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FINAL REPORT

**POPULATION AND DEVELOPMENT IN THE EASTERN CARIBBEAN:
ASSESSMENT AND STRATEGY**

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Michael Micklin
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Executive Summary

This document provides an assessment of the Eastern Caribbean Population and Development Project (538-0039), which extended from July 1982 through June 1992, as well as recommendations for a follow-up project. A wide range of project documents and related materials, including a mid-term project evaluation and three component final evaluations, were examined (see References) and other relevant information was obtained through interviews with project participants in four countries: Grenada, Dominica, St. Lucia, and Antigua (see Appendix B). The following summary addresses the principal questions contained in the Scope of Work provided to this consultant.

The Population and Development Policy Project contained two principal elements: (1) activities designed to improve the delivery of family planning services in Eastern Caribbean countries and (2) activities aimed at strengthening national population policies. Under the original project design, there were two implementing agencies: IPPF/WHO was responsible for the family planning component and CARICOM managed the population policy component. Amendment 1 phased out the CARICOM activities while adding support for IPPF/WHO, while Amendment 2 shifted project support to the Caribbean Family Planning Affiliation (CFPA) as the principal implementing agency. Other organizations that conducted or assisted project activities include Tulane University, The Population Council, The Population Reference Bureau, and John Snow International.

The population policy component of the project was only moderately effective. While National Population Task Forces were organized and national policy statements were produced in 1986 by all countries in the region, the policies have not been implemented. National Population Planning Units are now at work in several countries, but results have been minimal except in St. Lucia. The project also included a task devoted to development of medical policies, dealing with delivery of family planning services, but it too was only partially successful. Generally, there is a need for further elaboration and refinement of EC population policies, and limited support for this work should be provided in a new USAID population project (see below).

The family planning component of the project consisted of a number of complementary activities, some of which were quite successful while others were outright failures. Major project achievements in this area include the following. First, a large number of family planning clinics were renovated and equipped, and a system was established for ensuring a ready supply of contraceptives available to Ministries of Health. Second, scores of nurses and auxiliary family planning workers have been trained in service delivery and counselling, largely by CFPA. Recipients find this training to be very effective, and want more of it. Third, information,

education and communication (IE&C) activities, again through CFPA, have improved public knowledge of family planning issues and methods. There is a continuing need to reach certain segments of EC populations, e.g., adolescents and men. Fourth, the project resulted in some significant research of practical use for family planning programs. Of principal importance is the set of Contraceptive Prevalence Surveys conducted by Tirbani Jagdeo. In addition, 14 operations research (OR) projects were completed under the leadership of Tulane University and The Population Council, although there is little evidence that results have been put to much use. Qualitative studies of male attitudes toward reproduction and family planning were also conducted in three countries.

These positive results are offset partially by some major project shortcomings in the area of family planning. First, the management information system (MIS) implemented by JSI has resulted in little improvement in program performance data. The system is much too sophisticated for the needs and capabilities of FPAs in the region, and the logistics developed have proven to be too costly. Moreover, JSI has yet to submit any progress reports to USAID. Second, the private sector family planning clinic and day care center established at the Frequente Park Industrial Park in Grenada are not sustainable facilities. Recurring costs are high, and there is little evidence that cost recovery measures would be successful. Nonetheless, solutions to this problem are still being explored. Third, efforts to increase the sustainability of MOH and FPA service delivery programs have had little effect. There is likely to be a continuing need for financial and technical assistance from USAID and other donors.

Recommendations addressed to specific questions in the Scope of Work include the following:

1. Design and carry out modest management improvement activities through technical assistance and training, with emphasis on improving what exists rather than introducing new systems. Regarding FPAs, reinforce what IPPF/WHO has been doing for years with its Programming, Planning, Budgeting Review (PPBR) exercises. Use external technical assistance sparingly and ensure that it is relevant and appropriate for the region. Terminate the JSI-assisted MIS now because it is probably not sustainable, is largely a duplication of the FPAs existing MIS, and is not being used effectively.
2. Be more realistic about the possibilities for cost recovery. Given that most health services are free, there probably should not be a charge for family planning services in that sector in the absence of a change of government policy regarding cost recovery for health services generally. The FPAs already charge for contraceptives and related services.

3. Be more realistic and cautious regarding possibilities for privatization of family planning services, e.g., getting industries to fund services for their workers. Even if one or two of such programs were feasible, they would be insignificant in most of the region.
4. Reduce dramatically and promptly the staffing and hours of service of the family planning clinic at Frequente Park. Continue funding through the end of the project (July 1992) and continue to seek alternative means of support for the clinic and day care center. One possible solution for the latter is to donate the equipment to GRENSAVE, which already operates two day care centers and is in dire need of various kinds of support. In any event, this is a problem which the U.S. Government had a substantial role in creating and, therefore, it should lead the search for a solution.
5. Assess carefully the ability of Ministries of Health and FPAs to pay for contraceptives. To the extent they cannot assure a continued supply, explore the possibility of continued support in this area. Nothing is more damaging to FP services than disruption of contraceptive supplies.
6. Assure continuation of periodic contraceptive prevalence surveys. Such studies are particularly important given the poor quality of data and the lack of analysis by governments and FPAs in the region.
7. Seek to improve the use of program performance information through training, development of appropriate management information systems, and carefully designed operations research.
8. Initiate efforts to improve coordination among donor agencies working in the population field in the Eastern Caribbean. With increasing scarcity of donor resources, it is imperative that financial and technical assistance be allocated in terms of a regional plan.
9. Strengthen the RDO/C capacity to monitor on-going projects and to respond quickly and decisively when problems are observed. Such action is necessary to avoid the kinds of shortcomings identified in the Population and Development Project.

Because of continuing demographic problems in certain countries of the Eastern Caribbean, a new population project would be a wise investment of USAID funds. The new project should be focused on the improvement of family planning services, with a small population policy component. Priority should be given to assuring availability of an appropriate mix of contraceptive methods, training

additional personnel for work in family planning service delivery and program management, and continuation of IE&C activities, particularly those designed for adolescents and men. Policy-related work should be concentrated on provision of technical assistance to National Population Planning Units in the areas of research and the use of demographic knowledge for development planning. CFPA is the appropriate regional institution to implement the new project.

I. Introduction

This report is in response to PIO/T 538-0000-3, issued by USAID/RDO/C. The broad objectives of this task are to (1) conduct a technical assessment of performance and effectiveness of work carried out under the Eastern Caribbean Population and Development Project (538-0039), (2) identify unmet needs in family planning information and services, and (3) provide USAID/RDO/C with suggestions regarding culturally appropriate and cost-effective ways of assisting with the improvement of family planning services in the region. The project was initiated on 28 July 1982 and the current Project Assistance Completion Date is 27 July 1992.

The consultant's work began on 29 September 1991 and was completed on 15 November 1991 with a debriefing at the USAID/RDO/C offices in Barbados. The original plan was to divide the task between two consultants. However, the other consultant contracted, Dr. Robert Wickham, was unable to complete the mission. A family emergency required his return to the United States after the initial briefing period in Barbados and the first country visit to Grenada.

Field interviews and observations were conducted in Grenada, Dominica, St. Lucia, and Antigua (see Appendix B for a list of individuals and organizations contacted). In Grenada this work was carried out by Drs. Micklin and Wickham and Mr. Neville Selman, Population Advisor, USAID/RDO/C; the remaining countries were visited only by Dr. Micklin and Mr. Selman. The duration of country visits ranged from two days in Dominica to one week in Antigua.

This report is based on several types of information. First, the original Project Paper and Amendments 1 and 2 provide detailed descriptions of the objectives, activities, levels of funding, and organizational responsibilities for each operational component. Second, a mid-term evaluation and three component evaluations were conducted between 1986 and 1990. The evaluation reports, though uneven in quality, contain useful assessments of project strengths and weaknesses as well as suggestions for modifications of the current project and/or guidelines for any future population project in the Eastern Caribbean region. Third, many, though not all, scheduled products of the project were made available for this exercise, including contraceptive prevalence and other surveys, operations research reports, IE&C materials, policy statements and analyses, and policy briefs. Fourth, other relevant materials, e.g., studies of population and development in the Caribbean, regional statistics, and assessments of other population projects in the region were consulted. Fifth, useful commentary on project activities was obtained during the country site visits, as was access to project records, workplans, and related materials. Finally, Dr. Wickham provided a brief but insightful analysis of the project based on his review of documents and his visit to Grenada. All documentation consulted is listed in the Reference section at the end of the report.

Section II of this report reproduces the Scope of Work prepared by RDO/C. Section III reviews the Project Paper and Amendments 1 and 2 as well as the three component evaluations. These documents are examined in some detail for several reasons. First, the project extends over a 10 year period and has been subject to significant changes in implementation strategies, personnel, and participating institutions. These changes must be considered in any assessment of project outcomes. Second, the three evaluations differ considerably in the degree of analysis presented and the substantive issues emphasized. Moreover, they contain a variety of explicit and implicit suggestions for project improvements. These details should be considered carefully, particularly in terms of subsequent actions taken (or not taken) by USAID and the implementing agencies. Third, development of an appropriate and feasible strategy for a new regional project must be based on a careful examination of relationships among overall goals and objectives, experience gained from previous interventions, and observed outcomes. Section IV examines demographic, social and economic conditions in the Eastern Caribbean as well as selected results from the most recent round of contraceptive prevalence surveys. Emphasis is placed on developing an argument as to why a new EC population project is justified. Finally, Section V presents a strategy for such a project. It begins with discussion of the generic elements required for implementation of a responsive and successful set of population interventions, and then outlines a general strategy for development of selected program activities. The report also contains several appendices and a list of references consulted.

II. Scope of Work

1. Review the Project Paper/PP Amendments, evaluations of the three main components of the population and Development project, 538-0039, and any other relevant regional and/or country material, assessing the achievements and shortcomings of the grantees in attaining the several goals and objectives set out in the cooperative grant and/or buy-in agreements.

2. Interview regional and country-based officials responsible for family planning/population activities, both public and private. Pursue with the principal officers of the grantees, Principal Technical (Chief Medical Officers) and Administrative Officers (Permanent Secretaries) of Ministries of Health, and any other officials, any unresolved issues relating to the development of family planning services and population activities in the participating territories in the Eastern Caribbean and Barbados.

3. Review current population policies in the OECS and the manner in which they are being implemented. Identify areas in the field of population policy which still need to be addressed and in which AID has a comparative advantage. Possible areas for investigation and analysis are: incentives and disincentives to the private sector clinic development (e.g., providing the costs, on a per capita basis, for family

planning services and medical examinations, pap smears, etc. as part of worker remuneration packages), collection of fees-for-service in public sector clinics which render services, purchase of commodities, and integrated education for providers of family planning and AIDS services and a cost-benefit analysis of these interventions.

4. Assess the nature of groups currently being provided family planning services, identifying those groups not currently reached by family planning interventions/messages. Analysis should ensure that issues of contraceptive distress and teen pregnancy are addressed in this assessment.
5. Review completed operations research activities and the utilization of the results of these activities, and identify any critical areas that remain to be investigated.
6. Assess CFPA efforts to date to develop a management information system and recommend what steps, if any, might be taken to further develop this system.
7. Assess the viability of private sector clinic development and other possible public/private sector initiatives in the area of population/family planning.
8. Assess the role of other donors/international organizations in providing assistance in the area of population policy and family planning (e.g., UNFPA and ECLAC assistance to national population units). Address possible ways in which AID efforts can be further integrated with those of other agencies/organizations and suggest those areas which are addressed sufficiently so as to preclude AID assistance.
9. Analyze current roles of CFPA, FPAs, IPPF, and governments and their possible future input in the areas of population and family planning. This analysis should include the role of service delivery, public education and information, family life education, training, demographic and contraceptive prevalence analysis, population targets, and sustainability of these efforts.
10. Assess the capability of the CFPA to be the lead implementation agency and the institutional home of the project. Indicate those areas in which the Affiliation's Secretariat can be strengthened, which areas would require technical assistance, and ways in which the ambiguity of CFPA's role vis-a-vis that of IPPF/WHR can be resolved.
11. Document these analyses, and make recommendations for USAID assistance based and prioritized on USAID's experience and comparative advantage in this sector.

III. Background

1. The Caribbean Regional Population and Development Project (538-0039) [7/28/82]

a. Objective. This project was designed to improve the balance between population and resources in the Eastern Caribbean by reducing birth rates, with an emphasis on the avoidance of unwanted pregnancies. Funding was provided for FY 1982 through FY 1985, with a total authorization of \$3,965,000; the RDO/C contribution was \$3.5 million, with the remainder contributed by AID/Washington.

b. Project Description. The project contained two principal components, one designed to increase leaders' awareness of the need for population and family policies, the other to improve countries' capacity to deliver family planning services. The first component was to be carried out by CARICOM in those member countries that wished to participate. Implementation of the second component was the responsibility of IPPF/WHO and was to be carried out in selected eligible countries, including Antigua, Barbados, Dominica, St. Vincent, Montserrat, and St. Kitts-Nevis. The specific activities called for were the following.

1) Policy.

Demographic Policy: At the regional level, an awareness-raising seminar followed by RAPID presentations, publications, and a publicity campaign was designed to educate policymakers about regional population issues. At the national level, national population task forces, including both public and private sector leaders, were to be established to review existing national population policies, implicit as well as explicit, and to design new or revised population policies, as appropriate. CARICOM was expected to assist these task forces by providing access to demographic data, analyzing key issues as identified by national leadership, and training population analysts.

Medical Policy: Various segments of the medical community were to be informed about new developments in family planning and contraceptive delivery as well as development problems related to rapid population growth. This was to be accomplished through (a) inclusion of the medical community in the task force activities, (b) establishment of a steering committee to conduct a comparative review of national medical policies, practices, and protocols, (c) organization of regional conferences and national seminars for the review of medical policies, and (d) provision of short-term training in the application of modern medical policies.

2) Improvement of Service Delivery

Training: Various participants in national family planning service delivery systems --- physicians, nurses, allied health workers, community development workers, pharmacists, and family planning administrators --- were to be trained in the latest accepted family planning techniques. Mechanisms included (a) seminars and refresher courses for physicians devoted to surgical sterilization techniques and the optimal role of the physician in family planning service delivery, (b) elementary and advanced courses for nurses focused on family planning practices and techniques, (c) on-site training in family planning service delivery for allied health workers, pharmacists, and family planning administrators, and (d) courses and in-country seminars for personnel involved in family life education and the training of family life educators.

Commodity Supply and Distribution: These activities were undertaken to ensure the ready supply of contraceptives in the Eastern Caribbean. This was to be accomplished through (a) provision of contraceptive commodities and technical assistance regarding their demand forecasting, procurement, receipt, storage, and distribution, (b) development of contraceptive marketing schemes for three to five islands, and (c) implementation of community-based contraceptive distribution programs in five countries (Barbados, Dominica, Montserrat, St. Lucia, and St. Vincent).

Improvement of Clinic Services: This component was designed to improve clinic utilization and upgrade physical facilities. Activities included building renovation, purchase of medical equipment and furniture, and technical assistance designed to achieve effective and appropriate use of clinic services.

Adolescent Extension Program: Two sets of activities were intended to improve the delivery of family planning services to the adolescent population. First, funds were provided for the establishment of up to eight adolescent clinics to be located in Barbados, Dominica, St. Kitts and St. Lucia. Each clinic was to be staffed by two appropriately trained nurses and to offer the following services: (a) clinical family planning services, including pregnancy testing, (b) contraceptives, (c) counselling on contraceptive use and sexually transmitted diseases, (d) referral to obstetric/gynecological services to be available at the clinic, and (e) an informal information and education program. Second, the project provided for the implementation of up to 10 youth outreach programs designed to reach the teenage mother and the post school-age, unemployed teenager. These programs were to provide two years of postnatal care for teenage mothers following delivery of the first child as well as information and education services. Each outreach program was to employ two family planning nurses who would visit selected communities every week for two months and repeat the program at six month intervals.

c. Program Support. Each of the implementing agencies was to provide appropriate program support. CARICOM funding allowed for 12 person-months of short-term technical assistance in the areas of demographic policy formation, population projections, computer simulation, demographic training, FP surgery, and contraceptive research. It also covered limited promotional activities, periodic audits, and mid-term and final evaluations. In the case of IPPF/WHO, the contract provided for (1) routine technical assistance connected with program implementation, (2) 17 person-months of additional technical assistance, (3) one-year contracts for two technical staff to be based in the Barbados office, (4) contraceptive prevalence surveys to be conducted initially in Montserrat and St. Kitts and in all participating countries in the fourth year of the project, (5) male attitude surveys to be conducted in up to three project countries, and (6) periodic audit of project activities and evaluation of project results.

d. Administration. Under this project CARICOM was provided funding for a one-half time administrator, administrative support staff, travel, and operating expenses. IPPF/WHO headquarters in New York received funding for a one-quarter time Project Director, a one-quarter time Program Assistant, and funds to establish a Caribbean office in Barbados. The Barbados office staff included a Project Officer, a one-quarter time Caribbean Representative, and a one-half time Financial Advisor.

2. Caribbean Regional Population and Development Project: Amendment No. 1 [09/25/86]

a. Objective. In February of 1986 the Project Advisory Committee concluded "...while the project has achieved many of its ambitious objectives, its work will not be complete when the current project assistance completion data arrives." It was therefore decided to extend the project by two years, with a new project assistance completion date of 31 December 1988. Consistent with the goal and purpose of the original project, the objective of the amended project was to "...provide further assistance to the governments and family planning organizations of the Eastern Caribbean states to bring their populace into better balance with available resources and to help Governments and peoples of the Eastern Caribbean to reduce the number of unwanted pregnancies in the region." This amendment added a total of \$941,300 to the project budget, \$591,300 for service delivery and \$350,000 for operations research.

b. Project Description.

1) National Demographic and Medical Policies

The remaining activity to be completed through this amendment was the formulation of additional population policies by governments in the

region. It was expected that CARICOM consultant would continue to work with four of the eight territories that had not yet formulated a national population policy. Under the original project each of the countries had adopted a medical policy that establishes protocols for contraceptive use, and therefore no further activity in this area was anticipated.

2) Family Planning Service Delivery through IPPF

Training: While some basic training was expected in order to compensate for the loss of personnel working in family planning programs, the training under this amendment was to be directed toward improvement of service delivery and reduction of delivery costs. As in the earlier phase of the project, training was to be provided to physicians, nurses, and allied health workers, with an emphasis on nursing personnel. Various mechanisms were to be employed, including formation of in-service training committees in each country, self-instruction training kits, and seminars at both national and regional levels.

Commodity Supply and Distribution: Difficulties had been experienced with this segment of the first phase of the project, including inadequate coordination by managers, poorly trained or motivated retailers, the lack of promotional materials, and inadequate institutional support. In order to overcome these problems, the amended project was to begin with a thorough management assessment and marketing audit of all CBD programs begun through the IPPF grant. This would be followed by development of a detailed workplan for technical assistance, training, and materials development and dissemination. In the area of commodity procurement, the amendment called for a regional workshop on "contraceptive supply management."

Improvement of Clinics: In spite of the clinic renovations accomplished under the first phase of the project, requests were pending for renovation of an additional 25 clinics. The amendment called for IPPF to assess the relative needs expressed by each government and come up with a plan for meeting the more critical needs.

c. Program Support

The principal support activities under the amended project consisted of a contraceptive prevalence survey for Barbados, technical assistance and support for training activities, and a final project evaluation. In addition, the amendment provided for the completion of contraceptive prevalence surveys already underway in St. Lucia, St. Vincent, Dominica, and Antigua. The amended project paper stated that "IPPF has arranged for the release of Dr. Tirbani Jagdeo from his duties as

Chief Executive Officer of the Caribbean Family Planning Affiliation, Ltd. to be the principal investigator in the conduct of the contraceptive prevalence surveys."

d. Operations Research

The original project provided for operations research activities, funded largely through a centrally-funded project with Tulane University. Six studies were conducted with Ministries of Health or Education, two were carried out with private family planning associations, and one covering three countries involved collaboration of two Ministries of Health and an FPA. The principal objective of the new OR component was to improve the cost effectiveness, accessibility and quality of utilization of family planning service delivery systems in the Eastern Caribbean. Emphasis was to be placed on strengthening the capacity of local organizations and agencies to handle their own data collection, analysis, and reporting tasks. Five major tasks were to be undertaken:

1) Assess Opportunities for OR in the Region.

Based on discussions with representatives of public and private service delivery organizations and potential collaborating groups, a data base of OR opportunities was to be developed and prioritized.

2) Preparation of OR Proposals.

Based on selection criteria to be developed jointly by the Population Council and RDO/C, 5-10 research opportunities were to be identified, of which 4-5 would be developed into full proposals.

3) Technical Assistance to Implementing Agencies.

Technical assistance was to be provided by the Population Council's Barbados office for each of the steps necessary to implement the research.

4) Integrating OR Techniques into Routine Program Management.

In addition to assistance with project implementation tasks, training would be provided with regard to broader aspects of methodologies for gathering, analyzing, and using data for family planning program decision-making. While most of this training was to be provided on-site, provision was made for short-term, third-country training, as needed.

5) Disseminating Project Results.

Dissemination was anticipated at three levels: national, regional, and international. Local seminars would be used to transmit OR project experience and results to members of implementing agencies who might not have been involved directly in the projects. At the regional level, a conference would be held in Barbados, with presenters selected from individual researchers who had worked most closely on the individual projects. Finally, results would be disseminated to the international population and family planning communities through a specially-developed English language edition of the INOPAL newsletter.

e. Contraceptive Social Marketing

This component was limited to discussions of the future of social marketing in the region, anticipating that there might be a future need for moderate RDO/C support. The two issues of primary concern were contraceptive product mix and geographic coverage.

f. Administration.

Under this amendment CARICOM received a no-cost extension of nine months to complete its policy work. The IPPF/WHR contract was extended for two years, through 31 December 1988, for the purposes of undertaking additional training activities, further improvement of clinic services, continued distribution of contraceptives, and provision of additional technical assistance. The Population Council was contracted to implement the OR research projects described above. Finally, the Futures Group, under the centrally-funded SOMARC project, was expected to continue its contraceptive social marketing activities.

The amended project was to be guided by a Project Advisory Committee, composed of (1) a representative of CARICOM, (2) the IPPF/WHR Caribbean Project Manager, (3) the Population Council's Caribbean OR Project Manager, and (4) the USAID Chief of the HPE Division, RDO/C. Responsibility for routine project management and coordination was to be the responsibility of the USAID Health and Population Advisor(s).

3. Caribbean Regional Population and Development Project: Amendment Number 2 [06/26/87]

a. Objectives.

The general project goals of bringing population into balance with existing resources and preventing unwanted pregnancies are continued under this second

amendment. However, based on experience through mid-1987 and recommendations provided in a 1986 project assessment (Mamlouk et al., 1986), this amendment added several new elements designed to overcome specific constraints to efficient and effective provision of family planning services on a more sustainable basis. These constraints include: (1) weak program management, (2) excessive reliance on external technicians, and (3) excessive dependence on external sources of program funding. Thus, the amended project purpose was to "...increase the impact and sustainability of family planning activities in the Eastern Caribbean...through establishment of an appropriate policy environment, greater use of private sector service delivery mechanisms, expanded educational and motivational campaigns, and improved management, efficiency and technical capability of private voluntary and public sector family planning institutions." Under this amendment, \$3,000,000 was added to the project budget, including \$50,000 for service delivery, \$862,000 for management assistance, \$470 for private sector activities, \$455,000 for IE&C activities, \$189,000 for technical family planning training, and \$974,000 for administrative and contingency costs. AID's total project funding was therefore increased to \$7,666,000.

b. Project Description

Activities described under Amendment 1 were to be continued through their respective completion dates. In addition, several new activities were incorporated under Amendment 2.

Information, Education and Communication. IE&C activities, implemented by the Caribbean Family Planning Affiliation, Ltd., were to be designed to address two related problems in contraceptive use: method discontinuation and inaccurate information about family planning methods. CFPA was to develop and implement an IE&C strategy designed to overcome these two obstacles. This task would involve mixed-media campaigns that (1) encouraged continued method use and (2) disseminated accurate information regarding contraceptive methods, joint responsibility, male role in family planning, and the determinants and consequences of young adult fertility. CFPA was to work directly with national FPAs and to hold a regional workshop intended to assist affiliates to improve their communications strategies, develop IEC materials to promote national family planning events or reach specific audiences, develop add-on products for the CFPA materials, and select appropriate media for different messages. In addition, a series of seven one-day seminars were to be held in each of the seven EC countries for influential business, government, community, and media leaders to promote the concept of family planning, familiarize these leaders with CFPA and FPA programs, and to solicit financial and volunteer support for the associations.

Management Assistance. This activity was designed to improve the capability of managers of CFPA, BFPA, and the affiliated FPAs to design, evaluate, and manage programs more effectively. It consisted of four principal components.

1) Program Management Assistance.

Technical assistance was to be focused on the use of basic management tools: annual goals and objectives, integrated work plans and budgets, and annual review and revision of programs based on performance. The project paper notes that "This activity will be closely coordinated with the IPPF Program Planning and Budget Review (PPBR) system currently in use to assure that no conflicting or duplicative requirements are imposed." FPA program managers would be taught to use information provided through a newly developed management information system (described below) to evaluate the cost effectiveness of their programs, to determine the most efficient means of complementing government health programs, and to increase the efficiency of their staff and financial resources. Moreover, the annual project analysis and review was expected to assist FPA managers in identifying needed research to be undertaken in the OR component of the project. Base-line information was to be provided through a study of the cost-effectiveness of current activities. Technical assistance was also to be provided for development of " ... a quick, low-cost methodology to measure program impact on contraceptive usage which can be used for rapid, relatively reliable annual surveys," that supplement the more comprehensive Contraceptive Prevalence Surveys to be conducted every 5-10 years. Implementation of this component was to be achieved through (a) an assessment of management needs for each participating institution, (b) development of institution-specific training and technical assistance plans (c) a one-week general training course to be offered to all affiliates, (d) annual one-week training/program review sessions, and (e) technical assistance of up to two weeks per year for each FPA.

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

This component was to provide the basis for future monitoring and evaluation activities as well as the day to day administration, logistics, and financial management of the program. The project paper stated that "Care will be taken to avoid duplication of information gathering as well as the imposition of unnecessary data collection burdens on the voluntary agencies." Information was to be gathered on a monthly basis through standardized data collection forms, analyzed by CFPA, and then returned to local FPA Executive Directors for their use. CFPA would also prepare cross-country analyses. The project paper also indicates that "Computerizing data collection and analysis at the local level should assist the smaller FPAs in program design, management, and evaluation by enhancing the capabilities of the limited staff which operate these organizations." (The Barbados FPA was also to receive a computer and was expected to provide monthly data to CFPA). Design and

implementation of the system was to be coordinated by CFPA staff. Short-term technical assistance was to be contracted for system analysis, identification of hardware and software requirements, and adaptation of software to provide a "turnkey" system. At least one refresher course was to be conducted each year of operation.

3) Revenue Generation.

The project paper comments that CFPA and its affiliates have made little effort with regard to revenue generation/cost recovery and fund raising. On the assumption that programs should be increasingly self-sustaining, this component of the project was to improve FPA skills in the areas of cost recovery and fund-raising. Technical assistance was to be provided by CFPA in the organization of a regional workshop on revenue generation, proposal development, and fund-raising. Each FPA was also to receive direct assistance in formulating a revenue generation strategy and setting fund-raising objectives. Moreover, CFPA was to establish a clearinghouse to provide information and assistance on potential funding sources, proposal deadlines, and other relevant topics.

4) Commodity Supply Logistics.

In order to overcome problems of commodity supply, this component of the project was designed to reorganize the logistics system. CFPA was to provide technical assistance in the analysis of the current logistics system and procedures for data collection and reporting. In 1989 CFPA was to assume responsibility for maintenance of commodity supplies and their distribution. The eventual goal was to have all commodity procurement for public sector health programs integrated into the standard pharmaceutical supply and distribution system, with each government ordering commodities directly and maintaining adequate national stores.

5) Private Sector Programs.

A preliminary feasibility study (Wasek and Stewart, 1988) had previously identified several industrial sites with potential for a viable family planning program. This component of the project was designed to evaluate these sites more fully and select five for project implementation. Selection criteria included: financial feasibility of the clinic, severity of the national population problem, level of commitment from the sponsoring company, geographic balance, and replicability. The project paper also stated that "Prior to development of any subproject, a firm commitment for recurrent cost support from the first year of clinic operation will be required from the sponsoring organization." Tasks included (1) preliminary market research

survey of employees' family planning needs and preferences, (2) financial feasibility analysis, (3) site selection, (4) facility renovation/construction, (5) staff recruitment, (6) development of IEC campaign, (7) staff management training, and (8) provision of contraceptive commodities.

6) Coordinated Regional Training Program.

The CFPA training agenda comprised two types of activities: (1) conducting training-of-trainers programs and (2) serving as a regional clearinghouse on training programs scheduled throughout the region by all funding agencies. Training in family planning and family life education was to be focused on new personnel working in the field, although refresher training was also to be offered. Moreover, CFPA was to arrange exchange visits among affiliated and outside programs to keep members informed about new research findings and service delivery improvements. In addition, CFPA was to develop and maintain a regional training calendar of relevant activities scheduled throughout the region by all participating agencies. This information system would include schedules, costs, issues, audience, and focus, and would also provide the names of all persons who had received training under the various programs.

c. Administration

Under this amendment responsibility for project implementation was transferred to CFPA. At the time, CFPA served 21 affiliated FPAs (excluding Barbados, Jamaica, and Trinidad and Tobago), with seven countries eligible for direct participation in project-funded activities: Antigua/Barbuda, Dominica, Grenada, Montserrat, St. Kitts/Nevis, St. Lucia, and St. Vincent and the Grenadines. Selection of CFPA as the implementing agency was based on the goal of reducing the current complicated structure of program management in population planning and increasing reliance on local institutions. Coordination of the CFPA component with the ongoing program elements implemented by other institutions was to continue to be the responsibility of the Project Advisory Committee (which met annually). Technical assistance for management training, development of the MIS system, private sector clinic development, commodity supply systems, and revenue generation was to be contracted directly by RDO/C. Overall project management and monitoring was to be carried out by the USAID Health and Population Advisor(s), under the direction of the Chief of the Health, Population and Education Office, RDO/C.

4. Evaluation Results

Three separate evaluations of the Caribbean Regional Population and Development Project have been carried out. The first evaluation (Guengant et al., 1987) examined the CARICOM component. The second evaluation (Novak et al.,

1989) was focused on the IPPF/WHO component. The final evaluation (Pilgrim et al., 1990) considered the CFP component. This section reviews briefly the findings and recommendations of these reports.

a. The CARICOM Component

1) Population Policies

a) Findings. While this final evaluation found significant progress in development of the organizational infrastructure necessary for effective population policies, it also pointed to the uneven progress among EC countries and a clear hiatus between policy formulation and implementation. National Population Task Forces (NPTFs) had been appointed in all eight countries, though their activities were negligible until mid-1986. The increased activity of the NPTFs after that date appeared to be largely a response to the mid-term project evaluation (Mamlouk et al., 1986). The final evaluation reported that all countries had drafted population policies, and that "In all the documents, the rationale, objectives and goals, as well as policy and programme measures, were clearly stated." Nonetheless, these documents varied in "...quality, content, and priority listing." For example,

- o Montserrat aimed to increase population size, while Dominica and St. Kitts were concerned about the possibility of population decline; only Grenada, St. Lucia, and St. Vincent desired to reduce rapid population growth.
- o Reduced fertility targets were identified only in the documents of Dominica, Grenada, St. Lucia, and St. Vincent. However, "...all policy documents, regardless of the country's fertility level, emphasized the goal of reducing the number of both unwanted and teenage pregnancies."
- o All documents stated a desire to achieve major improvements in the health and nutritional status of citizens, and to increase life expectancy.
- o All of the policy statements discussed migration targets, though specific goals varied.
- o Research and data collection issues were mentioned only in the documents of Antigua, Dominica, St. Kitts, St. Lucia, and St. Vincent.

The evaluators concluded that "...all eight policies examined appear well articulated and consistent." Moreover, they judged that relationships between demographic and socioeconomic variables were addressed adequately, thus providing "... a starting point for the development of sound planning regarding population issues, specific to each country situation."

The fact remains that population policies had been adopted officially in only three countries: St. Lucia (August 1985), Dominica (August 1986), and Grenada (June 1987). The evaluators were told by government officials in St. Vincent, Montserrat, and St. Kitts that adoption was likely to occur before the end of 1987. In Barbados, the need for an explicit population policy was not viewed as an urgent matter. With regard to the other countries in the region, the evaluators concluded that "There is still a long way to go to convince politicians and planners of the contribution that population policies can make to the solution of (demographic) problems, through a truly multisectoral approach to development."

More disturbing is the evaluators' conclusion that, even in those countries that have adopted a policy, there was no evidence that "...policies would automatically become working documents, frequently referred to by those responsible for national development planning." Clearly, they anticipated a continuing need for work designed to further policy implementation and its integration into the process of development planning. It was assumed that responsibility for this task would lie with the national population councils (NPCs) and population planning units (PPUs) the NPTFs were expected to create.

The evaluation pointed to weaknesses in the institutional arrangements for the NPCs and the PPU's. CARICOM Secretariat guidelines indicated that the NPC should be located in the Planning Unit, Ministry of Finance/Planning. However, among the three countries that had appointed a national population council, only Dominica had followed the CARICOM model. In both Grenada and St. Lucia the NPC was associated with the Ministry of Health. Among the countries without a functioning national population council, only St. Vincent had reached a decision to locate the council within the planning ministry. Another problem identified was the lack of adequate intellectual, material, and financial resources for the PPU's. Not surprisingly, the evaluators noted that in the three countries that had adopted policies and formed NPCs, "...activity has virtually come to a halt. The NPCs are waiting for external stimuli to move them to the next phase.... Specifically, they are relying on the CARICOM Secretariat to provide the leadership role. This dependence on the Secretariat is likely to continue in the near future."

The other project activity associated with population policy development involved raising levels of awareness of population and development issues and the need for policy development and implementation. This was to be accomplished through specialized conferences at national and regional levels and increased media coverage of population-related topics. In spite of some progress along these lines, the evaluators comment that "...awareness and knowledge are still, in many respects, superficial," thus contributing to the slow progress in population policy adoption and implementation in most countries of the region.

- b) Recommendations and Lessons Learned.
 - (1) Recommendations.
 - o The various outcomes of the project should be publicized in the form of a monograph, primarily for "leaders" and policymakers, showing the catalyst role CARICOM has played during the project. Other forms of publicizing the project should also be considered, including press releases, articles, communiques, and panel discussions.
 - o Institution building should be continued at both regional and national levels. CARICOM should form a small population unit to assist NPCs and PPUs with regard to (a) research, the results of which could be disseminated and publicized rapidly, (b) formulation of specific population programs, (c) planning, including the integration of demographic considerations into national development plans and the formulation of sectoral policies, and (d) monitoring the effective implementation and evaluation of results of overall population policies.
 - o A system for monitoring regional and national social, economic, and demographic indicators should be established by the CARICOM PPU, and the results published and disseminated regularly, with brief, nontechnical comments.
 - o CARICOM should not pursue a media campaign plan in connection with its population and development program.
 - o Collaboration with institutions using advanced technology should always include training of local personnel and technology transfers to the region.

(2) Lessons Learned

- o A small project can achieve a lot provided that certain conditions are met: a favorable environment, the choice of the right persons, and implementation by an efficient institution. The \$250,000 allocated for the demographic policy project was well spent.
- o The participation of Caribbean scholars and professionals in the activities of the project were essential to its success.
- o The multiplicity of institutions working on Caribbean population issues was not a handicap. Rather, it resulted in healthy collaboration in the region, with the activities of each institution reinforcing those of the others.
- o The CARICOM Secretariat proved to be an effective executing agency in the population field, serving to link related activities of regional institutions. The positive comments received from respondents reflected "...a strong and widespread desire to further technical cooperation at a broad regional level, in order to alleviate the constraints of smallness and lack of personnel in the OECS countries."
- o The positioning of the NPTFs under the Ministries of Health tended to isolate them from the mainstream of national planning. Moreover, the inadequate representation of planners in the NPTFs was detrimental to the adoption of national policies and the development of sound planning regarding population issues.
- o In all the Caribbean countries there are still critical population-related problems, though they differ from one country to the next. The formidable tensions facing the countries of the region in the next 20 years have yet to be fully recognized and properly addressed.

2) Medical Policy

a) Findings. The evaluators argued that, at the beginning the project, formal family planning policies and protocols were essentially nonexistent except in St. Vincent which had a longstanding public sector program. Nonetheless, national governments did support family planning

activities directly (Dominica, St. Kitts, and St. Vincent) or indirectly (Barbados, Grenada, and St. Lucia).

The Medical Steering Committee did develop a Draft Medical Policy on Contraceptive Services in the Caribbean Community, but it suffered from a number of deficiencies.

- o It was more a reference document than a policy document.
- o It was not well organized.
- o It was too narrow in focus.
- o Protocols were not considered as mandated by the project paper.

Although the National Medical seminars were well attended by a cross section of the medical profession, not much effort was made to expand the Medical Steering Committee document. The outcome of the national seminars was essentially reports or minutes of the seminar proceedings prepared by CARICOM and sent back to the countries for comment. In most instances, these reports were filed and ignored or misplaced. Only Montserrat took the next step of producing a summary of policy statements.

Several factors contributed to the failure to achieve goals established for this component of the project. First, CARICOM performance was hindered by staff turnover and inadequate project administration. At the local level, staff turnover in the Ministries of Health and the lack of priority assigned to the project by technocrats and politicians had negative effects on project performance.

The evaluators concluded that "The project objective of getting medical policy and protocols for contraceptive services formulated and disseminated was mostly not achieved."

- b) Recommendations
 - (1) Remaining funds should be used to provide technical assistance for the broadening and refinement of the policy efforts to date and the development of protocols. Cognizance should be taken of the PAHO efforts with respect to the development of a Maternal and Child Health Policy Manual so that duplication of effort may be avoided.

- (2) Given IPPF/WHR's continuing training activities under its grant extension, it should be the new executing agency for such an effort, since policy and protocol information could then be incorporated into training activities.

b. The IPPF/WHR Component

1) Findings.

a) Overall Performance. The evaluators conclude that "The overall objective of the Population and Development Project, the expansion of family planning services and their integration into the region's Ministries of Health services has been achieved." All MOH clinics now offer full family planning services; commodities are ordered, stored, and distributed by the Ministries of Health (except Barbados); the administrative staffs of these programs (except Grenada) are MOH employees.

b) Training of Family Planning Personnel. The grant was not successful in attracting a sufficient number of physicians to its training programs. This was in spite of alterations in physician training activities. In contrast, the evaluators concluded that "...the grant was extremely successful in providing initial and refresher training ... to the region's nurses and community health aides." However, at the time of the evaluation the self-instructional kit had not been completed in final form. Family Life Education activities had been undertaken, but this activity was dropped because it was being handled adequately by UNFPA.

c) Commodity Supply and Distribution. The evaluators concluded that "...the grant has successfully expanded the supply and, until recently, ensured the continued availability of commodities to the government supported family planning programs." Moreover, responsibility for inventory control and forecasting was transferred successfully to the Ministries of Health of the respective governments (excepting Barbados). However, two problems were identified. First the range of contraceptives available in the clinics was judged to be too narrow. Second, the transition from IPPF/WHR to CFPA as the regional distributor resulted in some resupply delays.

Based on visits to two CBD sites (St. Lucia and St. Vincent), the evaluators found mixed results. The St. Lucia program was functioning well, while the St. Vincent program was poorly managed and of questionable cost effectiveness.

d) Improved Clinic Services. In spite of some bureaucratic delays and communication breakdowns, the scheduled clinic renovations were completed

and resulted in improved service delivery. On a related task, the establishment of training committees within each Ministry of Health, the evaluators found success in only some countries. They concluded that IPPF/WHO could have expended more effort toward creation of these committees.

e) Program Support. The evaluation team concluded that "...the level of consultant support was, in most cases, adequate and timely." Support was inadequate with regard to two project tasks: the self-instructional family planning manual and the contraceptive prevalence and male attitude surveys. The problem was the delay in producing the finished products. At the time of the evaluation, the self-instructional manual was available in draft, as were but one of the five contraceptive prevalence surveys (Barbados) and one male attitude survey (Grenada). The evaluators concluded that additional technical assistance from IPPF/WHO would have speeded these activities along. That may be true of the manual, but it is a questionable conclusion with regard to the surveys. These studies were subcontracted to four separate investigators (Tirbani Jagdeo had responsibility for the five CPSs), and it is difficult to imagine the circumstances under which technical assistance could have hastened production of the reports to any significant degree. However, the evaluators do point to one aspect of technical assistance that is of the utmost importance. Once these (and any similar) reports are available, program administrators and policymakers need to be trained to use the data effectively. The evaluators suggest a series of in-country seminars as a training mechanism. This idea should be considered carefully for any future project.

f) Grant Administration. There were staff reductions in the IPPF/WHO Barbados office in 1988, resulting in delays in the submission of some administrative reports and problems in reconciling accounts. Moreover, the six-month project reviews scheduled with each Ministry were not held and annual workplans were under-utilized by Ministry personnel. Overall, however, the evaluators conclude that "...the IPPF/WHO office performed well in the support and administration of the subgrant agreements in the eight participating countries, considering the level of staffing." (It should be noted that the staff reductions were agreed upon previously with RDO/C.)

2) Recommendations and Lessons Learned

a) Recommendations

- o Improve FP service delivery by (a) expanding the range of contraceptives, (b) ensuring the smooth transition of commodity supply responsibility from IPPF to CFPA, (c) developing innovative strategies to involve more

physicians in family planning programs, (d) increasing the availability of voluntary female sterilization where current demand exceeds supply, (e) providing "refresher" training and training materials, (f) introducing the self-instructional kit to the MOH, School of Nursing, and FPA staff in each country, and demonstrating how the kit should be used, and (g) convening in-country seminars to demonstrate the effective use of results from the CPSs.

- o Promote program sustainability by development of in-country managerial capability.
- o Support the continued development of the Association of FP nurses in the Caribbean as a regional professional organization
- o Support and strengthen existing integrated young adult programs through (a) integration of family planning into the programs of agencies and organizations that cater to youth, (b) using persons sensitive to young adult needs, problems, and behavior to staff the project, and (c) integrating family planning into skill training center curricula and those of other institutions of learning.

In addition, the evaluation team offered several country-specific recommendations:

Grenada

- o The IPPF/WHO Field Director and the Project Coordinator should meet with MOH officials to obtain a commitment to support future training activities. If such support is not forthcoming, USAID should support continued training for the next 1-3 years.
- o USAID should provide the Project Coordinator with a microcomputer for the tabulation of service statistics and general program management.

St. Lucia

- o USAID should encourage IPPF/WHO to support the addition of one assistant to the SLFPA CBD program.

St. Vincent

- o The period of physician training in family planning, in Jamaica, should be reduced.
- o Family planning should be given more emphasis during nurses' training.
- o USAID should support an in-depth evaluation of the cost-effectiveness of the CBD program operated by the SLFPA. If not viable, this program should be terminated.

Antigua

- o USAID should sponsor in-country training courses for family planning nurses every two years. (The implication is that this assistance should be provided throughout the Eastern Caribbean.)
- o Provision should be made for overseas training (UWI, Jamaica) in family planning techniques for at least one nurse every two years.
- o Provision should be made for overseas training (UWI, Jamaica) in the Training of Trainers course for at least one nurse every two years.

St. Kitts

- o Provision should be made for overseas training (UWI, Jamaica) in family planning techniques for at least six nurses.
- o Provision should be made for overseas training (UWI, Jamaica) in the Training of Trainers course for at least one nurse.

b) Lessons Learned

- o Additional administrative support in the IPPF/WHR office in Barbados, a relatively inexpensive input, could have contributed to a more efficiently managed project.

- o It was a mistake to provide, and later withdraw, incentive stipends to encourage staff participation in early stages of project activities, such as the operations research projects and the adolescent outreach program. Such payments are unlikely to be available when governments assume responsibility for these activities.
- o A major success of the IPPF/WHR grant was the use of in-country coordinators. However, additional support from local governments, e.g., secretaries, might have lessened the burden on the coordinators.
- o It is important that the plan for the complete evaluation protocol (including the SOW) is completed early in the project by making it a deliverable within the contract.
- o Throughout the project a cumulative, annual audit of project (planned and unplanned) should be maintained. Each year this list should be reviewed and updated by the Project Director and the AID/CTO. This would free evaluation teams from the time-consuming task of reconstructing a detailed history of project accomplishments (usually from incomplete and, sometimes, conflicting records).

c. The CFPA Component

1) Findings

a) Information, Education and Communication. The evaluators conclude that the project was successful in achieving the goals of this component. At the time of the evaluation CFPA had completed and disseminated all of the video productions scheduled, half of the radio talks and messages, approximately 60 percent of the posters, and nearly half of the pamphlets. All of the proposed communications workshops had been conducted, but apparently only two of the seven Influentials Seminars were held (in Antigua and St. Vincent). The report goes on to comment that "CFPA's productions of quality consistent, professional and culturally sensitive publications ... have been prodigious in terms of timeliness and quantity." Nonetheless, a number of publications and/or productions scheduled under the contract "...were deferred, reduced, or abandoned," in part because CFPA was unable to recruit an experienced audio-visual person. The evaluators also comment that there is a need to expand the various target groups and to measure the degree of impact of the IEC productions.

b) Regional Training Programs. The report concludes that "The project was exceedingly successful in providing initial and to a significant degree follow-up training in the region." Fifty-two persons had received training in counselling. In addition, two annual regional workshops for FPA executive directors were held, as well as the two Influentials Seminars mentioned above. The evaluators are critical of CFPA's "philosophical orientation" toward training, particularly in the area of counselling. The report contains a lengthy, rambling, and largely incoherent discussion of counselling issues; it is difficult to determine how these reflections bear on CFPA's training activities. One important comment cites the lack of attention to evaluation of the effects of training for participants and the institutions/programs to which they return.

c) Management Assistance. Given the sizeable financial investment in this aspect of the project, one would have expected the evaluators to examine the programmed activities very carefully. Regrettably, the evaluation team did not have access to the principal provider of management assistance, John Snow International (JSI), or to relevant progress reports. (Note: As of October 1991, JSI had not submitted any such reports to RDO/C). Consequently, many important questions regarding management assistance are left unanswered.

The four elements of management assistance were: (1) training and technical assistance in program management for CFPA and its affiliated FPAs in the Eastern Caribbean, (2) development of a management information system for CFPA, the affiliated FPAs and the Barbados FPA, (3) training and technical assistance in revenue generation strategies and techniques for CFPA and the affiliates, and (4) technical assistance and training in contraceptive commodity supply logistics.

In the period preceding the evaluation, two management training workshops of five days each were held for FPA executive directors and, apparently, others (since there were 30 participants). The evaluation lists a variety of relevant substantive topics that were discussed, but offers no assessment of overall effectiveness and outcomes. There is no mention of technical assistance provided.

The report does not provide specific details of the management information system that was to be implemented. Instead, it presents a brief, yet insightful, critique of the rationale underlying the inferred need for a sophisticated management information system in this organizational setting. The principal issue is whether the routine operations of the FPAs would be improved significantly as a result of the considerable investment in training

and technology required to implement and maintain the new system. There is less doubt about the value to CFPA.

The evaluators also raise serious doubts about the viability of revenue generating strategies, although no mention is made of project activities in this area. During their field visits they encountered "...overwhelming consensus...that 'it can't be done here'" (in the Eastern Caribbean). The report does not suggest that this goal should be abandoned, but rather that it should be considered more carefully and realistically.

According to the evaluators, "The commodity logistics sector of the technical assistance and management component has had its share of difficulties." Apparently, some of the problem was due to disagreements among USAID engineers assisting with construction of a warehouse in Antigua. Other difficulties stemmed from the lack of appropriate staff at CFPA. The actual status of this component of the project is not specified.

d) Private Sector Programs. Following a feasibility study (Wasek and Stewart, 1988) of several possible sites for an industry-based family planning program, it was decided that under this contract three such clinics would be established through CFPA, with appropriate technical assistance. At the time of the evaluation, only one such facility had been provided, the family planning clinic/child care center at the Frequente Park Industrial Estate in Grenada. The evaluators present a mixed, in some respects conflicting, assessment of this activity.

At one point they state that "In light of experiences to-date, there seems to be a need to re-examine the entire PSP objectives." They suggest that a better investment of scarce resources is to improve family planning services offered through ministries of health. The evaluators go on to say, however, that "...the success of the Frequente Industrial Park - meaning the family planning clinic and the child care center - (is) a model which might be offered to private employers with interest in such facilities. It is reasonable to conclude that the general experiences gained (there) could be effectively used by CFPA in seminars/workshops for business leaders, and government agents with responsibility for IDCs in the region." An important, yet unresolved, issue is whether employers have a sufficient level of commitment to this activity. It should also be noted that the evaluators had no data on use or cost-effectiveness of this facility upon which to base their assessment.

2) Recommendations and Lessons Learned

a) Recommendations

The evaluators provide 49 general and activity-specific recommendations, as well as 31 that are country-specific. Because these suggestions are available in the country report, only those judged to be most useful for this report are listed below.

- o USAID should continue to support CFPA and enhance its role as a regional institution, responsible for promoting and implementing family planning programs in the Eastern Caribbean.
- o USAID should assist CFPA and IPPF to clarify and define relationships and responsibilities in relation to the FPAs in the region.
- o USAID should assist CFPA to expand and strengthen its staff...
- o CFPA should undertake a comprehensive analysis of the overall skills, resources, and minimum capabilities of its member FPAs. Concurrently, similar assessments should be made of...MOHs and other competing NGOs in (delivery of family planning services), family life education, human sexuality, etc....Outcomes of this assessment will afford CFPA opportunities to respond in timely ways to the...needs of FPAs in the region.
- o USAID and IPPF should assist in designating business, industry, and community leaders to serve on CFPA's board, with particular emphasis on their potential for fund raising and/or other revenue generation programs.
- o CFPA should conduct a review of the family planning policies of the respective territories to determine the need for organizing and conducting workshops (with national policymakers and/or implementers) for the purpose of clarifying goals and setting specific targets.
- o CFPA should expedite the development of the Clearinghouse, and develop an appropriate user/requests system for FPAs and MOHs.

- o CFPA should design materials targeted specifically for educating males in their key roles in family planning.
 - o CFPA should expand the "training of trainers" focus as a means of insuring maximum multiplier effects at the affiliated territories level.
 - o CFPA should develop a comprehensive training manual for all affiliated FPAs.
 - o CFPA should articulate a systematic and coherent policy on counselling.
 - o CFPA should develop ongoing program evaluation based on continuation rates, cost per acceptor, method usage, etc.
 - o CFPA should undertake periodic clinic evaluations to assure standards of service and client satisfaction.
 - o CFPA should re-evaluate the JSI input to development of a management information system. [paraphrased]
 - o CFPA should plan for instituting territory-relevant cost recovery mechanisms where feasible.
 - o USAID should continue to provide direct managerial assistance in the private sector program, specifically the overall management of the Frequente Park child care center and family planning clinic. It is anticipated that in the foreseeable future, USAID should maintain the level of such inputs to maximize the effective and efficient functioning of the private sector programs.
- b) Lessons Learned
- o CFPA's institutional capability is to some extent determined by the collective competencies in the organization. [Lesson: rapid personnel turnover can be detrimental to the performance of the organization; mechanisms to ensure staff stability should be explored.]
 - o Each FPA compiles annual reports, each being distinctive and varying in focus and detail. CFPA maintains these reports, but

does not unify them [into a single document]. Such an achievement would facilitate [the work of] evaluation teams.

5. Assessment of Caribbean Regional Population and Development Project

a. Achievements

In many respects, the Population and Development Project represents a comprehensive, responsive, and appropriate approach to the demographic problems and family planning needs of the Eastern Caribbean. The project is comprehensive in its intended attention to both the improvement of population policies and the delivery of family planning services that meet client needs. There is an implicit recognition that awareness of population issues, particularly among policymakers and other national leaders, and the presence of an institutionalized expertise for assessing population and development relationships and crafting policy responses, are necessary though not sufficient conditions for development of a viable and effective program of family planning education and service delivery.

Responsiveness is reflected in at least two ways. First, the various amendments to the project indicate a willingness to adapt project components to the changing needs and priorities of the region. They also suggest that project managers were paying some attention to lessons learned as the various activities were implemented. Second, the provision for evaluations of each major component showed recognition that expected and actual outcomes may not coincide, even with the most carefully designed activities. Nonetheless, a critical question guiding this assessment is how to increase the responsiveness of medium- and long-term intervention projects in the area of family planning and population.

The appropriateness of the approach is seen in the attention given to regional cultural patterns and to the social and economic realities faced in the countries to be served. Emphasis was placed on developing policies and program interventions that did not violate the norms and values of Eastern Caribbean populations. With only one glaring exception (the management information system), interventions were designed to fit the needs and capabilities of the recipient populations and organizations. Moreover, the choice of CFPA as the implementing agency for most of the work conducted under Amendment 2 shows a genuine concern for developing an internal institutional capacity for dealing with regional problems. It is encouraging to note that much of the success of specific project activities would appear to be due to this attention to appropriate interventions, and discouraging to observe that failures often reflected neglect of such considerations.

Nonetheless, considering the elegance of the overall project design, one is struck by the fact that so few of the specific activities were implemented with relatively minor problems and resulted in the desired outcomes. Clearly, the major achievements are found in the interventions designed to improve the delivery of family planning services. This conclusion is borne out by the three evaluations discussed above and by the site visits conducted in connection with this report. First, a large number of clinics were renovated throughout the region. There were some delays in accomplishing these improvements, but they do not appear to have been preventable. The MOH staff interviewed seemed to be quite pleased with their clinic facilities, and did not suggest that lack of physical infrastructure was a major barrier to the delivery of effective family planning services.

Second, although there are still some questions about the optimal system for assuring a ready supply of the appropriate mix of commodities to governments throughout the region, the IPPF/WHR and CFPA components of the project have resulted in improved contraceptive distribution. This responsibility is presently located with CFPA, managed by its Program Coordinator. The CFPA Executive Director believes that commodities are now flowing smoothly and meeting the needs of Ministries of Health. Of the four MOHs contacted, only one (St. Lucia) indicated a problem with contraceptive shortages, but all suggested the need to broaden the range of methods available. The real issue is cost-effectiveness. Can an alternative system be developed that would lower the cost of providing EC populations with ready access to the full range of contraceptives desired? This question must be given high priority due to USAID's apparent decision to withdraw gradually from its program for providing contraceptives to the public sector in LDCs. If, as expected, USAID support will be continued for no more than another two or three years, then regional governments must explore alternative ways of obtaining the appropriate contraceptives at the lowest cost. The MOH representatives interviewed recognized that their governments must eventually assume the responsibility of commodity supply; only in Grenada was there concern that this would be a serious financial problem.

The preceding paragraphs indicate that, for the region as a whole, family planning clinic facilities and the flow of contraceptive commodities have been improved as a result of the Population and Development Project. When the project's contribution to actual service delivery is considered, results are uneven. Training was a major emphasis under both the IPPF/WHR and CFPA components. The evaluations conclude that training of nurses was "extremely successful," while that targeted for physicians was not. Interviews conducted for the current report also revealed that obtaining cooperation and participation of physicians with regard to family planning activities was generally difficult, particularly in Grenada, St. Lucia, and Antigua. Without exception, representatives of the MOHs and FPAs stated that their staff had benefitted from the training received under this project and expressed a desire for more of it. One training session in progress was observed briefly in

Dominica, and it appeared to be guided in a very professional manner by the CFPA Training Officer. The IPPF evaluation noted one problem with respect to training, i.e., the failure in some countries to establish a training committee within Ministries of Health. Not only would such committees be of benefit for MOHs, they could also be used to develop national training plans that would integrate the needs of both public and private sectors. This is but one of several ways in which family planning needs could be addressed on a national level rather than in terms of a public - private dichotomy, resulting in more efficient use of scarce resources.

There can be little doubt that one of the most successful aspects of the Population and Development Project has been the implementation of information, education, and communication activities. This work has been primarily the responsibility of CFPA, and the evaluators found that this work had been executed and/or planned very well for the most part. They did suggest that target groups could be expanded and that results of these activities should be evaluated. Interviews with the CFPA Executive Director indicated that extensive IE&C efforts have been directed toward teenagers, men, and younger women, with an emphasis on couples as target units. Elaboration of this focus is discussed in a new CFPA planning document. CFPA recognizes the need for evaluation of these activities, and support for such work funded by Population Concerns is pending.

A major problem encountered in any assessment of family planning service delivery in the Eastern Caribbean is the lack of comprehensive, timely, information. Indeed, a major objective of Amendment 2 to the Population and Development Project was to improve management information systems in both the public and private sectors. Results of this effort are discussed below under "Shortcomings."

Several research activities were undertaken through this project. Contraceptive prevalence surveys were conducted in all eight EC countries between 1984 and 1988. From a technical point of view, these studies were very well done. The samples are relatively large and representative of the populations. The full range of relevant questions was asked, and the statistical analyses are presented in a readily understandable way. The reports are well written and provide useful guidelines for both policymakers and family planning program managers. One problem encountered concerns the delay, typically between one and two years, in publishing the results. As noted in an earlier section of this report, Amendment 2 to the project stated that Tirbani Jagdeo, Executive Director of CFPA and principal investigator for all the CPSs, would be released from his CFPA duties to complete this work. In actuality, Dr. Jagdeo worked on these studies in his "spare time" under subcontract to IPPF/WHO. In retrospect, this arrangement probably contributed to the delays encountered in getting the results to the point of publication. A more serious problem is that there was no provision for maximizing the likelihood that the results would be used. Apparently IPPF/WHO was responsible for distributing copies of the reports. Several MOH and FPA officials claimed they had never received

copies of the report for their country. Moreover, no one assumed responsibility for organizing in-country workshops to review findings with Ministries of Health and FPAs and to discuss their policy and program implications. The need for such an effort should have been anticipated by IPPF and/or RDO/C.

In addition, three studies of male attitudes toward reproduction and family planning were conducted. These are qualitative in nature, and provide useful insights as to the problems in reaching this important target population. Again, however, there were delays in publication and no attention to follow-up activities designed to ensure proper use of results.

A third set of research projects was funded under the original project Amendment 1. The focus of this work was operations research, designed to improve the cost effectiveness, accessibility, and quality of care provided in family planning programs. Nine studies were conducted by Tulane University early in the project. Under Amendment 1, another five studies were conducted by Caribbean institutions in collaboration with the Population Council (one of which was not completed). Emphasis was to be placed on "...strengthening the capacity of local organizations and agencies to handle their own data collection, analysis, and reporting tasks." The four studies that were completed covered: (1) promotion of contraceptive use among women in high risk groups in Grenada, (2) strategies for increasing contraceptive use in factories in Barbados, (3) determinants and quality of condom use in Barbados and St. Lucia, and (4) the effects of continuing education at the Jamaica Women's Centre on teenage childbearing. While the four studies varied somewhat in quality, all employed an acceptable research design and results were reported concisely and clearly. More importantly, results were disseminated both nationally and internationally, and policy implications were addressed. In short, these studies met their stated objectives and should be seen as a good investment of project funds. However, there was also an expectation that this work would lead to development of local FPA capabilities to conduct OR research on their own. There was no evidence among the FPAs visited of such a capability. Moreover, the obvious connection between OR research and the development of management information systems (see below) does not seem to have been pursued. Since the OR studies were designed, if not completed, prior to initiation of the MIS activities, there was ample opportunity to explore potential linkages. That this was not done reflects poorly on overall project design and management.

Although at the time of the CARICOM evaluation the medical policies and protocols had not been developed satisfactorily, they are now available. It is not clear, however, whether they have been distributed to users and whether any necessary training/technical assistance has been rendered.

b. Shortcomings

Although the evaluation of the CARICOM component concluded that the population policy activities had been successful, the country visits suggested that much work remains to be done in this area. National Population Task Forces and Population Planning Units were operative only in Grenada and St. Lucia. The Dominican NPTF needs to be reorganized, and the PPU was never established. According to one government official, the Cabinet wasn't ready for the 1986 policy statement. However, there is renewed interest of the GOD in some population issues, e.g., those relating to manpower and employment. In Antigua there appears to be some interest in rewriting that government's 1986 policy statement, but there is no existing organizational structure that could lead this activity. Of the EC countries not visited, only St Vincent has a functioning PPU. The Coordinator is now in a training program at the University of Michigan. Nothing relevant has happened in Montserrat and St. Kitts.

The NPTF of Grenada is chaired by the Director of Budget and Planning, and meets monthly. The Coordinator of the PPU is away for a three month training course in Moscow. His position, now funded by the UNFPA, will be picked up by the GOG when UNFPA support is terminated. During the past year this unit has been moderately active. It organized two workshops (with ECLAC assistance), focused on vital statistics registration and coding of cause of death data. A series of TV spots and other public information releases were developed for World Population Week. The PPU Coordinator and the Director of Statistics worked with the Ministry of Planning to develop a chapter on population for the new national development plan (though this chapter was never provided for us to read). Examination of the draft development plan shows little attention to demographic conditions and trends. The PPU has apparently prepared a workplan for 1991-92, but it was not produced for our examination. The Director of Statistics indicated that there was a continuing need for technical assistance for the PPU, e.g., from a population intern (perhaps through the University of Michigan program) and/or from a senior population specialist. In particular, assistance is needed with research and the dissemination of information to planners and policymakers. There is also interest in revising the 1986 policy statement.

St. Lucia appointed an expanded National Population Council in September of 1991, and its first meeting was scheduled for 27 October. The Council's first task is to revise the 1986 policy statement. The Population Planning Unit, supported by UNFPA (through February 1992), has been functioning for about two years. During the past year the Coordinator has produced six one-page policy briefs and a public information packet regarding the Council's work. Considerable effort has gone into raising public and official awareness of population issues. With ECLAC assistance, a video on population and development issues in the Eastern Caribbean was produced ("Charting our Destiny"). The Coordinator has hired a research assistant

and a secretary (using GOSL funds). The RA is now completing a small study of teenage fertility in the EC region using available data, with emphasis on implications for FLE programs. Government support and collaboration appears to be strong. The government will pick up the Coordinator's salary when UNFPA funding ceases. Moreover, the PPU has worked closely with other agencies in preparation of the next national development plan, though in a reactive rather than proactive role. The coordinator is reviewing drafts of sector chapters of the plan, but as yet there is no indication of whether his suggestions will be adopted. A PPU workplan for 1990-92 was developed, and a new one is in preparation. The St. Lucia PPU has made great progress over the past year (cf. Micklin et al., 1991). The physical facilities and technical equipment available are adequate, and the Coordinator is working hard to strengthen the program of activities. However, it is clear that additional technical assistance will be required for this unit to take full advantage of its opportunities.

If one accepts the conclusions of the CARICOM evaluation team, then it is clear that, with the exception of St. Lucia and, possibly, Grenada, Eastern Caribbean population policies have deteriorated since 1986. It is also possible that the evaluators gave too much credence to what they were told and paid too little attention to what was actually produced. In any case, much more attention should be devoted to the development of EC population policies. The existing PPUs can do much of this work, but additional technical assistance will be necessary. Activities should include further efforts at awareness raising, strengthening of population councils and policy units, and training designed to stimulate integration of population into the development planning process. It is expected that success in this area would only strengthen complementary efforts with regard to improvement of family planning programs.

In the area of family planning services there are a number of project activities that did not produce the desired results. Perhaps the most obvious is the management information system that was to be implemented under the CFPA component by John Snow, Inc. (Note: The following discussion is based on field interviews and the CFPA evaluation. It was not possible to discuss these matters with JSI staff, and the organization has not submitted any progress reports to RDO/C, as noted above.) JSI began its work in April 1988 with an inquiry among Eastern Caribbean MOHs and FPAs as to their interest in participating in the MIS portion of the project. Affirmative responses were received from one MOH (St. Vincent) and five FPAs (Antigua, Dominica, Grenada, St. Lucia, and St. Vincent). The MIS proposed was one that JSI had developed for use in the United States. Detailed information was to be recorded for each visit of each client enrolled in the family planning program, including name, address, service site and patient numbers, purpose of visit, medical and counselling service(s) received, supplies dispensed, service providers, method at end of visit, referrals made, residence, gender, employment status, number of living children, educational attainment, religion, marital status, and source of referral. This information was to be recorded on a standardized form. The

original plan was that CFPA and the FPAs were to be provided with microcomputers. The FPAs were to receive the monthly data collected by the MOHs, record them on diskettes along with their own data, and send the diskettes to CFPA for processing at the end of each month. Results were to be reported to the participating FP programs approximately one month later. JSI was also to provide training and technical assistance to CFPA and the MOHs/FPAs with regard to use of this information.

A variety of problems developed that contributed to the failure of this activity to meet its objectives. First, only CFPA was provided with a microcomputer, requiring an altered plan for transmitting the MOH/FPA data for processing. The procedure adopted was to ship the forms directly, which turned out to be expensive and time consuming. Second, the CFPA staff member responsible for this task resigned in mid-project. Two secretaries were trained to handle these responsibilities, but the result was an interruption of data processing and reporting. CFPA claims that the problem resides with the reporting organizations in that the data are often faulty and/or delayed in arrival. The MOH/CFPAs argue that reports of results are delayed for several months, particularly since the CFPA staff member resigned. Third, apparently little effort was made by JSI to train MOH/FPA staff in the use of the information received from CFPA. The FPA Executive Directors interviewed indicated that the tables and graphs received from CFPA were "useful," but were unable to indicate specifically how this information was used for program monitoring or planning. Fourth, the MIS duplicates, in large part, information already collected by the FPAs as required by IPPF/WHR. FPA staff argue that the extra effort required for the MIS is a burden with insufficient payoff. The results they receive from CFPA are aggregated and add nothing to what they already know about program performance. No attempt has been made to do the kind of micro research that the relatively sophisticated MIS permits; indeed, such research probably exceeds the needs and capabilities of these small FPAs. For the larger MOH programs, a sophisticated MIS may be justified, and several MOH representatives expressed interest in assistance with improving program data collection, analysis, and utilization. However, such a system should be designed specifically for the EC region, not borrowed from a sociocultural setting with quite different needs and capabilities.

Another major shortcoming is found in the effort to develop private sector family planning facilities, specifically the clinic/day care center located in the Frequente Park industrial complex in Grenada. The ambivalent evaluation of this effort provided by Pilgrim et al. (1990), discussed above, reflects the sensitive issues involved. While the feasibility study (Wasek and Stewart, 1988) suggested that private sector, employment-centered family planning facilities could be beneficial to the EC region under certain conditions, it also stated explicitly that sustainability would be a continuing problem. This caution must have been considered by USAID when it decided to go ahead with the Frequente Park project. Apparently there were

political pressures, external to USAID, that contributed to this decision. The fact that only one such facility was developed attests to the difficulties involved.

The principal problems encountered at Frequente Park include the following. (1) The level of utilization of the family planning clinic is very low. There have been only about 50-55 new acceptors per year, and during the past 12 months only one IUD was inserted. Low use is probably due to the small labor force working at the facility (roughly 250 employees when the capacity is in the neighborhood of 1,000-1,250) and the inability to attract a physician to take up office there. According to the General Manager of the Grenada Industrial Development Corporation (GIDC), the labor force is expected to increase to 500-650 in the near future, but other information suggests that this growth is not assured. (2) The costs of maintaining the clinic and day care center are high given the relatively low levels of use (the day care center now serves 22 children, with an upper limit of 32). The companies resident at the facility have shown little interest in subsidizing either service, although short-term assistance may be a possibility. The GIDC has provided a free lease and janitorial service for the first two years, but the General Manager is unsure whether this support can be continued. The standards at the day care center were set intentionally to correspond to those of UNICEF, requiring more staff at higher salaries than other day care centers operated by the MOH and GRENSAVE (the local Save the Children affiliate). Moreover, the budget for this activity is further increased by the fact that portions of salaries of the GFPA and GRENSAVE Executive Directors are included, to cover their administrative responsibilities for the project. Finally, the day care center has added air conditioning, and this will surely increase the utilities bill considerably.

In short, this is not a self-sustainable activity. USAID must weigh its options carefully, particularly their political ramifications (a fact that is recognized by the U.S. Embassy Charge d'Affaires in Grenada). Alternative courses of action include (1) continuing subsidization by USAID, but perhaps at a reduced level taking into account cost-cutting measures, (2) finding another source of subsidization, e.g., the GIDC resident companies, the MOH, or another international donor, (3) reducing standards at the day care center, thus allowing lower costs, (4) increasing use of the FP clinic, e.g., by improving services available through a resident physician, opening the facility to residents of the surrounding area, or conducting a campaign to increase use among current employees, and (4) withdrawing USAID support altogether, which would likely result in the closing of both the clinic and the day care center.

Amendment 2 introduced the objective of increasing the sustainability of EC family planning programs. This concern is consistent with the philosophy evolving within AID/Washington which anticipates the eventual withdrawal of USAID from many, if not most, LDC technical assistance programs. While this objective is not unreasonable under certain conditions, it is questionable for countries with limited financial and technical resources and serious development problems. For example,

in a brief but insightful article Philip Harvey (1991) identifies four reasons why this focus is misplaced in the area of preventive health care (including family planning):

1. It encourages a belief in will-o'-the-wisp, substituting unsubstantiated hopes ("self-sufficiency") for reasonable expectations (cost-effectiveness, for example), resulting in distorted policies.
2. It shifts the emphasis --- even when conscious efforts to the contrary are made --- away from the poorest beneficiaries to middle-income and even upper-income beneficiaries.
3. It reverses the time-task priority sequence for development programs, which calls for starting the most time-consuming tasks first. Instead, a self-sufficiency focus makes it more likely that the most difficult jobs will be left for last.
4. An over-emphasis on "self-sufficiency" distracts programmers from the more important tasks of providing the services they were trained to provide.

Harvey (1991: 54) concludes that "'Self-Sufficiency' should be dropped from the family planning lexicon."

The evaluation of the CFPA component emphasized the pessimistic view of Eastern Caribbean family planning program managers regarding the likelihood of achieving program sustainability in the near future. This is not to say that cost-recovery schemes, modest fund-raising activities, efforts to broaden the base of donor support, and procedures designed to ensure greater cost-effectiveness should be abandoned, particularly in the private sector. However, USAID must be realistic about the services people are willing and able to pay for (particularly when the large majority of public sector health services are typically provided free of charge) and the ability of governments to offer such services to those who need them given the competing demands of other development sectors. It is highly likely that there will be a strong demand for subsidization of family planning programs in the region for years to come, and that without USAID support the ability of women to voluntarily control the number and spacing of their births will be weakened considerably.

c. Lessons Learned

The activities planned and implemented under the Population and Development Project have produced mixed results. Nonetheless, several useful principles can be derived from this experience to guide future projects. First, those tasks that relied on regional personnel and institutions appear to have been the most successful. External consultants may be necessary, but should not be given lead

responsibility. Second, given the characteristics of the EC countries --- small, resource poor, relatively isolated --- there are real advantages to be found in the use of a regional institution to coordinate and assist national population activities. CFPA and, to a much lesser extent, CARICOM, were able to elicit collaboration of national organizations and to meet their varying needs. Third, there is a continuing need to invest in human resource development. Highly capable and committed personnel are available to work on population activities in all countries of the Eastern Caribbean, and the training provided through this project has contributed mightily to this pool of talent. However, these skills must be reinforced and, at times, replenished. Fourth, the fact that a significant portion of the activities planned under the project were not carried out as expected or resulted in less than satisfactory performance indicates a need to sharpen USAID's monitoring skills, either directly via its own staff or through implementing agencies. Finally, although clear progress has been made toward the broad objectives of this project, the demographic and socioeconomic conditions and trends now evident in the Eastern Caribbean point to the need for continuing population assistance activities.

IV. Regional Demographic, Social and Economic Setting

This section provides a brief overview of relevant characteristics of the Eastern Caribbean. Particular attention is paid to implications for population assistance programs.

1. Demographic Conditions and Trends

Table 1 presents current and projected population figures for the EC countries. The regional total is expected to increase from the 1990 figure of 820,000 to just over one million in the next 35 years, a gain of about 25 percent. The largest relative increases over the next decade are evident for St. Lucia and St. Vincent. Annual rates of population change over the past two decades are shown in Table 2. Only St. Lucia has shown a consistently high rate of growth. These figures are somewhat deceiving in that they suggest that the EC countries are not experiencing much in the way of population pressure. That, however is not the case. Crude birth rates are relatively high in Dominica, Grenada, St. Kitts, St. Lucia, and St. Vincent, as are rates of natural increase (Table 3). Moreover, infant mortality rates are at least moderately high in most of these nations. The factor that accounts for the differential between population growth and natural increase is emigration. Guengant (1985) estimates that annual net emigration during the 1970s, as a percentage of 1980 population, ranged from 0.6 percent for Barbados to 2.3 percent for Grenada. Only Montserrat and Barbados show a figure less than 1.1 percent. This flow of out-migrants has served to relieve the pressures that could have resulted from the relatively high fertility rates, but it has also robbed these countries of potentially valuable human resources, which influences prospects for sustained socioeconomic development (see below).

The geographic distribution of population in these countries also bears on the interpretation of the pattern of growth. Table 4 reports the trend in population concentration since 1970. In at least four countries (Antigua, Barbados, St. Kitts and St. Lucia), a moderately large and growing proportion of the population resides in places labeled as urban. More generally, as shown in Table 5, population densities are very high, especially for the agricultural population. Increasing urbanization and population density are known to exacerbate environmental deterioration, particularly in poor countries. Given the dependence of the EC countries on tourism as the principal means of generating foreign exchange, any condition that increases environmental damage could be disastrous for development prospects.

These data suggest that even moderate population growth can be problematic for the Eastern Caribbean countries. Emigration has helped to avoid the problems that might have arisen from high fertility, but that safety valve may soon be eliminated as receiving countries tighten immigration restrictions. In short, the

pattern of population growth and the demographic context support the need for reduced rates of population growth in this region.

Table 1

Estimated and Projected Populations,
Eastern Caribbean Countries, 1990-2025 (thousands)¹

	1990	2000	2025
Antigua/Barbuda	76	79	91
Barbados	255	265	298
Dominica	82	87	104
Grenada	85	83	91
Montserrat	12	13	15
St. Kitts/Nevis	44	45	50
St. Lucia	150	177	230
St. Vincent/ Grenadines	116	128	158
Totals	820	877	1,037

¹ Medium variant figures.

Source: United Nations, World Population Prospects 1990. Population Studies No. 120. New York: Department of International Economic and Social Affairs, 1991, Table 31.

Table 2

Estimated Annual Rates of Population Change,
Eastern Caribbean Countries, 1970-1990 (percentages)¹

	1970-75	1975-80	1980-85	1985-90
Antigua/Barbuda	1.37	1.29	0.10	0.18
Barbados	0.56	0.28	0.29	0.17
Dominica	0.26	0.84	1.52	0.60
Grenada	-0.08	-0.97	-0.55	-0.53
Montserrat	0.89	-0.24	0.42	0.46
St. Kitts/Nevis	-0.52	-0.44	-0.18	-0.07
St. Lucia	2.00	2.00	2.02	1.86
St. Vincent/ Grenadines	0.98	0.98	1.25	1.10

¹ Medium variant figures.

Source: United Nations, World Population Prospects 1990. Population Studies No. 120. New York: Department of International Economic and Social Affairs, 1991, Table 31.

Table 3

Estimates of Crude Birth and Death Rates, Infant Mortality Rate, and Rate of Natural Increase, Eastern Caribbean Countries, 1989

	CBR ¹	CDR ²	IMR ³	NI ⁴
Antigua/Barbuda	15.8	5.1	20.3	10.7
Barbados	16.0	8.1	15.8	7.9
Dominica	20.8	5.1	17.1	15.7
Grenada	28.3	7.4	32.2	20.9
Montserrat	*	*	*	*
St. Kitts/Nevis	23.1	10.2	38.0	12.9
St. Lucia	27.4	6.2	19.8	21.2
St. Vincent/ Grenadines	23.8	6.0	23.4	17.8

¹ Crude birth rate (per thousand population)

² Crude death rate (per thousand population)

³ Infant mortality rate (per thousand live births)

⁴ Rate of natural increase (per thousand population)

* Information not available

Source: World Bank, Social Indicators of Development 1990. Baltimore: The Johns Hopkins University Press, 1991.

Table 4

Estimated Percentage of Population Living in Urban Places,
Eastern Caribbean Countries, 1970-1990¹

	1970	1980	1990
Antigua/Barbuda	33.7	30.8	32.0
Barbados	37.1	40.1	44.7
Dominica	*	*	*
Grenada	*	*	*
Montserrat	11.1	11.1	12.4
St. Kitts/Nevis	34.3	41.3	48.9
St. Lucia	40.1	41.9	46.4
St. Vincent/ Grenadines	15.0	16.8	20.6

¹ Urban place defined as capital city

* Data not available

Source: United Nations, World Urbanization Prospects 1990: Estimates and Projections of Urban and Rural Populations and of Urban Agglomerations. New York: Department of International Economic and Social Affairs, 1991, Table A.1.

Table 5

Area, Population Density, and Agricultural Density,
Eastern Caribbean Countries, 1989

	AREA ¹	POP. DENSITY ²	AGRI. DENSITY ³
Antigua/Barbuda	440	175	642
Barbados	430	591	686
Dominica	750	108	427
Grenada	340	277	672
Montserrat	*	*	*
St. Kitts/Nevis	360	117	280
St. Lucia	620	229	677
St. Vincent/ Grenadines	340	327	585

¹ In square kilometers

² Population per square kilometer

³ Agricultural population per square kilometer

* Data not available

Source: World Bank, Social Indicators of Development 1990. Baltimore: The Johns Hopkins University Press, 1991.

2. Socioeconomic Conditions

A variety of sources have emphasized the development problems faced by Caribbean countries, in general, and the Eastern Caribbean region, in particular (Hope, 1986; Thomas, 1988; Deere et al., 1990; Inter-American Development Bank, 1990; Micklin et al., 1991). The general consensus is that aggregate indicators would place EC countries among the upper third of LDCs. For example, consider Table 6. The United Nations Human Development Index (based on measures of life expectancy, literacy, mean years of schooling, and adjusted real Gross Domestic Product), calculated for 160 more and less developed countries (United Nations Development Programme, 1991), shows a wide range of scores for the Eastern Caribbean. While Barbados is ranked 22nd among the world's nations, the remaining EC countries tend to be ranked just above the mean score, ranging from 46th for Antigua to 79th for St. Vincent. Nonetheless, EC economies are fragile, largely dependent on unstable industries such as tourism and export agriculture. Rates of unemployment are high, especially for young people. Large proportions of adolescents drop out of school prior to finishing the secondary level. While not a solution for these development problems, lower rates of population growth would relieve some of the strain on governments' limited financial resources.

3. Fertility and Family Planning

The principal sources of information on reproductive and contraceptive behavior in the Eastern Caribbean are the contraceptive prevalence surveys conducted between 1984 and 1988 (Tables 7-14). Table 7 shows that only Barbados and Dominica have achieved replacement level fertility (TFR = 2.1), with Montserrat close to that point.¹ In three of the remaining countries (St. Kitts, St. Lucia, and St. Vincent) fertility is approximately one child above the replacement level, and in Grenada it exceeds replacement by three children. Contraceptive prevalence rates vary considerably, ranging from 33-37 percent in Grenada to 61-64 percent in St. Vincent. Generally, CPRs below 60 percent are viewed as unsatisfactory.

¹ While an accurate TFR cannot be calculated for Antigua because of the absence of a recent census, Guengant (1985) estimates that it had declined to around 2.2 as early as 1975-79.

Table 6

Human Development Index, Eastern Caribbean Countries, ca. 1990¹

	Life Exp. ¹	Educ. Attain. ²	Adjust. Real GDP ³	Human Dev. Index ⁴	Rank ⁵
Antigua/Barbuda	72.0	64.9	3,940	.832	46
Barbados	75.1	68.1	4,898	.945	22
Dominica	76.0	64.2	3,020	.800	53
Grenada	71.5	65.6	2,810	.751	64
Montserrat	*	*	*	*	*
St. Kitts/Nevis	67.5	62.0	3,150	.719	65
St. Lucia	70.5	56.0	2,940	.699	68
St. Vincent/ Grenadines	70.0	56.2	2,100	.636	79

¹ Life expectancy at birth (in years), 1990.

² Educational attainment is represented through a weighted index consisting of percent of the adult population literate (1985) and mean years of schooling (1980).

³ Real Gross Domestic Product, 1985-88, adjusted for diminishing returns relative to the poverty line.

⁴ The Human Development Index is calculated as 1 - average deprivation reflected in Columns 1-3.

⁵ Rank among the global set of 160 countries for which data are available.

* Data not available.

Source: United Nations Development Programme, Human Development Report 1991. New York: Oxford University Press, 1991, Table 1.

Table 7

Selected Characteristics and Findings, Contraceptive
Prevalence Surveys, Eastern Caribbean Countries

Country	Year of Survey	Sample Size	TFR ¹	GFR ²	CPR ³	CPR ⁴
St. Kitts/Nevis	1984	808	2.9	122.0	41.1	*
Montserrat	1984	389	2.4	*	52.6	*
Grenada	1985	884	4.9	205.1	33.0	37.0
St. Vincent	1988	1,001	2.9	*	61.4	64.3
Antigua	1988	974	*	*	57.9	60.2
Barbados	1988	1,000	2.1	*	59.4	61.9
St. Lucia	1988	987	3.2	*	52.0	54.8
Dominica	1988	963	2.0	*	54.1	56.7

¹ Total Fertility Rate.

² General Fertility Rate.

³ Fecund, in-union women aged 15-44.

⁴ Fecund, in-union, non-pregnant women aged 15-44.

* Data not reported.

Table 8 shows the types of contraception women say they are currently using. With the exception of Grenada, the pill is the dominant method, accounting for 34 percent (Dominica) to 58 percent (Montserrat) of use. In most of these countries tubal ligation is the second most prevalent method, followed by injections and IUDs. Condom use is relatively low, ranging from six percent in Montserrat to 14 percent in Grenada and St. Kitts. Data on the future contraceptive intentions of nonusers (Table 9) indicate that between 33 percent (St. Vincent) and 78 percent (Grenada) of women are "doubtful" users or opposed to contraceptive use, suggesting the existence of a sizeable target population for contraceptive information programs.

Table 10 presents information on the sources from which contraceptive services are obtained. The pattern varies considerably among countries. FPAs are the predominant source only in Grenada and Montserrat. Government clinics are the major source in Dominica, St. Vincent, and St. Lucia. In St. Kitts, private physicians are the source for the majority of users, and in Antigua and Barbados commercial outlets are used most frequently.

Data presented in Table 11 show that a sizeable proportion of EC women are in need of family planning services. Of the women who want more children, the vast majority want to delay the birth for up to two years, which clearly suggests the need for contraception to control birth spacing. Moreover, from one-fifth (Antigua) to one-half (Montserrat) of the women interviewed stated that they didn't want any more children, indicating a need for contraception to prevent unwanted births. In spite of the moderate to high contraceptive prevalence rates reported in Table 7, there appears to be a sizeable level of contraceptive failure among Eastern Caribbean women. Table 12 indicates that a large percentage of last births were either mistimed or unwanted, ranging from 45 percent in Barbados to 67 percent in Dominica. Mistiming of births appears to be a more serious problem than births that are not wanted at all. The final column of Table 12 indicates that in five of the eight countries at least one-fifth of the at-risk women of reproductive age have an unmet need for family planning services.²

² For a discussion of the measurement of unmet need for contraception see Bongaarts, 1991 and Westoff and Ochoa, 1991.

Table 8
 Percentage Distribution of Methods Used by Current
 Contraceptors, Eastern Caribbean Countries

	Pill	Condom	IUD	T.L.	Injection	Others
Antigua	49.8	10.5	*	21.6	6.1	12.0
Barbados	49.2	13.4	9.4	18.2	1.7	8.1
Dominica	34.5	12.0	3.3	23.8	22.5	3.8
Grenada	15.7	13.9	12.4	25.9	12.3	19.9
Montserrat	58.2	6.5	21.0	3.1	6.1	5.0
St. Kitts- Nevis	48.4	13.8	9.4	6.4	5.6	16.4
St. Lucia	39.2	12.5	9.7	16.3	15.9	8.6
St. Vincent	42.0	12.9	4.4	23.0	11.7	6.0

* Not reported separately; included among others.

Source: Contraceptive Prevalence Surveys, 1984-87.

Table 9
 Future Contraceptive Intentions among Nonusers,
 Eastern Caribbean Countries (percentages)

	Positive	Tentative	Doubtful	Opposed
Antigua	28.4	21.4	7.0	43.2
Barbados	20.6	16.4	26.0	37.0
Dominica	13.3	18.9	25.0	42.8
Grenada	5.7	16.4	20.0	57.9
Montserrat ¹	59.6			40.4
St. Kitts- Nevis ¹	62.7			37.3
St. Lucia	24.3	29.2	11.9	34.6
St. Vincent	26.5	40.7	8.3	24.5

¹ Categories are "will use" and "will not use."

Source: Contraceptive Prevalence Surveys, 1984-87.

Table 10

Sources of Contraceptive Methods among Current Users, Eastern Caribbean Countries¹ (percentages)

	FPA	Clinics	Physician	Commercial	Other
Antigua	17.9	17.4	13.1	47.7	3.7
Barbados	20.1	17.2	15.1	46.9	0.7
Dominica	3.8	81.9	2.3	12.1	0.0
Grenada	68.5	8.4	3.0	15.2	4.9
Montserrat ²	53.0		32.1	12.3	2.7
St. Kitts-Nevis ²	20.9		57.7	21.4	0.0
St. Lucia	23.5	44.1	9.8	20.3	2.3
St. Vincent	14.1	69.1	11.2	4.9	0.7

¹ Users of tubal ligation omitted.

² Clinic and physician usage reported as single figure.

Source: Contraceptive Prevalence Surveys, 1984-87.

Table 11

Desire for More Children among Fecund, In-Union Women,
Eastern Caribbean Countries

	Want More Children			Don't Know
	Within One Year	Within Two Years	Don't Want More Children	
Antigua	8.4	61.6	22.5	7.4
Barbados	9.2	30.8	29.1	30.9
Dominica	4.6	61.6	30.2	3.7
Grenada	*	*	*	*
Montserrat		37.0	49.3	13.7
St. Kitts- Nevis ¹		39.8	46.9	13.3
St. Lucia	4.8	51.1	41.1	2.9
St. Vincent	3.8	9.7	33.9	2.6

¹ Percent wanting more children not differentiated by desired interval.

* Information not reported.

Source: Contraceptive Prevalence Surveys, 1984-87.

Table 12

Planning Status of Last Birth and Percentage of Women in Need of Family Planning Services, Selected Eastern Caribbean Countries

	Planning Status of Last Birth (%) ¹			Percent in Need of Services ²
	Wanter	Spacer	Limiters	
Antigua	44.0	44.0	11.9	16.9
Barbados	54.6	31.1	14.3	21.7
Dominica	33.4	53.6	13.1	26.7
Grenada	*	*	*	26.2
Montserrat	*	*	*	8.9
St. Kitts-Nevis	*	*	*	11.0
St. Lucia	37.1	50.8	12.1	25.2
St. Vincent	34.3	52.6	13.1	20.3

¹ Parous women only. Wanters desired the pregnancy at the time it occurred; Spacers include those women whose last birth occurred earlier than desired; Limiters gave birth after they had desired to have no more children. Note that the sum of Spacers and Limiters provides an estimate of the proportion of births that were unwanted.

² Includes in-union, nonpregnant, fecund women who did not want a child within a year and who were not using a family planning method. This definition of need covers interests of both child spacing and birth limitation.

* Information not reported.

Source: Contraceptive Prevalence Surveys, 1984-87.

Male partners are known to have a significant influence on whether women use contraception. Data presented in Table 13 show that only in St Vincent did more than half of the women surveyed indicate that their partner encouraged use of contraception. In a sizeable proportion of cases, ranging from 32 percent (St. Kitts and St. Vincent) to 48 percent (Barbados), partners never discussed the matter of contraception. This finding suggests the need for increased efforts to provide education and information to potential contraceptive users, particularly males.

The timing of initial contraceptive use is also of critical importance to the success of family planning programs. Table 14 indicates that no more than one-fifth of the CPS respondents used some contraceptive method at first intercourse, and for Grenada and Montserrat this figure is less than 10 percent. With the exception of Antigua and Dominica, more than half of these women delayed first use for more than one year after becoming sexually active. These data point to the importance of providing contraceptive information and methods to women prior to their initial sexual activity which, for Caribbean men and women is during mid to late adolescence.

The topic of adolescent pregnancy and childbearing has received considerable attention in the Caribbean (Jagdeo, 1984; Guengant, 1985; Barker and St. Victor, n.d.; Micklin et al., 1991). Though teenage birth rates have dropped in recent years, they remain higher than is desirable. Early childbearing is closely related to school dropout rates, particularly for young women, and to unemployment and the lack of occupational mobility among youth. When these facts are considered along with the health risks of too early childbearing and problems of child care faced by young parents, it becomes clear that development of programs of contraceptive information and services targeted to teenagers is an extremely high priority for the Eastern Caribbean.

4. Justification for a New Regional Population and Development Project

A new population and development project for the Eastern Caribbean is justified for several principal reasons. Although the initial project accomplished several key objectives, the conditions under which Eastern Caribbean couples can effectively control their reproductive behavior have not been established. Government leaders and other influential persons are only partially aware of the demographic issues their countries now face. Little effort has gone into the formation of population policy planning groups. Existing policies are out of date and require revision. Professional skills necessary for demographic analysis and policy implementation are generally lacking. In short, the policy environment in EC countries is not adequate to support appropriate consideration of demographic influences on social and economic development or to provide the needed foundations for effective family planning programs.

Table 13

Male Attitudes toward Partner Contraception as Reported
by Fecund, In-Union Women, Eastern Caribbean Countries

	Encouraged	Did Not Encourage	Never Talked
Antigua	44.2	9.3	46.4
Barbados	45.0	7.0	48.0
Dominica	45.3	10.3	44.5
Grenada	46.0	16.2	37.9
Montserrat	*	*	24.1
St. Kitts- Nevis	*	*	32.3
St. Lucia	41.4	10.0	48.6
St. Vincent	62.9	5.4	31.7

* Information not reported.

Source: Contraceptive Prevalence Surveys, 1984-87.

Table 14

Timing of First Contraceptive Use Relative to First
Sexual Intercourse, Eastern Caribbean Countries (percentages)¹

	At First Intercourse	Within 6 Months	6-12 Months	More Than 12 Months
Antigua	21.1	23.8	16.7	38.4
Barbados	20.6	16.1	12.1	51.2
Dominica	12.1	28.9	13.9	45.8
Grenada	7.0	9.8	15.9	62.1
Montserrat	6.1	15.7	19.8	59.0
St. Kitts- Nevis	12.9	13.6	16.6	56.9
St. Lucia	15.9	19.4	9.3	55.5
St. Vincent	20.3	13.8	7.2	58.6

¹ In-Union women excluding those with tubal ligation.

Source: Contraceptive Prevalence Surveys, 1984-87.

While progress has been made in the area of family planning services, national programs should be strengthened. Data from the contraceptive prevalence surveys show that at least one-quarter of women of reproductive age have an unmet need for contraceptive services. Moreover, those who are now using contraception effectively will have a continuing need for contraceptive supplies. Over time, increasing numbers of youth will require contraceptive information and education and access to appropriate services; this need is particularly acute for young men.

Existing family planning programs need to be organized more efficiently. There will be a continuing need for staff training. Information necessary for appropriate monitoring of program performance is not currently available in usable form. Information systems appropriate for the needs and capabilities of EC MOHs and FPAs have yet to be devised. These programs are far from being self-sustainable. Continued financial and technical support is absolutely necessary, while at the same time limited efforts at cost-recovery and fund raising should be pursued.

In the process of designing a new project, USAID should pay close attention to experience gained over the past 10 years. Valuable lessons include the following:

- a. Project design should take into account the regional activities of other donors, principally the UNFPA. Regional needs should be examined comprehensively, leading to a complementary division of labor among donors. In this way, duplication of effort can be avoided.
- b. The project CTO must monitor closely the performance of project implementers. Long delays in the initiation of activities or the production of scheduled reports can be avoided only if the responsible project officer uses his/her authority effectively. External, mid-project evaluations are another useful mechanism for assuring that project objectives are met, but only if USAID acts upon the recommendations received.
- c. The project should be implemented through a regional organization. Extra-regional consultants should be used sparingly, and only when the necessary skills and/or knowledge is not available within the Eastern Caribbean.
- d. Management issues, including provision of appropriate information and mechanisms to improve the use of that information, should be a principal focus. However, the management information system implemented should be appropriate to the needs of regional organizations and compatible with existing information processing technology.
- e. Strengthening the capacity for effective delivery of family planning services should be the primary, though not the only, objective of the project. Particular attention should be paid to reaching under-served populations (e.g., men,

adolescents), staff training, guaranteeing access to low cost and effective contraceptive methods, and improving knowledge of family planning and contraceptive issues through appropriate information, education, and communication strategies.

f. Assistance should be provided to both public and private sector organizations, recognizing that in the EC region responsibility for provision of health services, including family planning, resides largely with governments. FPAs should be viewed as important, but secondary, actors in this field.

V. Strategy for a New Caribbean Regional Population and Development Project

1. Fundamental Considerations

Four elements are essential for establishing a successful population program: information, a network of effectively managed organizations to carry out program activities, qualified personnel, and a supportive policy environment. If any of these elements is poorly developed or absent, the program will suffer.

a. Information Sources

Three types of information are relevant: demographic, economic, and social indicators of national and subnational characteristics; population policy indicators, and program performance indicators. Demographic indicators for EC countries are dated, but this situation will be rectified once results of the 1990-91 round of censuses are available. An important source of data on reproductive and contraceptive behavior is the series of Contraceptive Prevalence Surveys carried out between 1984 and 1988. Because the information provided in these surveys is critical for the design of family planning programs, CPSs should be conducted every five years or so. Thus a new set of surveys should be scheduled for 1992 or 1993. Social and economic indicators are collected and published by each government, but annual reports are usually delayed by several years. Indicators for many of these countries are available in reports published by international organizations such as the United Nations, the World Bank, the Inter-American Development Bank, and the Economic Commission for Latin America (ECLAC).

Population policy indicators are more difficult to obtain. Gross indicators are available through the periodic Inquiries of Governments conducted by the United Nations (see Micklin, 1991). The policy statements developed by EC governments in 1986 provide more detailed information, but since most of them were never acted upon they do not reflect real policy environments. Development of a detailed set of population policy indicators for the Eastern Caribbean is an important task that remains to be done.

There are two types of program performance indicators: (1) data reflecting routine program operation (e.g., number and types of clients served and services provided) used for monitoring performance and (2) periodic evaluations of program outcomes. In spite of the attention devoted to development of management information systems under the original Population and Development project, most of the FPAs and MOHs in the region require further assistance in the organization and use of performance indicators. Evaluations of organizational and project performance have been conducted, usually by donor agencies, and results have been used to refine the objectives and activities of implementing organizations.

b. Institutional Structures and Relationships

Population programs in the Eastern Caribbean are carried out by a variety of organizations. At the national level, activities are implemented through both public and private sector organizations. In the public sector the principal actors are Ministries of Health, National Population Committees, and Population Planning Units. In some countries, the Ministry of Education is involved through family life education programs, and Ministries of Planning/Finance are slowly becoming aware of the significance of demographic information and policies. In the private sector population activities are centered in the Family Planning Associations.

At the regional level, work on population is conducted by ECLAC, CARICOM, and the CFPA. ECLAC and CARICOM have assisted with the development of demographic information, most notably the national population censuses, and the formation and operation of groups working on various aspects of population policy. CFPA's efforts have been concentrated on strengthening national family planning programs through provision of training and technical assistance.

Population activities in the region are sponsored by several international organizations, the principal ones being USAID, the United Nations Population Fund (UNFPA), and the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). In addition, a variety of specialized Cooperating Agencies (CAs) serve as intermediaries between the sponsors and regional/national organizations, largely through the provision of technical assistance. Although donors working in the Caribbean meet annually, an effective system for developing complementary projects has not been worked out. Because donor resources for population projects are becoming even more scarce, it is imperative that the major donors work collaboratively to plan cost-effective programs and projects that meet national and regional needs.

c. Human Resources

In the Eastern Caribbean there is a scarcity of technical and managerial personnel trained specifically to work on population activities. In most EC countries

one finds a few well-trained and dedicated people working in MOHs, FPAs, and PPUs, but overall there is a need to increase the number of qualified specialists available to work on one or another aspect of population-related projects. Investment in appropriate training is the most effective way of reducing the need for population assistance programs. Opportunities for training should be provided in all relevant areas, including demographic and policy analysis, population planning, service delivery, and program management.

d. The Policy Environment

As indicated in previous sections of this report, EC population policies require further development before they can be implemented effectively. Attention should be given not only to fertility, population growth, and the delivery of family planning services, but also to matters such as infant mortality, international migration, and population aging (see Micklin, 1991). Moreover, population policies should be formulated and used in the broader context of national and regional development policies. Demographic conditions and trends are closely related to critical development issues such as employment, education, resource management, and tourism. Population planning needs to be integrated more effectively into the development planning process.

2. Program Structure

The principal consideration here is the choice of an implementing agency. The organization chosen should be located in the region and should have demonstrated the ability to do high quality work and to meet deadlines. The Caribbean Family Planning Affiliation meets these requirements. It has worked effectively with public and private agencies throughout the region and generally produces scheduled products on time. CFPA is particularly skilled in training, communications programs, and technical assistance, all of which are necessary for the activities to be outlined below. The organization is well-managed and financially responsible. In developing the project paper, USAID should consider carefully ways to strengthen CFPA.

CFPA is likely to require technical assistance with implementation of some activities. Whenever possible, this assistance should be obtained within the Caribbean region.

Project activities should be developed in collaboration with both public and private sector organizations. Because of the structure of health systems and policies in the region, emphasis should be placed on improving public sector delivery of family planning services. FPAs should be encouraged to play an innovative, supportive, and complementary role vis a vis the public sector. Means should be sought to increase cooperation and collaboration between the public and private sectors. Depending

on the size of the project budget, it may not be possible to work in all EC countries. Countries that should be given highest priority include Grenada, St. Lucia, St. Vincent, Antigua, and St. Kitts.

3. Program Activities

a. Improving the Delivery of Family Planning Services

As in the previous Population and Development project, this objective should be given highest priority. Activities should be focused on (1) increasing the availability of low cost and effective contraceptive methods, (2) providing culturally appropriate information and education regarding matters such as human reproduction, the risks of early childbearing, the advantages of birth spacing, and method use, (3) training personnel in service delivery and program management, (4) developing an information system for monitoring program outputs and outcomes that is appropriate to the needs and capabilities of MOHs and FPAs, and (5) providing technical assistance to program managers with regard to use of performance indicators for planning.

Particular attention should be given to reaching critical, under-served segments of these populations. The most obvious targets are adolescents, men, and economically disadvantaged women of reproductive age.

Training activities should be focused on nurses, community health aides and other auxiliary personnel, and program managers. Given the resistance of most physicians in the region to working in family planning activities, physician training should not be given high priority.

The issue of program sustainability should be considered carefully, as noted earlier in this report. Most of the region's governments recognize that ultimately they will have to assume much, if not all, of the responsibility for purchase of contraceptive commodities. USAID should plan this transition over the next few years, and expect that some governments may require continued support for purchase of contraceptives. Preliminary discussions indicate that the Eastern Caribbean Drug Service (ECDS) would be willing and able to coordinate provision of contraceptives for the EC countries within the next few years. In other respects, complete sustainability of family planning programs may not be a realistic expectation. At the very least, technical assistance is likely to be required for the foreseeable future. Moreover, it should be kept in mind that investment in primary health care, including family planning, is relatively inexpensive and has a huge payoff in furthering the development process.

b. Strengthening the Policy Environment

USAID should consider the possibility of including a population policy component in the new project. The decision as to whether this should be done, and what kinds of activities should be pursued, should be based on discussions with the UNFPA Caribbean Program Director. For the past several years UNFPA has been supporting activities in a number of Population Policy Units in the region, though that project is scheduled to end in early 1992 (see Micklin et al., 1991). Whether UNFPA will continue to support policy activities is not presently known. Those Population Policy Units that are currently active (Grenada, St. Lucia, and St. Kitts) are doing some useful work. This is particularly true of the St. Lucian unit.

Support of national population policy units should be supplied indirectly, through CFPA. USAID should not be funding staff salaries or the purchase of expensive equipment. These budget items should be the responsibility of national governments. Rather, the new project should concentrate on providing technical assistance through CFPA staff and its regional consultants. Useful activities would include the following: (1) Revision of the 1986 policy statements; (2) Organization of seminars and media campaigns aimed at making policymakers, planners, and other influentials aware of national demographic issues, the bearing of population conditions and trends on development, and the role of population policies in development planning strategies; (3) Compilation of national demographic, social, and economic indicators on a regular basis, perhaps housed in a data bank within CFPA, (4) Conduct of a new round of Contraceptive Prevalence Surveys, implemented nationally with training and technical assistance from CFPA³, and (5) training of PPU staff and personnel from sectoral planning units in the use of demographic information in the planning process.

³ In the four countries visited in connection with this report, national sample survey units are either now being organized or there is at least strong interest in doing so. CFPA could also help with this important task, again providing training and technical assistance. Once created, these units could be responsible for periodic CPSs. External support of the data collection and analysis is likely to be required in most countries in the region.

Appendix A: List of Acronyms Used in Report

BFPA	Barbados Family Planning Association
CARICOM	Caribbean Community
CBD	Community-Based Distribution
CFPA	Caribbean Family Planning Affiliation
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CTO	Cognizant Technical Officer
ECLAC	Economic Commission for Latin America
EC	Eastern Caribbean
ECDS	Eastern Caribbean Drug Service
FP	Family Planning
FPA	Family Planning Association
GFPA	Grenada Family Planning Association
GIDC	Grenada Industrial Development Corporation
GRENSAVE	Grenada Save the Children Association
IE&C	Information, Education and Communication
IDC	Industrial Development Corporation
IPPF	International Planned Parenthood Federation
IPPF/WHR	International Planned Parenthood Federation, Western Hemisphere Region
JSI	John Snow International
LDC	Less Developed Country

MIS	Management Information System
MOH	Ministry of Health
NGO	Nongovernmental Organization
NPC	National Population Council/Committee
NPTF	National Population Task Force
OR	Operations Research
PPBR	Program Planning and Budget Review
PPU	Population Planning Unit
RDO/C	Regional Development Office, Caribbean
SLFPA	St. Lucia Family Planning Association
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
UWI	University of the West Indies

Appendix B: List of Organizations and Persons Contacted

1. GRENADA

Mr. Winston Duncan, Executive Director, Grenada Family Planning Association

Ms. Thera Creft, Nurse Supervisor, Family Planning Clinic, Frequente Park

Ms. June Alexander, Nurse/Educator, Family Planning Clinic, Frequente Park

Ms. Clarissa DeGale, Supervisor, Child Care Center, Frequente Park

Mr. W. Ralph Hogg, Manager, Abbot, Ltd., Frequente Park

Mr. Curlan Gilchrist, Director of Statistics, Ministry of Finance

Mr. Terrance DeAllie, Acting General Manager, Grenada Industrial Development Corporation, Frequente Park

Mr. Kennedy Roberts, Health Planner, Ministry of Health

Mr. Allan Bierzynski, Vice President, Grenada Family Planning Association

Dr. Bernard Gittens, President, Grenada Family Planning Association

Ms. Margaret Park, Executive Director, GRENSAVE

Ms. C. Horsford, Permanent Secretary, Ministry of Health

Dr. E. Friday, Chief Medical Officer, Ministry of Health

Dr. Doreen Murray, Senior Medical Officer, Ministry of Health

Mr. Noland Murray, Director of Budget and Deputy Director-General, Ministry of Finance

Ms. Annette Veler, Charge d'Affaires, U.S. Embassy

2. DOMINICA

Ms. Doreen Nicholas, Permanent Secretary, Ministry of Health

Ms. Jean Jacob, Principal Nursing Officer, Ministry of Health

Ms. Cynthia John, Regional Supervisor, Community Health Services,
Ministry of Health

Ms. Dorothy James, Health Educator, Ministry of Health

Mr. Willie Fevrier, Executive Director, Dominica Planned Parenthood
Association

Mr. Cary Harris, Development Coordinator, Economic Development
Unit, Ministry of Finance and Development

Mr. Michael Murphy, Chief Statistician, Ministry of Finance and
Development

3. SAINT LUCIA

Mr. Percival McDonald, Permanent Secretary, Ministry of Health

Dr. Debra Louisy-Charles, Senior Medical Officer, Ministry of Health

Mr. Cornelius Lubin, National Population Coordinator, Ministry of
Planning

Mr. John LaForce, Executive Director, St. Lucia Family Planning
Association

Ms. Sherita Gregoire, Managing Director, Eastern Caribbean Drug
Service

Ms. Ethel Jean-Baptiste, Census Officer

4. ANTIGUA

Dr. Tirbani Jagdeo, Chief Executive Officer, Caribbean Family
Planning Affiliation, Ltd.

Dr. Jean-Pierre Guengant, Member, CFPA Council

Ms. Bonnilyn Kelsick, Community Health Nurse, Ministry of Health

Ms. Hazelyn Benjamin, Executive Director, Antigua Planned Parenthood Association

Mr. Eden Weston, Permanent Secretary, Ministry of Economic Development

Mr. Franck Jacobs, Chief Statistician, Ministry of Planning

Ms. Ann Syrett, U.S. Embassy

Appendix C: Country Trip Reports

Grenada

1. Frequente Child Care Center & Family Planning Clinic
 - a. Present:

Winston Duncan, Exec. Dir., GFPA
, FP Clinic Supervisor
, FP Nurse/educator
 - b. One of 4 GFPA clinics (no diffs in fee structure)
Three are full service; one focused on youth (IEC)
 - c. Frequente clinic has low rate of use: 50-55 new acceptors per year; one IUD in past 12 months (have yearly stat report); oriented to low income pop. who work at factory complex; some question re: whether can extend services to surrounding community (entrance probs; competing public clinics).
2. Abbott Industries, Frequente Park
 - a. Present: Ralph Hogg, Managing Director
 - b. The companies occupying the Park differ in terms of profitability as well as interest in offering f-p services. Hogg feels that addition of physician would help increase use of f-p clinic (reducing likelihood that women attending clinic would be identified as users of f-p).
 - c. Roughly 250 current employees in Park (another figure given is 279), which was designed for perhaps 1000-1250. Fifty employees at Abbott; piece-work operation producing parts of hoses for IVs, shipped out and assembled elsewhere.
 - d. Plant in operation about 3.5 years. So far, only 5 pregnancies among female staff. Abbott provides 3 mos maternity leave beyond 3 mos provided by National Insurance Service.
 - e. Hogg believes very low rate of pre-and postnatal care. Four or five Abbott employees using day care facility.
3. Mr. Courtland Gilchrest, Director of Statistics

- a. Mr. G supervises Mr. Desmond John, coordinator of the Population Policy Unit, who is away doing a 3 month training course in Moscow. Mr. John's position is now UNFPA-funded, but the government will pick up the cost if funding not continued.
- b. The census is moving forward. Coding begins in November, and by February processing with the optical reader is expected to be completed. Preliminary results are expected by April 92. Some early results, for the country as a whole, were issued for World Population Day.
- c. The GOG, through the Department of Statistics, has established a survey unit, which will coordinate all government surveys. In April 92 GOG will begin a bi-annual labor force survey, which will eventually become quarterly.
- d. This unit is composed of the Director, an Assistant Statistician (who is also the Deputy Census Officer), 2 Statistical Officers, a core of ca. 30 enumerators, and a computer programmer. They plan to add another mid-level professional in 92. Equipment consists of 10 PCs and a dot-matrix printer (a laser is on order). They have access to a GOG (Min. of Finance?) mainframe.
- e. The activities of the Population Policy Unit include:
 - 1) a workshop on vital statistics registration (91), coordinated by ECLAC. MOH personnel invited and examined the flow of information.
 - 2) a planning workshop for physicians regarding cause of death coding and statistics.
 - 3) series of TV spots and other public info during World Population Week.
 - 4) a chapter on population for the National Development Plan. (Copy of this chapter never received from Gilcrest; 1990 draft of deve plan gives little explicit attention to pop conditions and trends).
 - 5) During the coming year the Pop. Pol. Unit will try to influence operational activities of MOH.
 - 6) Requested a copy of Pop. Council work plan for 91-92, but it was not delivered as promised.
- f. Assistance needed by the unit:
 - 1) technical assistance. A population intern, through U. of Mich. program, expected this year. Also could use some senior specialist guidance.

- 2) help w/research.
 - 3) help w/dissemination of information.
- g. G stated that the old pop policy (1986) needs up-dating and revision; they are planning to do so. There is a need for the pop. coordinator to have more authority and power. The pop. unit should be a separate gov't department. The Nat. Pop. Council is chaired by the Director of Budget and Planning; it meets monthly.
4. Mr. Terrance De Allie, Acting General Manager, Grenada Industrial Development Corporation
- a. The principal topic of the meeting was the Day Care Center and Family Planning Clinic in Frequente Park.
 - b. The Park now has about 7 companies, w/275-300 employees, which could increase to 500-650 soon. (realistic?). The GIDC wants to retain the day care center and f-p clinic (Mr. D'A has a two-yr. old; elsewhere we learned that at least 5 of children in center are of GIDC employees). They have provided free lease and janitorial costs for the first 2 years. However, Mr. D'A also recognizes that neither unit is economically viable. Options include:
 - 1) F-P Clinic: have MOH operate unit (and perhaps make local residents eligible); bring in physicians to offer general MCH services, and perhaps increase usage. Consensus is that will be difficult to save.
 - 2) Day Care Center: Turn over to GRENSAVE?; increase subvention and/or fees
 - c. Corporation not doing too well. Income comes from (1) gov't subvention (25%) and rental of buildings (75%). Only about 55% of rental being paid. GIDC staff now at 8 professionals and 13 support staff. 3 more prof's needed (???) [what will they do?]
5. Kennedy Smith, Health Economist, MOH
- a. MOH now merging FP and MCH programs and AIDS and IEC programs through UNFPA assistance. Apparently part of major reorg of med care system.
 - b. PAHO has received \$1.7 million from IDB for improvement of health management info systems; some will come to Grenada. For 92 are focusing

on development of health system policies. [French MD ran off with data from 4 years of research, so have to begin all over again.]

6. GFPA: Winston Duncan, Exec Dir., Bernard Giddens, MD, Chairman of Board; _____, member of Board
 - a. Meetings w/MOH and MOEd next week to discuss collaboration. Degree of commitment to FP at MOH perceived to be low, e.g., re clinic operation. Negative influence of Catholic Church and Catholicism believed to be factor inhibiting action at MOH. Dr. Noel, a longtime influential physician was major barrier. [He died recently.] Mrs. _____, chief nurse, carries on that tradition [Billings Method preferred].
 - b. Demand for FP said to be low. Partial (and faulty) CPS conducted in 90, shows CPR in 50s.
 - c. Duncan indicates that GFPA had input to Nat Pop Pol statement.
 - d. Duncan suggests need for national coordinating body for FP services. Doreen Murray would be link to MOH. Joint coordinating committee? OK with GFPA.
 - e. What does GFPA have to offer MOH?
 - 1) Yrs of experience of nurses
 - 2) Counselling services
 - 3) Vocational services
 - 4) Tech Assist re FLE services and training
 - 5) GFPA youth center as possible model for similar MOH center.
 - f. What are relations w/CFPA?
 - 1) Pay \$100/yr subscription
 - 2) CFPA provides TA and training relevant to Caribbean setting; IPPF does not. [CFPA provides training, TA, and educational materials; IPPF provides core funding and large equipment].
 - g. What is ideal GFPA-CFPA relationship?
 - 1) medium-term planning; discussion of experiences and needs.
 - 2) Some question whether annual meeting is enough (typically, CFPA holds several)

- 3) Suggestion that CFPA Board play stronger role in planning (and perhaps TA and training). Was recent attempt at strategic planning involving Jagdeo and reps from several FPAs.
- h. Frequent Park Clinic and Day Care Center
 - 1) Issues differ for 2 facilities. Need KAP survey for pop eligible to use FP clinic. (One done, poorly)
 - 2) Can clinic be opened to public??
- 7. Margaret Mark, Director of GRENSAVE
 - a. GRENSAVE operates 3 other centers, at lower standards. However, these are higher standards than at gov't day care centers.
 - b. Need 90-95% subvention to operate Freq. Park facility. (AC cossts are going to be very high, and this not factored in)
 - c. Not clear what are gov't standards re child care centers.
 - d. Monthly salary costs are about \$7,000 for 166 children at 3 other GRENSAVE centers, and \$6,127 for 22 children at F. Park.
- 8. Meeting at MOH with Mrs. Horsford, new PS., Doreen Murray, and Dr. Friday, CMO.
 - a. Because of influence of Dr. Noel, nurses still promote Billings method and unwilling to push modern FP.
 - b. CMO appears to reject idea of help with training from GFPA---or any other form of collaboration. Says own staff can do it. (Rumor has it that he's on his way out) MOH would like to put on 2-3 day training workshop, but would need funding. UNFPA prospects for continued funding uncertain.
 - c. Most of gov't commodities come from CFPA, some purchased directly. Would be difficult for gov't to purchase most of won commodities.
 - d. Claim that 98% of women receive prenatal care (too high?) Apparent that none of these people have much idea of level of care actually received.
 - e. Gov't new anticipating integration of FP, pre- and post-natal care, and cervical cancer program. Appropriate person needed to coordinate these services.

9. Mr. Murray, Deputy Director of Budgeting, Ministry of Finance.
 - a. Gov't considering personnel cuts up to 2,400 posts. Actual number not yet defined. Now assessing personnel needs over next 3 yrs. Education, health, and soc. security to be given priority.
 - b. Looking for ways to increase efficiency of employee performance.
10. Annette Veler, Charge d'affaires, U.S. Embassy
 - a. Interested to see how Frequente Park facility can be saved. Understands that politics involved in establishment in first place.
 - b. Possibility of relocating equipment to other GRENSAVE facilities.
 - c. Real problem of creating sustainable programs and facilities in microstates of subregion recognized.

DOMINICA (6-9 Oct. 91)

Ministry of Health: Mrs. D. Nicholas, PS; Miss Jean Jacob, Principal Nursing Officer; Mrs. D. James, Health Educator; and Mrs. C. John, Regional Supervisor

1. Org of FP Services
 - a. Began in 77 as integ. MCH-FP program w/in MOH. Now operate 51 health centers in 8 Parishes (country-wide coverage). Nursing staff trained locally, some overseas. All services free. MOH provides 95% of services; DFPA relatively new program, and provides other 5%.
 - b. Methods offered include: orals (most popular); condoms, IUD, foam (not popular), and sterilization.
 - c. F-p is integral component of MCH/family health services.
 - d. Information System:
 - 1) Quarterly reports at national level. Monthly reports from health centers. Manual available for guiding info collection (done in 1983). System now being computerized with PAHO assistance.
 - e. Two special populations identified: adolescents; men.

- 1) Male motivation program funded by UNFPA (now terminated)---speakers, media messages.
 - 2) Was male OR study (where is it?) Men now more concerned about contraception because of AIDS.
- f. CFPA has provided training, local as well as regional, counseling, FLE, human sexuality. Assistance seen as relevant and effective.
 - g. Future program needs include contraceptive supplies, training (e.g., in counselling), equipment; more training for peer counselors, who must be monitored closely.
 - h. Problems: contraceptive supplies (e.g., Noristerat (sp?) not now available); lack of sustained motivation among clients; Haven,t seen copy of CPS, need more info re use of studies like CPS; teenage pregnancy [no attempt to set up separate clinic for teenagers; have found that they prefer to go to same clinic as adults]; teens generally have first child before making first visit to f-p clinic; FLE must be strengthened; have just put together sex ed course for primary schools---much work to be done with teachers re sex ed and counselling in general.
 - i. MOH relations w/DFPA are excellent; MOH staff on Board of DFPA. The two orgs collaborate in training.
 - i. Sector plan does not indicate any prob with pop growth; major problems in health stem from poverty.
 - j. Latest MOH annual report for 87; more recent one at printers.

Mr. Carey Harris, Coordinator, Economic Development Unit

1. This office part of Min. of Finance & Development; reports directly to PM.
2. Dev. Planning at sector level now in progress (sector papers in areas of trade & industry; health; tourism; community development; agriculture; and education. Will begin with sector plans and work toward macro plan.
3. In conjunction with dev. planning, Harris interested in creating routine sample survey (biannual).
4. Population unit never got off ground. Cabinet wasn't ready for 1986 statement re pop policy. Gov't is interested in some pop issues, e.g., manpower development. Harris believes is some utility in pop awareness

programs for leaders and technicians. Has been problem of getting political leaders to face problems and make use of info available.

5. Gov't has asked OAS and UNDP for assistance with environmental problems.

Mr. Willie Fevrier, Exec. Dir, DFPA

1. Two principal foci of program, education and services, w/emphasis on education.
 - a) FLE in 2 of 10 secondary schools; would like to do more but lack staff (work now done by Exec Dir and one nurse). Schools claim to have staff trained in FLE; curric for primary schools; none for secondary schools, but expected by next year.
 - b) Respond to requests from comm and youth groups for presentations.
2. Services include clinic and CBD program.
 - a) Clinic offers contraceptives, preg tests, pap smears (begun only this year), and physical exams. Clientele growing rapidly (about 13 new acceptors/month and total of 200 clients/month. Large increase in users this year due to gov't running out of one injectable.
 - b) CBD service funded by AID. 34 outlets in rural districts (shops, bars, 2 pharmacies, indivl distributors); offer condoms and foam tablets. Distributors make 40% profit.
 - c) Have arrangement with physician who would perform sterilizations if asked; low demand.
3. Use of info: F has read "parts" of CPS; vague.
4. CFPA relationship:
 - a) CFPA provides media materials (posters, radio spots); booklets on various methods.
 - b) Training includes counselling workshops (one going on now; observed); workshop on pop and dev; management

workshops (financial control; budgeting; personnel relations); MIS will be computerized.

- c) CFPA Exec Directors' annual meeting useful; also recent strategic planning meeting.

5. MOH relationship:

- a) Collaboration very good.

5. Record/information system:

- a) Forms sent to Antigua (which duplicates IPPF efforts). Own system reports data monthly, quarterly, and annually. Comment that 3 diff formats used; need to synthesize into single system. Reports from Antigua delayed about three months; graphs and charts provided are useful. [Now these reports and graphs not being received because CFPA person in charge has left; Problem???

6. DFPA has no contraceptive social marketing program. No special program for teenagers apart from FLE. However, began under-20 club at youth center; participants occasionally come to clinic for presentations; interest has waned since coordinator left.

7. Funding:

- a) Receive at least 80% of funding from IPPF; some help from CFPA?; remainder from sale of contraceptives; fund raising campaign hasn't gotten off ground, but will be emphasized in 92 (Board and volunteers need to develop strategy; need some TA from a facilitator).

8. Future Needs:

- a) Outreach person to initiate and maintain contact with communities.
- b) Difficult to gain acceptance of programs among teenagers. Need diverse programs not directly related to sexuality (e.g., sports, drama); sexuality message can be introduced in subtle ways.

- c) Requests to IPPF negotiated through 3-year planning document; annual discussions with regional consultant for regional planning (Hetty Seargent).
- d) Would like better facilities (more space; location off main road); desire to set up small library (students often come to do assignments; now no space for them).
- e) Need computer equipment to improve reporting system.
- f) Are concerned that IPPF funding might decline in future, though IPPF has said it won't. Population Concerns visited; interested in aspects of FLE program; a project will be submitted soon.

9. Notes from Annual Report of Chief Medical Officer, Dominica, 1987:

MCH: "Includes integrated services in child welfare, nutrition, care during pregnancy, labour and delivery, and family planning. Each district nurse is responsible for conducting antenatal and child health clinics on a weekly basis through organized appointment system utilizing combined clinics." (p. 54)

Total of 1,462 pregnant women registered at health clinics in 1987. Percent of coverage high in all districts except Roseau, ranging from 93 to 98 percent. In Roseau, with 2 private physicians (who may take up the slack), coverage was 77 percent.

Of a total of 1,713 deliveries, 14.4 percent were done at home, 16.5 percent in health centers, and 69.1 percent in hospital. Since 1984 home deliveries have decreased from 36 percent.

"Family planning services constitute an integral part and have been fully integrated as a component of the MCH programme. The oral contraceptive continues to be the method of choice by users followed closely by the injectable." (p. 56). 71.4% of current users and 75% of new acceptors are in 20-34 age category.

"The functional organization of the primary care services is by districts and care is delivered by a health team. The district health team consists of all health workers at the district level. It is managed by a committee --- the district medical officer, health visitor, environmental health officer, and family nurse practitioner. The team is

collaboratively responsible for the delivery of health care in the form of preventive, promotive, curative, and rehabilitative services.

The district is the key level in the primary health care system and serves as the base for local programming, management, supervision and financial control. At this level programmes proposed by the central level are analyzed and adjusted to suit the specific needs of the community" (p. 108).

10. Michael Murphy, Chief Statistical Officer

a. Census of 91

- 1) Preliminary report prepared with data by Parish, age, sex, and locality. Will finish coding by December 91. Hope to use optical reader for cleaning in early 92...First detailed report???
- 2) Now designing study of migration at local level using community nurses as informants (being done by Albert Murphy, nephew)
- 3) Now writing proposal for funding of survey unit. Recent survey of 600 households (expenditures). Would like to collect more info re labor force.
- 4) Equipment includes two 386s and several 286s.

St. Lucia

1. Cornelius Lubin, Coordinator, Population Policy Unit

- a. Council now in place (since 19 Sept. 91). Working toward more detailed statement of population policy. Planning first meeting of expanded council for Oct. 27th. The Council has 18 members. Teenage fertility is a major substantive issue.
- b. Lubin has one R.A. (Denise Richards); gov't pays her salary as well as that of a secretary. Lubin seeking additional training for Ms. Richards (probably in U.S., thru Census Bureau, hoping for AID support). She has BA from UWI (is Trinidadian). Lubin receptive to idea of pop intern through Michigan program.
- c. Ms. Richards now working on study of teenage fertility (using available data; e.g., census and regional data for comparison). Focus on implications for FLE

programmes, e.g., determinants and consequences of adolescent pregnancy. Results in a month or so.

- d. Lubin has now produced 6 policy briefs and a packet of information regarding the council's work.
- e. CFPA
 - 1) Sometimes receives information.
- f. UNFPA
 - 1) Support ends in Feb. 92, tho hoping for additional funding. Now funds Lubin's salary and travel. PM supportive of Pop. Unit, and would continue Lubin's salary if UNFPA support ends. UNFPA also provides for TA from ECLAC.
- g. Development Planning:
 - 1) Lubin now reviewing sector papers and making comments. No reactions as yet.
 - 2) Lubin receptive to idea of separate population sector identified for planning purposes; would further goal of integration.
- h. Awareness Raising
 - 1) ECLAC did video for Grenada, St. Vincent, and St. Lucia ("Charting our Destiny"). This is principal component of Unit's work, using radio and TV.
 - 2) Policymakers now members of council. Intend to invite members of various interest groups as well.
- i. Lubin believes new CPS may be needed.
- j. Workplan for 90-92; developing new one.
- k. Receive lots of calls for info from ministries and from students.
- l. L agrees that annual meeting of pop unit coordinators would be useful. Perhaps could be organized thru CFPA and/or OECS. Directors first, then include planners? (mm)

- m. Unit has one IBM computer and one Epson printer.
2. John LaForche, Exec. Director, SLFPA
 - a. Has been Exec. Dir. only since 1 October.
 - b. 70% of support from IPPF; one project with Partners for the Americas; other income from sales of contraceptives and provision of services, including CBD (charge for all services). Charge \$EC10 for new acceptor service and \$EC5 for continuing service. Don't now do pap smears, but intend to.
 - c. Provide IEC to 10 factories, with a basic charge of \$EC1/month. Payments late, and actually collect only about 50%.
 - d. Work plan now in preparation, but no \$ figures as yet. Reports to IPPF have been late in past, but now on time. Board wasn't active in past, but now is.
 - e. Seminar with CFPA scheduled for 23 Oct., and will have Board meeting in P.M. Topic is how to sensitize business to FPA needs and generate support. Board will also try to generate more support from gov't (which now supports two nurses).
 - f. Gov't has prohibited teaching of f-p in schools, tho do teach FLE. SLFPA no longer invited to give FLE talks in schools.
 - g. Little knowledge of CPS data; says will use. Also plans use of Pop. Unit materials and TA from Jagdeo and Guengant. Finds CFPA extremely helpful (regional and local workshops); counselling, management.
 - h. As result of findings from St.L male study, FPA has mounted male campaign in Oct. 91.
 - i. Availability good in St.L., but method mix is wrong (e.g., injectables not sufficiently available).
 3. Ministry of Health.
 - a. St.L very good in PHC; other countries use as model. Have 32 health centers and 2 district hospitals; all offer f-p and postnatal care. Condoms and injectables offered.
 - b. Shortages of f-p supplies; problem w/CFPA?

- c. Health workers have weak attitude re: f-p; problem of program. Also problem of getting support from physicians. However, PM is concerned with pop and f-p. Church a problem; Cath church strongly opposed to f-p at first, now less opposed.
 - d. MOH now reassessing publicity campaign re contraception; especially concerned with probs of AIDS.
 - e. FLE in schools; MOE w/contributions from MOH.
 - f. Haven't received copies of St.L CPS (problem of IPPF).
 - g. MOH to receive 5 micros (from French).
 - h. Info system needs up-dating. All done manually; community nurses provide monthly info re new acceptors, continuation, method use, etc. Need to improve system). Do not participate in CFPA reporting system.
4. Sherita Gregoire, Eastern Caribbean Drug Service (ECDS)
- a. Would be easy for ECDS to take over supply flow for EC gov't contraceptive needs. Realized 44% saving first year with other drugs.
 - b. ECDS needs couple years notice before taking over supply function. Needs to have unit costs for planning purposes.
5. Ethyl Jean-Baptiste, Census Coordinator
- a. Will finish cleaning data in Dec-March period. Preliminary processing has begun. Expect first detailed information available by March 92.
 - b. Expect growth to have declined.

Antigua

1. CFPA (Tirbani Jagdeo, Jean-Pierre Guengant)
- a. Use of Demographic Information
 - 1) Demographic indicators relevant to development not produced by countries in region. Migration estimates especially poor. Guengant estimates that 70-80% of net migration from Caribbean is to U.S. and Canada.

- 2) Idea of CFPA data bank. Documentation center could be expanded to include regional info from new censuses, survey data, etc. in addition to info re: f-p, FLE, etc.
Existing doc center has regional distribution list.
- b. Re the pop units that were to have been established:
- Dominica: nothing as yet
St. Lucia: functioning; activity during past year
St. Vincent: not much has happened; coordinator (Kitty Israel) now in training course at Michigan.
Grenada: Not much has happened; Desmond St. John (coordinator) in training course in Moscow.
St. Kitts: Nothing.
- c. Technical Assistance
- 1) Example of Denise Richards (StL): JPG "lotusized" her in a couple of days (Feb. 91). Provided help with analysis she was doing.
 - 2) CFPA could easily provide TA to pop units, particularly on how to use available demog info for policy and planning purposes. [Generally, planners and policymakers and demog analysts need to know what they can do for one another and what their varying needs are---MM]. At present there is no source of this kind of TA; lack of national universities is problem. Need to develop core of professionals in this area. **THE LONGSTANDING HUMAN RESOURCE PROBLEM!**
 - 3) What kinds of support services (TA, training) are necessary for population and development planning, policy formation and implementation, information systems, program development, implementation, monitoring, evaluation, etc.?
 - o national level
 - o regional level
- d. Re; CPS: IPPF is responsible for dissemination of results and provision of copies to countries. They have not followed up on this responsibility (e.g., St. Lucia. Jagdeo did CPS's on his own time under contract to IPPF. Alternatives??
- e. The question of E. Caribb. development:

- 1) Need for regional econ specialization. EC countries doing better than larger Caribb. neighbors (e.g., Guyana, Jamaica, TT, Barbados). Issues include:

- o remittances
- o migration
- o retirees (emigrants who may return home)
- o tourism
- o environmental damage (see book by Watts)

- 2) Strategies:

- a) Preserve quality of life and natural environment
- b) Focus on a few "niches"
- c) Promote more responsible behavior, e.g., respect for the welfare of others
- d) Stress quality rather than quantity
- e) Relevant populations: residents, potential migrants, tourists, emigrants (remittances and returns)
- f) Learn from experience: e.g., Guadeloupe and Martinique in 80s (successful economies attracted European investment and immigration as well as returnees; now pop growth has returned to levels of 50s and 60s ... ca. 2%). Lesson: pop growth adapts to econ climate.

f. Youth Unemployment

- 1) Problem of school dropouts (esp. males at sec level); migration only alternative for the more talented. [see A. Simmons paper re OECS youth in Canada and U.S.)
- 2) Classrooms crowded, but only about 25% of students retained by age 16.

g. Abortion levels estimated to be high in EC. Something wrong with f-p system. (IMPORTANT POINT)

h. Recent CFPA planning documents: meeting of exec directors; training philosophy; 3-year plan.

2. CFPA (second session)

a. IEC/FLE

- 1) IEC formats: posters, pamphlets, radio spots, videos, press releases.

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- 2) All IEC activities preceded by examination of data available to define needs and strategies.
- 3) No negative messages used, only positive. (e.g., no threats). Messages culturally sensitive.
- 4) IEC campaigns began with awareness creating messages; have now progressed to focus on target groups with specific needs.
- 5) Focus on integrated, multimedia messages (e.g., radio, TV, pamphlets reinforce and complement one another)
- 6) In 91, Caribbean Family Planning Day was occasion for a series of articles in each country re f-p program.
- 7) Some indication that FPAs need help with how to use materials effectively, e.g., where to place posters.

b. Target Approaches for IEC

1) Teenagers

Vulnerable pop because of lack of knowledge. Many girls talked into having sex when they don't want to and/or aren't ready. Effort to raise young women's self-esteem and generate confidence to say "no". Important next step is to prepare youth for entry into sexual life (Under what conditions should sex activity begin? With what expectations and consequences?)

Have developed sex ed curricula for schools. Advocacy seminars promoting sex ed in schools (Jamaica); radio talks aimed at policymakers and teachers; eight-part radio drama ("Don't Blame Us, Teach Us).

2) Men

J feels degree of opposition of men to f-p is exaggerated (see three studies in EC countries). Believed that men have less power over women in Caribbean (research??). Try to place f-p messages within context of the couple, promoting male responsibility. Fert control more effective for women who have discussed matter with partner (CPS results). Probably high frequency of extramarital sex contacts. Is need to deal with men in terms of their needs, not only those defined as couple needs, those of children, etc. MALE BEHAVIOR LIKELY RELATED TO PROBLEM OF HIGH SCHOOL DROPOUT RATES; NEED TO CONSIDER RESEARCH AND PROGRAM IMPLICATIONS.

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- 3) IEC work hasn't been evaluated adequately. Some evidence from IEC work in Dominica. Pop Concerns will fund impact evaluation of CFPA activities, w/concentration on IEC.

c. Training (see CFPA draft document)

- 1) Early efforts focused on contraceptive delivery and f-p communications. New emphasis on counselling and quality of care.
- 2) J says FPAs should be users of CFPA materials, rather than creators of their own materials.
- 3) There is an editorial committee to review materials produced.
- 4) Have been formal evaluations of all training interventions (Available in CFPA reports to AID?) [check with Neville]
- 5) Need for training of FPA staff in communications.
- 6) Management Training
 - a) Seminar to be held 16 Nov. Will include: budgeting and program financial analysis; project implementation and monitoring; use of data in program planning.
 - b) J says problem w/MIS as now structured is that govt's don't cooperate...don't send info on time.

d. Contraceptive Logistics Project

Advantage of continuation to CFPA is that they have worked the bugs out of the system. Now execute it effectively. (Some doubts re cost effectiveness; need to examine real costs of time, storage, etc. and compare w/costs of using ECDS.)

e. The MIS Component

- 1) JSI work began in April 88; CFPA work in July 87. Arrangement was to have been that JSI designs system training, while CFPA implements it. Supposedly JSI rep took forms to MOHs and asked if would be useful to them. Responses received from MOHs and FPAs as follows:

	DESIRE TO IMPLEMENT MIS	
	MINISTRY OF HEALTH	FAM. PLANN. ASSOC.
BARBADOS	No	No
DOMINICA	No	Yes
GRENADA	No	Yes

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ST. KITTS	No	No
ST. LUCIA	No	Yes
ST. VINCENT	Yes	Yes

- 2) Equipment provided minimal; computers only to CFPA and to Grenada (day care center equipment).
- 3) Costs of shipping forms prohibitive (Not anticipated: why? feasibility study should have done so).
- 4) Original idea that FPAs would be provided w/micros; MOHs would provide info to FPAs who would process and pass on to CFPA via diskette. Didn't work out. WHY?
- 5) Software was developed by JSI. The CFPA MIS manager left because work was too clerical. Two secretaries trained to take over tasks.
- 6) Reporting from existing system monthly, with about one month delay from time of getting raw data. No effort to train FPA personnel on how to use info they receive via MIS. MAJOR WEAKNESS IN SYSTEM. Responsibility for this task was apparently to have been shared by CFPA and JSI.
- 7) Funding for the MIS project included:
 - a) CFPA: equipment and salary of one person
 - b) JSI: All the remainder (nearly 700K)
- 8) JSI involvement to date includes several visits to sell the system; modification of the forms; some training; and installation of the system (INVOLVING...???). No reports received to date by AID.
- 9) Is there a need for a high-powered MIS in the region? Doubtful! CFPA suggests modification in terms of FPAs sending only aggregate data and receiving summary from CFPA. Could be done w/diskettes. ALTERNATIVE: train FPAs to collect and summarize own data. But is need for some training and perhaps TA re uses of data.

f. Frequente Park F-P Center and Day Care Center

- 1) JSI did feasibility study (Grenada, St. Kitts, Barbados)

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- 2) Was anticipated that subsidies would be required and that complete sustainability would be difficult.
- 3) Only Grenada worked out. Problems included:
 - o No physicians to occupy space in clinic
 - o Lower employment at industrial park
 - o Lack of employer interest, e.g., no financial contribution
 - o Higher standards (UNICEF) at day care center, requiring more staff and higher salaries
 - o Probable higher costs at day care center w.A-C
- 4) How can costs be reduced sufficiently to make facilities viable? (Interest of Kennedy Roberts, in role as Chair of GRENSAVE to explore possibilities)

3. CFPA (Third Session)

a. Staff:

- 1) Exec Dir (Ph.D.)
 Prog. Coordinator (M.A.): pub. admin.
 Training Officer (M.A.): soc. Psychol.
 Doc. Officer (B.A.): Librarian (50% effort)
 Office Manager
 Financial Officer
 3 secretaries
 cleaner/office attendant
- 2) Need for communications officer (writing scripts, pamphlets, etc.); person should have video experience

Several staff involved in training; outside consultants used as needed.

Turnover has always been a problem. J has tried to deal with turnover problem in several ways:

- o gratuities (one month/yr of service)
- o noncontrib. health benefit program
- o compensatory days

However, because of project-based funding situation, people always anticipating end of project and are looking for other work to protect their source of income.

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b. Facilities

- 1) CFPA owns the building. Space is adequate, but building needs a new roof and rewiring. Also have problems with water backing up.
- 2) Equipment needs include: another computer (now have one 386, software [CD ROM, for access to popline], Ventures or Pagemaker [for desktop publishing], a mouse, Freelance, Magellan, DOS 5.0, and a laser printer [now have Epson]. Also could use photocopier; a FAX is being provided by IPPF. Need more than one telephone line.

c. Membership

- 1) Now includes 19 countries (Belize and Bahamas will drop out soon; Guyana and Suriname have already done so).
- 2) Board composed of 8 members; in the odd year a 9th is added thru ex president as ex officio.
- 3) Complete elections every 2 yrs.; 2 at-large members elected every year.

d. Activities

- 1) Want to maintain focus on adolescents. The idea is to empower teenagers and young women to have children when they want to and when would be best for them (timing issue).
- 2) For all persons, want to focus on sexual and reproductive health care, an integrated focus.
- 3) Some concern with births mistimed later in life, e.g., women 30-44. Last child often unwanted.
- 4) Generally, want to develop life planning skills, including number and spacing of children.
- 5) Males: need to know more re methods, services, and reprod responsibility. Need to know more about mechanisms of social control and social support (e.g., adolesc-parent relations, gender diffs). Research??
- 6) Need to develop doc center/data base. Training needed re how to use info (users) and how to teach people to use it (CFPA providers).

- 7) J wants to make FPAs centers of excellence in communication activities. This would require more training in counselling, communications (materials and strategies. CFPA would train FPA staff; the FPAs would then have the expertise to obtain some/increased gov't support. Problem now is that FPAs don't know how to use effectively the materials now provided (e.g., posters, videos, etc.).
 - 8) Need for more participation by FPA volunteers to lobby for more support from gov'ts.
 - 9) Re the MIS: Need to diagnose what when wrong with the proposed system. Still a need to help FPAs with skills needed to prepare budgets, financial reporting, generate income.
4. PS, Ministry of Economic Development
- 1) No five-year plan for a long time. Lack of economists to work on this effort. Low pay in gov't a major issue.
 - 2) Do produce a 5-yr indicative plan, made up of sectoral plans.
 - 3) Mentioned probs of immigration.
5. Miss Kelsick, Director, St. Johns Health Center
- a. Antigua divided into 7 health districts, with 8 health centers and 17 subcenters. Family planning services are free. However, no problem seen if charge is instituted; "People devalue that which is free".
 - b. Methods provided include orals, depo, foam tablets, and condoms. No IUDs. Public hospital does tubal ligations. Services provided by nurses, with no medical support. No shortage of nurses.
 - c. MOH provides quarterly reports to CFPA.
 - d. Adolescents are principal target pop. Peer counselling is provided at 3-4 locations; FLE is provided in schools.
 - e. Teenage deliveries are believed to be relatively low. They accounted for 17.5% of all deliveries in 1990 and 21.6% in 1986. The highest proportion of deliveries is in the 26-35 age category (40%).

- f. No programs directed specifically toward men.
 - g. People are still afraid to talk about family planning. There is a need to provide more information and education. Also a need to provide medical support in clinics.
 - h. No problems with availability of contraceptives, but the range is limited.
 - i. Collaboration with CFPA:
 - 1) Training that has been provided has been useful. Need for computer training.
 - 2) Some question as to whether medical protocol binders have been received.
6. Ms. Hazelyn Benjamin, Exec. Dir., Antigua Planned Parenthood Association
- a. There is little collaboration with gov't; e.g., case histories of clients switching to FPA not provided. Need to avoid duplication of effort.
 - b. Services offered by APPA include daily clinic services, physician referral, a CBD program with 28 outlets (pharmacies, supermarkets, bars, gas stations) and an IEC program.
 - 1) IEC includes media messages and responses to requests for talks to community groups and school counselling sessions.
 - 2) Have ordered "Let's Talk...,"
 - c. Staff of 5 (2 nurses [including exec. off.]; one other dropped for financial reasons), one driver/projectionist, one secretary/bookkeeper, and one field worker.
 - d. Funding: 80% IPPF, 17% from services, 3% from fund raising. Info System: daily, monthly, semi-annual and annual reports. Now using two systems of record keeping: CFPA/JSI and IPPF. This has proven problematic; the APPA does not have a computer system.
 - f. B mentioned issue of letting pregnant/birthed teenagers back into school. Believes society too small to do so. They should be educated, but not in school.

- g. Abortion said to be "very high." Done by almost all private physicians. Not stigmatized. Apparently law exists that allows for abortion under certain (broad) conditions. B believes is need for much more counselling for those choosing abortion; need to be aware of what they are doing and the consequences.
- h. B aware of CPS; some use made (e.g., info re program dropouts).
- i. MIS: Many forms rejected by CFPA. B upset; believes that forms filled in correctly. Only recently has APPA decided it can use info provided by CFPA through MIS.
- j. The Future: No great changes anticipated. There is no problem of access to services in Antigua. The problem is motivation to use services available.

7. Franck Jacobs, Chief Statistician and Census Officer

- 1) Last full census in 1960; partial census (20% sample) in 1970, but it was flawed. Post-enumeration survey conducted in Sept. 91; coverage looks good. Had expected a pop of around 80K; now expect somewhat lower (?)
- 2) Are in process of producing prelim figures (can't release as yet). Full coding and editing expected in next few months. First detailed report by March.
- 3) Expect 91 census to provide good data that can be used for planning purposes.
- 4) Gov't has probs with production of statistical yrbks. Last one in 88, but data collected for 89.
- 5) Gov't interested to develop sample surveys system; household expenditure survey planned and budgeted for 92.
- 6) Training opportunities needed. Stat Office has candidates, but given low priority by gov't. AID funding could help.
- 7) Antigua intends to rewrite early pop policy statement.

Appendix D
Scope of Work

SECTION C

DESCRIPTION/SPECIFICS/WORK STATEMENT

I. PURPOSE

The Contractor shall provide USAID with the services of two experts who will deliver to USAID/RDO/C written technical analyses which will assist USAID/RDO/C in identifying: (1) the unmet needs for family planning information and services, (2) what assistance is required from AID, and (3) the most culturally appropriate and cost effective ways in which such assistance might be delivered in future.

II. SPECIFIC TASKS

- A. Two short term experts, a Population Specialist and a Family Planning Specialist/Economist, are required to conduct the following tasks, which shall culminate in the preparation of a report to be used by USAID/RDO/C to develop a Project Implementation Document (PID) and a Project Paper.
- B. The experts will meet with USAID officials upon execution of this contract and determine a work plan, including sharing of responsibilities for completion of the scope of work. Preparation of the report will be coordinated such that a single joint report, addressing all the requirements of the SOW will be the result (deliverable).

C. Activities:

1. Review the Project Paper/PP Amendments, evaluations of the three main components of the Population and Development Project, 538-0039, and any other relevant regional and/or country material, assessing the achievements and shortcomings of the grantees in attaining the several goals and objectives set out in the cooperative grant and/or buy-in agreements.
2. Interview regional and country-based officials responsible for family planning/population activities, both public and private. Pursue with the principal officers of the grantees, Principal Technical (Chief Medical Officers) and Administrative Officers (Permanent Secretaries) of Ministries of Health, and any other officials, any unresolved issues relating to the development of family planning services and population activities in the participating territories in the Eastern Caribbean and Barbados.
3. Review current population policies in the OECS and the manner in which they are being implemented. Identify areas in the field of population policy and implementation which still need to be addressed and in which AID has a comparative advantage. Possible areas for investigation and analysis are: incentives and disincentives to the private sector clinic development, (e.g. providing the costs, on a per capita basis, for family planning services and medical examinations, pap smears, etc. as part of workers' remuneration packages), collection of fees-for-service in public sector clinics which render services, purchase of commodities, and integrated education for providers of family planning and AIDS services and a cost-benefit analysis of these interventions.
4. Assess nature of the groups currently being provided with family planning services and the quality of those services, identifying any groups which are not currently reached by family planning interventions/messages. Analysis should ensure that issues of contraceptive distress and of teen pregnancy are addressed in this assessment.
5. Review completed operations research activities, the utilization of the results of these activities, and identify any critical areas which remain to be researched.
6. Assess the efforts to date made by CFPA to develop a management information system and recommend what steps, if any, might be taken to further develop this system.

7. Assess the viability of private sector clinic development and other possible public/private sector initiatives in the area of population/family planning.
8. Assess the role of other donors/international organizations in providing assistance in the area of population policy and family planning (e.g. United Nations Economic Commission for Latin America and the Caribbean - UN ECLAC is rendering assistance to three governments in establishing national population planning units). Address possible ways in which AID efforts can be further integrated with those of other agencies/organisations and suggest areas which are sufficiently addressed so as to preclude AID assistance.
9. Analyze current roles of CFPA, FPAs, IPPF, and governments and their possible future input in the area of family/population planning. This analysis should include the role of service delivery, public education and information, family life education, training, demographic/prevalence analysis, population targets, and sustainability of these efforts.
10. Assess the capability of the Caribbean Family Planning Affiliation Ltd. to be the lead implementation agency and the institutional home of the project. Indicate those areas in which the Affiliation's Secretariat needs to be strengthened, what areas would require technical assistance and in what ways there can be a resolution of the ambiguity of CFPA's role vis-a-vis that of IPPF/WHR.
11. Document these analyses, and make recommendations for USAID assistance, based and prioritized on USAID's experience and comparative advantage in this sector.

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