix in Jamaica does not make maximal use of long-term, cost-effective methods, which are less expensive over the long run and better suited to the needs of older, higher parity women. However, method mix may not improve, nor contraceptive prevalence increase from its present plateau, without more short-term investment in counselling.

The Jamaican method mix is heavily weighted to oral contraceptives. Of the overall prevalence of 54.4 percent, the oral includes 19.5 percent; female sterilization and the IUD together account for only 15 percent of program acceptors. By comparison, other mature programs with contraceptive prevalence over 55 percent tend to rely more on the two long-term methods. The Dominican Republic in 1986, with a contraceptive prevalence rate of 50 percent, had 30 percent prevalence in these two methods. Colombia, in 1986 with general prevalence of 63 percent, had 27 percent in these two methods. Worldwide experience suggests that as family planning programs have grown toward maturity, the profile of the user has become increasingly important, and the method mix has evolved so that acceptors use the most effective method appropriate to their needs.

Long-term methods are cost effective in two ways. First, as the method mix depends more on effective methods, fertility targets become easier to achieve, since fewer users of more effective methods are needed to achieve similar reductions of fertility. Second long-term methods are cheaper to provide when the couple years of protection they offer are considered. For example, using the costs of supplying oral contraceptives as a base of 100, with the costs of the method amortized over the duration of protection it provides, the cost of providing protection through a female VSC is 59, male VSC 44, and IUD 42. By the same token, the cost of condom protection is 179 (Hutchings, Jane and Lyle Saunders, "Assessing the Characteristics of Contraceptive Methods", PIACT, 1985). Thus program sustainability over the long term will be enhanced by better method effectiveness.

Renewed emphasis on counselling is needed to improve the method mix and to move the program to the next plateau of prevalence. The family planning community in Jamaica is concerned that the rate of growth in the program has slowed. Other than young people who are just now coming of age, the group of potential acceptors who may next be attracted to the program are those who are familiar with methods and who may have tried family planning, but for whom fears and side effects present major barriers. A number of concerted changes will be required to reach these acceptors. Marketing in terms which tap the personal value to the acceptor of family planning is one means. Method-specific advertising addressing side effects is another. But these interventions in the domain of social marketing program must be

- 37 -

supplemented by counselling. Face-to-face counselling is indispensable to reinforce the information provided by social marketing, to provide an opportunity for interaction and dialogue, to test understanding and to probe for concerns and barriers.

Improvements in counselling for method choice may result in changes in method mix to increase prevalence of long-term methods. Better counselling is critical in making this transition. Promotion of all methods to allow an acceptor to make a free and informed choice of the IUD or VSC requires knowledge, interpersonal skills, privacy and time from the family planning provider. Improved delivery of counselling may also result in increases in prevalence if continuation rates rise, if acceptors can better weather the minor side effects and inconveniences of method use, and know to get help for serious side effects.

Given that counselling requires personal interaction, time and space, the number of points in the delivery system where counselling can be provided is limited. Public sector clinics, and at present to a lesser extent, private sector physicians and work-based programs may offer counselling. While the social marketing program can provide mass media awareness and educational messages, it does not offer counselling. Thus, while consumers in the fourth-seventh deciles may be able to seek commodities in the social marketing program, they will have to turn to other providers for counselling. Initially they will turn to public sector facilities because they have been in the habit of using them. Those fortunate enough to have work-based services may use them. But private physicians may not initially be a major resource. Thus for the near future, the public sector must be viewed as the major provider of counselling to both the safety net and the social marketing consumer.

Increases in the amount and effectiveness of counselling provided in public sector facilities will require short-term increases in investment of public sector resources. Staff time and supervision would account for most of the cost increase, but training and materials development will also add to the cost. Staff time is probably the biggest issue. It is evident that primary health care facilities are overextended, with insufficient staff time available to fulfill their complex charge. Scarcity of trained personnel is already a major problem in the public sector. At a time of declining public sector resources, if the decision is taken that increased counselling is important, considerable thought will have to be given to how to do this without adding new categories of public sector workers, without adding numerous new vertical program workers, and without paying premiums to attract staff. There may be the possibility of expanding staff time in remote clinics by using circuit rider staff; larger facilities may have enough demand to warrant judicious addition of staff, but cost issues will have to be addressed.

127 -

- 38 -

Over the long term, it may be possible, however, to expand counselling resources by greater reliance on private sector providers. One model which may be attractive builds on the system used by the Jamaican Family Planning Association (JFPA). The JFPA has arranged with a private physician to work at their clinic to be available to acceptors on a fee-paying basis for services which the clinic nurse cannot provide. The physician pays rent to the JFPA at concessional rates for the space.

This model could work to increase counselling resources available to Jamaican acceptors. Under this model, a primary health care facility, which sees many family planning acceptors, could make an arrangement with a physician so that the physician would be located nearby. The clinic could refer those wanting to see a doctor or needing services quickly which the clinic nurse or referral system could not provide. Perhaps by the volume of acceptors that the clinic could refer, acceptors would be offered a lower price than standard fees. This parallels in some respects an arrangement which has developed for the reading of PAP smears. Due to problems in the clinic system, turnaround of smear results was averaging three months. Patients were given the option of paying to have smears read in the private market and many women chose this option.

Thus, the change to step up counselling in the public sector would have major benefits in terms of increased prevalence and improved cost effectiveness of methods, but would require increased expenditure. USAID may decide that in the context of the move to increase private sector participation, and the decision to phase out USAID assistance to population over time, the long-term payoffs exceed the short-term increased investments. Then when USAID assistance ends, the program would have achieved the next plateau of contraceptive prevalence, the method mix would be more effective, and a system with more diversification of use would be in place, although with the public sector remaining a significant provider of counselling for family planning.

#### 4.1.3 Impact of the Recommended Strategy

Beyond the impact on revenues and expenditures, the recommended strategy would have its greatest effects in four areas -- improving the quality of local services, improving the perception of quality and raising the personal value of public services to users, establishing the ethic of paying for services and moving consumers to the private sector.

In terms of revenues and expenditures, the recommended strategy would result in a mixed bag of savings and costs. The strategy would lead to some revenue collection through fees and would cut commodity costs for free products to consumers beyond the safety net group and possibly first-time users. On the other hand,

- 39 -

the strategy would call for increased short-term expenditure to beef up counselling and implement the fee-collection system.

With respect to improvements in program quality, the impact of the recommended strategy has already been described. Facilities could lay claim to some fraction of revenues raised to put toward urgent needs they see in their programs and improve quality by being able to offer a complete, basic service. Worldwide experience suggests that consumers value more, and comply with usage more, services for which they had to pay. The improvements in quality will also help staff morale as suggested by Lewis, op. cit.

The establishment of user fees would also institutionalize the principle of paying for services. Already, service consumers are being asked informally to pay for services. But the implementation of a fee structure would establish the ethic of paying, at all times and for all services, among groups that can afford to pay, a principle which has up to now not existed in the Jamaican health system.

Adoption of user fees may also result in some users choosing private services, depending on the price set for primary health care services. Implementation of a new public sector fee will by definition bring the public price closer to that charged on the open market. Public service users with the most income may view the gap between the public and private price as only marginal, particularly if they view private services as offering a higher quality product. There is considerable evidence in Jamaica that inconvenience of public facilities, understaffing, and preference for the service which private physician's offer make private services preferable if the user can afford them.

The adoption of public sector user fees and of restrictions on free commodities would also support the privatization process in another way. The change will increase the likelihood of the successful development of a self-financing program of contraceptive sales in the commercial sector. The commercial sector will have difficulty competing in the provision of contraceptives or family planning services as long as services are free in the public sector.

#### **4.2 Role of the NFPB**

In the new era in family planning in Jamaica, marked by more sustainable services with a broader base of support, the role of the NFPB would change. The change in role would largely take the form of substituting a powerful advocacy and coordination role for the present mix of advocacy, coordination and implementation responsibilities. The NFPB's role, in general, would turn on providing advocacy, developing public relations, strategic thinking, and providing innovative leadership to Jamaica in the areas of population and family planning.

129

- 40 -

This is where the NFPB's comparative advantage lies. The NFPB has the national mandate to perform this kind of function. No other organization, with the exception perhaps of the Planning Institute of Jamaica (PIOJ), has this kind of mandate. And the PIOJ's mandate covers a number of technical areas, so it cannot focus its efforts on family planning the way the NFPB can.

Comparative advantage is important in another way. With respect to program operations, the MOH and the JFPA have the comparative advantage. Once the NFPB begins to actively exploit its new advocacy and coordination role, there will not be time for the nuts-and-bolts implementation activities required by program operations. The Ministry of Health, in its responsibilities for public health, must have systems in place for recruiting, supervision, training, and commodities management. For the NFPB to participate in program operations would be a duplication of effort when resources are terribly constrained.

Thus the NFPB should move into the advocacy role and leave behind the operational functions it now performs. The NFPB should not be operating any vertical family planning programs. These, and the funds to support them, should be transferred to the MOH. The NFPB should not plan to handle future commodity procurement; the MOH should be trained to take over this function. Similarly, the NFPB should have input into program planning -- for personnel selection criteria, for training of staff, for program operating hours, etc. -- but should not be involved in actual implementation.

Initially, it may be difficult for the NFPB to visualize its role without the implementation functions it has traditionally handled. The new role is a very powerful, exciting one which will put the NFPB at the center of most of the "noise" in family planning in Jamaica. First off, the NFPB should on an annual basis organize a planning process, in which all the policy and implementation actors would take part, to develop national population goals and a unified strategy for their accomplishment. The national goals should be long-range ones, expressed in quantified terms covering service targets by sector, contraceptive prevalence, fertility, funding, etc. The unified strategy would be a workplan showing which sector will do what, where and by when. This plan should be updated annually.

Based on this planning, the NFPB would be responsible for assuring that adequate funds are provided by the GOJ; within the government, by the MOH; and from the private/corporate sector. The public relations and advocacy function will be essential here. To keep services well funded, the NFPB will need to raise the profile of family planning with active programs of publicity, presentations in government of needs and success stories, etc.

120 -

- 41 -

Further, the NFPB would be responsible for creative thinking and innovation in all areas related to family planning. For example, the NFPB would evaluate contraceptive innovations and plan for their introduction into the national program. The NFPB would appraise new delivery systems, such as community-based distribution and plan with the MOH how to implement them. As mentioned elsewhere, the NFPB would coordinate (but not implement) the national CSM program. The NFPB would produce information, education and communication (IEC) materials as part of its advocacy role. These efforts would be coordinated with the PIOJ. To subsidize the costs of the IEC program, it may be possible for the NFPB to obtain corporate sponsorship of campaigns. Lastly, the NFPB would collaborate with the MOH in the development of training materials to increase the effectiveness of counselling in MOH facilities.

Through this advocacy and leadership role the NFPB would provide technical sustainability to the national family planning program. The NFPB would be the fabric underlying the entire system, and its leadership would provide the momentum for growth and development of the program. This technical sustainability is vital to a vibrant system, but too often is overlooked in considerations of financial sustainability. In the new era in family planning, the NFPB would contribute to the financial sustainability of the operational arms of the national program by galvanizing support for cost recovery and private participation. But the NFPB would not in itself be financially sustainable. An advocate and leader organization does not have users/clients who can "buy into" program support.

An example of how the NFPB and the MOH would interface with policy and programmatic plans would be that of user fees which may be adopted. The NFPB should be a leader in the planning process; from its intimate knowledge of family planning in Jamaica it should have a significant contribution to make in the design of a system which would be effective and yet maintain prevalence. To preserve prevalence, the NFPB could market the change to consumers through a public information campaign much like those which have been used to market deregulation of gas prices and the general consumption tax.

121

## 5. INCREASED PARTICIPATION OF PRIVATE PRACTICE PHYSICIANS

### 5.1 Background

Research about general practitioners will be undertaken to learn the following:

- Number and distribution of general practitioners
- Those who have a "special interest" in family planning
- Structure of practice
  - Fee for office visit
  - Percent clients female
  - Estimated income distribution of clients
  - Percent of practice ob/gyn related
  - Percent of practice family planning related
  - Estimated time spent in "counseling" per client
- Contraceptive methods most commonly "prescribed" Why?
- Brands most commonly prescribed Why?
- Contraceptive methods most resisted/accepted by clients Why?
- Existing constraints to IUD insertion, if any
- Interest in weekend VSC practice, if any
- VSC: training, experience, method preferred
- Family planning questions/concerns most frequently raised by clients
- Percentage of female clients with whom physician takes initiative of mentioning contraception regardless of cause of client visit
- Under what circumstances?
- At what age is client when family planning first discussed with her?
- Estimated percentage of clients who discontinue recommended contraceptive method after 3 months of use - 6 months - 1 year
- What birth spacing interval most frequently recommended
- At what age/parity tubal ligation is recommended to a client
- Cost to client of a year's use of injectable contraceptive through his/her practice
- Fee for IUD insertion
- Most acceptable source/time/style of continuing education
- Most desired topics of continuing education

The recent survey of public sector clinic users contained information about their use of private physicians, including frequency and circumstances of use. Private physicians are providers of health care for a significant proportion of Jamaican women. Although few (12%) saw a physician for family planning, many of these women or their families (67%) have at some time been a client of a private physician. The reasons these women visit private physicians are for serious illness (41%) or for a thorough

- 43 -

check-up (39%). But private physicians are not providing family planning information or methods to these women, when they come in, even to those who sought out a complete check-up. Only 10% of the respondents reported that the private physician gave them family planning advice during the visit. This suggests that physicians are not yet serving as a source of family planning counselling and methods to women. These visits are a great missed opportunity for the national family planning program to enlist physicians to participate in family planning service delivery.

These women will continue to seek private medical care when they can afford it. Although satisfied with clinic services, they perceive private medical care as better than public. Forty percent (40%) of MOH clinic users state that they see private physicians because of the quality of medical care they receive there. Nearly as many (38%) perceive that their waiting time is shorter at the private office than at the clinic. But these women see cost as a major barrier. They estimate that a visit to a private physician will cost Ja.\$80.00 (Ja.\$6.89 equals US\$1.00), even more than they actually paid on their last visit, an average of Ja.\$65.00. Nearly half (49%) report that cost is the reason they do not use the private physician.

From the vantage point of the clinic user, private medical care is both attractive and used. But this use is not buttressing what the national family planning program is trying to achieve. For this reason the Assessment Team is recommending that steps be taken to realize the potential of private physicians.

## **5.2 Recommended Strategy**

There are two primary issues involved in the potential contribution of private practice physicians to the sustainability of the national family planning program: 1) their effectiveness in motivating women to accept and continue to use family planning methods and 2) the extent to which public sector consumers of family planning services will shift into the private sector.

The operating assumption of the Assessment Team is that any increase in the privatization of family planning services delivery accomplished through private practice physicians will occur among general practitioners. Specialist physicians, such as obstetrician/gynecologists, who deliver family planning services are affordable only to the economically very well off. This target clientele already uses the private sector exclusively. Many General Practitioners, on the other hand, serve clients who still use public sector outlets for delivery of a variety of health and family planning services.

### **5.2.1 Counselling**

The ability of a private practice physician to counsel his/her clients concerning family planning affects both success in

133

- 44 -

contributing to overall contraceptive prevalence, as well as the willingness of clients to pay the physician for family planning services rather than to receive them free in the public sector.

Recent qualitative research in Seaview Gardens, undertaken on behalf of the Government of Italy, shows clearly that "counseling" -- that is, the sympathetic understanding of an individual's life circumstances which have impact on her willingness/unwillingness to accept family planning, information given in terms which the individual can understand, active probing for concerns not volunteered and constraints which should be addressed, and the interpersonal rapport which all these suggest -- is of enormous importance to women in their child-bearing years. Indeed, this research shows that these low-income women seek the service they call counseling and will pay to travel considerable distances in order to get family planning services from a provider whom they consider a good counselor.

A private practice physician, however, may face several constraints in providing counseling. First, the physician is a considerable authority figure to many clients, especially perhaps to those in the lower income groups. Authority figures are usually not those with whom people feel most comfortable discussing their private concerns, showing their "ignorance" of health matters, or even asking questions. The physician's demeanor may also increase the distance perceived by the client between herself and the provider.

Additionally, the physician may feel a financial constraint to the provision of effective family planning counseling. Private practitioners' flat-fee charge for office visits is based on their perceptions of the average amount of time spent per client and of the average socioeconomic level of their target clientele. Since counseling is time intensive, some physicians may feel that its costs to them are more than they can recover in their office visit fee.

Two other reasons may also be involved. First training programs may not have flagged as essential areas of patient education a woman's reproductive history and contraceptive use. If training is the limitation, this can be remedied. A second reason may be the traditional division of labor between the public and private sectors. As described earlier, the MOH and the national family planning program have done well to offer MCH/FP services to all Jamaicans. As a consequence, physicians may have stopped "competing" with the public sector in these areas. Here too, education to consumers that private physicians are a resource, and to the physicians themselves to routinely address these areas may be very important.

Given these constraints, the Assessment Team recommends that the survey research among General Practitioners proposed for

BY

- 45 -

the Project design period be used to identify those GPs who report themselves to be "especially interested" in family planning services delivery. This core group can then be targeted for special training through continuing education seminars and the like in improved client communications and motivational techniques. The approach to physicians concerning this potentially sensitive area of training (What physician wants to think that s/he does not already communicate effectively with clients?) should be carefully planned and presented and carried out under the aegis of whatever professional body is perceived as most acceptable to the target doctors. The Association of General Practitioners may be especially useful in this activity.

It may also be possible to have the nurses and midwives in area Ministry of Health clinics systematically recommend doctors who have participated in this family planning counseling training to the clinic's family planning clients who request or need referral to a doctor and who do not want to, or cannot wait, until an MOH physician is next available at that clinic location.

#### 5.2.2 Affordability of Fees :

One model of operation has been identified which could affect the affordability of private physician fees. At the E Street Clinic, the JFPA rents office space to Dr. Reed for his private practice at a concessional rate. In addition, the clinic staff refer all clients needing to see a doctor for some aspect of their family planning visit to Dr. Reed. This creates a "guaranteed" demand for his services. In return, Dr. Reed agrees to be available for clinic referrals during all clinic hours and to charge any clients referred to him by the clinic a reduced fee per visit. The volume of practice which the clinic provides him allows Dr. Reed to reduce the price per "unit" visit. Dr. Reed is free to see private practice clients not referred by the clinic at his normal office visit fee.

The Assessment Team recommends that the Ministry of Health review the possibility of renting clinic space at concessional rates to private practitioners who in turn agree to provide services according to the Dr. Reed model. This would partly ease the shortage of MOH physicians conveniently available to back-up clinic staff and to meet the demand for referrals -- which has been frequently referred to by MOH staff. Also public sector clients originally referred to the physician through a public sector clinic might well continue to seek family planning services from that doctor but as a part of his private practice.

Where it is not possible because of space constraints to rent MOH clinic space to a private practitioner, the Dr. Reed model may still operate effectively. In such a case, the MOH clinic could make an agreement with a general practitioner in the neighborhood of the clinic (perhaps one who has agreed to take the

135

- 46 -

training in family planning counseling mentioned above). In return for the "guaranteed" volume which clinic referrals could provide, the physician would agree to be available during clinic hours for referrals and to charge any client referred by the clinic an agreed upon, lower-than-normal fee.

In summary, it may be possible to work with private physicians to make them more frequent and effective counsellors of clients about family planning needs. This would help to reinforce the message by providing another channel of information beyond those of public sector practitioners and mass media. Further, to a limited degree, volume clientele arrangements may bring private services into reach by the highest income social marketing consumer. These two steps would not, however, generate large cost savings stemming from significant reductions in the MOH primary health care system. As long as that system provides primary health care with family planning as an integrated service, the system has to maintain an extended network of clinics. One change that might occur, however, if resupply is handled by the commercial sector and if private physicians become more active in counselling, is that public sector practitioners may have more time for fewer users seeking advice.

### 5.2.3 New Services Offered

Expanded use of private sector resources in family planning services delivery may be accomplished through broadening the range of contraceptive methods available there.

#### VSC

Currently, almost eighty-nine percent (89 percent) of all voluntary surgical contraception is provided by the public sector. This is largely thought to occur because of the prohibitively high price of the procedure in the private sector and the absence of operating theater space accessible to private practitioners. The private sector price is largely a result of the cost to the physician of the equipment required (especially if s/he uses laparoscopy) pro-rated over the relatively small number of times an individual physician would be called upon to use this equipment in his/her practice. Operating theater space, surgical nurses, and the like are also required and are costs to the doctor which s/he passes on to the consumer.

It may be possible to find small groups of private physicians who, in exchange for free or nearly free weekend use of public sector operating theater space and equipment, would find it financially advantageous to offer VSC services at prices much more nearly affordable to lower income clients. MOH clinics are traditionally closed on weekends and represent, therefore, unused potential at these times. Participating private physicians would be expected to provide their own support staff and consumable supplies. If client referrals were provided by local MOH clinics

136

- 47 -

so that a predictable volume of business could be available, this arrangement might be even more attractive to the private sector.

The advantage to the user of this private service might be such things as more convenient times (outside working hours, etc.) when the service is available and avoidance of the reported waiting list for VSC services in the public sector. (A previous significant decline in VSC acceptors has been attributed to this waiting list and the implied unavailability of services in the public sector.)

While the Assessment Team has not been able to explore the feasibility of this suggestion, a number of MOH staff feel that such an option should be pursued.

### IUD

The IUD should make a small but steady contribution to the private sector method mix. As a purely commercial method, the IUD -- and its attendant insertion costs -- may be prohibitively expensive for social marketing consumers. However, if a mechanism can be found by which low-cost IUDs can be put into physicians' hands, it may be possible for the IUD to occupy a small niche in private sector services.

On the commercial market, copper-T IUDs sell for as much as J\$ 162, or US\$ 23.50, at wholesale. Pharmacists' mark-up and physicians' insertion fees are additional. This price structure puts the method out of reach of non-affluent consumers.

During a period of overstock, the NFPB made available to physicians USAID-donated IUDs at Ja.\$60 (US\$ 8.71). These had been purchased through the AID-central purchasing facility for US\$1.00. This demonstrates that there is a market for a low-cost IUD. It may be possible for the NFPB to obtain a low-cost IUD, for example, through the IPPF/London central purchasing mechanism, for resale to physicians. Access to the low-cost IUD can be tied to agreement by physicians to hold the insertion fee to a reasonable, previously agreed-upon level. It is recommended that options such as this be explored so that the IUD can maintain its place in the private sector method mix.

### Injectable

Injectables have proven to be a popular method in the public sector program. Twenty percent of public sector acceptors use injectables. Given this popularity, ways and means to make injectables affordable to low-income consumers should be explored.

In September 1990, one injectable, Schering's Noristerat, was available direct from the local distributor for Ja\$44.50 and from pharmacies for Ja.\$57.00.

- 137 -

- 48 -

The major share of the Jamaican market for injectables, however, seems to be held by Upjohn's product DepoProvera -- a three-month contraceptive. An annual donation to the MOH/NFPB by the UNFPA of approximately 50,000 vials is responsible for DepoProvera's prevalence in the Jamaican contraceptive environment. UNFPA brings these vials into Jamaica at approximately US\$1.00 each. Additionally, the GOJ/MOH purchases, through the JCTC, an estimated 500 vials annually. Both the UNFPA and GOJ purchases are made through offices (regional or European) other than that of the local distributor for Upjohn -- H.D. Hopwood.

The local distributor accounts only for sales to private physicians -- approximately 1200 vials annually. The firm reports that product sold by them to local physicians is used primarily for treatment of endometriosis. This limited use occurs, they report, because private doctors no longer feel they can afford to stock DepoProvera for contraceptive use in competition with the free product available to all potential users in MOH clinics.

Primary obstacles to expanded acceptance and use of DepoProvera, Hopwood reports, are the inconvenience to doctors of clients' complaints of occasional breakthrough bleeding, and client anxiety over sometime-delayed return to fertility after discontinuation of use. The USFDA's negative position on DepoProvera as a contraceptive does not seem, they say, to be a constraint in Jamaica.

The cost to the distributor of a single vial of DepoProvera is currently US\$ 1.87 and must be paid in foreign exchange. As of January 1991, it is sold by the distributor directly to physicians for Ja.\$66. The price which Upjohn charges the local distributor is based on the volume of sales generated by a "pool" of eight Caribbean nations -- Jamaica, Haiti, Bahamas, Cayman, Bermuda, Trinidad, Barbados, and Curacao. Distributors in each country receive the "pool" price.

The price to the consumer of a three-month supply of DepoProvera is increased from the basic cost of product, Ja.\$66, by the cost of the visit to a physician in order to obtain the injection. (Injections may be given only by doctors or by nurses/midwives under the supervision of a doctor.) Office visit fees reportedly range from J\$ 40-80 among general practitioners in Jamaica. Minimum total cost to the consumer for contraception through use of DepoProvera can be, then, J\$ 106/three-month period or J\$ 35/month -- an amount quite expensive for lower-income users.

To enlarge significantly the provision of DepoProvera through the private sector, it appears that two events must occur. 1) Large-scale availability through the MOH of free product to the social marketing consumer needs to be greatly diminished or ended to provide physicians with the financial incentive to stock DepoProvera; and 2) some means must be found to lower significantly

138

- 49 -

the combined price to the consumer of product and office visit. While the feasibility of these changes should continue to be explored, it is not likely that these will be readily accomplished.

139.

## 6. PRIVATIZATION OPTIONS IN WORK-BASED FAMILY PLANNING SERVICES

Private enterprise and the insurance sector may be able to take a more active role in the provision and support of family planning, as a means of shifting the burden of some operational costs from the public sector. The degree to which the more active role will provide relief to the public sector depends on whether the private sector can be induced to pay for services which are now subsidized. The degree to which the support might expand prevalence relates to how many new acceptors are brought in by these programs, who were not previously using family planning provided by another part of the system. To activate the private sector, it will be important to appeal to corporations in terms of the profitability implications of involvement, such as reduced turnover or reduced maternity leave benefits, and to their sense of corporate citizenship.

### 6.1 Background

As of January, 1990, two providers made work-based services available in private enterprises. Private entrepreneurs did not contribute to the operational costs of these programs. The NFPB served 37 firms, of which the majority were in the garment manufacturing sector. The JFPA served 58 firms, including local service enterprises like hotels, a major newspaper, etc.

A variety of other health services exist for employees, which are more or less involved or amenable to the provision of family planning services. Some firms, including Grace Kennedy and the sugar estates, have their own health room in the factory to provide first aid or simple care of illness. It appears that at present these units do not offer family planning. In the free zone, the manufacturers collaborate in the operation of a health clinic, under the supervision of a physician, staffed by a nurse practitioner and a nurse, which actively provides family planning services, using commodities supplied by the NFPB. Firms also have contracted with local health maintenance organizations (HMOs) to provide health services to their employees; this is the arrangement the telephone company uses for its employees, in addition to having on-site nurses in the largest work sites. Physicians at the HMO are prepared to offer family planning if requested. Grace Kennedy meets the more major health needs of its staff through reimbursement, with oversight of billing by a large HMO, which serves many employees. Note that, historically, Grace Kennedy, with one of the most comprehensive health programs on the island, has never covered maternity benefits.

With respect to the insurance sector, some firms already cover VSC and pay for office visits. The impact of a more active role for this sector would stem primarily from cost savings in the public sector resulting from shifting other family planning

- 51 -

services to the employer/employee through the vehicle of insurance premiums. Note that more reimbursement by the insurance sector does not necessarily mean more private enterprise resources for family planning. Any costs incurred by the insurer would be passed along to the employer; many employers in Jamaica share the costs of insurance premiums with employees in one form or another.

## 6.2 Recommended Strategy

The recommended strategy is to reconstitute the present free programs to become self-supporting.

All firms care about profitability; and firms, particularly those in the garment industry, are also very concerned with achieving increased worker productivity. If it can be demonstrated to them that convenient family planning services produce returns in terms of productivity, they may become interested in providing financial support.

Cost-benefit analysis, packaged in a graphic presentation suitable to decision makers, has been used in other countries to gain the collaboration of private entrepreneurs. The Technical Information on Population for the Private Sector (TIPPS) Project has used this effectively. This methodology may be very helpful in getting private sector participation.

With respect to the development of a cost-benefit analysis, a range of types of firms should be considered for inclusion. Some firms have largely white collar staffs, of whom the majority may be men. Thus, pregnancy-related turnover and decreased productivity are less problematic. Furthermore, in these firms, fertility may have already come under control due to the relatively high socioeconomic status of workers. For these firms, which likely pay generous maternity and family support benefits, the returns of a family program versus outlays for benefits may be positive, but few births will be averted.

By contrast, in firms which employ large numbers of poor, nearly unskilled women, employee benefits are probably comparatively lower and fertility may be higher. More births would be averted, but returns to investment in family planning would be fewer, coming mostly from the mandated, paid maternity leave and from lack of absenteeism and turnover. This extends the break-even and payback periods. Garment assembly firms are examples of this latter type of firm. These are the ones where fertility gains could be made, but where the cost-benefit case is that much harder to make given the slow flow of returns. Sugar estates, given their rural, agricultural base, and the low level of benefits they pay, may also be a useful prototype.

141

- 52 -

Prior to developing the cost-benefit models, it may be useful to survey prototypical firms to determine the magnitude of unwanted fertility they experience. Worldwide experience suggests that working women take more control of their fertility; anecdotal evidence in Jamaica suggests that this is the case, but there may still be excess fertility which manufacturers would like to help to control.

Enterprises may also respond to the corporate citizenship argument. Firms like to be, and to be known as, good corporate citizens. If they could get publicity for being involved, they may feel more inclined to take part. This applies both to provision of family planning, where news photos may show the firm president and important politicians opening the facility, and to support of the development of advertising, IEC materials, etc. where the company logo can be displayed. There are important precedents in Jamaica for such public-private partnership. The adopt-a-school program is a case in point.

A lengthy process of consensus building is likely to be required to obtain firms' consent to participate and provide financial support. For this reason, a survey to determine interest has not been proposed. Without laying the proper groundwork and developing tools like cost-benefit analysis with which to gain participation, firms would not likely indicate interest up-front.

St. Lucia provides an example of the consensus building required. Funding was terminated to the family planning association for a factory program which had been subsidized. Enterprises agreed to a per employee service charge, once they had seen the cost-benefit presentation and participated in one-on-one conversations about it. Although general meetings were effective in conveying information, face-to-face contact was needed to secure agreement (Logan, David; "Developing a Self-Financing Factory-Based Contraceptive Distribution Project in St. Lucia").

The strategy also suggests that work-based programs be made more effective. It appears that, at present, some firms do not strongly back these services, by letting the program come into the organization at times convenient to the workers, by offering a private place for counselling, and so forth. If firms could more clearly see that it is in their own interest to support these services, gains in convenience and privacy for counselling may pay off in increased prevalence and even in improved method effectiveness.

As far as the delivery of services goes a number of models may be considered, beyond that of the employer operating the service. For example, the JFPA could be contracted to provide the service through mobile team and referral to their fixed facilities for clinical services. Or, a group of firms located in a geographical area could contract with a provider near them to

- 142 -

- 53 -

provide the service at the provider's facilities. Examples of the type of infrastructure that would lend itself to this are health maintenance organizations which already handle the health needs of groups of employees and free-standing practitioners serving health needs of employees in the free zone.

With respect to commodities, no free commodities should be provided by the public sector for work-based programs. Employed acceptors can afford to pay social marketing prices for contraceptives and should assume this responsibility.

In some countries, it has been useful also to gain the cooperation of the insurance sector in the expansion of privately-supported services. It is unlikely that in Jamaica this change would be feasible or would have much impact on contraceptive use. Some insurers already reimburse for surgical contraception; Jamaica is said to be highly competitive in the insurance industry, so it can be expected that this benefit would be generalized in the near future. Office visits to physicians are also already covered, so for example if a woman wanted an annual PAP smear, she could obtain family planning advice and services at the same time. Thus the only elements of family planning services not presently covered are reimbursement for supply methods and IUD purchase, IUD insertion and visits solely for the purpose of counselling.

The costs of doing business in Jamaica are comparatively high in the insurance industry. The payout rate of premiums in benefits is approximately 85 percent. While this may provide a sufficient profit margin in the US where the costs of doing business are lower, administrative costs in Jamaica make this a very slim profit margin. For this reason, and because employers are constantly seeking to offer their employees who contribute to premiums the most affordable coverage, it is very unlikely that reimbursement for supply methods would be added to the benefits package.

Lastly, it is not likely that this change, even if feasible, would have much impact. It is doubtful whether many new acceptors, not presently using contraception, would come in to the system just because of the availability of reimbursement. The price of Perle orals and Panther condoms is so low in Jamaica now (\$0.07 for a cycle of pills and \$0.15 for 9 condoms) that price cannot be a barrier to the insured acceptor.

### 6.3 Role of the NFPB

The NFPB will play a vital role in developing private enterprise support for work-based services, in advocating with firms. The process of reconstituting the private enterprise programs to become self financing will require effective marketing to the firms, seizing of opportunities to show off corporate

143

- 54 -

successes, creative thinking about organizational structures for the services, etc. The NFPB is well situated to conduct this type of dialogue. The cost-benefit analyses which facilitate such policy dialogue should be prepared with hands-on involvement of the NFPB and the JFPA. They should be trained to make the cost-benefit case to the firms; this level of participation is essential so that advocacy function which supports the ongoing operation of the services continues beyond the period of outside assistance. This is technical sustainability, and it is as important as financial sustainability where marketing and policy are recurring issues in the support of an activity. The NFPB should advocate and coordinate, but not operate, work-based programs.

- 149 -

## 7. INSTITUTIONAL STRENGTHENING: NEEDS AND TOOLS

By now a considerable amount has been said about the roles of the different actors in the new era of family planning. The new program is conceived as one with increased sustainability in the operational arms, with a strong programmatic advocate in the NFPB, and with an active private association in the JFPA. Thus, issues of role need not be reviewed again. What is important here is assuring that the actors have the capability to fulfill their roles. A number of institutional needs have been identified appropriate for institutional strengthening. The purpose of this section is to identify those needs and the tools which can be used to meet them.

### 7.1 National Family Planning Board

1. RAPID model of population development. The NFPB, and to a lesser extent, the PIOJ, will be responsible for advocacy in population and family planning, for gaining support in the highest levels of the GOJ for funding and operation of programs. The NFPB will also seek support and involvement on a continuing basis from the private sector and opinion leaders. One tool which may be very useful in this education process is a presentation of the RAPID model of population development. The RAPID model portrays population development in a country according to various assumptions, and shows the impact on health services, education, food and housing requirements, etc. The presentation is very effective with decision makers. It graphically portrays the impact of continued population growth. At the same time, it can respond dynamically to changes in parameters suggested by members of the audience, since it is driven by a computer. Both the NFPB and the PIOJ may be interested in learning how to run and present the model so that they can use it in their advocacy efforts. It is recommended that the model be developed and the technology transferred to these organizations.
2. Target setting, method mix. At present, it does not appear that quantified, long-range goals have been developed to guide program development. One problem is the lack of goals related to method mix which incorporate cost-effective, long-lasting methods, like the IUD and VSC, developed in terms of the profile of Jamaican acceptors' age and parity. The only projection of method mix available to the Assessment Team shows the method mix remaining at virtually the status quo. As has been described above, pill prevalence is probably too high and long-term method use too low for the age and parity of

- 56 -

Jamaican acceptors. This phenomenon means that cost-effective methods are not being exploited, nor are opportunities to achieve greater fertility reduction for given levels of prevalence, which arise when long-term methods are used appropriately.

The Target-Setting Model could be very useful in developing long-range goals, examining the contribution of different sectors, and in looking at the relationship between method mix, prevalence and fertility reduction. This is a very user friendly, computer model based on the proximate determinants of fertility. The user provides estimates of the proximate determinants of fertility, such as contraceptive prevalence, breastfeeding, etc. and the model relates these to various fertility reduction targets, potential method mixes, and estimates of the contribution of different sectors. This technology could be readily transferred to the NFPB for use during the annual planning process, and for other purposes as needed.

3. Costs of rearing a child. Some mature countries, e.g. Tunisia, have commissioned studies to look at the cost of rearing children as another tool for policy dialogue and for education/awareness campaigns. It was suggested to the Assessment Team that this might be a good idea for Jamaica.
4. Training of general practitioners. Continuing education seminars and other appropriate avenues for educating general practitioners to the importance of contraceptive practice and reproductive history to the overall health status of women should be designed and implemented through the NFPB. Such training should help motivate general practitioners to take a pro-active role in promoting and supporting contraceptive use among their clients. Practical skill training such as for IUD insertion should also be made available.
5. Commercial sector representation on the Board. In view of the necessity of increasing sustainability in the national family planning program, it may be useful to have representation from the commercial sector on the Board of the NFPB. At present, the Board does not have any members with a bottom-line orientation. If that perspective could be added to NFPB activities, it might be very useful in increasing self sufficiency in the national program through the NFPB's leadership.
6. CSM-Plan to streamline approval process for advertising. In the past, plans for the advertising campaigns for the CSM program have been held up by a cumbersome review

146

- 57 -

process. The approval process should be streamlined. The MOH should be involved in advertising to make certain that it is factually correct. Otherwise the advertising agency, and the marketing manager of the NFPB, should be involved in designing ads for the target market, lower-income consumers.

7. CSM-Observation tour to see commercial program. As the CSM program is revamped to put it on a commercial footing, it may be useful for representatives of the NFPB to see a counterpart program in another country. The program in Indonesia or Haiti may be a good example, since it is based on a purely commercial endeavor, with USAID support only to advertising. This is the model which is desirable in Jamaica.
8. CSM-Marketing and business plans. As described in the recent Evaluation of the Population and Family Planning Services Project, a marketing and business plan should be developed for the CSM program. The strategy should provide direction for workplans and be a management tool in appraising program accomplishments. The plans should contain specific descriptions of the target market for Perle and Panther and reflect pricing decisions for the products appropriate to those target markets.
9. Program of regular data collection on family planning "market and consumption patterns". In the debriefing of the Assessment Team, the need was voiced for a regular program of data collection about usage of services and source. Such regular data would be an important management tool to program managers seeking to develop a strong program based on a variety of providers and methods. The data would reflect the extent to which consumers were turning to new sources and methods. This regular program should be built into the design of the new project, and cover use of public and private facilities, type of facility used, consumer profiles, commodity used, price paid, among other data.
10. Sustainability external commission. It may be useful to develop a sustainability committee for the national family planning program composed of individuals who are external to the program. It is very difficult for interested parties to take part in such a committee because of concerns about vested interests. The strategy of external commissions has been used very successfully in Jamaica in the program of divestiture of government-run hotels and businesses. This model could be considered in the work of making the national program more self sufficient.

- 58 -

11. Non-profit organization management and marketing skills training. For the NFPB to play effectively its expanded role of advocacy and coordination, skills training in management and marketing of non-profit organizations should be provided. Staff at the NFPB will need to be able to market the organization and handle public relations to give family planning a high profile. Further, the NFPB will be playing a key coordinating role with other actors, like the MOH, the commercial pharmaceutical sector, and private enterprise, and will need to have skills to plan, organize and dynamize complex activities.
12. Organizational marketing and business plan. For the organization to have a clear picture of what it is about, it would be very useful for the NFPB to develop an organization-wide business and program-wide marketing plan. The NFPB has recently held a staff retreat and participated with a consultant in a planning exercise. This is a very good beginning. However, the workplan as it currently stands does not provide clear direction to the NFPB for what it itself should be doing, versus what the MOH or the commercial sector should do. Goals should be quantified and all activities directed toward achievement of those goals.
13. Revised job descriptions. The role changes described for the NFPB may well warrant reflection in new job descriptions for the staff. In the new era, duplication of effort is eliminated by clarification of responsibility in the NFPB for advocacy and coordination, and in the MOH for public sector program operations.
14. IEC and Parish Liaison Officers. The Evaluation noted that the role of the NFPB parish liaison officers, as local population information officers, has not been realized. During the Assessment Team's work, much confusion was voiced about the specific responsibilities of this group. As the NFPB implements the World Bank IEC project, with a full complement of staff, the IEC program should become increasingly dynamic. The IEC Division should develop and implement the planned new IEC campaign, coordinate and monitor the outreach and youth programs, and work with the Ministry of Education to revise the family life education program. In support of this, the NFPB should clarify local IEC programming and the roles of the parish liaison officers vis a vis the NFPB and MOH.
15. Advocacy/participation of private physicians. Private physicians (particularly general practitioners) presently see many low-income women of reproductive age but do not

148

- 59 -

mention reproductive health and family planning during the visit. Since this group can be an important resource to Jamaican women for family planning, it is important that the NFPB, perhaps with funds provided by the new project, advocate with and market to private physicians the need to increase their involvement. The design process for the new project should identify the activities to be conducted. Two marketing approaches to be considered are public relations with physicians about the importance of their involvement, and marketing to consumers the information that private physicians can help with family planning.

## 7.2 Ministry of Health

1. User fee strategy, waiver criteria, and logistics. If requested, USAID could provide assistance to the MOH in developing a user fee strategy, in refining criteria which define membership in the waiver group, and in logistics. Since both Family Planning Initiatives and Health Sector Initiatives (532-0152) are involved with the MOH in primary care, the two projects should share any related costs.
2. Training for IUD insertion. Rates of IUD insertion have declined from the already low previous level. The Assessment Team probed to determine whether this had to do with prescribing patterns related to sexually-transmitted diseases. This does not appear to be the issue. Instead the issue is the lack of training of providers in how to insert IUDs, stemming from the massive turnover of staff and flight of trained personnel abroad. In order to exploit this method for women to whom it may be suited, it may be useful to provide supplementary training in IUD insertion.
3. Training re VSC. As described previously, VSC is a very cost-effective method for women with completed families. VSC is probably not represented sufficiently in the present method mix in Jamaica. In the period 1985-1989, this may have been due to unavailability of services. At this writing, this situation had improved with the reopening of the VSC facility at Victoria-Jubilee Hospital.

There are a number of issues surrounding VSC that should be addressed. First it may be important to make sure that staff of the MOH realize that VSC is in many mature programs the most prevalent method. The US is a case in point. Second, the MOH's interest in minilap with local anesthesia should be fostered, and other parts of the

149

- 60 -

program (for example young doctor training and retraining of physicians already in practice) should be geared to that. Minilap kits should be made available to private physicians who are interested in providing this method. Lastly, all-method counselling should be improved, so that women with completed families will be able to make a free informed choice of VSC.

4. Counselling. In the effort to increase use of long-lasting methods and improve continuation rates, the need for improved counselling in MOH facilities has been identified. This is a complex issue since it touches not only on staff training and materials available for counselling, but also on staff time which can be devoted to this service. It may be useful for USAID to provide TA in the area of counselling to determine where the needs are (training, materials), and what the options are for counselling in oversubscribed MOH clinics.

### 7.3 Jamaica Family Planning Association

1. Organizational business plan. The JFPA also needs an organizational business plan. This will be developed in Fall, 1990, and should address, among other things, the mechanics of converting the subsidized work-based program to one paid for by employers.
2. Non-profit organization management and marketing. The JFPA also needs training in these areas. The JFPA may be able to call upon IPPF/WHR for provision of this training.
3. Assistance from IPPF/WHR. The JFPA has previously been based in the parish of St. Ann, with only a small office in Kingston to support the work-based program. The JFPA is moving its base to Kingston and would like to enhance its national image. IPPF/WHR may wish to help the executive staff and the Board of the JFPA to consolidate its national base of support with technical assistance in policy dialogue, public relations, marketing and management. IPPF/WHR may also be able to work with Board members to expand their view of their role and their skills in advocacy and institution building.

150

## 8. COST IMPACT OF PRIVATIZATION MEASURES

In order to summarize the discussion on privatization options, it may be useful to step back and try to estimate how much the options would cost the public sector to implement and the magnitude of cost savings produced. Tables 11 - 14 show the cost impacts for each of the four areas, CSM, public sector, work-based programs and private physicians. These areas are listed in order of feasibility and cost savings; putting the CSM program on a commercial footing is highly feasible and will result in sizeable savings for program operations. Public sector cost recovery measures may take a bit longer to implement, but will also have appreciable results. Putting the work-based programs on a self-supporting basis will result in a smaller saving, after a lengthy consensus-building effort. Lastly increased participation of private physicians will over the long term generate cost savings to the public sector, but the magnitude of these cannot be quantified at present.

### 8.1 Commercial Social Marketing

Table 11 shows the cost picture for the CSM program. If oral contraceptives could be put totally into the commercial sector, a savings of \$166,000 would be generated on the product and its packaging. Too, if condoms could be sold at a break-even price, a savings of \$135,000 would accrue on product and packaging. Costs for advertising would increase, since none has been conducted for a long time. Advertising would cost \$125,000. However, it may be possible to get corporate sponsorship for ads which would save \$19,000, and the Panther breakeven price includes a contribution for advertising of \$69,000. Market research would cost approximately \$45,000, but the Panther breakeven price includes a \$26,000 contribution for market research. On balance, \$245,000 would be saved annually by making the CSM activity commercially viable.

151

Table 11  
Cost Impact Picture - CSM Measures  
US \$

Social Marketing Measure	Cost +	Cost -	Possible Net Change in 1 Year
- Commercial OC (Product) (Package)		189,161 27,000	- 166,161
- Break Even Consumer Price for Panther (Product) (Package)		100,589 34,226	- 100 539 - 34,226
- Adv. NFPB Corporate (15%) Contribution Panther Breakeven Price Contribution	125,000	18,750 69,110	+ 37,140
- Marketing Research Panther Breakeven Price Contribution	45,000	26,330	+ 18,670
Total -			245,116

Based on costs p. 49 in Evaluation and sales of 2,139,118 condom units, 515,412 cycles OCs.

## 8.2 Public Sector

As shown in Table 12, three steps are proposed in the public sector. First is the implementation of user fees. This would probably be accompanied by some technical assistance (TA) in design and logistics of the system. The cost savings would be large once the system was established. If user fees recoup 10 percent of the recurring cost budget of the MOH tab of Ja.\$14 million for family planning operations, this would be Ja.\$1.4 million annually, or approximately \$200,000 per year. The estimate of 10 percent was chosen because public hospitals are collecting from 5-24 percent of their recurrent costs.

Table 12  
Cost Impact Picture - Public Sector Measures

Public Sector Measure	Cost +	Cost -	Net Change
User Fees	TA on design, logistics	X	After short-term investment, cost recovery appreciable. If 10% of MOH FP costs = Ja \$1.4 million/year.
Restrictions on Free Commodities	TA on design, logistics	X	Savings on commodities payable in foreign exchange could be considerable. If half of MOH consumers can be transferred to CSM, \$46,000/annum.
Improved Counselling	TA on training, materials budget support for staff	X Long-term if continuation improves + cost-effective methods increase.	Can not be quantified now.

Second is restrictions on free commodities. Again TA on design of the intervention and on logistics might be needed to get the system going. But the savings would be considerable for commodities which have to be paid in foreign exchange. If half of the present MOH consumers could be transferred to CSM products, the cost savings would amount to \$46,000 each year. Once the public sector survey is completed, data will be available on the exact number of public sector acceptors who could be transferred.

Third is the improvement in counselling in the public sector. TA for training and materials may be appropriate, but budget support for staff time may also be required. The latter would be the "big ticket" item in this option. The change would produce cost savings, related to increased continuation of use of methods and to more reliance on cost-effective, long-term methods. But it is not possible at present to quantify the net change stemming from this option.

153

**8.3 Work-Based Programs**

One basic change is recommended for work-based services (see Table 13): that the services be made self-supporting. This would reduce donor/private voluntary funding by \$100,000 for the JFPA work-based program, and public sector expenditure for the operation of the NFPB program on perhaps the same order of magnitude.

Table 13

Cost Impact Picture - Work-Based Measures

Private Enterprise Measure	Cost +	Cost -	Net Change
* Self Supporting System	TA on cost-benefit analysis	X Operational cost	After short-term investment, saves recurring cost of factory program (JFPA program cost \$100,00 U.S./annually)
* More Numerous and Effective Services	TA on organizational structure, counselling in work-based programs	X Long-term if continuation improves and cost-effective methods increase.	Cannot be quantified now.

**8.4 Private Practitioners**

The various options recommended for private providers could be accomplished with relatively small outlays (Table 14). Net change in this area, however, cannot be quantified at present.

Table 14  
Cost Impact Picture – Private Practitioners  
(US \$)

Private Practitioners Measure	Cost +	Cost -	Net Change
- Counselling Training Increased load of FP services delivery in private sector	X	X	Cannot be quantified now
- Referrals (Dr. Reed MCH clinics model)			
Referrals	- 0 -	- 0 -	"
Client service in private sector		X	
Space rental (revenue generation for MOH)		X	
- Private VSC			
Use of space and equipment on weekend	- 0 -	- 0 -	"
Referrals	- 0 -	- 0 -	
Clients served in private sector		X	
- Private Sector/Public Drugs			
Drugs Clients served in private sector	?	X	"

**8.5 Economic and Financial Considerations**

The preceding pages summarize the potential actions which the GOJ may adopt to increase the involvement of the private sector in the provision and financing of family planning. These initiatives were reviewed to assess their potential to increase contraceptive prevalence, and/or reduce the financial burden to the public sector of providing family planning services and commodities. In each area, an analysis was prepared of the cost impact of various recommendations, in terms of whether additional investment will be required or savings/revenues will be generated.

- 66 -

The two initiatives with the greatest potential to increase contraceptive prevalence would be from the increased intensity of social marketing resulting under a Contraceptive Social Marketing program in the commercial sector, and from increased physician awareness and counseling regarding their patients' use of contraceptives. Further work to quantify the increased number of acceptors, and the investment costs associated with these initiatives will be undertaken during project design.

Rough estimates of the annual costs which some of these initiatives would shift from the public to the private sector, and/or the revenue which would be generated to support public sector family planning programs, are provided below.

**Savings to the Public Sector (US\$):**

Shift of CSM to Commercial Sector	- \$ 245,000
Limiting Free Commodities to Those Who Can Afford to Pay	- \$ 46,000

**Revenue from User Fees (1990\$J):**

Visit Fees of J\$15/visit <sup>1/</sup>	- J\$ 1,100,000
---	-----------------

The three interventions identified above will transfer nearly \$300,000 in foreign exchange expenditures annually to the private sector and generate J\$1,100,000 in local currency for program support. With population increase and projected increases in prevalence, these estimates would all increase in real terms. Other variations of these proposals would generate other estimates of foreign exchange savings and local currency revenues; this combination appears to maximize public sector savings in foreign exchange compared to local currency revenues.

---

<sup>1/</sup> Estimate based on the assumption that 25% of the women that made family planning visits to GOJ clinics in 1989 (286,661) would be able to pay J\$15/visit.

156 -

- 67 -

## 9. CONCLUSION

This paper has explored ways in which private sector participation in the funding and provision of services in Jamaica could result in a more diverse, more sustainable family planning service delivery system. Among the alternatives that the paper has examined are the involvement of the commercial sector in implementation of the CSM program, use of cost recovery in the public sector, the role of private enterprise in work-based family planning and the participation of private sector physicians.

This analysis has been driven by concerns about the ability of the GOJ to support the national family planning program in the medium term. During the period of the next seven years, two changes are planned which would dramatically alter the environment in which the program operates. First a major donor, USAID, is phasing out its support. Second, the program is seeking not only to maintain current levels of service but to expand usage. Just to sustain the present 55% contraceptive prevalence rate means that the program must grow in size along with increases in the Jamaican population. To attain a 62% contraceptive prevalence rate, the goal identified in the present Five-Year Development Plan, means that women will have to be brought into the program from the sizeable group of Jamaican women who are lapsed users or who know about family planning but have never used it. These women may be resistant to family planning, influenced by side-effect fears and rumors. Gains in prevalence from within this group will not easy.

The background analysis has considered the potential private sector/cost recovery strategies in terms of impact on service delivery and feasibility, and has taken a preliminary look at the financial implications of their adoption. While these measures would help to reduce the gap brought about by the two changes described above, it does not appear from the preliminary look that they will close it. Thus, the GOJ faces the issue of providing additional funds to the program or risking declines in services (and usage) if those funds are not made available.

But GOJ resources are very constrained and there are no immediate prospects for this situation to improve. The national family planning program will have to compete with other sectors for the additional financing it requires.

The program will need a powerful advocacy agent to support its requests for additional financing. The potential locus for this agency is the NFPB. As outlined in the above analysis, the NFPB can move into a much more powerful advocacy role to promote the program. The NFPB can make the case to all levels and branches of government, in newspapers, to opinion leaders, in communities, etc. about the importance of family planning and the need to increase its use. The active marketing and IEC campaign

- 68 -

can also increase for individual women their sense of the personal benefits of family planning use, and their understanding of methods and appropriate use.

But adoption of this role may require the NFPB to focus more directly on advocacy, communications and marketing and less on direct program operations. Other organizations may have a comparative advantage for direct service delivery and commodity logistics, and time for NFPB staff members on these tasks may take away from concentration on advocacy. The NFPB will still be involved with service delivery entities in a leadership and coordination role.

Changes in the Jamaican family planning program to increase private sector involvement and to strengthen the advocacy function will not be easy. The organizations which comprise the system will be affected and new ways of functioning will need to be adopted. The present donor-government partnership and joint planning process are an important resource to allow the difficulties to be identified and addressed and problems of the transition kept to a minimum. In the interests of smooth continuation and expansion of family planning service delivery, communication and coordination of change are essential.

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

INTRODUCTION

In an ideal world, programs which have been as successful as Jamaica's would be able to simply continue and refine what they are doing so well. But the Jamaica program, due to changes in donor participation, is facing a major change in how it does business. Organizations which were free previously to focus on service delivery now have to look at how programs will be funded, competition for funds from other programs, and elimination of duplication of effort in an environment of constrained resources. As in many mature programs, the Jamaica program has hit a plateau; prevalence has not increased in a decade, and the next groups of acceptors who need to be attracted to the program are hard to reach groups, like adolescents and resistant acceptors who fear side effects. This adds to the gravity of the situation. Program leaders recognize that to bring in those acceptors, and to offer Jamaican acceptors the most effective methods appropriate to their family planning needs, will require significant strides in improving program effectiveness.

The need for programmatic improvements and increased sustainability raise questions about roles of the participating organizations, responsibility for program advocacy and implementation, and comparative advantage of organizations to carry out various functions. The organizations themselves will be challenged to adopt new ways to operate, all the while working to expand the reach of the successful program, and to make it self sustaining.

The present discussion will look at how the needs for effective and sustainable operations affects the participating organizations and their roles in the national family planning program. The discussion will address the local participating organizations, e.g. the NFPB, MOH, and the JFPA, providing a brief description of its role in the program and a situation analysis of its present status and what it may need to do as the system changes. The section will also touch on other organizations/institutions to be involved in the program, such as the Women's Center, the Jamaica General Practitioner's Association and the commercial sector, as well as other donors in the sector. The concluding section identifies the policy issues the system may be facing as a result of these changes.

The design has considered many of the policy and administrative issues facing these organizations, and has proposed various solutions. But this is an evolving situation, where all the actors are moving into the unknown. Difficult challenges lie ahead for the organizations as the service delivery system seeks a new equilibrium, and it is impossible to say now precisely what decisions will be taken and how they will affect program functioning.

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

One thing is important to keep in mind, however. The new system depends less on donor participation. And along with fiscal autonomy comes programmatic autonomy. Decision-making, authority and responsibility will devolve increasingly on the program itself. This kind of increased investment and ownership of a program can reap significant benefits in improved management and oversight. It is with this hope in mind that this project design has been developed.

PARTICIPATING ORGANIZATIONS

NFPB

Description

The National Family Planning Board is the statutory body in the GOJ responsible for coordination and promotion of population and family planning programs in Jamaica. Created in 1967, the NFPB is semi-autonomous; its parent organization is the MOH and the Board of Directors of the NFPB responds to the Minister of Health. Expenditure of the NFPB in 1989/90 was approximately US \$1.5 million, of which more than one-third derived from USAID (Day1XXX and XXX).

The NFPB is organized into seven directorates, including administration, service delivery, statistics and research, special projects, IEC, social marketing and public relations. In addition to its present collaboration/coordination functions, the NFPB operates a large contraceptive social marketing program based on contraceptives donated by USAID. Through this program, oral contraceptives are sold at the equivalent of approximately US \$0.12 per cycle and condoms at US \$0.07 per pack of three; no significant marketing of these products to consumers has taken place since 1985. The NFPB operates three single-purpose family planning clinics, which handled 4% of family planning visits to public sector clinics in 1988. The NFPB also conducts a work-based program which brings family planning to 37 firms, primarily in the garment assembly sector. Lastly, the NFPB stocks contraceptives for the entire public sector program and distributes them throughout Jamaica.

Situation Analysis

Given the twin changes in the operating environment of the national program--the need to revitalize program functioning simultaneously with increasing sustainability--it is imperative that the roles and functions of the participating organizations provide all the supports (e.g. political leadership, advocacy, technical direction) that service programs need in an economical fashion. Presently, the national program includes an organization, the NFPB, with an advocacy and coordination mandate, the potential of which is unrealized. While the primary implementing agent is the MOH, the NFPB retains some operational functions, which may be diluting its ability to carry out the key advocacy role. The remainder of the discussion of the NFPB will examine the advocacy role vis a vis the operational role.

160

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

Advocacy/coordination mandate. The NFPB is empowered under the National Family Planning Act of 1970 to perform a variety of coordination and advocacy functions for family planning in Jamaica. The most significant of these for the purposes of this discussion are the following as given in the Act:

Prepare, carry out, and promote the carrying out of family planning 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.

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.

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.

These functions illustrate the powerful mandate of the NFPB as the prime coordination and promotion body in the national program. Little emphasis is put in the mandate on the role of the NFPB to actually operate programs. Instead, the NFPB is charged with galvanizing the other operational entities, leading and directing them, to ensure an effective national program of service delivery.

The leadership function is vital, both from the sustainability angle--to assure programmatic survival (as in Maslow's basic hierarchical need for organizational survival), and for the program to grow. Dynamic program leadership is needed to turn around the present programmatic stagnation, so that acceptors get more effective methods suited to their needs and hard-to-reach groups are brought in. The NFPB is ideally placed to provide that leadership, and to lead the participating organizations in a proactive planning and management process which

- 1) addresses systematically improvements in method mix, and orients program operations to institutionalize the promotion, counselling and service delivery to achieve this method mix,
- 2) seeks to overcome policy barriers to program growth, such as policy barriers to limitations on private sector participation in family planning service delivery,
- 3) seeks to actualize private service provider groups to participate in the delivery of family planning services, by actively including them in planning and adopting this role,
- 4) maximizes the private commercial sector's ability to aggressively market temporary methods (oral contraceptives and condoms), and to provide powerful mass media campaigns related to fears of side effects and to the personal benefits to acceptors of use of family planning.

161

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

This leadership function will result in development of strong working relationships with counterpart organizations, like the MOH or the Women's Center. In the recent past these have not existed. There are problems in communication between the MOH and the NFPB at every level, from top management, to the directorate level, and down to the field level. While the seconding of an NFPB staff member to the MOH to act as family planning coordinator has helped, the lack of an active joint planning process has hampered effective implementation of the program.

The considerable emphasis in the new project on the development of the advocacy role will, hopefully, change these relationships for the better. If the NFPB is dynamically driving the development of the national family planning program, and working closely with the other actors, the problems of lack of communication may be lessened. Further, this should have implications for improving program effectiveness. Under the project, in tandem with the changes in the NFPB's advocacy role, it may be possible to bring more specific focus to clinical methods and service delivery systems needed to support them. The Medical Committee of the NFPB/MOH is charged with stewardship of the delivery of these methods, and under the new project may more actively manage the program to deliver these.

Limited operational function. As described above the NFPB plays a limited operational role in provision of family planning services. This is of concern for two reasons: it may take away from the NFPB's ability to play the strong advocate role, and it may lead to maintenance of duplicative structures with other programs better situated to handle operations.

For these reasons, it is recommended that the operational elements of the NFPB's program be divested. The vertical clinics should be examined with an eye to turning them over to the JFPA if they fill an important niche as single-purpose clinics, to the MOH if they are appropriate for development into integrated programs, or to be closed if they are redundant with MOH clinics. The work-based program may be consolidated with the JFPA's work-based program which is being put on a self-supporting footing. In line with its mandate and advocacy role, the NFPB should coordinate with these other organizations about the direction of program development.

The CSM program should be put into the hands of the commercial sector. Because this program has been based on donated commodities and highly subsidized marketing costs, it has not been operated aggressively with marketing and price increases to keep it in line with inflation. Among the public sector programs, the sales of orals and condoms is the easiest to make self sustaining by privatization. The commercial sector can be an effective partner in view of its comparative advantage in marketing, to respond rapidly to changes in the marketplace, and to take reasonable business risks. By comparison, government organizations must maintain systems of checks and balances, minimize risk, and focus on consensus building. The government's comparative advantage is in these essential functions. The NFPB would retain the coordinating role in the private partnership program, working with the commercial firms to develop letters of agreement, marketing plans, etc.

16/2

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

Another operational function at the NFPB is the distribution system for contraceptives for the public sector. The MOH, of course, also simultaneously stocks the same clinics with commodities for primary health care. From the perspective of public administration in Jamaica, the long-term desirability of the NFPB and the MOH maintaining parallel structures to stock the same facilities should be examined.

In the short run, it is recommended that the NFPB continue this function, and that the Project strengthen the NFPB's capabilities. This is appropriate for two reasons. First, at present in Jamaica, the budget line item for contraceptives is viewed as an integral part of the procurement and distribution function. As long as that view prevails, the power to control the budget line--and the priority which contraceptive supplies have in the program--militate for the NFPB to retain the function. Over time a solution may be found to allow the distribution system per se to be separated from the budget item/power balance issue. For example, if the NFPB becomes the powerful advocate agent, it may be able to obtain full funding for the line item, turn funds over to the MOH and track the priority acquisition. Second, the MOH system appears to have problems in its own right, and the time may not be right to make more demands on the system and risk contraceptive outages.

Over the long-term, USAID, which has interests in the operation of the health sector may want to take a hard look at the MOH distribution system, with an eye to increasing efficiency there. The stand-alone distribution system at the NFPB may not be sustainable. It is now based on vehicles provided by USAID; over time, as these go out of service, the NFPB may have difficulty replacing them. The same constraint applies to the MOH, however, the MOH may have better access to replacement vehicles from the GOJ. The Health Sector Initiatives project at USAID (532-0152) has some concern for effective management of MOH pharmaceuticals; under its auspices, technical assistance and policy planning could be undertaken. Family Planning Initiatives has an interest, since this issue is tied to the overall sustainability of the family planning program. Whether the NFPB or the MOH manages the distribution program, considerable technical assistance is needed for efficient functioning of the procurement and distribution system. The two projects may want to combine forces in working out solutions.

For the NFPB to gear up to become the powerful advocate organization, and to transfer its operational functions to other entities, will not be easy. Organizational change in this degree is always difficult, requires great commitment and investment of time and resources.

Ministry of Health

Description

The MOH is the major provider of public sector family planning services. As indicated above the MOH handled 96% of the 255,662 public sector family planning visits in 1989. The MOH delivers family planning services through a network of hospitals and through 360 primary health clinics. Family planning is a considerable part of MOH services; in 1989, family planning represented nearly 15% of MOH visits and was the third most frequent service provided after curative care (46%) and child health services (19%).

163

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

Given the way family planning services have evolved in Jamaica, the MOH is also the major provider in the total system, including private sector sources. According to the 1989 Contraceptive Prevalence Survey, the MOH provided 88% of all surgical contraception procedures and 65% of other methods.

Situation Analysis

Historically, the MOH has served Jamaica well in meeting the primary health care needs of families. In fact, the success of the public program, in MCH and family planning, has dampened the development of these services in the private sector.

However, in recent years, funding of MOH programs has been level or declining, and the 1980s saw a retrenchment of services. Between 1983 and 1988, visits of every type were down by as much as 8-54%, with family planning declining 18%. Declines in usage were probably the result of a combination of actual declines in quality of services and consumer perceptions of declines in quality stemming from long waits, personnel shortages, and delay in special services like reading lab tests. Personnel shortages, particularly of nurses, have hampered service delivery and saddled the system with increased costs when it tries to compete with private sector (or foreign) salary structures.

Sustainability. The present resource constraints on MOH operations will increase when USAID phases out. To address the lack of sustainability in the health sector as a whole, the health sector finance issue of user fees for service is being considered by the MOH. The adoption of user fees appears in the policy matrix of the World Bank social adjustment program, and in conjunction with USAID's Health Sector Initiatives Project (532-0152), a planning process and technical assistance is being undertaken to develop new policies and implement new approaches.

Adoption of user fees for family planning must be considered in light of the impact on health sector financing and on beneficiaries (both as the fees support a quality service and as they tax the consumer for use). Exposition of the latter impact belongs more properly in the social soundness analysis; suffice it to say here that from the beneficiaries' perspective, this may be an appropriate time to implement user fees in family planning. An eventual user fee policy should address the needs of the poorest of the poor (the safety net consumer) and any other groups whose needs must be specially targeted (e.g. first-time users).

With respect to the administrative and institutional analysis, the larger issue has to do with the impact of the policy on the program and on financing in the sector. To assure that the implementation of fees does not hurt program usage, these fees should be phased in along with fees for other primary health care services, particularly for curative care. Furthermore, arrangements must be made--within the MOH, and between the MOH and the Ministry of Finance--first to permit local institutions to keep some of the funds, as an incentive to them to collect the fees, and second to link the funds generated with family planning program operations. This link is necessary if those funds are to ensure the continuation and improvement of services, the rationale for adopting user fees for service in the first place.

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

Along with user fees, another change in services is the possibility of restricting the provision of free contraceptives (orals, condoms and eventually perhaps injectables) so that these are available only to the safety net consumer. The rationale for this has two facets. First, it would relieve the public sector of the burden of finding foreign exchange for some portion of its new contraceptive procurement task, by transferring the social marketing consumers who use the public sector clinics for counselling to the commercial sector for their commodities. Second, it would also increase the likelihood of the successful development of a self-financing social marketing program in the commercial sector. To the consumer, this policy would also permit the public sector to distribute the CSM products free to the safety net and special groups who are eligible for free contraceptives. They would then continue to use the same product if their circumstances changed and they "graduated" to private sector sources.

User fees may be adopted by the GOJ at some future point as a policy decision. Because the development and implementation of the system is needed at the level of the health sector, it is recommended that technical assistance to the activity come from Health Sector Initiatives. Since family planning fees are a small component of the full system, no TA is planned for this under Family Planning Initiatives.

Program Effectiveness. The MOH is a pivotal actor in moves to make the national family planning program more effective. First, the MOH is presently the major provider of family planning services; over time, even if private providers become more active, the MOH will remain a major provider, particularly of clinical methods. Second, the MOH, through its professional councils, plays a vital role in decision-making about standards and organization of professionals in private practice.

Whereas the NFPB has a dynamic leadership role in the move toward greater effectiveness, the MOH will be the implementing agent. If through the Medical Committee, under the leadership of the NFPB, policy decisions are made to strengthen clinical methods delivery, the MOH will then be called upon to assure that the services are in place, and that promotion and counselling make known that availability. With respect to clinical methods, there are access problems in Jamaica. Although the system as a whole has sufficient service sites, these are not all staffed by providers trained to insert IUDs. Careful attention should be devoted to this problem, so that training programs can be conducted on a regular basis to resolve the problem. At the same time, if an acceptor can really get an IUD at a clinic, promotion and counselling for the method in the cafeteria of methods will need to be strengthened. The availability of VSC suffers from much the same problem, although complicated by the fact that operating room time and teams are required, as well as equipment. VSC service availability and counselling in a multi-method program both need to be strengthened. For the program to meet the needs of older, high parity Jamaican women, support of clinical methods in the MOH needs to be expanded.

165

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

The MOH will also be involved as the program seeks to activate private providers of services. With its medical oversight responsibilities, the MOH will be integrally involved as the system confronts the types of services which can be offered by various types of providers and the training required for those services. Questions which have been resolved in the public sector, due to long experience with that program, will now surface as private providers become more involved. Examples include nurses performing counselling roles, private physicians using depo provera for family planning, etc. Once these practice issues are resolved, private providers will also need training. Private physicians may need training in IUD insertion; physicians and their counselling staffs may need to learn how to handle the questions of depo provera acceptors about break through bleeding. The NFPB and the MOH will be key when these issues are confronted, and plans made to implement solutions.

Ministry of Education

The Ministry of Education (MOE) has historically cooperated with USAID to develop a family life education (FLE) curriculum. In a small USAID-funded activity conducted between 1983 and 1986, a number of tasks were accomplished: workshops for counsellors, school nurses and teacher trainers; booklets for students; curriculum guidelines and radio programs. Notwithstanding these discrete successes, family life education was not institutionalized in the schools as a result of the activity. The integrated teaching process appears to have diluted the message; materials for students were didactic and visually unattractive; and the decision to include the program in local schools was left up to the head teacher or counsellor. Because of the increasing problem of adolescent fertility in Jamaica, reaching adolescents with the family planning message remains essential. The Project will assist the MOE to institutionalize FLE in the schools, provided the curriculum adopted is acceptable to the NFPB and that the curriculum is mandatory in the schools.

Jamaica Family Planning Association

Description

The JFPA, founded in 1957, operates a diverse program of service delivery, IEC and public relations. The JFPA has two direct service clinics which offer all methods to consumers on a sliding-fee scale. The JFPA runs an outreach program (previously funded by USAID/NFPB) in St. Ann's and Trelawny; the Trelawny program in 1989 had a higher incidence of adolescent acceptors than any parish in Jamaica. The association also operates a work-based program to bring family planning services to workers in 90 firms (1989), including local service industries like a newspaper, hotels and restaurants. The JFPA has been actively promoting family planning through a play, "Pepper", and a video, Real Man. Both have been very well received and the JFPA is seeking to have a local commercial distributor show these media presentations on the distributor's touring caravan.

166

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

The JFPA has an important national role to play. When there are issues in family planning, where government intervention is constrained by politics, a private, autonomous organization may have space to move. XXXFor example, a private organization might be able to dramatize the need for family planning to reduce maternal mortality from illegal abortion when a public advocate might not be able to. Furthermore, the JFPA is affiliated with an international non-governmental donor (IPPF/WHR) whose involvement is apolitical. This provides both continuity and a degree of flexibility which governmental donors cannot always guarantee.

Situation analysis

The JFPA has achieved these successes during a tumultuous period of its development. The association, which had been located in Ocho Rios, has decided to go national and to relocate its headquarters to Kingston, the national capital. This has made it all the harder to manage the successful Ocho Rios program, while increasing the organization's scope to the national horizon.

To add to the difficulty of relocation, USAID has phased out its support to the JFPA. USAID had been supporting the JFPA through an operational program grant, which ended in May, 1990. Since then, the JFPA had to (and continues to) reconstitute its bases of financial support. This has led to some dislocation of programs.

Without USAID's funding (which amounted to 36% of JFPA's funds (J\$ 1,548,098 in 1989) directly through an operational program grant and an additional 14% indirectly through the NFPB), funding is extremely tight for the association to conduct its programs and establish its national base. USAID is providing TA to the JFPA to help that organization develop a business plan for a sustainable program. The JFPA's successes should, if marketed well, provide a platform for fund raising, even from IPPF/WHR.

Although USAID will no longer provide support to the core program for ongoing activities, USAID will enter into a cooperative agreement with the JFPA for the latter to administer the private sector seed grants under the Family Planning Initiatives Project (the JFPA may also receive a grant under this program to start a revolving fund for IUDs and injectables sold to private physicians). Locating the seed grant program at JFPA would achieve some capacity building with JFPA, in addition to administration of the seed grant program. The program will fund innovative pilot activities in the private sector which have the promise of becoming self-sustainable. Examples include a "revolving drug fund" to put low-cost methods in the hands of physicians who serve low-income women, tests of whether the addition of a family planning nurse or educator are sustainable and increase family planning services, tests of "week-end VSC" (to maximize use of operating room facilities), and tests with private firms such as plantations of the sustainability of adding family planning to the health services they provide their workers. Administering this fund will give JFPA more project management experience and expand approaches to private sector provision of services. Under the new project, USAID will provide TA to the JFPA to assist with implementation of this activity.

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

Other Private Organizations/Institutions

Two other private organizations and institutions will be involved in the Family Planning Initiatives Project. The private physicians activity may work with the Jamaica General Practitioners Association in trying to activate private physicians to provide more family planning services. This organization is loosely formed; it has a President and a Board and holds monthly meetings. The organization does not have a permanent staff, although it has access to secretarial support. Thus it would be difficult to do any permanent institutional strengthening, such as providing a computer for development of a mailing list or for mass mailings. If private sector seed grants would help to expand services through provider groups like the Nursing Association of Jamaica or the Midwives Association, collaborative work with these organizations groups may be done. The exact type of relationship (TA from the JFPA, subgrant from the program) would depend on the level of institutionalization of the group.

The Project will make a grant to the Women's Center for work with adolescents to delay the first pregnancy. The Women's Center, founded in 1977, has had a highly successful program to help school girls after their first pregnancy. The Women's Center has a large donor base, including both local charities such as the United Way and international donors, like the Norwegian Red Cross, and the Swedish and Canadian International Development Agencies. The Women's Center has five regional centers and is seeking to expand this number to seven, with UNFPA support. This will complete the network of fixed centers in Jamaica. The Women's Center is also in the process of developing a network of outreach offices in the deep rural areas. This is a new initiative, taking a variety of forms according to the human and physical resources available in those areas. The Women's Center is in process of obtaining legal status as a foundation.

The Women's Center will reach adolescents with family life education in the schools. The Women's Center grant would not support core costs of the present program, but would be designed to support all costs of the new activity. The Women's Center is aware that the grant would be one-time only, in view of USAID plans to phase out its population assistance.

Other Donors

Policy Framework

The policy framework laid out below shows some of the key policy issues and decisions the Jamaica family planning program will have to make:

1. Role and function of NFPB.

- 1a. Is the NFPB willing to be a powerful advocate, and thereby to begin to exert leadership in making the family planning case to government and the public, to raise funds, develop a political power base and assure the continued survival of the program?

ANNEX E  
ADMINISTRATIVE AND  
INSTITUTIONAL ANALYSIS

1b. Programmatic leadership. Is the NFPB willing to lead the program so that it now begins to grow again, by

1b1. leading the system to systematically address method mix through a mechanism such as the Medical Committee, to ensure that Jamaican families are using the most appropriate methods for their needs?

1b2. leading the system to address policy barriers limiting program growth?

1b3. leading the system to actualize the participation of private providers in the delivery of family planning services?

2. NFPB operations

2a. Social marketing operations. Is the NFPB willing to let the commercial sector enter an affordable, quality product into the marketplace, at a price that can sustain the product over time, and aggressively market these products?

2b. Social marketing advertising. Is the NFPB willing to ensure that a fast-moving, marketing based process for approval of advertising campaigns exists within its structure?

2c. Single-purpose clinics. Is the NFPB willing to divest itself of these?

2d. Work-based programs. Is the NFPB willing to divest this program?

3. Parameters of public services

3a. Program effectiveness: Is the MOH willing to address service delivery issues, such as clinical methods provision and counselling, policy barriers to program growth, and issues related to increased participation of private service providers?

3b. Health sector finance:

3b1. User fees. Are the NFPB and the MOH willing to collaborate to develop and implement a user fee policy which includes fees for curative and family planning visits?

3b2. User fee retention. Is the MOH willing to allow local facilities to keep a portion of fees collected as an incentive to the clinic to collect fees?

4. Distribution of contraceptives. Is the GOJ willing to ensure through the NFPB and/or the MOH that contraceptive requirements are funded and procured?

5. Role of the JFPA. Is the JFPA able to carry out marketing activities which will raise funds, from its major donor, enterprises and consumers of its services, to insure its survival?

## INTRODUCTION

"...the successful implementation of a family planning program and public acceptance of conscious fertility regulation can desensitize people to this form of intervention. What was once considered suspect becomes tolerable and even laudable. At the same time, such battles can never be considered finished, for the politics surrounding family planning are complicated and can change."

"Culture and the Management of Family Planning Programs",  
Donald P. Warwick, STUDIES IN FAMILY PLANNING, Vol. 19,  
Jan./Feb. 1988.

The Jamaican family planning movement was conceived in the late 1930's. It is not a coincidence that its advocates were involved with the political movement for independence and nationalism (Wynter 1990). At first, it was considered part of the eccentric baggage of the educated creole elite and soundly condemned by the organized churches. Despite government support (verbal), it was not until the 1970's that an administration committed itself publicly. By then, family planning was part of the development strategy accepted internationally.

There were other trends that converged to make the campaign succeed. During the past three decades, the population in general made socioeconomic advances. Women, in particular, gained acceptance as income earners, especially in the informal sector where they comprise the majority of workers (Witter and Kirton 1990). Traditional beliefs about fertility have begun to crumble, despite certain strong myths that continue to prevail. The commonalities of family planning policies by successive administrations have helped to establish continuity and a permanent foundation for the campaign. Thus, with the hefty technical and financial support in the 1980's from international agencies, Jamaica was able to move to a mature stage in its program.

Since 1978/1979, however, the CPR trend has appeared to stall or to plateau. When compared to other countries at the same stage, Jamaica reflects hard core problem areas that could prohibit further progress (POPTech 1991). Some of the main problems relate to users of contraceptives and grow out of the sociocultural framework of Jamaica. Beliefs still held and even more recently, misconceptions formulated, result in negative attitudes towards family planning. These include attitudes towards the body. Working class Jamaicans believe that they must keep their bodies strong and clean (hence the latest song "Healthy Body"). Coitus though weakening is essential to the mental health of men; while for women, menstrual flow, coitus and pregnancy are not considered weakening. For women, to have coitus is to avoid the danger of blocking up natural vitality. The body's interior is regarded as mysterious, and there is fear of "losing things up there" (Brody 1981). This may stimulate resistance to IUDs, condoms and barrier methods. It is reported that some women view the condom (like the IUD) as an invasive object that could slip off and cause sickness, sterility or even death by blocking off the tubes (MacCormack, Draper 1987).

Beliefs about fertility although fading, can still be influential. Women, it is thought, must have babies to release natural vitality. Fertility is still seen as essential for men to produce children in order to prove their manhood. Women and especially young women, feel the pressure to become pregnant to achieve independence, respect and perhaps even an income from the "baby father". With the difficult economic situation and the increasing financial independence of women, the old belief that woman's main role is child bearer and child carer, is diminishing (Durrant-Gonzalez 1982).

Aside from the sociocultural factors, there are the political implications that must be considered. With the development of family planning services mainly in the public health sector, the service becomes controversial because of its socio/political base. Both political parties have run major campaigns as opposition parties on the promise that they would improve the health services to poor people (1980 and 1989). The family planning services have been perceived as one of the most successful aspects. To dislocate them could result in an outcry, both from political critics and vocal special interest groups (women's groups, sections of the media etc.). This could be strident if measures are taken outside of a general policy to revamp the public health sector (e.g. fee collection), or if action begins simultaneously with a general election campaign. In view of the impending enactment of the General Consumption Tax, it would be an appropriate time to introduce new policies that ensure sustainability and improvement of services.

The history of the public health sector in Jamaica could, however, act as a deterrent to increased private participation. Public health care was originally one of the sops offered to the majority of the population at the beginning of this century, after the failure of the sugar plantations and the economic depression that affected the former slaves and their families. Epidemics of yaws, typhoid, Spanish influenza and malaria terrified the population. Unable to treat such new illnesses with the traditional methods (primarily herbal medicines), they were forced to turn to what were modern methods introduced by a small cadre of doctors, consisting of a few Jamaicans and several English physicians. Medicine was always a profession chosen for service and encouraged by the Colonial Administration which offered training to a select few in the "Mother Country" (Chambers 1990).

172

The public health sector was, therefore, the sector that helped the poor and offered services based on the British health system . In order to meet the needs of the majority of the population, successive governments found themselves having to meet soaring expenditures without any chance for recovery. But the expectations of professionals, civil servants, politicians and the public that: each citizen has a right to free health care (like free education) became one of those insurmountable goals that plagued each party which came to government. Today, it is difficult to remove the welfare oriented, service-for-all philosophy that surrounds the public health services, even though they are increasingly incapable of meeting the growing needs of the population (Appendix A).

The most difficult decisions for this project therefore, will be those that pertain to the political will and commitment to support privatization of some aspects of the family planning program. The program has been consistently successful from the public's viewpoint, and therefore, is perceived by the political directorate as one area of accomplishment. Not least of all, the brand names PERLE and PANTHER have become so familiar to Jamaicans that they have been incorporated into the popular culture as generic terms for contraceptives. Thus project planning must recognize these political forces and introduce change in ways designed to minimize program disruption and political backlash.

173

#### OBJECTIVES AND METHODS FOR SOCIAL SOUNDNESS ANALYSIS

The overall aim of the SSA was to define and examine the participants and beneficiaries of the Project (see Appendix B for terms of reference).

This task included:

- (1) Discussion of the socioeconomic and political factors that related to project activities.
- (2) Identification of socioeconomic and cultural characteristics of beneficiary groups, as well as indirect beneficiaries, disaggregated according to gender.
- (3) Identification of GOJ policies that would facilitate or impede the project.
- (4) Discussion on how benefits could reach the beneficiaries, especially groups likely to adversely affected by some project activities.
- (5) Review issues and constraints such as at the local, national decision making level.
- (6) Identify and review sociocultural constraints that may impede or delay target population's participation.

In order to achieve these objectives, it was necessary to:

- Review secondary data on family planning in Jamaica as well as literature pertaining to other countries at a similar stage of development.
- Interview representatives of the various target populations involved.
- Analyze literature on sociocultural factors related to family planning today in Jamaica.
- Extrapolate conclusions from recently gathered data (Hope Enterprises and Russell/NFPB) in order to give an up-to-date profile on users and potential users of contraceptives.
- Liaise with Team Leader to understand overall project activities and details.

- 174

### RATIONALE FOR TARGET POPULATIONS AND BENEFICIARIES

The proposed project encompasses a wide range of groups involved with family planning in Jamaica. Based on the overall objectives and activities, the target populations can be categorized according to short term and long term beneficiaries, as can be seen in the matrix which follows. Although this categorization has been adopted, it can be seen that it sometimes overlaps or reoccurs in the various components.

- (1) USERS
- (2) NON-USERS especially those problematic, at risk groups
- (3) HEALTH CARE WORKERS
- (4) PUBLIC AND PRIVATE DOCTORS
- (5) GOJ POLICY MAKERS

#### (1) USERS

The most recent CPS indicates that 76% of the users of contraceptives in Jamaica are women (MacFarlane, Warren 1989). This could indicate that women are the main decisionmakers regarding use of contraceptives in sexual relations, conception and child bearing. Simultaneously, the majority of family planning products and services are delivered through the public health centers to women (MacFarlane, MacFarlane 1989). It is important therefore, to introduce gender considerations and to disaggregate the potential beneficiaries for effective implementation.

175

INPUT	SHORT-TERM BENEFICIARIES	LONG-TERM BENEFICIARIES	CONSTRAINTS
<u>Training/Dialogue</u> - Clinical methods for public and private physicians  - Seminars with GOJ policy-makers and NFPB	- Nurses, midwives - Health care staff  - General practitioners - Ministry of Health	Users who will get more information and better service  Development of the health sector through knowledge and discussions  - Seminars for technical  - NFPB as advocate with professional groups and policy makers.	- Debate over method mix results in no central focus.  - Indecision among doctors regarding IUDS. - Procedures allowed for Midwives and Nurses may be restrictive. - NFPB may not be able to complete necessary management restructuring on time
<u>Public Policy</u> 1. MOH collaboration for privatisation of services.  2. If primary health care fees implemented in clinics  3. Organize health centre to have fee collection capabilities  - Fee for service policy instituted to improve quality of services  - Monitor revenue collection.  - MOE committed to FLE in school curriculum.  - Planning for improved method mix.  - Implementation of widely available programs of clinical methods, counselling and procedures.	- Ministry of Health - Health Centres          - MOE	Less financial burden  Sustainability of programme.  GOJ Users: CSM consumers in clinics pay fee for service & may switch to private safety net consumers could profit from more clinic counselling.	- Follow-up and motivation of public health centre personnel  - Lack of support by MOE Departments and schools for FLE.  - Organisation of the fee collection capabilities problematic, especially in rural areas.

POPTech/USAID: INITIATION OF BILATERAL FAMILY PROJECT (JAMAICA) SOCIAL SOUNDNESS ANALYSIS

INPUT	SHORT-TERM BENEFICIARIES	LONG-TERM BENEFICIARIES	CONSTRAINTS
<p><u>Commodities</u> Transfer marketing and distribution of CSM to private sector</p> <p>Introduction of low-dose pill</p> <p>Price Increase</p> <p>GOJ can concentrate on poor women</p>	<ul style="list-style-type: none"> <li>- Private doctors benefit from training</li> <li>- Pharmacists</li> <li>- Retailers</li> </ul>	<p>CSM Users who pay more and get better product and service</p> <p>a) pay more b) better product service</p>	<ul style="list-style-type: none"> <li>- Political decision to commercialise products and raise prices.</li> <li>- Criticism from small liberal women's groups, political vested interests, etc.</li> </ul>
<p><u>Social Communication</u></p> <ul style="list-style-type: none"> <li>- Research (policy and social marketing)</li> <li>- CSM Training for pharmacists, physicians and nurses.</li> <li>- Public relations to private physicians to encourage involvement.</li> <li>- Mass media campaign to women users ("ask your doctor ....")</li> <li>- Agressive marketing of CSM products addressed to side effects and personal benefits of users</li> <li>- FLE Programme</li> <li>- Institutional strengthening</li> </ul>	<ul style="list-style-type: none"> <li>- Private Sector.....</li> <li>- Poor women benefit from aggressive marketing.</li> <li>- Pharmacists and physician:</li> <li>- Lower income users (esp. women)</li> <li>- Teenagers</li> <li>- Hard core non-users</li> <li>- Rural women</li> <li>Ministry of Education &amp; school children</li> <li>- Women's centre</li> <li>- NFPB</li> </ul>	<p>GOJ which can decrease subsidy on commodities and shift commodity distribution responsibility to private sector</p> <p>Families who otherwise would suffer from lack of information, too many dependants and unwanted pregnancies.</p> <p><u>Teenagers</u> who need information</p>	<ul style="list-style-type: none"> <li>- Transition to new brands including removal of Perle name</li> <li>- Churches and conservative organizations will question hard-sell of contraceptives.</li> <li>- Some schools, PTAs and parents may not want FLE in schools.</li> <li>- Professionals might not participate fully in seminars.</li> </ul>

177

The important subgroup which depends on the public sector program is the poor, most probably unemployed and rural women who are presently users.

According to the World Bank/University of the West Indies Living Standards Survey 1989, 32.7% of the Jamaican population fall below the poverty line. In these poor households, 55.5% of expenditure was on food, with that expenditure slightly higher in rural areas (Anderson 1990). The distribution of this poverty population was 70% in the rural areas. According to the plan, women in these areas will be the priority for free access to counselling and commodities through the public sector. They are the least able to pay and are most likely to be still influenced by traditional beliefs about fertility and manhood. They also have had less exposure to information on family planning, methods and procedures.

Table 1  
Frequency Distribution of Expenditure Priorities  
(three most Important Expenses Used)

Priorities	F
Food	22
Rent	8
Transportation	6
Education	6
Savings	1
Self/Children	5
Utilities	3
Clothing	1
Health	1

Source: Hilary Robertson-Hickling and Sue-Marie Lee Preliminary Report on Strategies of the Poor Women for the Survival of the Family and Action taken by the State of Private Agencies. Prepared for UNICEF, 1988.

178

Poor women in urban areas would also be a priority; however, the extent of poverty and access to various methods and information, will lessen the impact on them. These women would be more likely to be employed occasionally, in service jobs, especially in the informal sector where they comprise the majority of workers (Harris, Boyd 1989). Access to clinics, health centers and private doctors would also be more improved for them. The lower middle or C and D socioeconomic groups of women who are now users of contraceptives will be expected to pay the increase on commodities, both at the public health center and at the pharmacies. Some women may shift over to the private doctor in view of the fee-for-service policy at the centers, and the obvious benefits of paying for better services and less waiting time.

Many of this group utilize public sector services (Hope Enterprises 1991). They are semi-employed and semi-skilled, occupied in categories such as domestic work, factory work and vending. About 30% are self employed. If not employed, their sources of income are: boyfriends/partners, parents or husbands - in that order. About 44% live with a partner and 33% have a visiting union. Since 74% had attended secondary or all-age schools, the clientele of the public sector seems to be more educated when compared to the national sample; and they are certainly not "the poorest of the poor". 51% of the women surveyed were currently using contraceptives. Only 11% ever visited a private doctor for family planning - although 70% visited private doctors for other illnesses, indicative of their ability to pay if fee-for-service is implemented in the clinics.

Male users of contraceptives in Jamaica mainly rely on condoms. The major reasons for using condoms, according to a national survey (Russell/NFPB 1991), are: to prevent pregnancies (26%), to prevent AIDS (13%) and to prevent STDS (11%). Condom users purchased these products from pharmacies, grocery stores or clinics; and the most popular brands were Panther, Sultan, Rough Rider and Atlas - with Panther far ahead in the market. Condoms were also spread evenly throughout the economic groupings, in comparison to other methods. This recent study ranked the respondents' main reasons for not using contraceptives as: (1) not sexually active, (2) taking chances, (3) partner uses contraceptives, (4) side effects.

#### (2) NON-USERS

The most important non-users for this project are: women currently in union who are not using contraceptives (about 45% CFS 1989), teenagers and men, especially young men who are sexually active and have serial relationships. The women at risk (those not using family planning and who do not want to become pregnant) include those who are discouraged because of bad side effects, preconceptions of bad side effects, male partners who refuse to either use contraceptive methods or to have their female partner attempt to prevent pregnancy. There is also the group which feel peer pressure to "have their lot" or to produce a child for traditional role recognition. We hypothesize that these women at risk appear to be mainly young, poor or financially dependent, semi-employed and without skills or a completed primary school education. The survey of public health clientele revealed that 83% did not initiate contraceptive use until after the birth of the first child. Among those who were not using contraceptives, 34% had tried and stopped, 23% had never tried, and 26% "did not like". There was strong evidence that "bad side effects" or hearsay regarding bad side effects were the reason for cessation (Hope Enterprises 1991).

The rate of pregnancies among teenage girls has not increased, but it has not decreased sufficiently in comparison to other age groups (MacFarlane, Warren 1989). Over two thirds of all Jamaican women were reported to have had their first pregnancies before the age of twenty, and age at first birth is declining. This was probably under-reported due to the possibility of abortions which are now on the increase. At the same time, teenage girls are reported to feel self conscious and shy to go to the public health clinic, or to approach an adult in order to seek family planning information or to begin using contraceptives. And there is considerable anecdotal evidence that youngsters are turned away from the clinics when they seek services. Access to contraceptives and counselling for both teenage girls and boys is limited. The schools have not yet adopted a definitive family planning education policy, nor have other potential groups (church and community groups) dared to approach the subject still regarded as controversial and bordering on immoral.

Young men who are sexually active and not supportive of family planning, are important target groups. They may be in both urban and rural areas, unemployed or unskilled, and not capable of supporting children - much less a mother and child. With the economic situation worsening, this group should be considered one of the most significant target groups for promotion and information dissemination. Their desire to merely be seen to father a child and the resulting predicaments for the women involved and in fact, the country, are critical issues in the future family planning campaign.

181

(3) HEALTH CARE WORKERS

The first point of contact for most users is the health care worker: the nurse or the midwife who acts as counsellor. This is due to the spread of public health centers and the delivery system in Jamaica which is, de facto, staffed and run by nurses and other technical personnel such as midwives. According to the Ministry of Health (interview with Primary Health Care Nurses Co-ordinator), there are 360 registered nurses in the primary health care family planning centers and 57 assistant/enrolled nurses. There are also 270 midwives although there should be a permanent cadre of 389 on staff.

RN II and Midwives in Public Sector Midwifery

Parishes	Cadre	At Post (in field)
KSA	44	35
ST. THOMAS	26	17
PORTLAND	15	10
ST. MARY	30	18
ST. ANN	37	21
TRELAWNY	28	24
ST. JAMES	25	22
HANOVER	22	13
WESTMORELAND	24	17
ST. ELIZABETH	25	20
MANCHESTER	35	23
CLARENDON	47	27
ST. CATHERINE	31	26
<b>T O T A L</b>	<b>389</b>	<b>273</b>

Source: Primary Health Care Annual Report  
Primary Health Care Nurses' Co-ordinator  
Ministry of Health, 1991.

Despite the low status given to midwives in Jamaica (as in many other countries), they rank high in the opinion of many poor people, particularly those in far-flung villages. Midwives, according to the Nurses and Midwives Act 1964, are the only health care personnel who are allowed to administer certain prescription drugs and emergency measures in the absence of a doctor (see Appendix C for NURSES AND MIDWIVES ACT - REGULATIONS). They have also been the channel for reaching women in rural areas during the post-partum stage and counselling them about family planning. The present situation regarding this target group is uncertain. They have recently been lobbying : (1) not to be reassigned to Local Government, and (2) for improved benefits e.g. pensions. Their training however, through the Victoria Jubilee and Cornwall Hospitals, appears to be thorough and professional. There remain today, few "nanas", the original traditional midwives, whose skills and presence were much valued in each community.

#### NURSES AND THEIR SIGNIFICANCE

According to the register of the Nursing Council of Jamaica, there are 11,943 registered nurses and 7,191 midwives based on their records from April 1952 to February 1991. Needless to say, many of these personnel have either migrated, died or moved out of nursing. The number of practicing nurses today is more in the area of three to four thousand, many of whom will be the most important catalyst in family planning for a community or village. Some of them have been trained in various aspects of family planning, though not all. These people are vital. If they are missing due to migration, the service suffers, the system becomes understaffed, overburdened and trained staff for clinical services may not be available. Their training is important - to be sympathetic counsellors to women and to be knowledgeable in offering all methods to the receptor. Attitudes can pose barriers, for example, if the nurse acts as an authority figure vis a vis the acceptor or believes that adolescents should be turned away.

(4) PUBLIC AND PRIVATE DOCTORS

According to the register of the General Practitioners' Association (Interview: Dr. Samuels), there are between 1,200 and 1,000 doctors in Jamaica 40% of whom are female. The total number has not changed since 1982 due to fluctuations caused by migration and further specialized studying overseas. 75% of these doctors practice in Kingston and St. Andrew, while the rest cover the rural areas. According to Dr. Lucien Jones, President, MAJ, about 40% of doctors are general practitioners. The shortage of doctors, particularly in the rural areas and public sector, has led to an importation of doctors from India and Sri Lanka by MOH. The GPs play a vital role at the primary level in curative services, but have problems related to referral services. Many have both public and private practices, in order to maintain links with hospitals, operating theaters and referral facilities within public sector. It is also necessary to allow senior doctors and specialists to be consultants to the public sector to retain their presence - however limited.

Most GPs do not have nurses in their offices, so that some family planning procedures and treatments are not possible. There is also the general attitude that family planning is the property of the public sector, so most GPs do not pay much attention to counselling, method application and follow-up. It is possible that they have never had sufficient training or exposure to these services. Women, too, do not realize these practitioners can respond to their needs. Because of these barriers, the Project will seek to involve these practitioners to increase opportunities and to reinforce the family planning message.

(5) GOJ POLICY MAKERS

In view of other progressive policies already in the pipeline, to improve the public health sector's services, streamline its management and to privatize some aspects, including a more general fee-for-service policy, it does appear that GOJ policy makers, especially in the MOH, are making practical decisions in order to create a more sustainable system and to decrease the pressure on the public purse. This group is well ahead of many comparable managers in other developing countries with regard to planning for a more viable future in health services. It is, however, the detailed implementation and motivation down the line that will take some time.

This is where the NFPB must play an important role in supporting the Ministry, taking the lead in family planning in the private sector lobbying effort and constantly advocating family planning in public forums. Jamaica cannot afford to be complacent about its record. And the NFPB must now take up the challenge to lead the program and the crusade.

185

SUMMARY OF USAID/NFPB FAMILY LIFE EDUCATION PROJECT

Executing Agency: Ministry of Education

Duration: May 1983 - December 1986

Budget: J\$403,414.70

OBJECTIVES

- To improve the self concept of teenagers
- To reduce teenage pregnancy
- To lessen susceptibility of adolescents and pre-adolescents to sexual abuse
- To introduce the concepts of population control and its influence on various sectors of the economy.

ACTIVITIES

- (1) Workshops for Counsellors, schools nurses and teacher trainers. 3,365 participants were involved in these sessions which took place throughout the island.
- (2) Booklets for Students  
THE FACTS OF LIFE  
MY BODY AND ME  
FAMILY LIFE EDUCATION
- (3) Curriculum Guidelines and Handbook for Teachers were also printed and circulated.
- (4) 10 radio programs were produced and broadcasted. and 6-5 minute slots for the television services LUCKY VALLEY.

**PROBLEMS**

"...there is a real danger that the objectives of the project will be diluted and forgotten behind a screen of ambiguities and evasions".

Evaluation of FLE by Hermione McKenzie and Amy Lee, 1983.

- Methodology of "infusion" or integrated teaching of the subject along with other subjects appears to have diluted the message and resulted in avenues of escape for those teachers who found the topics of sexuality difficult to handle.
- Printed materials for students were generally unattractive and written in a didactic style.
- There seems to have been little feedback, or perhaps little was documented on the results of the activities, though much was reported on the activities themselves.
- Inclusion of FLE into the individual school's curriculum has been therefore, left up to the decision of the head teacher or counsellor.

**MOE'S PROBLEMS REPORTED BY PROJECT DIRECTOR**

- Inadequate project staff
- Shortage of materials
- Shortage of writers to integrate subject into other materials
- Need for audiovisual equipment and aids
- Weak support from other departments.

COMMENT BY PLANNING INSTITUTE

(July 7th, 1987 - letter to USAID)

"The goals of the former Project were not fully met and this second project proposal is intended to continue the work begun with the first project..." (upon request for extension of funding).

RECOMMENDATIONS

- (A) Ministry of Education publicly commit itself to FLE in the school system
- (B) That FLE be adopted in the teachers' colleges as a compulsory and examinable subject
- (C) That FLE be taught as a separate subject in schools or at least, treated as a separate topic
- (D) That material be developed by professional communication experts, targeted to various student age groups and attractive enough to stand on their own
- (E) That feedback be regularly monitored and results incorporated into the project.

## ISSUES AND CONSTRAINTS

The main issues and constraints are:

\* **THE GOJ THROUGH THE NFPB AND THE MOH.** will have to decide what policies they will adopt concerning the commercialization of the social marketing program, about fee-for-service in the clinics and other service delivery issues.

\* **NFPB MANAGEMENT REORGANIZATION/RETHINKING.** The NFPB has a major role in the dynamic growth of the family planning system. To realize this role, the NFPB must rethink its management strategy and reorganize or retook to meet the new priorities. For example, advocacy and leadership will be reflected in functions related to social marketing, public relations, promotions and lobbying.

\* **POOR AND RURAL WOMEN.** This project assumes that these women will be the major target group for the public sector. Privatization of the social marketing program and fee-for-service to those who can afford to pay, will allow the public sector to concentrate on the users who are really in need of free commodities and services. This will be made more accessible to them if commodity and service fees are charged to clients who can pay.

\* **LOWER MIDDLE INCOME EARNING WOMEN.** This group will pay more and will get more in the shift to the commercial sector. They will also be the targets of a massive advertising and promotions campaign coinciding with the changes, to lend prestige to the products and make people more willing to pay the increased price. Though this group will have to pay more in the public sector, their commodities and services will still be accessible to them - for psychological reassurances.

**\*HARDCORE NON-USERS.** The aggressive marketing to be conducted through the CSM will clearly and explicitly address the problems of side effects, a major barrier to use for non-users. These campaigns will educate non-users about what to expect and hopefully attract them to use family planning.

**\*SCHOOLCHILDREN.** It would be extremely beneficial if family life education could be integrated effectively into the school system so that young people do have information and knowledge about family planning before they reach stages of sexual activity. This would mean another major policy decision by GOJ (MOE). But in view of past experiences (see FLE section), this would have to be a well defined and focussed project.

**\*PRIVATE DOCTORS.** Private doctors may take part in the program, but care has to be taken in planning initiatives that respond to their needs and interests. While performing a humanitarian function, they also must earn their livelihoods. They may become more involved in family planning for the same motivations - to better serve clients, but not at the expense of their livelihood. For these reasons, the project will be testing approaches to private sector service expansion that will be self financing over time.

**\* HEALTH CARE WORKERS.** Nurses and midwives have long carried the main burden of family planning services, counselling and face-to-face communication. Their professional characters allow them to do certain procedures. But in reality, they often must do all procedures due to the shortages of doctors, especially in rural areas.

**\*BRAND NAMES PERLE AND PANTHER.** Perle and Panther are essentially generic terms for popular contraceptives, which have become affectionate euphemisms in the vernacular. Consequently, it is important that any change in product necessitated by GOJ pharmaceutical laws about ethical pharmaceutical, be implemented in a phased way so that Jamaican acceptors are not deterred in their use. The Panther name, associated as it is with an over-the-counter condom, can continue in the marketplace regardless.

## RECOMMENDATIONS

- (1) **Poor and rural women** should be the beneficiaries of whatever scarce resources the GOJ might have. This would be to prevent them from being discouraged, defaulting from using contraceptives, as well as prevent any political backlash that might occur.
- (2) **The transition from Perle and Panther to other brands** should be scheduled strategically along with advertising and social marketing campaigns, in order to move the consumers along with the developments.
- (3) **Private professional and private voluntary organizations** should be lobbied in order to get their involvement in the campaign, and their input into the details of some components.
- (4) **NFPB** should restructure and reorganize its management and its goals to support the advocacy functions it needs to carry out. This should begin immediately and not be postponed.
- (5) **MOH AND MOE** should be lobbied for policy commitments and implementation. This should be done by the NFPB which should take the lead in the project.
- (6) **NFPB** should do **FURTHER ANALYSIS** of the hard core non-users and persons who have not been brought into the family planning campaign; this analysis will assist the social marketing campaign and refine the targeting of messages and selection of channels of communication.
- (7) **Technical personnel** - both in the public and private sectors - such as nurses, midwives, counsellors, should be trained and encouraged to participate more actively in family planning procedures and services.

ANNEX G.1  
ECONOMIC ANALYSIS

FAMILY PLANNING INITIATIVES PROJECT  
ECONOMIC ANALYSIS

I. INTRODUCTION

Economic analyses of projects are to serve the purpose of demonstrating that the discounted economic and social benefits of the project are greater than their costs, and that the rate of return from project activities is greater than would be the case for alternative investments. In addition, an economic analysis includes an assessment of the efficiency of activities proposed for the project relative to alternative activities. While it was not possible to undertake a highly quantitative analytic approach to these questions in the time allowed for design of the Family Planning Initiatives Project, consideration of these questions in more general terms is provided below.

II. BENEFIT-COST ANALYSIS

Regarding family planning assistance in general, studies conducted over the past two decades in a number of different countries have established that the value of benefits from the implementation of family planning program greatly exceeds program costs 1/. The same finding can be shown for the Family Planning Initiatives Project. In 1981, Robinson estimated that the net present value of the benefits from averting a birth in Jamaica was J\$ 7,991 (US\$ 4,486) 2/. Inflating this figure by 18.7% per year to 1991 would provide a rough estimate of the direct benefits from averting a birth of J\$ 41,824 (US\$ 5,228). Under STATIN's population projections for the period 1990 to 2000,

---

1/ Sirageldin, I., Salkever, D. and Osborn, R.W. (1983) Evaluating Population Programs: International Experience with Cost-Effectiveness and Cost-Benefit Analysis, New York: St. Martin's Press.

2/ Robinson, W.C. (1981) A Cost-Benefit Analysis of the Proposed Jamaican Family Planning Project, p. 17 (ADSS, AID/DSPE- C-0053). Robinson estimated the value of the benefits of a birth averted as equal to the present value of the sum of the stream of consumption needs saved. Given the high unemployment in Jamaica (15-20%), Robinson assumed that the marginal productivity of additional labor was close to zero, and thus that averting a birth would not lead to a reduction in overall output. This methodology does not include valuation of the private benefits and costs of a child. However, the fact that the 1989 CPS found that 18% of births over the previous 5 years were unwanted would suggest that the private benefits from the bearing of some children are close to zero.

ANNEX G.1  
ECONOMIC ANALYSIS

approximately 62,000 births will be averted under scenarios assuming a moderate decline in fertility as compared to a low decline in fertility (immigration is held constant between the two scenarios). Thus a rough estimate of the direct benefits of a moderate decline in fertility would be US\$ 324.1 million. If inputs in the Family Planning Initiatives Project, valued at US\$ 7.0 million, are responsible for at least 2.2% of the 62,000 additional births averted between the low and moderate fertility decline scenarios, then the benefit to cost ratio for the project will be greater than one.

That project benefits are likely to exceed project costs also can be demonstrated by estimating the births which will be averted through provision of contraceptive commodities. Over the LOP, approximately 27.4 million condoms, 6.6 million cycles of pills, and 14 thousand IUDs will be provided by the project. Utilizing the Wiskik-Chen method, these commodities will provide approximately 658,095 couple-years of contraceptive protection. Assuming a woman or reproductive age has at least a 10% chance of becoming pregnant in any year, then at least 65,810 births will be averted solely through provision of the commodities. The economic benefits of averting these births can be roughly estimated to equal US\$ 344.1 million, far in excess of the US\$ 1.8 million in the project budget for contraceptives 3/.

### III. COST-EFFECTIVENESS ANALYSIS

Consideration of the cost-effectiveness of the interventions proposed for the Family Planning Initiatives Project revolves around three questions:

- o Will project interventions improve the cost-effectiveness of the delivery of family planning services to women who are current users of family planning methods?
- o Are project interventions to increase acceptance of family planning among non-users cost-effective, relative to other interventions to reach these women-at-risk?

---

3/ These figures should be considered only as rough estimates of the benefits and costs associated with the provision of USAID commodities. First, all of the births averted through provision of USAID contraceptives will not occur in the first year of the project, and adjustment in discounting has not been undertaken for births averted in subsequent years. Second, costs associated with the provision of the commodities through GOJ facilities or private pharmacies should be included with the product costs. However, it is unlikely that these adjustments, which would decrease benefits and increase costs, would affect the conclusion that project benefits exceed the costs associated with achieving them.

193

ANNEX G.1  
ECONOMIC ANALYSIS

- o Is the mix of project interventions to increase acceptance as compared to more efficiently deliver family planning services "optimal"?

Several project components are intended to improve the cost-effectiveness of the delivery of family planning services to current users of family planning methods. For example, the objective of the "Clinical Services" component of the project is to develop policies and strategies with respect to method-mix, and to provide training in the provision of longer term methods, in order to orient the service delivery system to promote more effective (and cost-effective) family planning methods, such as the IUD and voluntary surgical contraception (VSC). Project inputs to strengthen contraceptive forecasting, procurement and distribution at the NFPB are expected to improve the cost-effectiveness of the provision of commodities through improved management of inventory and logistics. Studies of the cost-effectiveness of the single-purpose clinics of the NFPB, and of the work-based programs, will provide information upon which the NFPB can determine the appropriateness of utilizing their scarce resources for support of the provision of clinical services.

Other project components are intended to increase acceptance of family planning among non-users. For example, the project will support a pilot effort at the Women's Center to develop a program through schools to motivate adolescent girls to delay pregnancy - at least until they finish high school. While the outcomes of earlier family planning sub-projects trying to reach the adolescent group have been mixed, development of an effective model to reach adolescents would be expected to have significant returns, not only in delaying first pregnancies, but also in reducing total fertility of the adolescents who adopt family planning.

Advertising and mass media promotional campaigns under the CDC component are also expected to increase the adoption of family planning methods. To the extent that advertising increases the volume of contraceptives sold in the program, the average cost per cycle/condom delivered would decline relative to the fee charged for the commodity, which will help to achieve program self-sufficiency.

Finally, while the provision of many family planning services by physicians may not be more cost-effective than the provision of the same services by nurses in the public sector, private physicians may be encouraged to play an important role in motivating non-users to either start or resume use of a family planning method, and/or shift women to use of more effective clinical methods (e.g. the IUD) 4/. Further, it is hoped that pilot efforts under the "Private Sector Seed Grants" will develop more cost-effective means for private sector physicians to provide family planning services.

---

4/ While public clinics are the primary sources of family planning services, many women interviewed in the Public Sector Clinic Users (PCSU) Survey indicated that the clinic nurse did not talk with them about family planning. Thus, it would seem that health professionals in both the public and private sectors could improve their role in providing family planning motivation and counseling. Training inputs of the World Bank project with respect to public sector personnel will complement private sector physician training activities in the USAID project.

194

ANNEX G.1  
ECONOMIC ANALYSIS

It is difficult to determine if the mix of project components between those intended to reach non-users, as compared to provide services more cost-effectively, is "optimal". Over the next 5 years, the size of the population cohort within the child-bearing age will increase, while at the same time, the external assistance for family planning of a number of donors will be phased out. Thus, clearly project components intended to increase the cost-effectiveness of the provision of services to current users are important for reasons of maintaining program effectiveness and in achieving program sustainability. While efforts to reach non-users are inherently less cost-effective than the provision of services to users, these efforts are essential to achievement of the objective of increasing contraceptive prevalence to 62% by the year 2000. Thus, a mix of activities, such as proposed for the FPI project, is likely to be more cost-effective than selection of components only to improve the cost-effectiveness of service delivery, or to reach non-users.

ANNEX G.2  
FINANCIAL ANALYSIS

JAMAICA FAMILY PLANNING INITIATIVES PROJECT  
FINANCIAL ANALYSIS

I. INTRODUCTION

The analysis in this appendix is organized into three sections. The first section presents background information of relevance for consideration of economic and financial issues related to the **Jamaica Family Planning Initiatives (FPI) Project**. Specifically this section reviews: i) information about trends and prospects for the Jamaican economy and in government financing for the health sector and family planning, ii) Government of Jamaica (GOJ) policy regarding user fees and issues related to the Jamaican population's willingness and ability to pay proposed fees for family planning services, and iii) descriptions of other donor input into family planning. The second section of the annex reviews estimates of the recurrent costs associated with the provision of family planning services, contraceptives, and operation of the National Family Planning Board (NFPB), and of the potential for various sources to provide financing for these costs. The final section of the annex provides a description of the current public pharmaceutical system in Jamaica, and information which may be considered in selecting among the options for future procurement and distribution of contraceptives for public sector institutions and for Commercial Distribution of Contraceptives (CDC) sales.

II. BACKGROUND INFORMATION

A. Recent Trends and Prospects for the Economy of Jamaica

Jamaica's economy has grown little in real terms over the past 2 decades. Exports of alumina, bananas, bauxite, sugar, and tourism, are equal to about half of the GDP, and account for about two-thirds of foreign exchange earnings, making the economy vulnerable to external shocks such as fluctuations in international prices and demand, and poor weather. Downturns in these sectors led to the accumulation of significant amounts of external debt, equal to 180% of GDP in 1985. Stabilization and structural adjustment policy measures were strengthened in the mid-1980s, and coupled with the fall in oil prices in 1986, most macro-economic measures for Jamaica improved until the disruption caused by Hurricane Gilbert in September 1988. Prior to initiation of the Persian Gulf conflict, the World Bank projected that rates of economic growth for Jamaica might equal up to 4% per annum through the 1990s. Among the policies required to achieve these economic gains is further reduction of the fiscal deficit, improvement of effectiveness of monetary policy, flexible adjustment of the exchange rate, and further reduction of government controls on prices. Nevertheless, these brighter prospects for the Jamaican economy must be considered fragile due to the openness of the economy, and the continued stringency required.

ANNEX G.2  
FINANCIAL ANALYSIS

Unemployment has been a pervasive feature of the Jamaican economy. Unemployment has been at levels around 15% when only job seeking members of the labor force are considered, and over 20% when all unemployed members of the labor force are considered. Unemployment is significantly higher for the younger age groups (14-24 years of age), and among women. Women are estimated to be the heads of 39% of households in Jamaica. In 1987, 15.2% of female heads of households were unemployed, in comparison to 5.8% of male heads of households.

The distribution of income in Jamaica is unequal. In 1989, the bottom 3 income deciles claimed 9% of national consumption, the middle 4 deciles claimed 29%, and the top 3 deciles claimed 61%. The level of income going to the majority of Jamaican households is low relative to estimates of the cost of a "least cost basket of goods". Inflation rates averaging 18.7% per annum during the 1980s have eroded the purchasing power of the households, particularly of the poor as their incomes have not been indexed for inflation.

B. GOJ's Population Goals and Family Planning Objectives

The principal objective of the GOJ's population policy is to maintain its population under 3 million by the year 2000, in order to approach favorable conditions for economic and social development of the country. Jamaica's Five-Year Development Plan (1990-1994) outlined the following objectives for the National Family Planning Program: i) increasing access to all family planning services (including tubal ligations); ii) strengthening infrastructure by renovating/upgrading and equipping primary health care centers; iii) increasing the number of daily services at primary health care clinics; iv) expansion of public education in family planning; v) targeting special clinical services at specific groups (e.g. adolescents, males, working women); vi) expanding provision of mobile services (e.g. to industrial work places and deep rural areas); vii) expanding product mix in the CDC program; viii) increasing the cost of CDC commodities to an affordable level in order that the program will become self-sustaining; and ix) to involve the private sector to become more responsive in providing and paying for family planning services for their employees. Overall, the GOJ aims to make the national family planning program more cost-effective and financial sustainable by the year 2000 1/.

---

1/ USAID/Jamaica (June 26, 1990) Jamaica Family Planning Initiatives Project (532-0163), Project Identification Document, p. 1.

19-1

ANNEX G.2  
FINANCIAL ANALYSIS

As part of project development, USAID supported a review of options for increased privatization and cost recovery in the Jamaican Family Planning program. This review argued that the financial resources of the GOJ would more likely be adequate for tasks of provision of family planning advocacy and education, and for provision of family planning services for segments of the population that are unable to pay, if efforts were made to increase the role of the private sector in the provision of family planning services for the population that is able to pay 2/. The policy climate in Jamaica has been supportive of privatization in general, including in the health sector. Consideration of privatization options for the health sector began in 1985 when then Prime Minister Seaga appointed the Ogle Committee to examine alternative means of financing health care. This Committee reviewed a range of options and identified the privatization of public hospitals as key among the initiatives to bring reform. At the same time, the Cabinet endorsed the adoption of user fees in public hospitals increasing the private sector's role in financing of public provided services. While the Manley government has reversed the decision to privatize public hospitals, it is still pursuing efforts to privatize the provision of hospital ancillary services. Thus, components of the FPI project, designed to increase the private sector's provision of family planning services, have been developed within a climate supportive of cost recovery and selective privatization, as part of an overall strategy to increase the sustainability of health services.

C. Trends in Government Financing for Health and Family Planning Services

Over the period 1985/6 to 1987/8, the GOJ's actual recurrent expenditures declined as a share of GDP from 30 to 27%, although this trend reversed in 1988/9 partially due to the relief and reconstruction efforts following Hurricane Gilbert. A GOJ's recurrent budget equal to about 25% of GDP by 1995 is considered consistent with efforts to improve the overall macroeconomic situation in Jamaica 3/.

Over the same period, actual recurrent expenditure for the Ministry of Health (MOH) fell as a percent of the GOJ's recurrent expenditure, and equaled 7% of GOJ recurrent expenditure in 1988/9. MOH recurrent expenditure in

---

2/ Smith, J. and Ravenholt, B. (September 1990) Privatization and Cost Recovery Options for the Jamaican Family Planning Program, 54 pp. (draft).

3/ World Bank (April 26, 1989) Jamaica - Adjustment Under Changing Economic Conditions, Washington, DC: World Bank, p. 46 (Report No. 7753-JM).

1990

ANNEX G.2  
FINANCIAL ANALYSIS

1988/9 was 24% lower in real terms than in 1984/5, using the overall GDP deflator. Actual expenditures probably declined somewhat less in real terms as about 60% of MOH recurrent expenditure is for wages and salaries, which have not increased as rapidly as overall prices.

Actual expenditures for the "Pharmaceutical Services Division" of the MOH varied from 3 to 12% of recurrent expenditure for the MOH over the same period. These actual expenditures equalled from 34 to 100% of their budgeted levels. This is in contrast to achievement of actual expenditure of 80 to 100% of the budget for the MOH as a whole. Management of cash flow for placement of large procurements, and constraints on foreign exchange, were suggested as reasons for the underexpenditure of the pharmaceutical budget. Between 1984/5 and 1987/8, GOJ expenditure for drugs declined in real terms by 75%. The decline in per capita terms would be even more dramatic.

In contrast to the above trends, the MOH's actual expenditures for Primary Health Care (PHC) increased in real terms by 12% between 1984/5 and 1988/9, and from 18 to 26% of total MOH recurrent expenditure. PHC expenditure has consistently been over 94% of budgeted levels. Concurrently, budgetary allocations for hospitals have declined in real terms, and as a percent of the total MOH budget.

The GOJ budget for the NFPB, although included under the overall PHC budget, did not enjoy the same growth experienced by the rest of PHC services during the same period. GOJ expenditure for the NFPB however fell less in real terms (11%) than overall recurrent expenditures of the MOH. GOJ recurrent expenditure for the NFPB claims about 2% of overall recurrent expenditure of the MOH (see Table 1).

Projections of the recurrent financial resources which will be available to the MOH and its programs are dependent on assumptions regarding GDP growth, the share that GOJ recurrent expenditure comprises of GDP, MOH's share of GOJ recurrent expenditure, and the MOH's decisions regarding the allocation of their recurrent resources to PHC and family planning programs. Under a "best case" scenario, assuming GDP growth of 4% per annum through the 1990s, and assuming static government expenditure shares, the recurrent budget available to the MOH would be 48% higher in real terms in 2000 than in 1991. However, assuming the share of GDP taken up by GOJ recurrent expenditure falls during the period to about 25%, then the recurrent budget available to the MOH would only be 29% higher in real terms by 2000. Slower economic growth would likely result in lower increases in real expenditure, even if the share of GDP claimed by the GOJ recurrent budget is higher than 25%.

199

ANNEX G.2  
FINANCIAL ANALYSIS

In view of the continued financial stringencies ahead, the MOH is pursuing a set of policies to improve service efficiency. These include: i) review and rationalization of the health services delivery network, ii) enhanced cost recovery through user fees and insurance, iii) decentralization of administration, iv) privatization of hospital ancillary functions, v) strengthening of procedures for drug supply systems, and vi) other measures to improve management.

D. User Fees

The collection of user fee for health services can increase revenue for the health sector, and possibly reduce cost by signalling patients that they are consuming valuable resources, and/or shifting use to the private sector. Background information regarding Jamaica's current policies and experience with user fees and discussion of issues related to changing fee policies is presented below. Scenarios estimating possible levels of revenue under user fees are presented in the second section of this annex.

1. Hospital User Fees - Current Policy and Experience 4/.

User fees (e.g. registration, drug, lab, and x-ray fees) have been in effect at Jamaican public hospitals since the early 1960s, although temporarily eliminated in 1972 and 1973. The Seaga government increased hospital fees in 1984/5, and fees have not been adjusted for inflation since that time 5/. Exemptions are provided for family planning services, immunizations, and dental treatment for children on the school dental program, and for individuals with high-risk pregnancies, or registrants in the Food Aid program.

An analysis by Lewis (1989) found that revenue from hospital fees was equivalent to 7 to 27% of individual hospital's operating expenditures in 1986/7. Fees collected are initially deposited in the hospital's account, and later transferred to an MOH account. From 1985 to 1990, each hospital received a refund of 50% of the revenue from these fees to use as the hospital administration saw fit 6/. The remaining 50% of the fees formed an extra-budgetary pool of funds which the MOH used in support of secondary

---

4/ Information in this section is based on reports by Lewis (1988, 1989) and interviews with MOH officials.

5/ However, at the time of project design, the MOH had made Cabinet submissions to increase the fees for drugs as well as those for insured or private patients.

6/ A 1989 study by Lewis found that hospitals allocated the bulk of fee revenue for maintenance and supplies.

200

ANNEX G.2  
FINANCIAL ANALYSIS

and tertiary services. Hospitals could apply to receive the remaining 50% they collected from this pool by submitting a budget for special projects. Hospital administrators' readily perceived that the hospital directly benefited from its fee collection efforts by receipt of 2 or 3 payments: one representing their budgetary support from taxation, a second representing a refund of 50% of the fees they collected, and possibly a third representing an award from the 50% pooled by the MOH on behalf of all secondary and tertiary services.

Starting in 1990/1, the Ministry of Finance (MOF) required that the MOH estimate the revenue from hospital fees and show these estimates as hospital-specific "Appropriations-in-Aid" (AIA) 7/ within the overall budget for the hospital. This change has been unappealing to hospital administrators for several reasons: i) concern that the MOF will disproportionately cut budget support for the hospital from taxation sources if the hospital projects significant revenue from fees, ii) concern that the MOF may not return fee revenue collected in excess of the AIA, iii) loss of flexibility in that fee revenue is budgeted at the same time as budget support from taxation. Further, if the MOF provides additional budgetary support for hospitals that do not collect their full AIA, then this provides a disincentive for maximizing collections. The MOF, MOH, and administrators are working together to develop policies so as to provide incentives for hospitals to maximize the collection of hospital fees according to the current schedule from non-exempt patients.

## 2. Primary Health Care User Fees - Potential and Issues

Up to the present, the MOH has not had any formal system of charges for service provided in non-hospital facilities, although there is some evidence that "donations" are collected at some primary care facilities. The 1990/91 budget also included AIA estimates for fee collection for primary care services by regional Primary Health Care administration. Committees at the MOH however are considering instituting fees at Type III and IV facilities for a variety of services, although these will be lower than fees for similar services provided at hospitals. In order that fees should not pose a deterrent to health seeking behavior, exemptions are proposed for MCH services (i.e. antenatal and postnatal clinics, well baby clinics and immunizations, and nutrition clinics), curative services for children under 5 years of age, dental services up to the age of 16, and groups already fulfilling the

---

7/ An "Appropriation-in-Aid" is an estimate of the amount of the hospital's budget which will come from patient fees, as compared to the amount of the budget to be paid by the national government from taxation revenue. \*\*/

201

ANNEX G.2  
FINANCIAL ANALYSIS

criteria for Food Stamp recipients 8/. Fees are under consideration for family planning services and commodities as it is not believed that payment would be a deterrent to usage.

Collection procedures and related administrative issues need to be resolved. One proposal is for the postal service to sell "PHC Stamps" which users could redeem for services provided at health clinics. Another proposal would involve the development of a PHC card which could be sold by hospitals and against which patients could "charge" services they obtain at health centers. Technical assistance to provide analysis of these and other administrative options for PHC fees is recommended. The 1990/1 budget provides estimates of PHC AIAs, suggesting that revenues collected for PHC services will also be included in the annual budgetary process, rather than treated as extra-budgetary funds.

Fees for family planning currently under consideration are:  
Pill Cycles - J\$ 5.00/cycle, Depo-provera - J\$ 10.00/injection, IUD insertion - J\$ 20.00, and tubal ligation - J\$ 50 to 200 assessed on a sliding scale. These fees would more than cover the CIF cost of the contraceptives if procured from IPPF (i.e Pill = J\$ 2.00/cycle, IUD = J\$ 7.84/device, and Depo-provera = J\$ 6.88/dose) 9/., and likely the costs of transport in Jamaica as well. Further, to the extent that Jamaican women's choice of method is affected by price 10/., this schedule of fees provides an incentive to use more effective methods, (i.e. a couple year of protection with the pill would cost a woman J\$ 65.00, with depo-provera would cost J\$ 40.00, with an IUD would cost J\$ 8.00 (assuming an IUD is used for 2.5 years)).

Recent surveys, specifically the Contraceptive Prevalence Survey, and the Public Sector Clinic Users (PSCU) Survey, 1990, did not find that cost was an important factor in deciding to practice family planning. This survey also found that 48% of respondents paid some sort of fee or donation at the public clinics, but that 75% of those paying made a donation of J\$ 2.50 or less.

---

8/ The following groups are eligible for Food Stamps: pregnant and lactating women, children under 5, and recipients of Poor Relief or Public Assistance. Others eligible for Food Stamps are the handicapped, or those otherwise determined to be indigent. Means tests for indigence currently are: households with incomes below J\$ 3,000 for a two person family, or J\$ 7,200 for families with greater than 2 persons.

9/ IPPF prices as of February 1991, plus 20% for insurance and freight, converted at an exchange rate of US\$ 1.00 = J\$ 8.00.

10/ Schwartz, B. et.al. (1986) reviewing data for Jamaica found that price was statistically significant as a factor influencing the choice of contraceptive method.

202

ANNEX G.2  
FINANCIAL ANALYSIS

Over half (54%) of the respondents did not pay for transportation to the clinic, although 24% paid between J\$ 3.50 and 10.00 for transportation. When respondents were asked about payment for family planning services, half replied that a charge of up to J\$ 5.00 would be considered trivial, and a charge of J\$ 10.00 to J\$ 15.00 would be reasonable. For a cycle of pills, half of the respondents considered that a charge of J\$ 3.00 would be trivial, and J\$ 5.00 would be reasonable.

Survey data on health care consumption patterns in Jamaica supports the findings of the PSCU survey regarding the ability of some segment of clinic users to pay fees, as well as illustrates the necessity of the MOH adopting policies to protect access to services for the very poor. STATIN's Household Expenditure Survey (HES), 1984 found that on average 1.6% of Jamaican households total expenditures were for all health care expenditure, and that poorer households allocated a smaller percentage of their expenditure for health care. The Survey of Living Conditions (SLC) found that by 1989 expenditures for health care had increased to 2.3% of total household expenditure <sup>11/</sup>. Assuming that households could afford to spend 0.3% of their total expenditure on contraceptives (0.3% of expenditure would equal half of the estimated total expenditure on health care for one household member in a family of 4), then at the proposed GOJ prices, the top four income deciles could afford a year of contraceptive protection on the pill, the top seven income deciles could afford a year of protection by depo-provera injections or sterilization, and all but the poorest income decile could afford a year of protection from an IUD. The top 4 income deciles could afford 150 condoms at J\$ 0.50/condom, or 100 condoms at J\$ 0.75/condom. However, only individuals in households in the top 2 income deciles could afford 150 condoms at J\$ 0.75/condom (see Table 2). (For further discussion of issues related to contraceptive users' sensitivity to price see the discussion on the "Commercial Distribution of Contraceptives" in Section III).

Jamaica has traditionally displayed the commitment to the principal that citizens in need of health services, but unable to pay, will not be turned away from services. The MOH's proposal to exempt Food Stamp recipients from the payment of primary care fees is intended to target free access to health services to low income families. However, the 1989 Survey of Living

---

11/ Lewis (June 1988) found that estimates of a price index for a basket of pharmaceuticals and other medical products exceeded the general consumer price index, indicating that health care costs rose disproportionately in comparison with aggregate prices. This may in part explain why a greater proportion of household expenditures were allocated to medical care in the SLC, 1989 than in the HES, 1984.

203

ANNEX G.2  
FINANCIAL ANALYSIS

Conditions (SLC) found that 51% of the Food Stamp benefits were going to families in the poorest 40% of the population, while 49% of benefits were going to families in the wealthier 60%. Further, only half of households in the lowest income quintiles are enrolled in the Food Stamp program 12/. This suggests that exemption of Food Stamp recipients from payment of health fees may not sufficiently target free care benefits to those with the least ability to pay. Alternative options to identify the indigent might be explored. Respondents to the PSCU Survey appeared able to provide information about household income and so it might be possible to directly means test clinic patients. Alternatively, exemption might be determined based on answers to questions regarding education, indoor plumbing, electricity, ownership of appliances, primary fuel source, etc. For purposes of promoting contraceptive use, exemptions might be extended to all adolescents, and to new acceptors.

The institution of public sector fees for family planning services and commodities will also have an important role in the success of the effort to put the CDC program on a self-financing basis. Assuming that the MOH adopts its proposed family planning fees, then the cost of a visit for pill supplies will cost at least J\$ 5.00, plus the cost of transportation to the clinic and waiting time. These costs will lessen the economic and financial advantages to women to get contraceptives at public sector clinics, assuming that the price of a cycle of pills through the social marketing program is not far in excess of J\$ 5.00. Thus the adoption of fees in the public sector will provide an incentive for patients to move, or continue, to purchase contraceptives in the private sector, while providing some revenue from provision of supplies to women who elect to stay in the public sector.

E. Description of Donor Support

There are three principal foreign donors aside from USAID which currently support population and family planning activities in Jamaica - IPPF, UNFPA, and the World Bank.

Over the period 1985-1990, UNFPA provided support for family planning activities from between US\$ 250,000 and US\$ 400,000 per year. Specifically, UNFPA has provided financial support for: i) policy research at the PIOJ on the link of population growth to economic development, ii) family planning promotional activities for adolescents through Dehaney Park, the Womens' Center, and Family Life Education (FLE), iii) integration of family planning counseling skills for agricultural extension workers, and iv) provision of depo-provera. UNFPA plans to continue its support of the Women's Center and for the institutionalization of FLE.

---

12/ From the Survey of Living Conditions, 1989, pp. 33-34.

204

ANNEX G.2  
FINANCIAL ANALYSIS

In addition, studies will be undertaken on Jamaican women's perceptions of career options. However, the UNFPA is planning to phase-out their support for provision of depo-provera over the next 5 years.

The IPPF provides financial support for the operational costs of the JFPA. In 1988 and 1989, IPPF support (through its cash and matching grants) was US\$ 107,300 and US\$ 99,390 respectively, or approximately 30% of total income to the JFPA from all sources 13/.

The World Bank has more recently become a significant donor in the area of family planning. The Bank's **Population and Health Project** includes US\$ 6.3 million for support of family planning activities. While the project was slated to start in 1988, and run until 1994, project implementation has been slow and it is likely that the project will be extended beyond 1994. Approximately US\$ 3.3 million is to be provided to "Strengthen the Demand for Family Planning Services". One set of activities under this component is to strengthen the Population Unit of the PIOJ to disseminate information on population policy, educate GOJ officials regarding the relationships of population growth and social and economic planning, and to monitor and evaluate population information. A second set of activities is intended to strengthen IEC activities of the NFPB through training of 1,300 volunteers recruited through youth groups, and employers with more than 100 employees whose activities will be supervised at the regional level. This component will also support development of educational materials targeted to the adolescent population, and in support of a mass media campaign. Bank funds will support 6 additional staff, purchase 5 vehicles, and other incremental operational costs.

An additional US\$ 2.9 million (including US\$ 650,000 from the UNFPA) in the same **Population and Health Project** will be provided to "Strengthen Family Planning Service Delivery". One set of activities under this component is intended to ensure that MOH facilities have the clinical and counselling expertise, and supplies, to provide complete family planning services. Specifically the Bank project will: i) train 50 persons in tubal ligation and vasectomy outpatient procedures, ii) train 2000 MOH personnel in 1-2 days of in-service training regarding family planning counseling, and iii) provide 280 PHC centers with family planning equipment. Twenty-four (24) months of technical assistance will be provided to the NFPB to strengthen management information systems. A second set of activities under this component is to assist the NFPB increase their CDC sales of contraceptives by 20% per year

---

13/ Price Waterhouse (March 12, 1990) Audited Statement of Income, Expenses and Changes in Fund Balances for the JFPA, Years Ended 31 December 1988 and 1989.

205

ANNEX G.2  
FINANCIAL ANALYSIS

by strengthening the marketing research capability at the NFPB, and to assist in the introduction of a low dose contraceptive. The Bank project will fund: i) 4 additional staff for the CDC program, ii) train 700 wholesalers, retailers, pharmacists, and private physicians, iii) finance KAP studies to evaluate the impact of marketing messages on contraceptive sales, and iv) finance materials production, equipment and furniture for the CDC program.

The Population and Family Planning Project, under the health component of the project, also provides 22 person-months of technical assistance to the MOH regarding studies to review cost recovery policies. However, the Bank regards USAID as having the lead role in health fee policy 14/.

The World Bank also is providing US\$ 25.8 million to the MOH through the Social Sectors Development Project for the period 1989/90 to 1993/4. This project was developed to support the GOJ's Human Resources Development Program. Project components with some relevance to family planning include: i) US\$ 6.7 million to provide equipment and rehabilitate health center facilities ("Primary Health Care Development"); ii) US\$ 1.2 million for medical, surgical, and dental equipment at hospitals ("Purchase of Medical Equipment"); and iii) US\$ 15.7 million to replenish pharmaceutical stocks ("Building Stocks of Pharmaceutical Supplies"). Implementation of this project is expected to improve the quality of services provided by public sector facilities.

III. FINANCING FOR RECURRENT COSTS OF FAMILY PLANNING  
SERVICES AT GOVERNMENT HOSPITALS AND CLINICS

A. Financing of the Fixed Recurrent Costs of Family Planning Services

The Contraceptive Prevalence Survey, Jamaica, 1989 determined that 88% of all VSC procedures are performed in public hospitals, and that approximately 63% of users of other methods obtain services from public sector clinics or health centers. Thus public sector institutions currently play a key role in the provision of family planning in Jamaica. By the year 2000, if 65% of the women aged 15-49 continue to seek family planning services from public sector institutions, the system would be providing services to 84,561 more women than in

---

14/ Personal communication, Ms. Linda McGinnis, World Bank, March 5, 1991.

ANNEX G.2  
FINANCIAL ANALYSIS

1990, an increase of 37% 15/.

Estimating the additional fixed recurrent costs of providing family planning services at government hospitals and clinics to these women is difficult. In a fully financed system, it would be reasonable to assume economies of scale in the provision of services, whereby the fixed costs of providing services to these additional women would not increase by the full 37%. However, there is evidence that the fixed recurrent costs of government health facilities are currently underfinanced, e.g. staff vacancies and poor maintenance of facilities. Thus, while growth of the number of women aged 15-49 by the year 2000 might not require an increase of 37% of the current financing for the fixed costs of providing family planning services, an increase in recurrent financing of this magnitude, or greater, might be required to compensate for the current underfinancing of the fixed costs of providing services in government facilities.

Preceding paragraphs have argued that significant increases in the recurrent financing for the MOH over the next 10 years will be modest, perhaps up to 29% in real terms. Donor financing for the rehabilitation of public sector facilities will help with respect to upgrading the physical attributes of public sector institutions. While revenue from user fees may also raise the level of recurrent resources available, there will be many claims on this revenue to cover variable inputs such as drugs and contraceptives (see next section). Some current clinic users will shift to private sector sources of care, as has been the case over the past several years.

B. Financing Variable Recurrent Costs - Contraceptives

Over the period 1985/6 to 1989/90, the UNFPA and USAID provided contraceptive supplies equal in value to from 70 to 82% of the total value of contraceptives handled by the NFPB (approximately J\$ 3.5 million per annum). The remaining 28 to 30% of expenditure on contraceptives has come from the recurrent budget of the NFPB (J\$ 0.6 to 1.0 million). GOJ budgetary support for contraceptives, as well as revenue from non-CDC contraceptive sales, has been equivalent to 27 to 51% of the costs of contraceptives provided to the public sector (or maintained in inventory). Over the period, the GOJ would have had to have increased its budgetary support by about J\$ 1.5 million per year in order to have fully covered the costs of the public sector commodities. Income from CDC sales has been

---

15/ This figure is based on population projections under the assumptions of the "Moderate Fertility Decline, Medium Emigration" projection in STATIN (---) Population Projections, Jamaica, 1980-2015. Under this projection the number of women aged 15-49 was 637,000 in 1990 and is 770,800 in 2000.

ANNEX G.2  
FINANCIAL ANALYSIS

equivalent to 28 to 40% of the costs of the CDC contraceptives (see Table 3).

Table 4 provides estimates of the amount of revenue which public facilities would have collected had the family planning fees under consideration been in place (based on clinic utilization in 1989). A maximum of J\$ 4.1 million would have been collected assuming the fees were: a registration fee of J\$ 5.00, a pill cycle or 10 condoms was J\$ 5.00, an injection was J\$ 10.00; no users were exempt from payment; and the price elasticity of demand for family planning services was zero. A minimum of J\$ 0.9 million would have been collected assuming the same fees for methods as above, no registration fee, and that all new visits and half of revisits were exempt from payment. Revenues of J\$ 1.6 to 2.0 million would have been generated under scenarios between these extremes. Thus it would appear that the GOJ could generate sufficient revenue from its proposed fees to fill in the gap in government financing for contraceptives provided by public sector institutions in 1989.

The question then arises whether the resources generated from family planning fees will adequately supplement the current level of GOJ support for contraceptives as the number of women aged 15-49 increases, prevalence rates rise, and method mix changes over the next 10 years. Estimates of the financing requirements for contraceptives, in real 1991 terms, were estimated for 2 scenarios. The first scenario, or "Static Scenario" assumes that the number of women aged 15-49 is 770,800 in 2000, prevalence is 62%, but that there has been little change in either the method mix, or in use of public as compared to private services. The estimated financial requirement (in 1991 J\$) for contraceptives under this scenario is J\$ 2.2 million (in comparison to the actual financial requirement in 1991 of J\$ 1.8 million). The second scenario assumes the same increase in the number of women aged 15-29, and the same increase in prevalence, but assumes there is both a shift to more effective methods, as well as a shift of clinic users to the private sector. Under this scenario, the financial requirements for public sector contraceptives is J\$ 1.8 million, approximately the level of financial requirements in 1991 (see Tables 5 and 6).

Several points might be summarized here. The proposed level of MOH fees for family planning services would likely generate sufficient revenue to cover the cost of contraceptives currently provided by donors - even if a significant proportion of clinic attenders are exempted from payment. The proposed level of fees might, under certain assumptions, cover contraceptive costs for clinic users in the year 2000 if there was little change in method mix and reliance on the public sector. However, user fees would more likely be adequate, if during the 10 year period there is a shift to more effective methods, and of some users to the private sector.

ANNEX G.2  
FINANCIAL ANALYSIS

While the above scenarios illustrate the potential for user fees to cover the costs of contraceptives currently provided by donors, there are several administrative and implementation concerns which should be highlighted. First, given the shortage of foreign exchange from the Bank of Jamaica (BOJ), it is likely that the Jamaican dollar will undergo further devaluations over the next 10 years against major international currencies. If family planning fees, are not adjusted to reflect these devaluations, the revenue generated will be insufficient to cover the cost of the imported contraceptives. Second, administrative systems related to PHC funds have not been specified and thus it is unclear whether collection of these revenues will result in any real increase in the budget of the NFPB for the purchase of public sector contraceptives. Thus, over the LOP, USAID/J through project monitoring and the mid-term evaluation should collect and analyze information on family planning fee policy, the amount of revenue collected under family planning fees, and whether the GOJ has included in the budget of the NFPB adequate funds for all public sector contraceptive requirements. Conclusions and recommendations from these reviews should be included in USAID/J and other population family planning donors policy dialogue with the GOJ.

C. Financing the Recurrent Cost of the NFPB

Income and expenditure statements for the NFPB are part of their annual audit reports. Reports from 1985/6 to 1989/90 were reviewed to develop a profile of the expenditure by item through the NFPB including income from all sources. Over this 5 year period, personal emoluments have increased from 19 to 25% of NFPB expenditure. Concurrently, supplies and materials (including contraceptives from all sources) have declined from 36 to 32% of total expenditure. Subsidies to NGOs providing family planning services or education for adolescents, and sessional fees for VSC, comprised about 25% of expenditure, and other operating expenses the remaining 15%.

USAID support for personal emoluments has been less than 8% of total personal emoluments in any year. As noted earlier, UNFPA and USAID's contraceptive donations have been equal in value to 70 to 82% of total contraceptive expenditure. USAID support ranged from 13 to 76% of expenditure for training activities. Finally, nearly 95% of the NGO subsidies and sessional fees paid by the NFPB have been with USAID funds.

Over the 5 year period, overall expenditure by the NFPB (again with income from all sources) has declined by 13% in real terms. However, if subsidies and sessional fees, and the estimated expenditure for CDC contraceptives is deleted, the remaining level of expenditure has remained nearly constant in real terms over the 5 year period (see Table 7).

209

ANNEX G.2  
FINANCIAL ANALYSIS

The role of USAID and UNFPA support towards overall expenditure by the NFPB has been significant. Income from all Jamaican sources would have to increase by over 63% in 1989/90 (or J\$ 4.8 million) in order to cover expenditures now met by donors. However, USAID is phasing out its subsidy and sessional fees at the end of the current project, and the NGOs are preparing to find alternative sources of financing or alter their program to manage within their new financial circumstances. In any case, the NFPB will not pick up the financing for these NGOs. Further, re-orientation of the CDC program will mean that the NFPB will no longer have to provide financing for CDC commodities out of their government budget ary support or other income. Eliminating the financial responsibility for NGO subsidies and for CDC commodities reduces the gap between income from Jamaican sources and financing requirements to about J\$ 2.0 million in 1989/90, about 26% of NFPB income from all non-CDC sales and non- donor sources (see Table 8). This amount is roughly equal to the financial requirement estimated earlier for public sector contraceptives, and scenarios for financing this shortfall have already been reviewed.

Aside from increasing revenue from user fees for family planning services, the NFPB might also provide financing for contraceptives by reviewing their clinical programs and eliminating services which the NFPB cannot provide cost- effectively. Studies of the cost-effectiveness of the NFPB's clinical programs are recommended as part of the "Policy Analysis and Research" component of the project.

IV. PROCUREMENT AND DISTRIBUTION OF FAMILY PLANNING CONTRACEPTIVES,  
ORGANIZATIONAL AND FINANCIAL ISSUES

A. Pharmaceutical Procurement and Distribution Systems 16/.

Currently three organizational entities operate relatively independently with respect to the selection, procurement and distribution of pharmaceuticals in Jamaica: the University Hospital at UWI, the MOH through the Island Medical Stores (IMS), and the NFPB. The Jamaica Commodity Trading Corporation (JCTC), a private company with the GOJ owning 100% of its shares, is charged with tendering for all of the public sector's international pharmaceutical purchases, and about 17% of

16/ Information in this sector draws heavily from: Huff- Rouselle, M. and Turnbull, J.C. (November 1989) Assessment of Jamaican Public Sector Pharmaceutical System, PRITECH.

ANNEX G.2  
FINANCIAL ANALYSIS

pharmaceuticals sold by the private sector 17/.

Under the Financial Administration and Audit Law 34 of 1959, the Ministry of Finance (MOF) Supply Division acts as the central purchasing agent for the public sector. Tenders are currently issued for 18 months of supply. The MOH Supply Division sends drug orders and payment checks to the MOF Supply Division which forwards these to the JCTC for international procurement or to appropriate local suppliers. In 1989, it was reported that the MOF's processing of MOH orders took approximately 1 month. When the MOH's drugs are received through the JCTC, the MOF Supply Division is responsible for both customs clearance and transport to the IMS. The MOF Supply Division charges a 5% fee for foreign purchases through the JCTC, and a 2.5% fee for local purchases. Transportation costs are an additional 5%. Drugs and medical supplies were estimated to represent 30% of the MOF Supply Division efforts in 1988. Resource and management problems plague the MOF Supply Division, e.g. position vacancy rate is high (40%), and inventory systems are just beginning to be computerized.

The IMS are responsible for the storage, inventory management, and distribution of pharmaceuticals. The IMS distributes directly to MOH hospitals and to the health center facilities down to the district headquarters level.

The release of government budgetary funds on a monthly basis creates cash flow difficulties regarding the international procurement of pharmaceuticals, as generally procurement is not done on a monthly basis. It is estimated that cash flow problems can create delays of 2-3 months in the clearing of orders for drugs through the MOF Supply Division to the JCTC. These delays, coupled with shortages of drugs, would tend to lead to the local procurement of drugs in small quantities, at generally higher unit prices.

In contrast, the University Hospital and NFPB as statutory bodies can tender their international procurement directly through the Jamaica Commodity Trading Corporation (JCTC), and may also procure directly from the local suppliers. These organizations also have their own port clearing arrangements - in the case of the NFPB through a contract with broker in the

---

17/ The February 13, 1991 issue of The Daily Gleaner reported that the Deputy Prime Minister announced that the GOJ had decided to reduce the role of the JCTC. It is presently unclear what this decision will mean with respect to pharmaceuticals. However it is likely that the MOH, NFPB, and University Hospital will have the option in the future to undertake their tenders by themselves or through whatever organization (public or private) they choose.

ANNEX G.2  
FINANCIAL ANALYSIS

private sector. The NFPB maintains its own warehouses and distribution fleet and delivers directly to all MOH facilities. While the GOJ's grant to the NFPB is also released on a monthly basis, the NFPB can collect and retain revenue for service delivery at its 3 clinics and from contraceptive sales through the CDC program, and can maintain fund balances from one year to the next. Thus, the NFPB has options with respect to managing its cash flow requirements not currently available to the MOH.

C. Options for Contraceptive Procurement and Distribution Systems

Currently the NFPB procures and distributes contraceptives for public sector institutions and for the CDC program. While the NFPB may elect to continue carry out these roles other options exist which warrant consideration. Specifically, the procurement and distribution of contraceptives for the public sector health facilities might be shifted to the MOH, and/or the CDC program might be shifted further into the commercial sector.

1. Foreign Exchange Issues

Over the period 1985 to 1989, medicinal and pharmaceutical imports increased from 1.0 to 1.4% of total Jamaican imports. The value of donated contraceptives over the same period was equivalent to 1.7 to 4.4% of total medicinal and pharmaceutical imports, and from 0.02 to 0.04% of total imports (see Table 9). While in absolute terms it would appear that allocation of sufficient foreign exchange for the importation of contraceptives would not be a significant problem, competition for available foreign exchange is strong. In the public sector, insufficient foreign exchange from the MOF Supply Division was reported as one of the reasons that international tenders for MOH pharmaceuticals equals only 50% of MOH purchases, and for the underexpenditure of the Pharmaceutical Services Division budget as a whole. Bulk purchases of contraceptives through international tendering would be expected to lower unit foreign exchange costs. Unit prices for contraceptives from the IPPF suggest that the NFPB or JFPA can procure contraceptives for public sector clinics at, or in some cases below, the unit costs at which USAID has been providing contraceptives. In the private sector, a recent assessment of the foreign exchange system in Jamaica documented that the problem of accumulated foreign exchange arrears had been dealt with through banks' postponement of delivery of foreign exchange to private sector firms. By March 1991, the BOJ had raised the surrender rate for commercial banks' foreign exchange from 25 to 50%, and the report concluded that "the new (interbank) system faces an uphill battle to preserve foreign exchange availability for any transactions outside

ANNEX G.2  
FINANCIAL ANALYSIS

the Bank of Jamaica (BOJ)" 18/.

**2. Contraceptives for Public Sector Health Institutions**

Regarding the procurement and distribution of contraceptives to public sector institutions, the NFPB has several advantages over the MOH in the short run. First, it is clear that the MOH's budget for pharmaceuticals is very constrained and it is questionable what priority contraceptives would receive if budget and procurement responsibility for contraceptives were passed onto the Pharmaceutical Services Division of the MOH. It seems more likely that the NFPB can argue for adequate funds for contraceptive requirements, and that these funds can be defended against alternative claims within the NFPB. The Centers for Disease Control in Atlanta is currently providing technical assistance to the NFPB to develop skills in projecting contraceptive requirements, and this model can be easily extended to determine the associated financial requirements. A second consideration would be the fact that as a statutory body, the NFPB does not have to place its international orders through the MOF Supply Division, nor rely on it for port clearance.

However, there are costs related to the NFPB retaining control over contraceptive procurement and distribution for public sector institutions that would not be borne if this function were passed onto the MOH. Duplicative inputs principally relate to the 3 vehicles the NFPB uses to distribute contraceptives to public sector institutions (e.g. drivers' salaries and benefits, and fuel, maintenance, and depreciation for the vehicles). The customs broker's fee and other port clearance charges are not significant, and in fact may be less than the 5% fee charged by the MOF's Supply Division. Fees for rental of the NFPB warehouse would likewise also have paid even if the NFPB's operation were combined with the MOH's pharmaceutical procurement and distribution system as the IMS do not have sufficient space available for the stocking of contraceptives.

There may be longer run developments with respect to the provision of pharmaceuticals to public sector institutions which would permit elimination of the parallel system of the NFPB without jeopardizing the supply of contraceptives to public sector institutions. These longer run developments will be dependent on responses of the MOH to the dismantling of the JCTC, to proposals to privatize the provision of public sector pharmaceuticals, and to management improvements in the current system accompanying the provision of significant amounts of pharmaceutical supplies by the World Bank. The project's mid term evaluation should review the decision to leave the

---

18/ OEPE (November 14, 1990) Jamaican Foreign Exchange Systems, Kingston: USAID.

213

ANNEX G.2  
FINANCIAL ANALYSIS

procurement and distribution of public sector commodities with the NFPB to determine if sufficient improvements have been made in the MOH pharmaceutical system to recommend the NFPB's system be combined with it.

**2. Contraceptives for the Social Marketing Program:**

From 1978, the first year of the NFPB's full management responsibility for the CDC program, to 1989, sales of oral contraceptives increased from 175,572 to 515,412 cycles per year (193%), and sales of condoms increased from 801,648 to 2,139,118 units per year (167%). In 1989, pill cycle sales through the CDC program were estimated equal to 47% of all oral contraceptives used in Jamaica, and condom sales were estimated equal to 37% of all condoms used. The Jamaican CDC sales contributions to national prevalence of pill and condom use are among the highest for contraceptive social marketing (CSM) programs in the world 19/. Among the key elements related to the CDC program's success have been the establishment of the "Panther" and "Perle" brand names, the wide geographic distribution of private pharmacies/outlets through which the product is sold, and the low price at which they have been offered.

Nevertheless, the final evaluation of USAID's Jamaica Population and Family Planning Project identified several weaknesses in the current CDC program, specifically: i) lack of a strategic marketing plan, ii) insufficient independence on the part of CDC staff with respect to implementing marketing programs, iii) lack of a budget for the CDC program within which CDC staff can develop their activities, iv) failure to price the product to cover the costs of the program, v) need for introduction of other products - especially a low dose pill, and vi) lack of advertising and promotion 20/. Given that USAID will be phasing out its provision of contraceptives over the LOP, starting with the social marketing commodities, the NFPB must determine what strategy it will follow to rectify weaknesses in the CDC program, and increase its self-sustainability.

The evaluation report also identified several options to alter the management structure of the CDC program in order to facilitate improvement in the program's operations. These options ranged from restructuring the program to increase its operational autonomy within the NFPB, to moving the program further to the commercial sector. The following discussion reviews financial

19/ McWilliam, J. et.al. (1990) Evaluation of the Jamaica Population and Family Planning Services Project, (Project No. 532-0069), p. 52.

20/ McWilliam, J. et.al. (1990) op.cit., pp. 41-58.

ANNEX G.2  
FINANCIAL ANALYSIS

considerations as they relate to the options considered in the design of this project. Discussion of institutional issues related to the CDC program are covered elsewhere in the project paper (see Annex \*\*).

Prior to review of financial considerations related to the different management options for the CDC program it is important to note that the program is already a joint public-private sector effort. The NFPB contracts with private sector firms for: i) port clearance and transport of the commodities to the NFPB warehouses, ii) development and placement of social marketing advertisements for the CDC products, and iii) distribution of the commodities to private sector retailers. The distributing agency, Grace Kennedy Ltd., is the largest distributor of food and other products in Jamaica. Thus, the NFPB's choice regarding the future of the CDC program is not a choice between a public vs. a commercial sector program, rather whether the functions currently carried out by the NFPB for the CDC program of: contraceptive procurement and storage, marketing and advertising, and market research, should be passed onto the commercial sector for institutional and/or financial reasons.

CDC Program in the NFPB: One of the benefits of the NFPB continuing to operate the CDC program is that the NFPB would have direct control over the price of the CDC commodity to the consumer. In theory, this opens up all options from subsidizing the commodity, to setting prices over break-even levels so as to cross-subsidize other family planning services. For example, the NFPB might decide to price the CDC commodities at their marginal cost so that the revenue generated would allow the Board to cover the costs associated with replacing the commodities that USAID currently provides. If this were the Board's objective, the price to the consumer would be approximately J\$ 0.40/condom, and J\$ 6.50/cycle of pills (see Table 10). Alternatively, the NFPB might decide to price the CDC commodities to fully cover the costs of the CDC program. Assuming that the demand for CDC commodities is price inelastic (i.e. sales at these higher prices remain at 1989 levels of approximately 2.5 million condoms and 570,000 cycles), then the break-even prices of CDC products to consumers would be J\$ 1.32/condom and J\$ 10.18/cycle (see Table 11). Even at these break-even prices, the NFPB's products would be priced below comparable products in the Jamaican market 21/.

However, it is unclear the degree to which the demand for contraceptives in Jamaica is price inelastic. While a study of the demand for contraceptives in Jamaica did not find the purchase price of oral contraceptives in the

---

21/ In January 1990, a 3-pack of condoms in Jamaican pharmacies ranged from J\$6.50 to J\$10.00, and a cycle of pills ranged from J\$10.85 to J\$32.15. See Table 20 in: McWilliam, J. et.al., op.cit., p. 48.

215

ANNEX G.2  
FINANCIAL ANALYSIS

Jamaican market to be statistically significant in determining whether a woman chose to obtain resupplies from a private/paying or free source, prices were found to be negatively related to the choice to obtain the method from private sources. The authors of the study also cautioned that if the price increases in the private sector were very large, that the movement of pill users from the paying to the free group might become significant. In the absence of user fees, this shift would require the GOJ to provide free contraceptives to this group as well as to those currently going to clinics for re-supply. In the case of condoms, the study found that demand for the condom was more price sensitive, and that increases in price would be more likely to reduce use 22/. Reductions in condom use would result in costs to Jamaicans and their economy through increases in unwanted pregnancies and STDs (including AIDS).

Analysis based on households current expenditure patterns for health care would suggest that shifts to public sector clinics, or reduction in condom use might be substantial at break-even prices. Specifically, at the marginal cost prices, a couple-year of protection from condoms would cost J\$ 60, and from pills would equal J\$ 85. Households within the top four income deciles could afford these prices if they elected to allocate 0.3% of their expenditure to contraceptives. At the full cost, break-even prices, a couple-year of protection from condoms would cost J\$ 198, and from pills would cost J\$ 132. At these prices, only households in the top one or two income deciles would be able to purchase contraceptives for 0.3% or less of their total household expenditure. However, the actual sensitivity of Jamaican consumers to changes in CDC prices, and the degree to which advertising and promotion can influence this sensitivity, can only be determined empirically, under either option, it will be essential for the NFPB to monitor changes not only in CDC sales, but also changes in distribution (of all methods) through public sector institutions, changes in the sales of other private sector contraceptives.

It is important to consider the financial risks related to maintaining the CDC program in the NFPB. First, to ensure continuation of adequate supplies in the CDC program, the NFPB will have to build up sufficient cash reserves to be able to place international tenders for on the order of one year of supply. Assuming USAID funding for CDC commodities ceases by the end of the second year of the project, it is estimated that the NFPB would have to have accumulated the equivalent of US\$ 50,000 (J\$ 400,000) for condom purchases, and US\$ 273,600 (J\$ 2,188,800 in 1991 J\$) for purchase of pill

---

22/ Schwartz, B. et.al. (March 3, 1986) The Effect of Contraceptive Prices on the Choice of Contraceptive Method: A Three Country Comparison, 28 pp. plus tables.

ANNEX G.2  
FINANCIAL ANALYSIS

cycles for their first tender 23/. Given current revenue from the sale of CDC commodities, it is unclear that the NFPB will be able to build up this level of cash reserves by the end of the second year of the project (October 1993). Second, changes in the exchange rate of the Jamaican dollar and inflation will erode the revenue of the CDC program in real terms unless the NFPB continuously reviews how changes in input prices and sales volume influence prices for the CDC commodities. The track record of the NFPB with respect to changing the price of the CDC commodities is poor (2 price changes in 15 years). Were the NFPB's reticence to change prices continue in the future, then the decline in the real revenue of the CDC program would either cause it to operate poorly due to insufficient financing, reduce funding to other NFPB activities, or require the GOJ to provide a higher level of government funding for its support.

If the NFPB elects to maintain its current control over the activities of the CDC program it should endeavor to implement recommendations made by the final evaluation team of the USAID Population and Family Planning Services Project for this option. Specifically:

- o Elevation of the marketing officer's position to the level of Division Chief.
- o Continued employment of marketing officers with the level of capability and expertise as the individual currently holding the post.
- o Development of (multi-year) marketing and development plans for the CDC program, with the Board of Directors approving each year an annual plan and associated budget after which the CDC staff could implement the program with little further intervention by the Board of Directors.
- o Development and use of (multi-year) pricing and cash flow models for the CDC program to assure the financial soundness of the program.
- o In conjunction with these models, the Board should annually review of the prices of CDC commodities in order to adjust prices for changes in the price of inputs through devaluation, inflation, or other; and with regard to the population's response to prior price changes.
- o Placement on the Board of Directors for the NFPB individuals

---

23/ Ravenholt, B. (1991) Points to Consider in Making Decisions Concerning Management of the Social Marketing Program, pp. 5-6.

ANNEX G.2  
FINANCIAL ANALYSIS

with management and business experience who can give adequate attention and support to the management and financial requirements of the CDC program.

CDC Program in the Commercial Sector: One of the financial advantages to the commercialization option is that the NFPB would no longer have to finance the importation, packaging, and promotion 24/. of the CDC commodities. In the break-even analysis presented in Table 12, these costs are estimated to be J\$ 3,890,718 (sum of lines 17+25) or 70% of the estimated costs of the CDC program to the NFPB (J\$ 5,534,378). However, the NFPB would still have to cover certain costs included in the break- even analysis. Specifically it would have to cover: i) the direct costs and overhead associated with the CDC staff which would retain their advertising and research functions, ii) maintenance IEC/advertising (or a portion of these costs), and iii) research costs associated with the promotion of contraceptives sold in the commercial sector 25/. These costs would equal at least J\$ 1,488,680 or 27% of the total costs of the CDC program were it to remain entirely in the NFPB. The remaining 3% of program costs are assumed to be inputs which the NFPB reallocates to other programs 26/.

There are several ways the commercial option may be structured to cover these costs. The participating commercial firm(s) could agree to provide financing for a portion of the maintenance advertising costs associated with promoting pill and condom use and purchase at pharmacies (Table 12 assumes the commercial firm pays half of advertising costs). A "Return to Project Fund" might be developed into which the commercial firms would pay a fee to the NFPB, of either a fixed amount or a percent of sales 27/. The NFPB might arrange to waive import duties on CDC commodities in exchange for payment of a

---

24/ The advertising costs associated with the CDC commodities (or at least a portion) would remain at the NFPB.

25/ For further detail on the responsibilities of the CDC staff under Option 3, see Smith and Ravenholt (1990), p. 21.

26/ If the NFPB were to extend to its own program the level of subsidy it would provide the commercial sector option, the break-even prices to the consumer would be J\$ 0.73/condom and J\$ 8.41/cycle (see Table 12).

27/ In CSM programs in other countries, the fee may be a small fixed amount plus a percent of revenue ranging from 5 to 20%. Santiago Plata, Futures Group, personal communication, February 26, 1992.

ANNEX G.2  
FINANCIAL ANALYSIS

portion of this amount 28/29/. Finally, the NFPB could collect a royalty from leasing use of its trademarks for "Panther" and "Perle".

Of concern is also the issue of the price at which the commercial sector would offer social marketing contraceptive products. Prior to initiation of the activity, the NFPB and commercial firms would draw up a letter of agreement which would include agreement on an initial price at which the products could be sold, and documentation regarding under what conditions (devaluation, inflation, regulatory change, other) this price would be altered. One international supplier of 10-dose oral contraceptives indicated that it would provide these to its Jamaican distributor at the equivalent of US\$ 0.47/cycle. Assuming duty of 20%, a distributor's margin of 30%, and a retailer's margin of 25%, the final estimated price for a pill cycle to a consumer would be J\$ 7.33 (in real March 1991 J\$) (see Table 13) 30/. This price is above the marginal cost price through the NFPB (primarily because of the payment of duty) and below the full-cost break-even price for the NFPB.

However, it is unclear that a Jamaican distributor would be interested to provide oral contraceptives at this price. Assuming that the volume of sales is the same as in the break-even analysis, i.e. 570,000 cycles, then gross revenue to the distributor for pill sales would be J\$ 769,500. However, from gross revenue would have to be deducted costs for contributions to maintenance advertising, promotion, detailing, packaging - estimated at J\$ 651,818.

---

28/ Currently ethical pharmaceuticals, such as oral contraceptives, are assessed a 15% import duty and 5% consumption tax (but are exempt from the 40% stamp duty on other pharmaceutical goods). Condoms are assessed duty at a rate of 60% as rubber goods. Based on the assumptions in the break-even analysis, these duties would equal J\$ 468,000, or a little over half of the advertising budget requirement for the NFPB.

29/ The administrative feasibility of this option is not clear as it may be difficult to implement an exemption to the commercial sector for select contraceptive brands but not others.

30/ Information was not available at the time of project design on a commercial sector price for a social marketing condom. However, it is difficult to imagine that a commercial firm could obtain a condom at less than the IPPF price of US\$ 0.02/piece. Second, given that the Panther name is established, it is unclear the trade-off between additional maintenance advertising expenditure and price of the product. Third, given the externalities associated with the condom in preventing not only unwanted pregnancy, but also STDs (including AIDS), the GOJ has an interest in maintaining the price of the condom at a low level, even if some subsidy is involved.

219

ANNEX G.2  
FINANCIAL ANALYSIS

In addition, the firm may have some additional expenses related to program management, product warehousing, port clearance, packaging, and distribution to pharmacies. By this estimate, the net profit to the commercial firm from sale of the CDC oral contraceptives would maximally be J\$ 117,682 (see Table 14). The commercial firm would be able to achieve this same level of profit by placing the funds required to purchase the pills (J\$ 2,188,800) into a Jamaican bank at a simple interest of 5.4% per annum. If pill sales were lower, say only 500,000 cycles per year, then net profits would maximally be J\$ 23,182. It is unclear, especially in view of continued high inflation, and of the opportunity cost of foreign exchange, that a Jamaican firm in the commercial sector would be willing to place a cycle of oral contraceptives in the market at a price of J\$ 7.33/cycle (in real March 1991 J\$). If it were willing to do so, it is unlikely that it would provide the same level of advertising and promotion that have been included in the break-even price analyses for the NFPB.

However, commercial firms which wish to gain a substantial share of the market for their product may be willing, in the short run, to sell their product with little or no profit, in order to establish brand name recognition and enlarge its market share. However, in the longer run, were the commercial firm to elect not to continue to operate the CDC program under a letter of agreement with the NFPB, it is unclear whether there will be factors present in the market to maintain low prices (in real terms). Standard microeconomic theory would suggest that firms attempt to either profit maximize (i.e. set marginal revenue = marginal cost), or revenue maximize (i.e. set marginal revenue = 0). In either of these cases, when the industry exhibits declining average costs over the relevant level of production/sales, then the firm will not price the commodity at minimum average cost, nor sell the maximum level of product possible in covering costs (see Figure 1) 31/. While the higher the commercial firm raises the price of the social marketing product the more likely it becomes that other commercial firms will lower the prices of similar products in order to compete away a share of this market, the specific formulation of each pill, and health considerations to minimize switching of formulations, may reduce the impact of this competition. Finally, it will be important for the MOH to establish family planning user fees in the public sector not only to provide a mechanism for cost recovery for contraceptives provided to women who switch from re-supplying in the commercial sector, but also to reduce the financial incentives to women to switch.

---

31/ Most standard microeconomic texts will provide information on free vs. regulated pricing of natural monopolies. For example, see: Nicholson, W. (1985) Microeconomic Theory, Basic Principles and Extensions, Chicago: Dryden Press, pp. 432- 435.

220

ANNEX G.2  
FINANCIAL ANALYSIS

In summary, the current level of private sector involvement in the CDC program in Jamaica is appropriate with respect to maximizing the efficiency with which CDC commodities are distributed in Jamaica. As illustrated by the above analysis, from an economic or financial perspective there are pros and cons associated with either the option of strengthening the CDC program within the NFPB, or moving the program further into the commercial sector. However, it is clearer that the future success of either option would be more assured with a high level of NFPB/MOH commitment and support, and inputs to USAID technical and financial support. Given concerns with the institutional capacity of the NFPB to take the necessary steps to move towards a financially sustainable CDC program, USAID is proposing that the NFPB further commercialize the CDC program, beginning with the introduction of low-dose oral contraceptive. The design of the commercial approach would include elements to reduce anticipated downsides; as well as funds for monitoring the impact of this approach on contraceptive use, and the overall financial burden to the NFPB to provide contraceptives in public sector institutions. Ongoing monitoring and evaluation of this program can assist the NFPB in maximizing the benefits of the commercialization approach.

ANNEX H  
ENVIRONMENTAL  
THRESHOLD  
DECISION

AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

LAC-IEE-91-52

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Jamaica  
Project Title : Family Planning Initiatives Project  
Project Number : 532-0163  
Funding : US\$7,000,000.00 LOP, DA, POP  
Life of Project : 7 Years  
IEE Prepared by : Ralph Bird,  
Acting Mission Environmental  
Officer  
Recommended Threshold Decision : Categorical Exclusion  
Bureau Threshold Decision : Concur with Recommendation  
Comments : None  
Copy to : Robert S. Queener, Director,  
USAID/Jamaica  
Copy to : Charles A. Scheibal, USAID/Jamaica  
Copy to : Adrian de Graffenreid, LAC/DR  
Copy to : IEE File

James S. Hester Date 6/4/91

James S. Hester  
Chief Environmental Officer  
Bureau for Latin America  
and the Caribbean

ANNEX H  
ENVIRONMENTAL  
THRESHOLD  
DECISION

ENVIRONMENTAL DETERMINATION

Country : Jamaica  
Project Title : Family Planning  
Initiatives Project  
Project Number : 532-0163  
Funding and Funding Source : US\$7,000,000 LOP; DA, POP  
Proposed Obligation : FY1991  
Mission Determination : CATEGORICAL EXCLUSION  
Prepared By : Charles Scheibal, Mission  
Environmental Officer

A. Activity Description: The Project seeks to increase the quantity and quality of family planning services in Jamaica; and to assist the Government of Jamaica to develop self financing, sustainable family planning services. The Project will consist of three components as follows: (1) Policy Framework; (2) Sustainable Family Planning services; and (3) Institutional Strengthening.

Proposed Project activities do not contemplate any construction or other influence on the natural or physical environment.

B. Discussion: Implementation of the proposed project activities will involve technical assistance, training, research, and some commodity procurement which, when weighed against the criteria in Section 216.2 (c) (1) and (2) of AID's Environmental Procedures, are considered to qualify for a Categorical Exclusion for which an Initial Environmental Examination is generally not required.

This statement is submitted for Bureau Environmental officer review in accordance with Section 216.2 (3).

C. Approval

Approval:

*Marilyn A. Zak*

Disapproved: \_\_\_\_\_

Date:

*30 July 90*

Marilyn A. Zak  
Acting Mission Director  
USAID/Jamaica

ANNEX I  
LETTER OF REQUEST  
FROM THE GOJ

# THE PLANNING INSTITUTE OF JAMAICA



ANY REPLY OR SUBSEQUENT REFERENCE  
TO THIS COMMUNICATION SHOULD BE  
ADDRESSED TO THE DIRECTOR GENERAL  
P.O. BOX 634, KINGSTON

Telephone: 926-1480-8  
Telex: 3529 PLAN JAM JA  
Facsimile: (809) 926-4670

39-43 Barbados Avenue  
Kingston 5 Jamaica W.I.

Ref. No. C18-15-1

July 8, 1991

Mr. Robert Queener  
Director  
United States Agency for  
International Development (USAID)  
6B Oxford Road  
Kingston 5.

Dear Mr. Queener

Family Planning Initiative Project, 1992-98

This letter constitutes the formal request of the Government of Jamaica to the United States Agency for International Development (USAID) for assistance to support national development goals related to population through the Family Planning Initiatives Project.

The Planning Institute of Jamaica endorses the aims and objectives of the project and arrangements are in train to put into effect the terms and conditions specified in the project document.

We thank you for your cooperation and look forward to receiving a signed copy of the project document in due course.

Yours sincerely,

  
(Mrs.) Dorothy Jones  
for Director General

224



ANNEX J  
LETTER FROM GOJ ON FUTURE  
BUDGETING FOR CONTRACEPTIVES

017665

MINISTRY OF FINANCE, DEVELOPMENT AND PLANNING

30 NATIONAL HEROES CIRCLE,

P.O. BOX 512,

KINGSTON,

JAMAICA

June 20, 1991

ANY REPLY OR SUBSEQUENT REFERENCE  
SHOULD BE ADDRESSED TO THE FINANCIAL  
SECRETARY AND THE FOLLOWING  
REFERENCE NUMBER QUOTED:-

TELEPHONE NO. 92-28600-18

DATE RECEIVED 7/9	ACTION OFFICER PHAN	INFO TO: DIR	ARDG	OHNP	PEHR	OPPB	ESM	RIYBO	RIF	BUE BY 7/9	ACTION
		B/B.R									

862/05

Mr. Robert Queener  
director  
United States Agency for International Development  
6b Oxford Road  
KINGSTON 5.

Dear Mr. Queener:

Subject: GOJ Budget Commitment for Future Purchase  
of Contraceptives

I hereby acknowledge receipt of your letter dated April 8, 1991 re the above captioned.

The Ministry of Finance, Development & Planning has examined the proposals you have put forward and fully endorses the public sector programme for family planning delivery in Jamaica. This Ministry notes that there are two components to this programme:-

- (1) The Public Sector Programme (PSP) in which contraceptives have been made available essentially free of charge to users through the Ministry of Health Clinics; and
- (2) the Social marketing programme (SMP) through which oral contraceptives and condoms are sold to the market.

725-

The cost of the Public Sector Programme now being financed by USAID will be phased out beginning in 1993 and ending 1997. The Government of Jamaica hereby gives assurance that this cost of approximately US\$1.045m will be borne by GOJ over the period. The respective annual allocations will be provided under the National Family Planning Estimates of Expenditure.

In relation to the Social Marketing programme the Government of Jamaica is currently evaluating the programme in order to determine the best and most cost effective way of family planning delivery to the remainder of the population in order to ensure that the target of 62% contraception prevalence is maintained by the year 2000.

You will be informed of the Government's decision on the Social Marketing Programme.

Thank you for your wholehearted support on the programme to date.

Yours sincerely

  
Shirley Tyndall (Miss)  
Financial Secretary.

226.

ANNEX K  
LOCAL PRODUCTION OF  
CONTRACEPTIVES

Local Production

The issues related to local production of contraceptives are closely linked to the broader issues surrounding contraceptive supply and demand. Local production, and the intermediate steps of local packaging/processing, must be considered within the framework of efficient and affordable contraceptive supply. As Jamaica moves to a largely commercially-supplied market in contraceptive commodities, local production will be one option to investigate, along with other types of commercial procurement.

A decision to undertake local production requires careful review of the following areas:

- o assessment of long-term demand for a given method;
- o assessment of in-country technical capability specific to the product under consideration;
- o assessment of financial feasibility;
- o assessment of the institutional capability to continually monitor product quality;
- o comparison with similar in-country projects.

A series of progressively more detailed studies leading up to the final determination of the feasibility of local production is the normal decision-making process. However, the standard production processes provide from the outset guidelines based on the minimum annual output generally required to justify production -- approximately 15 million cycles of oral contraceptives; 70 million condoms, or one million IUDs.

Thus, for local production of contraceptives to be feasible a sizeable demand will be required. The present market in Jamaica alone does not reach the above levels. The annual consumption of US-donated social marketing commodities was 515,412 cycles of orals and 2,139,118 condoms in 1989. Because of the high price of other commercial brands, their share of market is small. Demand is expected to increase when two promotional activities take place: the CSM program of active marketing of orals and condoms, and the AIDS program promotion of condoms. Even with these demand creation activities, the Jamaica market alone may be insufficient for local production. Thus, in exploring the potential for local production, it may be important to consider production for regional export.

ANNEX K  
LOCAL PRODUCTION OF  
CONTRACEPTIVES

Commercializing affordable, quality contraceptives in the Jamaica market, with active promotion, is an essential step in "growing the market" before local production can even be considered. No Manufacturer would come in to a market flooded by subsidized commodities. Thus,, in the short-term, Jamaica may wish to concentrate on the intermediate step of putting social marketing products fully into the commercial market; this does not preclude the option of investigating local processing or packaging as a further means of developing the market.

For the types of contraceptives normally considered for local production there are intermediate stages, which can range from final packaging of imported products to complete production, testing and packaging. Capital costs and risks are much smaller than for full-scale production. However, costs for commodities can be reduced and quality is more readily assured than under full-scale production ventures. These intermediate stages may provide a feasible investment for Jamaica and should be investigated. The advantage of phasing in the production process is to allow more time for market development, as well as training and the development of quality control measures.

228

ANNEX L  
BASIS OF  
CONTRACEPTIVE  
FINANCING  
ESTIMATES

TABLE III

Contraceptive Requirements with Phase-out Plan  
Cost Estimates  
date: 3/22/91

Method	Pop & Family Health Proj.			Family Planning Initiatives Proj.					TOTAL 1992-97
	1990	1991	1992	1993	1994	1995	1996	1997	
Public									
Condom	\$137,444	\$140,015	\$149,591	\$128,854	\$102,112	\$71,979	\$38,277	\$0	\$488,812
OCs	\$101,400	\$104,717	\$113,140	\$97,993	\$79,283	\$57,141	\$30,777	\$0	\$378,333
IUD	\$3,712	\$4,140	\$4,979	\$4,608	\$3,981	\$3,126	\$1,786	\$0	\$18,480
Total	\$242,556	\$248,873	\$267,709	\$229,454	\$185,376	\$132,247	\$70,839	\$0	\$885,625
CSM									
Condoms	\$137,444	\$140,015	\$149,591	\$158,567	\$0	\$0	\$0	\$0	\$308,158
OCs	\$274,888	\$183,614	\$198,382	\$214,779	\$0	\$0	\$0	\$0	\$413,160
Total	\$412,333	\$323,629	\$347,972	\$373,346	\$0	\$0	\$0	\$0	\$721,318
COMBINED									
Condom	\$274,888	\$280,031	\$299,182	\$285,421	\$102,112	\$71,979	\$38,277	\$0	\$796,971
OCs	\$378,289	\$288,331	\$311,521	\$312,771	\$79,283	\$57,141	\$30,777	\$0	\$791,493
IUD	\$3,712	\$4,140	\$4,979	\$4,608	\$3,981	\$3,126	\$1,786	\$0	\$18,480
Other/ Reserve			\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$0	\$150,000
TOTAL	\$654,889	\$572,503	\$645,681	\$632,800	\$215,376	\$162,247	\$100,839	\$0	\$1,756,943
Phase-out schedule									
Public	100%	100%	100%	80%	60%	40%	20%	0%	
CSM	100%	100%	100%	100%	0%	0%	0%	0%	

NOTES & ASSUMPTIONS

1. This table should not be used to estimate the annual level of USAID contraceptive support. The table is based on projections of calendar year demand for family planning by method. It is not a table of fiscal year funding requirements needed to meet the contract cycles of A.I.D. contraceptive suppliers.
2. The OYB, CP and ABS estimates must not be drawn from this table. These A.I.D. budget estimates must be taken from the contraceptive Procurement Tables (CPTs) which project A.I.D. budgetary requirements based on actual distribution and consumption data.

ANNEX M  
Waiver of Requirement for Host  
Country Funding of International  
Travel

ACTION MEMORANDUM FOR THE DIRECTOR

*ml*

FROM: Rebecca W. Cohn, OHNP

SUBJECT: Waiver of Requirement for Host Country Funding of International Travel for Training Participants under the Family Planning Initiatives Project, #532-0163 to be paid out of Grant Funds

---

PROBLEM

Your approval is requested to permit participant trainees under the Family Planning Initiatives Project #532-0163 to undertake international courses with the international travel costs financed from Project Grant Funds.

BACKGROUND

Under the Family Planning Initiatives Project, the Government of Jamaica (GOJ), through the National Family Planning Board, has undertaken to provide the Jamaican dollar equivalent of US\$2.734 million in counterpart contributions of which US\$1.740 is estimated as foreign exchange cost for the procurement of contraceptives. The remainder of \$994,000 will be utilized for personnel and recurrent costs. During the life of the project the total number of participants to be trained overseas will be 20 persons at a total cost of \$100,000.

In recent years the National Family Planning Board has sustained severe GOJ budgetary cuts with the result that the Board is finding it increasingly difficult to continue to pay international travel costs for participants. Also, given the present exchange rate of JA\$10.15 = US\$1.00, the National Family Planning is experiencing extreme financial hardships in providing the funding for international travel, which averages JA\$7,136 for a 3-week return ticket to the training orientation site in Washington, D.C.

230

Under the Population and Family Planning Services Project, the Government of Jamaica (GOJ), through the National Family Planning Board, has undertaken to provide the Jamaican dollar equivalent of US\$16.4 million in counterpart contributions. Since the inception of the Project, March 31, 1982, the Government of Jamaica and its sub-projects have provided the amount of US\$16.1 million in counterpart contribution up to March 31, 1991. The Project, initially, had funding constraints which severely limited the total number of participants trained until Waiver No. 532-0069-87-05 was approved December 15, 1986. To date, 31 participants, 11 prior to December 1986, have been trained and one person planned before the PACD, March 30, 1992.

By virtue of Section 16C 2 of Chapter 16 of Handbook 10, the Mission Director may authorize the full or partial waiver of the host government's or other sponsor's responsibility for a specific mission-funded project when no general country waiver has been waived. The appropriate regional assistant administrator and OIT must be so informed.

RECOMMENDATION:

It is recommended that the Mission Director waive the requirement that the National Family Planning Board pay international travel for training participants selected under the Family Planning Initiatives Project #532-0163 and authorize full payment of international travel for participants from Grant funds.

Approve: Robert S. Greenor  
Disapprove: \_\_\_\_\_  
Date: July 23, 1991