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UNCLASSIFIED

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

JAMAICA

PROJECT PAPER

POPULATION & FAMILY PLANNING SERVICES

LAC/DR:82-1

Project Number: 532-0069

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY/ENTITY

JAMAICA

PROJECT NUMBER

532-0069

4. BUREAU/OFFICE

LAC

05

5. PROJECT TITLE (maximum 40 characters)

Population & Family Planning Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
 03 31 86

7. ESTIMATED DATE OF OBLIGATION

(Under "B:" below, enter 1, 2, 3, or 4)

A. Initial FY 82

B. Quarter 2

C. Final FY 85

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
ID Appropriated Total						
(Grant)	(773)	(733)	(1,506)	(2,736)	(2,264)	(5,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country		3,678	3,678		12,422	12,422
2. Other Donor(s)						
TOTALS	773	4,411	5,184	2,736	14,686	17,422

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PH	400B	400				1,089		5,000	
(2)									
(3)									
(4)									
TOTALS						1,089*		5,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

440 420 450 460

11. SECONDARY PURPOSE CODES

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

A. Code BRW BUW BWW
 B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To expand the coverage and increase the effectiveness of contraceptive services delivery.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Find MM YY
 07 84 01 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

* 372 utilized for procurement of commodities by AID/W.

17. APPROVED BY

Signature *Glenn O. Patterson*
 Title Mission Director
 USAID/Jamaica

Date Signed MM DD YY
 03 24 82

18. DATE DOCUMENT RECEIVED IN AID/W, OR DATE OF COMMENTS, DATE OF DISTRIBUTION

MM DD YY

PROJECT AUTHORIZATION

Name of Country: Jamaica
Name of Project: Population and Family Planning Services
Number of Project: 532-0069

Pursuant to Part I, Chapter I, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Government of Jamaica (The "Cooperating Country") not to exceed One Million Eighty Nine Thousand Dollars (\$1,089,000) (The "Authorized Amount"). The Grant will assist in financing foreign exchange and local currency cost of activities of the Population and Family Planning Services Project, such as the extension of family planning services throughout the islandwide network of hospitals and clinics of the Ministry of Health and through facilities of other public and private organizations, as well as the development and implementation of a national population policy and plan for Jamaica.

I approve the total level of A.I.D. appropriated funding planned for the Project of not to exceed Five Million United States Dollars (\$5,000,000), Grant funded, including the Authorized Amount, during the period FY 1982 through FY 1986. I approve further increments during that period of Grant funding up to \$3,911,000 subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority, subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

I. Source and Origin of Goods and Services

Except for ocean shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in the United States or in the Cooperating Country. Ocean shipping financed by A.I.D. under the Project shall be procured in the United States.

II. Conditions Precedent to First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(b) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.3, and of any additional representatives, together with a specimen signature of each person specified in such statement;

(c) Evidence that the National Family Planning Board has been given the necessary authority by the Government of Jamaica appropriate for its direction and implementation of the Project;

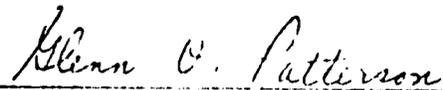
(d) A comprehensive plan to improve the National Family Planning Board's personnel, financial and resource management.

III. Condition Precedent to Ministry of Health Activities

Prior to the first disbursement under the Grant, or to the issuance of documentation by A.I.D. pursuant to which disbursement will be made for activities to be conducted by the Ministry of Health, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., evidence that it will establish and fill a post within the Ministry, for a full time Family Planning Coordinator with adequate authority to carry out the planning, coordination and implementation of all project-supported activities to be conducted by the various branches and divisions of the Ministry of Health.

IV. Condition Precedent to Sub-Projects

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made for any sub-project to be conducted by any organization other than the National Family Planning Board, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., a Grant Agreement and implementation plan for the sub-project. A comprehensive implementation plan covering all proposed activities of the National Family Planning Board's Adolescent Fertility Resource Center is also required prior to disbursement for this sub-project.



Glenn C. Patterson
Director

3/24/82

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LIST OF ACRONYMS

ACOSTRAD	-	Association for the Control of Sexually Transmitted Diseases
AID	-	U.S. Agency for International Development
AID/W	-	U.S. Agency for International Development, Washington
AHEA	-	International Family Planning Project of the American Home Economics Association
APHA	-	American Public Health Association
AVS	-	Association for Voluntary Sterilization
BUCEN	-	Bureau of the Census (U.S. Department of Commerce)
CBF	-	Crude Birth Rate
CBD	-	Community Based Distribution
CDC	-	Center for Disease Control (U.S. Public Health Service)
CDC	-	Commercial Distribution of Contraceptives
CHAs	-	Community Health Aides
DAEC	-	Development Assistance Executive Committee
DAI	-	Development Associates Incorporated
DEPO-PROVERA	-	Medroxyprogesterone acetate (injectable contraceptive)
DOS	-	Department of Statistics
FP	-	Family Planning
FPIA	-	Family Planning International Assistance
(OJ)	-	Government of Jamaica
IPAVS	-	International Project/Association for Voluntary Sterilization

IPPF	-	International Planned Parenthood Federation
IBRD	-	International Bank for Reconstruction and Development
IUD	-	Intra-Uterine Device
IE&C	-	Information Education and Communication
JAMAL	-	Jamaica Movement for the Advancement of Literacy
JFPA	-	Jamaica Family Planning Association
JHPIEGO	-	John Hopkins Program for the International Education in Gynaecology and Obstetrics
JLP	-	Jamaica Labour Party
JPP I & II	-	Jamaica Population Project
KAP	-	Knowledge, Attitude and Practice
MOH	-	Ministry of Health
MOA	-	Ministry of Agriculture
MOE	-	Ministry of Education
MYCD	-	Ministry of Youth and Community Development
NEET	-	Now Entering Education for Tomorrow
NFPB	-	National Family Planning Board
NPA	-	National Planning Agency
NCHS	-	National Center for Health Statistics
OCs	-	Oral Contraceptives
PHC	-	Primary Health Care
PHCC	-	Primary Health Care Center
PID	-	Project Identification Document
PC	-	The Population Council
PF	-	The Pathfinder Fund
PNP	-	People's National Party
RGD	-	Registrar General's Department
RAM	-	Repair and Maintenance Center

SDC	-	Social Development Commission
STD	-	Sexually Transmitted Disease
TFR	-	Total Fertility Rate
USAID	-	United States Agency for International Development (Jamaica Mission)
UWI	-	University of the West Indies
UNFPA	-	United Nations Fund for Population Activity
VJH	-	Victoria Jubilee Hospital
VISTIM	-	Vital Statistics Improvement Project
YWCA	-	Young Women's Christian Association

I.

SUMMARY AND RECOMMENDATIONA. Introduction and Overview

Jamaica's crude birth rate (CBR) of approximately 27 per 1,000 is about average for the Caribbean and lower than most countries in Middle and Tropical South America, where birth rates average about 34 per 1,000. Moreover, Jamaica's high rate of emigration has resulted in a fairly low net population growth rate of about 11 per 1,000 over the past several years; which compares favorably with most more developed countries. Assisted by a vigorous and widespread national family planning program begun in 1967, Jamaica has made excellent progress over the last decade in reducing its CBR by approximately 30%.

Despite Jamaica's relatively low population growth rate, the country has a serious population problem. This is because a number of problems exist which, if not checked with the assistance of a strong national family planning program, could result in a reversal of demographic gains already won. For example, Jamaica has one of the highest rates of adolescent fertility in the Western Hemisphere and national surveys of contraceptive attitudes and behavior continue to show strong preferences for large families. While large scale emigration has in recent years cut the population growth rate in half, there is no guarantee that this "escape valve" will remain open in the future and at Jamaica's current rate of natural increase the population would double in less than 35 years. Jamaica is a small island with limited resources which is highly dependent upon external market forces to fuel and maintain its economic growth. At present the country hopefully is beginning to turn around a long period of economic stagnation evidenced by seven straight years of negative economic growth resulting in a loss of over 25% income per capita in real terms. Unemployment, estimated at 26% officially, remains high and the Government can not now provide even the current population with adequate housing, education, health services and other public services essential to meeting basic human needs. Underlying these problems is the fact that after several years of fairly rapid decline, the crude birth rate in recent years has been declining at a much more modest rate.

Therefore, to continue and to accelerate the decline in the population growth rate of the 1970's, Jamaica needs to expand and revitalize its national family planning program in both the public and private sectors. The task is to meet the growing demand for family planning services while encouraging motivation towards adoption of smaller family size norms. At the same time efforts need to be made to develop specific population policies and plans at both the national and sectoral level.

Jamaican leaders recognize the vital role population growth plays in the economic and social development of the country and are committed to maintaining a strong national population and family planning services program. USAID in assigning family planning top priority in its Country Development Strategy Statement (CDSS) for Jamaica has also recognized the vital importance of this area of development assistance. Since USAID is currently the only

major source of external international assistance which Jamaica must have to implement its population and family planning services program, the success of the program will depend largely on both Jamaican and USAID resources. Most importantly, it will depend upon the political will and management expertise of Jamaican politicians, civil servants and program managers to utilize those resources wisely and productively.

B. Background Summary

Organized family planning services in Jamaica were made available for the first time in 1936 through the Jamaican Family Planning Association (JFPA), a private voluntary organization affiliated with the International Planned Parenthood Federation (IPPF). In those early years and well into the 1960's, JFPA played the major role in the delivery of family planning services and in establishing credibility for the program.

In 1967, the Jamaican Government officially recognized the problem of rapid population growth with the creation of the National Family Planning Board (NFPB). A subsequent National Family Planning Act of 1970 empowered NFPB to "-- prepare, carry out and promote the carrying out of population and family planning programs in Jamaica and act as the principal agency of government for the allocation of financial assistance or grants to other bodies or persons engaged in the field of family and population planning in Jamaica". The NFPB is further required to "coordinate" and where necessary "direct" work in population planning, research, sex education and operation of clinics delivering family planning services.

This broad mandate, together with the infusion of a considerable amount of external funding, primarily from USAID which has provided project support in excess of \$5 million since 1967, led to the development of a vigorous and comprehensive family planning education and service program under NFPB.

In 1974 the GOJ made the decision to "integrate" the NFPB into the Ministry of Health (MOH). Over 160 NFPB family planning clinics were merged with the Ministry's broader primary health care program. Most of NFPB's staff was transferred to the Ministry and the policy board became, in effect, an in-house committee of the Ministry with the Permanent Secretary as Chairman.

This move had both positive and negative effects. On the positive side, the number of public clinics offering family planning services has been substantially increased. Yet integration also had other effects. The shift of decision making from NFPB to the Ministry resulted in inefficiencies and delays in management of family planning programs and activities. Delineation of roles, functions and responsibilities between NFPB and Ministry staff units remained unclear with the result that key activities were sometimes inadequately carried out or not carried out at all. Morale suffered and staff turnover increased. Moreover, coordination and mobilization of non-Ministry of Health family planning programs no longer became a priority for a policy board made up solely of Ministry officials. And, although the number of public clinics offering family planning services increased after integration, the rate of increase of new and continuing acceptors declined significantly while the clinic drop-out rate increased.

Recognizing that integration had resulted in unanticipated and unwanted effects, the GOJ has recently begun to take steps to again separate NFPB from the Ministry of Health. A new policy board has been selected chaired by a private physician and consisting of only three (out of eleven) senior staff from the Ministry of Health. The NFPB senior staff is being strengthened by the addition of new central office and field personnel and consideration is being given to a new role for NFPB in the direct provision of family planning clinical services. The new board has received extensive publicity on its plans for significant expansion of voluntary sterilization services and a number of other non-traditional service providers (e.g. Ministry of Youth, Ministry of Agriculture) in the public sector have developed family planning proposals for funding through NFPB. In addition, efforts have been made to significantly expand family planning services through private sector organizations such as JFPA and Operation Friendship with specific focus on reducing high rates of adolescent fertility. These efforts are beginning to result in a reinvigoration of the national family planning program.

Population and family planning, at both broad policy and service levels, has been largely a-political. Both major political parties have given strong policy support to the goals of fertility reduction consistent with sustained social and economic growth and development. The Jamaica Labor Party (JLP) Government which came into power in October of 1980 has pledged to "maintain and expand the family planning program which it initiated". While Jamaica thus far has not yet promulgated an explicit, comprehensive population policy covering all key sectors of society, such a policy and plan has in fact been developed and endorsed at a national conference on population policy (June 1981) and is now being prepared for official action by the Cabinet.

C. Summary of Project Strategy
and Constraints

Despite Jamaica's long history of involvement in family planning and the degree of success it has enjoyed in reducing its population growth rate, serious constraints to effective implementation of its population program remain. The USAID strategy is designed to overcome these constraints, resulting in a large increase in contraceptive prevalence which will, in turn, result in a significant reduction of the birth rate.

There are three major constraints to Jamaica dealing effectively with its population problem: (1) the contraceptive services delivery system does not reach enough people and its services require qualitative improvement, (2) there is no central population policy or plan, and (3) socio-cultural barriers. Institutional weaknesses such as inadequately trained personnel and poor management practices inhibit the effective planning, development and delivery of family planning services. At the policy level, Jamaica has not yet promulgated an explicit comprehensive population policy for the country which would factor demographic considerations into social and economic planning and decision making and no effective policy and planning apparatus exists. Certain socio-cultural norms and practices such as family union patterns and popular mythologies regarding child bearing limits the extent to which small family norms and contraceptive practice are adopted.

This project will finance the human and physical resources which are needed to help overcome these constraints. Institutional weaknesses will be addressed through large scale training and management consulting interventions. At the policy level, key Jamaican agencies such as the National Planning Agency (NPA) and Department of Statistics (DOS) will receive assistance to strengthen their capacity for population planning and generation of essential demographic data. And socio-cultural barriers to family planning will be addressed through large scale information, education and motivation programs. This strategy builds upon past accomplishments of the national family planning program, strengthens existing weak areas and expands assistance to new high priority areas (e.g. adolescent programs) and institutions with major potential for increasing the overall rate of contraceptive prevalence. Though this is a four-year project, it is anticipated that USAID support will continue to be needed through the 1980's, at which time Jamaica's population growth rate should have reached an acceptable level consistent with the social and economic development goals of the country.

D. Summary Project Description

The overall goal of the Project is to improve the health, social and economic welfare of the Jamaican people by significantly reducing the birth rate. The target is to reduce the crude birth rate (CBR) from approximately 27/1000 in 1980 to 20/1000 or less by 1990. This is an ambitious goal that will require the enrollment of large numbers of new and continuing family planning acceptors into the national family planning program. The project purpose is to expand the coverage and improve the effectiveness of contraceptive services delivery. The specific target is to increase contraceptive prevalence from 58% to 70% of women now in-a-union by 1985. It is estimated that from 40,000 to 50,000 new family planning acceptors will have to be recruited and that contraceptive continuation rates of current acceptors lengthened to meet this target.

A strategy for project implementation has been developed that supports the primary family planning service delivery network of the Ministry of Health while also targeting sharply on special high priority elements of the population. For example, the Project will provide the bulk of all contraceptives used by the public sector in the national family planning program (with the notable exception of Depo-Provera) but will also fund special adolescent projects designed to reduce high rates of fertility among this important segment of the population. Sub-projects will work to expand and improve the services of several smaller organizations, in addition to the MOH, which are involved in outreach and contraceptive services delivery, thus expanding avenues of approach.

In addition to contraceptives and other commodities vital to the operation of the national family planning program, the Project will provide funds for training of over 13,000 health workers, educators and other personnel involved in the dissemination of family planning information and services. Outside expert technical assistance will be financed for services to be provided by the Population Council, the National Center for Health Statistics and a variety of local consultants. In addition, the Project will benefit substantially from a variety of technical experts who

are available through centrally-funded AID projects at no cost to this Project. The Project will also provide funds to support the NFPB's ambitious program of expansion of voluntary sterilization services, which is needed to supplement its grant from the Association for Voluntary Sterilization (AVS).

Two major categories of "special projects" will be financed. These include fertility projects of the YWCA, the Ministry of Youth, Ministry of Agriculture, the Jamaica Family Planning Association, Operation Friendship and the National Family Planning Board (Adolescent Fertility Resource Center). Other special projects are intended to support the development and implementation of Jamaica's national population policy and plan and permanent organizational infrastructure. These include assistance to the National Planning Agency, the Department of Statistics, the Registrar General and the University of the West Indies. All of these "special projects" are described in detail in Section III of this paper.

The following is a summary of the role of the Jamaican institutions who will participate in implementing the Project:

1. National Family Planning Board (NFPB)

The NFPB will be responsible for overall coordination of all activities. Other government and private sector institutions will receive funds under written agreements with NFPB who will monitor and evaluate their performance. In addition, NFPB will carry out a variety of direct service activities such as: a nationwide commercial distribution of contraceptives, clinical services through a pilot mobile unit service for rural areas, distribution of contraceptive supplies and equipment to all Ministry of Health and other agency facilities delivering family planning services and management of a program to support voluntary sterilization through government hospitals and clinics, a large scale nationwide program of family planning and population information, education and motivation, as well as short-term family planning training and orientation programs for allied agencies such as the Jamaican Federation of Women. NFPB will also play a major role in coordinating national population policy together with the National Planning Agency.

Outside the scope of the Project, NFPB intends to establish a model family planning clinic in each of the 15 parishes over the next several years.

2. Ministry of Health (MOH)

The MOH will improve and expand family planning services delivered through its primary health care clinics and hospitals. The over 380 MOH hospitals and clinics located throughout the island account for the large majority of all family planning acceptors in the national program. Accordingly, a major emphasis of the Project will be on upgrading MOH services through staff training, provision of commodities and improved management.

3. Ministry of Youth and Community Development (MYCD)

The MYCD, which has responsibility for non-formal education and training for out-of-school youth, will establish a family planning education and contraceptive distribution program in four of its major divisions: Social Development Commission, Children Services Commission and Vocational Training Division and the Women's Bureau.

4. Ministry of Agriculture (MOA)

The MOA will continue and expand its integrated nutrition and family planning education and contraceptive distribution program begun under the previous USAID-funded project and will also extend family planning training beyond its home economics extension officers to include all of the agriculture extension officers in the Ministry.

5. Jamaica Family Planning Association (JFPA)

The JFPA will expand its community outreach program to seven additional communities in St. Ann and Trelawny Parishes. It will also continue its innovative "Youth-to-Youth" rural outreach program initiated under the previous USAID-funded project.

6. Operation Friendship (OF)

OF is an urban-based, multi-faceted community organization that provides a variety of health, social and educational services to poor residents of Western Kingston. Under this Project, Operation Friendship will continue and expand its community adolescent fertility program and add a new mobile unit out-reach capability which will allow it to extend services to several nearby small rural communities.

7. Young Women's Christian Association (YWCA)

The YWCA will carry out a program of family planning counselling and contraceptive distribution to young girls at six Y Teen Centers, at three School Leavers Institutes and at selected secondary schools located throughout the island.

8. National Planning Agency (NPA)

The NPA is the agency responsible for long term social and economic planning for Jamaica, including population planning. Under this project NPA will set up a Population Planning and Research Unit which will provide the agency with the capability it needs to formulate, coordinate and oversee the implementation of the country's population policy and plan.

9. Department of Statistics (DOS)

The DOS has primary legal responsibility for the collection and analysis of demographic data. With the assistance of this Project, the DOS will create a Population Unit which will produce this data essential for population planning. The Unit will also strengthen the DOS's capacity to carry out periodic surveys of the population (the decennial census, household expenditure surveys, migration studies, etc.).

10. The Registrar General's Department (RGD)

The RGD is responsible for registration of births, deaths and marriages. This Project will provide the RGD with the technical assistance and other resources it requires to improve its capacity to register, process and analyse vital statistics and to provide NFPB, the DOS and other agencies timely data on mortality and fertility.

11. The University of the West Indies (UWI)

The UWI Sociology Department will establish a graduate level diploma course in demography which will be available to senior staff of Jamaican Ministries and agencies with population planning responsibilities and will carry out a variety of research projects on such topics as migration and fertility determinants which are of interest to population planners. Staff of the department will also carry out project evaluation activities such as surveys of contraceptive knowledge, attitudes and practices (KAP).

Summary Project Budget by Institution

<u>Institution</u>	<u>Funding Level (US\$ 000)</u>		<u>Total</u>
	<u>AID</u>	<u>Host Country</u>	
A. Public Sector			
1. NFPB	2,894	5,906	8,800
2. MOH	308	4,497	4,805
3. MYCD	293	816	1,109
4. MOA	94	253	347
5. NPA	112	261	373
6. DOS	76	170	246
7. RGD	110	343	453
B. Private Sector			
1. JFPA	212	42	254
2. OF	289	80	369
3. YWCA	32	38	70
4. UWI	140	14	154
Contingency	<u>440</u>	<u>-</u>	<u>440</u>
	5,000	12,420	17,420

E. Findings and Recommendations

The following are the major findings which are the results of the analyses contained herein:

- 1) Jamaica's high birth rate of approximately 27/1000 seriously undermines the capacity of the country to achieve sustained social and economic growth and development.
- 2) Jamaica has made the necessary commitment, and has the institutional capacity to significantly reduce its high birth rate.
- 3) Without support from this Project, which represents by far Jamaica's major source of external support for population-related activities and services, it is highly unlikely that the country will achieve its population objectives.
- 4) The activities proposed in this Project will have a direct and measurable impact on fertility reduction, and represent the best and most cost-efficient means to achieve this end.
- 5) Project monitoring and evaluation criteria and procedures have been established; there are no significant environmental issues and all statutory criteria have been satisfied.

Recommendation:

It is recommended that USAID authorize a grant in the amount of \$5,000,000 over a four year period beginning in FY 1982 to support this Population and Family Planning Services Project with the Government of Jamaica.

BACKGROUND AND RATIONALE

II.

A. The Population Problem in Jamaica1. Demographic Trends and Future Projections

The predominant characteristics of Jamaica's population movements over the last two decades have been (a) a significant break with past high fertility patterns resulting in a substantial decline in the crude birth rate from an estimated 40/1000 in the early 1960's to 34/1000 in 1970's to an estimated 27/1000 in 1980; and (b) a significant increase in emigration which has cut the rate of natural increase almost in half, resulting in a modest annual population growth rate of approximately 1.2 percent. The crude death rate which has fluctuated between 6/1000 and 7/1000 over the decade has not been a significant factor in this equation.

Jamaica's population at the end of 1979 stood at 2,160,900 (See Table). This represents an increase of 14 percent or 270,200 over the 1970 population of 1,890,700. In the beginning of the period the annual number of births was around 66,000; since 1973 this number has been declining but seems to be stabilizing around 59,000 in the late 1970's and 1980. Though it is true that it is difficult if not impossible to attribute fertility declines solely to levels of contraceptive use, as opposed to other interacting socio-economic variables, it is also true that the mid 1970's was the period of greatest activity in the national family planning program.

A closer look at changes in the age structure as well as age specific fertility rates, reveals information of interest to population program planners and managers. First of all, while the percentage of women in the reproductive ages 15 to 49 as a proportion of the total population increased only moderately from 20 to 22 percent between 1970 and 1979, this nevertheless represented a 28 percent increase in this group. As stated in the Social and Economic Survey of Jamaica for 1979, "such rapid growth in the number of women in the fertile ages generated powerful momentum for increase in the absolute number of births, even in the face of declining fertility rates". There has also been a great increase in the absolute number of the working age population which the economy has been unable to absorb. Currently, unemployment is near 30 percent. In addition, there has been a large increase in the school age population (from 22.4 to 25.9 percent of the total population, an increase of 16 percent in the group itself) which has placed a severe strain on the public education system. By contrast the percentage of population in the 0-4 and 5-9 age groups has declined since 1970, (Figure I). However, with 40 percent of Jamaica's population still under the age of 15 and about to enter the child bearing years, the total population will continue to increase over the next 20 years, even if the present fall-off in fertility is maintained.

Data on fertility in Jamaica (Table 2) indicate several interesting facts.

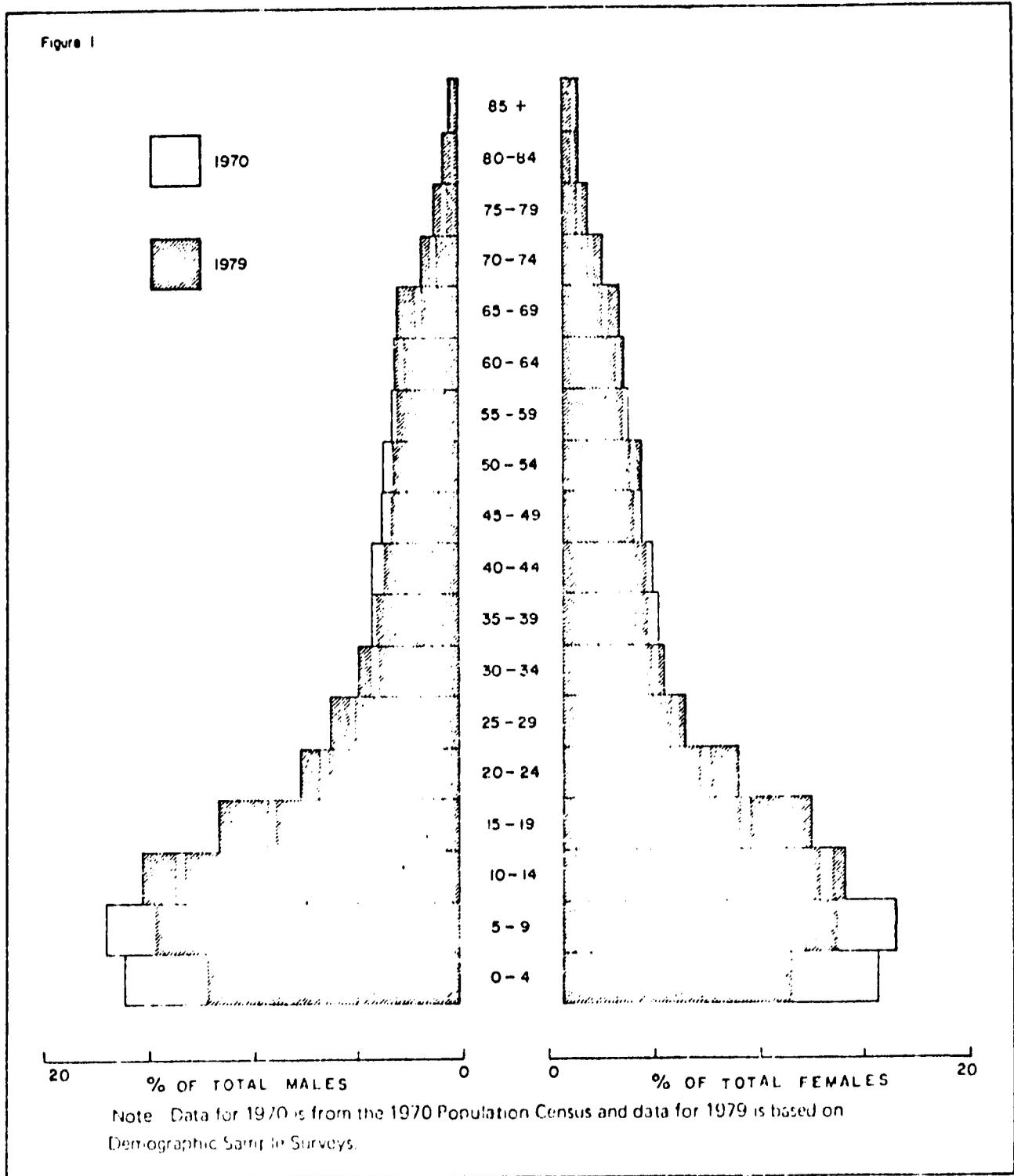
- (1) There has been a decline in the total fertility rate (TFR) from 5.7 in 1963 to 3.8 in 1978.
- (2) While all age groups registered a decline, the greatest declines occurred in the older age groups particularly women age 30-39.

POPULATION MOVEMENTS 1970 - 1979

Year	End of Year Population	No. of Births	Deaths	Natural Increase	Net Migration	Total Population Increase
1970	1,890,700	64,400	14,400	50,000	23,000	27,000
1971	1,911,400	66,300	14,100	52,200	31,500	20,700
1972	1,953,500	66,200	14,000	52,200	10,200	42,100
1973	1,991,000	61,900	14,200	47,700	10,200	37,500
1974	2,025,000	61,500	14,400	47,100	13,000	34,000
1975	2,060,300	61,400	14,000	47,400	12,100	35,300
1976	2,084,200	60,700	14,700	46,000	22,200	23,800
1977	2,109,300	60,400	14,200	46,200	21,100	25,100
1978	2,137,400	58,200	12,500	45,700	17,600	28,100
1979	2,160,900	58,300	13,300	44,900	21,400	23,500

Source: Demographic Statistics 1979, Department of Statistics

AGE SEX PYRAMID OF JAMAICA 1970 AND 1979



Source: Demographic Statistics 1979, Department of Statistics

- (3) While there was a decline in age specific fertility rates of adolescents (from 149 to 130), this rate remains one of the highest in Latin America and the Caribbean.
- (4) The downward trend in fertility followed the launching of the family planning program.

The significance of high rates of adolescent fertility is illustrated by a Contraceptive Prevalence Survey (late 1979) carried out by Dorian Powell of the University of the West Indies, which showed that over 2/3 of all Jamaican women have their first pregnancy while in their teens and that women who have children at an early age tend to have significantly larger completed families than women who postpone their first pregnancy to a later age (See Annex E). The survey also pointed out the positive effect of the National Family Planning Program in the reduction of overall fertility rates. Just over 1/3 of the total sample of women were practising contraception while contraceptive prevalence of women now-in-a-union was found to be 58%. However, factors mitigating against fertility declines are the aforementioned early age of first pregnancy, continued high family size norms (average of four children) and problems in the administration of the National Family Planning program which results in high drop-out rates and consequent unplanned pregnancies.

Finally, emigration is an extremely important factor in Jamaica's population situation. In recent years it has cut the population growth rate almost in half. The sex ratio increasingly favors females over males. In 1978 for example, the sex ratio of migrants to the U.S. and Canada (by far the destination of the largest number of migrants) was 870 males to 1000 females, with most of the females being in their prime reproductive years. This also has a depressing influence on fertility rates. The emigration of large number of relatively scarce skilled workers and professional and managerial persons has probably also had a serious adverse effect on the rate of overall economic development. Given the large relative volume of emigration, any significant interruption in this flow that may come about through the imposition of controls such as immigration restrictions from the U.S. will have major implications for future population growth. With respect to internal migration, the urban population is expected to increase rapidly while the rural population in absolute numbers should stay about the same (Table 3). Population projections to the year 2000 which are in line with the "low growth" projection of the National Planning Agency, indicate a total population of 2,775,000. Of this amount 1,670,000 (60%) is estimated as urban and 1,105,000 (40%) as rural. This reverses the current pattern of 48% urban and 52% rural. This projection is consistent with the "medium projection" done in the more recent analysis Population Dynamics and Prospects: A 1981 Assessment for Jamaica (Table 4) which projects a total population of 2,842,000 by the year 2000. The fertility reduction targets of this project are consistent with the "low projection" in the 1981 assessment which postulates a total population of 2,583,000 by the year 2000.

According to the National Planning Agency, what is taking place is "-- not an elimination or even substantial reduction of the population problem, but rather a transformation of its character and magnitude which calls not for complacency and relaxation of effort, but for new perceptions and a renewed willingness to design policies and programs to deal with the consequences of change".

2. Consequences of Demographic Change

The legacy of high past population growth rates leaves Jamaica today facing a serious population problem. Although there has been a sustained long-

THE TREND IN TOTAL FERTILITY IN JAMAICA, 1960 - 1978

Age Group	1960 ^f	1963 [*]	1970 ^f	1974 - 75 ^d	1977 - 78 ^o
15 - 19	153	149	167	141	130
20 - 24	288	188	302	234	210
25 - 29	256	271	263	186	178
30 - 34	206	227	190	130	125
35 - 39	129	150	127	78	75
40 - 44	47	52	47	49	28
45 - 49	8	8	8	9	5
TFR	5.4	5.7	5.5	4.1	3.8

f Census data

* Registration data

d Jamaica Fertility Survey
(average of 1974 and 1975)

o Registration data
(average of 1977 and 1978)

Sources:

- (1) G. Roberts et al Recent Population Movements in Jamaica, CICRED, 1974.
- (2) Jamaica Fertility Survey, Volume I.
- (3) Unpublished data from Ms. Lorna Murray, National Planning Agency, GOJ.

POPULATION PROJECTION, 1980 -2000

(in Thousands)

	1960	% of Total	1970	% of Total	1980	% of Total	1990	% of Total	2000	% of Total
Total Population	1609.8	100.0	1848.5	100.0	2143.4	100.0	2463.2	100.0	2775.3	100.0
Urban ^{1/}	540.5	33.6	751.0	40.6	1019.1	47.5	1330.2	54.0	1669.8	60.2
Rural	1069.3	66.4	1097.5	59.4	1123.3	52.5	1133.0	46.0	1105.5	39.8

Average Annual Compound Growth Rate, 1980 - 2000

Total population	1.3%
Urban	2.5%
Rural	-0.1%

^{1/} 13 principal towns

PROJECTION OF POPULATION CLASSIFIED AS PCOR

(in Thousands)

	1980	% Poor	1990	% Poor	2000	% Poor	Increase 1980 - 2000
Total population	2143.4	100	2463.2	100	2775.3	100	631.8
Assumed poor	1352.8	63	1452.3	59	1475.2	53	122.0
Total Urban	1019.1	100	1330.2	100	1669.8	100	650.7
Assumed Poor	509.6	50	625.2	47	701.3	42	191.7
Total Rural	1124.3	100	1133.0	100	1105.5	100	-18.8
Assured Poor	843.2	75	827.1	73	773.9	70	-69.3
Proportion of total number poor living in:							
Urban Areas	37.7		43.1		47.5		
Rural Areas	62.3		56.9		52.5		

Population Dynamics and Prospects
A 1981 Assessment for Jamaica

POPULATION (in thousands) AND INDEX OF
POPULATION SIZE (1980=100), JAMAICA, 1980-2010

	<u>Low Projection</u>	<u>Medium Projection</u>	<u>High Projection</u>	<u>Medium Pro- jection With No Emigration</u>
	<u>Absolute Numbers</u>			
1980	2170	2170	2170	2170
1990	2355	2512	2586	2694
2000	2593	2842	3066	3151
2010	2845	3153	3464	3586
	<u>Index (1980=100)</u>			
1980	100	100	100	100
1990	109	116	119	124
2000	119	131	141	145
2010	131	145	160	165

term downward trend in fertility, birth rates remain high, especially among adolescents, and the downward trend seems to be leveling off. Inefficient use of contraceptives by acceptors already enrolled in the program results in low continuation rates and large numbers of unwanted children. At the same time, it becomes more difficult to increase contraceptive prevalence as the program reaches out to traditionally "harder to reach" elements of the population such as adolescents and males, and large family size preferences remain strong within major elements of the population. Although high emigration rates considerably moderate the overall effect on population growth, for a variety of reasons, their rates are likely to diminish considerably in the future, adding another serious dimension to the problem.

The consequence of this for Jamaica is that it has a large population relative to the size of the country and the resources available to meet requirements for housing, employment, health, education and other basic human needs. It must therefore reduce its population growth rate to a level consistent with its plans for economic and social development. While a precise level has not yet been firmly established, the NFPB and the draft Population Policy and Plan for Jamaica urges the adoption of measures "To ensure that the population of Jamaica will not exceed 3 million by the year 2000".

Implications of the demographic picture for the development and conduct of the national population and family planning program are:

- (1) The need for Jamaica to adopt a comprehensive, multisectoral population policy with explicit demographic goals;
- (2) The need to place emphasis on expanding the volume and quality of family planning delivery system in order to both attract new family planning acceptors and retain acceptors already in the program;
- (3) The need to place special emphasis on reaching important sub-groups such as males and sexually active adolescents with family planning services;
- (4) The need to develop and implement a large-scale program of outreach and education designed to motivate the population to adopt smaller family size norms.

The Project provides support for programs aimed at meeting all of these needs which, together, will determine the country's success in meeting its population objectives.

II B

B. Existing Population/Family Planning Programs

1. Family Planning and Supporting Services

Contraceptive services delivery in Jamaica is provided through several organizations. (See Table on Estimated Annual Contraceptive Users by Institution). The physical and organizational infrastructure in place is significant. However, expanded coverage and qualitative and quantitative improvements in services are needed for Jamaica to deal effectively with its population problem. More people need to be reached in more ways, and the services provided need to be more effective. There are approximately 450,000 women between the ages of 14 and 40 in Jamaica, i.e. the potential number of contracepting women in the target group. Although precise figures are not available, it is estimated that 200,000 women in Jamaica actually use contraceptives, though many only sporadically and ineffectively. An estimated 160,000 use organized clinics and probably 140,000 of these use the family planning clinics operated by the MOH, mainly in its Primary Health Care Centers (PHCCs). An estimated 10,000 to 20,000 contracepting women use the services of private physicians while 20,000 to 30,000 administer to their own needs on a self-help basis through commercial outlets.

The Ministry of Health (MOH) is by far the predominant source of clinic-based family planning services in Jamaica, accounting for 7 out of 10 clients receiving services from clinic programs. An estimated 5% of the J\$135 million (U.S. \$76 million) 1980/81 budget of the MOH was used for family planning. At all levels throughout the MOH there essentially are no full time family planning personnel. At all levels, including medical, clinical, support, administrative and management personnel, population and family planning activities simply form a part of the total responsibilities of individual MOH employees.

The MOH has 20 general hospitals and 7 specialty hospitals. Most of these hospitals offer some form of family planning ranging from surgical (sterilization) to contraceptive supply services. In addition, newly-delivered mothers receive family planning counselling and contraceptive services through a special post-partum education program operating in 20 MOH hospitals. The MOH also has about 359 PHCCs, one third of which are on privately-owned premises leased by the Ministry of Local Government. All of the PHCCs theoretically offer some form of family planning services, though all are not fully operational.

The five types of PHCCs and their staff and functions relevant to family planning are described below. All of these centers are intended to provide educational and counselling activities subject to their staff capabilities. There are currently 191 Type I centers. Staff include a midwife and one or two Community Health Aids (CHAs). They are supposed to be visited weekly by a senior Public Health Nurse (PHN). There are currently 88 Type II centers.

Estimated Annual Active Contraceptive Users

<u>Institution</u>	<u>Year</u>			
	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
NFPB				
Clinics (15)*	5,000	18,000	20,000	22,000
Commercial Program	20,000	22,000	25,000	28,000
MOH	120,000	120,000	131,000	141,000
MYCD	9,000	10,000	11,000	12,000
MOA	1,000	1,500	2,000	3,000
JFPA	15,000	16,500	18,000	20,000
OP	10,000	11,000	12,500	14,000
YWCA	500	700	1,000	1,200
UWI**	6,000	6,800	7,500	9,000
OTHER (Private MD's non- project commercial, etc.)	13,500	13,500	14,000	14,800
	<u>200,000</u>	<u>220,000</u>	<u>242,000</u>	<u>265,000</u>

* To be established in 1982. May take over some MOH facilities

** University hospital and clinics. No direct project support.

Staff includes a PHN, one or two CHAs, a midwife and a Public Health Inspector. They are visited periodically by MOH physicians. There are currently 76 Type III centers which provide the great preponderance of family planning services. These are intended to be staffed by a full-time physician, several CHAs, a midwife, one or two PHNs, a nurse practitioner and a Public Health Inspector. Almost all of these centers actually have a physician at least part-time and 53 have a full-time nurse practitioner on staff. All of the various types of health centers offer the same basic services which varies only with the capabilities of the facility. For example, Type I health centers are not prepared to provide sterilizations or insert intrauterine devices and refer clients to Type II and III or to hospitals for those services. There are 22 Type IV centers and 2 Type V centers, which, except for the Kingston Comprehensive Clinic, are all located within hospitals. In practice, the PHCCs which actually have the services of a physician are over-burdened with the demand for family planning services, while other understaffed centers are underutilized.

Female sterilizations are performed in Jamaica at the rate of approximately 4,000 per year. Three-fourths of these are performed at the Spanish Town Hospital, the University (UWI) Hospital in Kingston and the Glen Vincent Clinic. A physician is required by law to perform this surgical procedure. The waiting time for requested sterilization averages several weeks, and there is currently a backlog of women waiting to receive this service. Most of the women undergoing sterilization are in higher age brackets with at least 4 - 5 children; hence, this part of the program currently has only moderate effect on birth rates. However, there is evidence that age and parity of women requesting sterilization is falling, which could have a very significant effect on lowering the overall birth rate if it continues. Male sterilization is essentially non-existent in Jamaica. Some motivational efforts are to be initiated, but they face tremendous socio-cultural barriers.

The MOH operates a special outreach program for adolescents in the Type III PHCC at Brown's Town called "Teen Scene". The staff consists of a project coordinator, a PHN, a midwife, a part-time home economics advisor. This activity, for which AID has financed equipment and staff salaries under the Family Planning Services Project, offers family life instruction, social activities and home economics and vocational training coupled with its primary focus on contraceptive services delivery including motivational work and medical examinations. In addition to its clinical program, the MOH also offers family planning educational services through its Bureau of Health Education (BHE). The BHE operates a printery in Kingston which produces educational supplies for use in clinics and with community groups. In addition, two BHE Health Educators are posted in each Parish to provide family planning counselling to clients of MOH clinics and to promote family planning in public schools and through community groups.

Finally, a related contraceptive services activity generally falling under the MOH is carried out through the Association for the Control of Sexually Transmitted Diseases (ACOSTRAD). ACOSTRAD is a private voluntary organization with its board chaired by a Senior Medical Officer of the MOH. It has no full time staff and operates entirely with volunteers to reduce venereal disease and promote sterilization and contraception through educational, motivational and counselling activities at schools and community organizations. The organization brings together community organizations in order to effect a multisectoral approach to educating the public on the causes and prevention of STD. It is especially active in the public school system.

Within the MOH, family planning services are primarily the responsibility of the Senior Medical Officer (SMO) for Maternal and Child Health Care and Family Planning who is under the Principal Medical Officer (PMO) in charge of Primary Health Care. The SMO in charge of MCH/FP has no formal authority over the several MOH units providing family planning services. In addition, because of substantial responsibilities in other areas and with limited support staff, she is not able to closely monitor family planning activities of the Ministry, coordinate the various divisions and take remedial actions when problems arise. This creates serious problems in the system, such as unexpected closures of family planning clinics, inadequate production and dissemination of contraceptive educational material, inadequately trained clinic personnel resulting in high drop out rates, and long implementation delays in initiation of new family planning activities. All of these problems could be substantially resolved if the MOH would give family planning the priority it needs by the establishment of a Family Planning Unit with full-time staff with authority to coordinate and manage all of the Ministry's numerous family planning activities.

The National Family Planning Board (NFPB) is the lead agency of government responsible for the development, coordination and implementation of the national family planning program. Since "integration" with the MOH in 1974, when it turned over operation of its 160 family planning clinics to the MOH, NFPB has not provided clinical services. However, a proposal is now being actively considered which would permit NFPB to again establish direct clinical services coordinated with those of the MOH. Current plans are for NFPB to establish 15 "comprehensive" family planning clinics, one in each Parish.

Current service activities of the NFPB include procurement and distribution to MOH and other clinics and organizations most of the contraceptives and clinical supplies used in the national family planning program. To carry out this important function NFPB operates a large warehouse and a number of delivery vans and has on staff a variety of supply management personnel ranging from warehouse supervisors to drivers. In addition, NFPB has a Marketing Division which is responsible for the management of the Commercial Distribution of Contraceptives (CDC) program. This is a successful and cost efficient program which accounts for as much as 10% of all family planning acceptors. Contraceptives (orals and condoms) are procured by NFPB through USAID and distributed through Grace Kennedy and Co. Ltd., a major Jamaican company, to over 1,300 retail outlets scattered throughout the country. Consumer prices are set low enough to be affordable to virtually everyone and include a specified percentage for the retailer, the distributor and NFPB. It is expected that the CDC program will be totally self-sufficient by the end of this project.

Other direct service activities include a variety of educational, counseling, training and informational services provided through NFPB's Information, Education and Communication (IE&C) Division. These include contraceptive education through the mass media, a walk-in, call-in "Answering Service" to the public for information and advice on family planning and training and orientation sessions to voluntary organizations such as the Jamaica Federation of Women. In addition, in 1981 the NFPB established an Adolescent Fertility Resource Center which provides information and technical assistance to Jamaican organizations operating adolescent fertility programs.

Equally important as NFPB's direct service activities, is the role it plays in setting national policy and coordinating family planning programs of other organizations. At the policy level, for example, NFPB has taken the lead in the development of a vastly expanded sterilization program to be carried out through MOH hospitals. With respect to interagency coordination, NFPB initiated the establishment of a national Population Policy Advisory Committee under the National Planning Agency and plays an active role on that committee. In addition, NFPB has initiated and financed (with USAID funds) a variety of family planning projects through other public and private entities.

Currently, NFPB has about 12 professional staff including administrative and supervisory, medical, communications, research and projects management and is in the process of recruiting additional staff to carry out its expanded activities under its new mandate.

In addition to the MOH and NFPB there are a number of other Jamaican organizations involved in family planning. Their programs are small individually, and even collectively, but they provide important avenues of approach, deal with particular problem groups and can supply vital support functions.

The Ministry of Youth and Community Development (MYCD) is the ministry of government responsible for non-formal education for out-of-school youth. The Ministry is also responsible for child care and protection and encompasses a large number of organizations and institutions concerned with youth services such as the Social Development Commission, the Children's Services Division, Vocational Training Division, 4-H Clubs, Youth Clubs and Child Care Institutions. Its importance for family planning is that it provides special access to a critical problem group, adolescents. At present it operates nine Youth Centers having a total of 2,500 resident and non-resident students. Two year courses of training in various areas are provided which include family life education.

The Ministry of Agriculture's (MOA) extension service offers a potentially valuable avenue of approach to the less accessible and more resistant rural population. Under the previous Family Planning Project over 60 female home economics extension agents were trained in a specially designed integrated nutrition education/family planning program developed by the American Home Economics Association (AHEA). With the active leadership of the director of the MOA Home Economics Extension Division, these agents have been conducting an integrated family planning and nutrition program in rural areas of the country reaching an estimated 3,000 farm families. They perform educational and motivational work and distribute contraceptive supplies, pills and condoms provided by the NFPB. Under the new project similar training will be provided to 6,000 male extension agents, hopefully with an attendant increase in program coverage.

The Jamaica Family Planning Association (JFPA) initiated family planning services in Jamaica in 1936. It established a number of clinics in rural parishes and in Kingston and generally succeeded in gaining credibility for family planning among most elements of the population. Since that time, the organization has alternately expanded or reduced its level of effort depending upon the degree of public sector involvement. Two years ago, after turning over much of its clinic program activities, JFPA made the decision to once again expand its service programs. An Executive Director and other senior staff were hired and a grant obtained from the Association for Voluntary Sterilization (AVS) to renovate JFPA's Kingston clinic to provide sterilization services. Another grant was obtained from USAID and NFPB to carry out a special "Youth-to-Youth" rural contraceptive education and distribution program using out of school youth as counselors and distributors. A community outreach program is also carried on in St. Ann's parish, the largest Jamaican parish in area, by four full-time adult outreach workers. The program includes the employment of a mobile unit. The JFPA currently operates two specialized family planning clinics, one in Kingston and one at St. Ann's Bay. By its own estimation these clinics see about 15,000 clients annually. Each clinic is staffed by nurses and family planning clinicians and motivators, as well as part-time physicians.

Operation Friendship is a highly regarded community-based organization with facilities in two locations in Western Kingston offering a wide range of services to the poor, such as health clinics, a day care center, a community college for secondary school drop outs, and a trade training center. A primary school and an adult literacy program under the Ministry of Education (MOE) and the Jamaican Movement for the Advancement of Literacy (MAJAL) are also operated on Operation Friendship premises. In late 1979, Operation Friendship initiated an adolescent fertility program under a grant from USAID and NFPB. The grant has financed the salaries of clinical personnel, youth outreach workers and family planning counselors/educators, commodities, training and research costs for the program. The family planning program is carried out in one of the poorest areas of Kingston and specifically addresses the adolescent problem group. The clinic has a full-time staff comprised of four outreach workers, four family planning CHAs, a physician and a family life educator. Daily classes are conducted at the clinic for the local population as are daily classes for school age mothers and day care for their children. Operation Friendship estimates that 10,000 clients visit its clinic annually. Neighborhood out-reach is being carried out by CHAs who are transported by van to target neighborhoods.

The YWCA operates a small counseling and clinical effort which is directed at the adolescent problem group. In addition to the main facility in Kingston there are six Y Teen Centers and three school leavers groups around the island. The staff consist of one full-time nurse/health educator and six part-time nurses. Clinical work is limited and mainly consists of the distribution of condoms and pills which are supplied to the YWCA by NFPB. Family planning educational and counseling services are also offered to the Y teens and to students in youth groups and secondary schools visited by the Y outreach staff.

In addition to those described above, several Jamaican organizations have been taking an increasingly active and important role in population policy and planning and in support activities for family planning services.

The National Planning Agency (NPA) is the agency of government responsible for long-term social and economic planning for Jamaica. It assists various ministries in the development of sector plans and analyzes data and produces reports on social and economic conditions of the country. The GOJ has designated the NPA as the lead agency for the formulation and implementation of population policy planning and development in Jamaica. The head of NPA will chair a permanent Population Policy Coordinating Committee. This development came about as an outcome of the national conference on Population held in June of 1980 which produced a document entitled "Population and Jamaica's Future: A Statement of National Population Policy" (see Annex G). This document sets forth broad population objectives and designated NPAs as the agency responsible for "the integration of the goals of National Population Policy in development plans and for monitoring the activities of other agencies in matters of population policy". The NPA historically has given major emphasis to economic planning and dealt with population matters only a limited ad hoc basis, principally because it lacks any significant expertise or personnel resources in the population area.

The Department of Statistics (DOS), which is under the Ministry of Finance, can and should be a valuable resource for population policy and planning. The DOS collects statistics relating to population and housing, immigration and emigration, vital occurrences and morbidity and other data. It provides statistics on the total count of the population as well as relevant characteristics such as age, sex, educational levels, union status, marital status and fertility variables. It also derives from its census of population and housing data on labor force levels, school age population, population growth projections and other information vital to economic and social planning. At the present time, greater emphasis is placed on economic than on social and demographic statistics, and the population program within the Department is fragmented and under staffed. The DOS does not have a demographer on its staff, and none of its personnel work full-time or specifically on population matters. It does produce a statistical yearbook and a demographic profile. Statistics, however, are not very reliable, where they do exist.

Official records of vital statistics represent one critical source of raw data for the DOS, as well as the planning organizations. Surveys can fill in some of the gaps left by incomplete data, but some raw data is needed in turn to confirm the surveys. Registration of births, deaths (including still births) and marriages is the responsibility of the Registrar General's Department of Jamaica. This data provides the basis for estimates of births, deaths and marriages compiled by the Registrar General's Department. However, despite significant improvements made (with assistance provided through AID's centrally-funded Vital Statistics improvement (VISTIM) Project) which upgraded the Department's registration system and helped process the large backlog of registrations, serious problems remain with both the quality and timeliness of vital statistics. At present there are several hundred local registrars (in the past they were primarily local postmasters) who, when available, record vital statistics and issue certificates in return for a nominal fee. Since registrar salaries are so nominal their work is more in the nature of part-time volunteer work. Registration in Jamaica is in poor shape, and the margin of error is unknown. It is estimated that 10% of births go unregistered.

The Sociology Department of the University of the West Indies is Jamaica's primary center for fertility research and training in demography. The Chairman of the Sociology Department, Professor Dorian Powell, has been active in population work and will be a member of the Population Policy Coordinating Committee. In early 1980 the Department carried out a large scale contraceptive prevalence survey for NFPB which has provided valuable information on current family planning attitudes and practices. (See Annex E for summary). However, until very recently the Department has not had a senior demographer to carry out a teaching program at the graduate level and the teaching and research demands on other staff has hampered the Department's ability to respond to the increased needs of a fast-growing national family planning program. The shortage or lack of demographers in the organizations supporting or directly involved in population policy and

planning, as indicated above, had been a constraint to the volume and effectiveness of these activities. Trained demographers are needed to serve appropriate institutions throughout the West Indies, as well as in Jamaica.

The University of the West Indies (UWI) Center for Advanced Training and Research in Fertility Management operates a Caribbean wide training program with special emphasis on family planning program management and physician training in sterilization techniques. It offers a full range of contraceptive clinical and counseling services, including special sessions for adolescents. The Center also carries out periodic medical research of special interest to family planners, such as a recent study on the safety and effectiveness of Depo-Provera. The Center is a vital element of Jamaica's national family planning program, but because it is receiving funds from other donors such as UNFPA and the Federal Republic of Germany to meet its needs, the Center has not requested additional funding under this project.

II. B. 2. AID-Supported Activities

Through a series of projects beginning in 1967, USAID has provided direct support to the NFPB and through NFPB to a variety of other Jamaican agencies and institutions offering family planning services. In addition, a number of AID-supported organizations provide support for the Jamaican population program. This support, primarily in the form of various types of technical assistance as well as maintenance of facilities and equipment for the voluntary sterilization program, is expected to amount to over \$200,000 a year throughout the life of the project. Annex F contains a summary of population assistance to Jamaica by AID-supported organizations. Historically, AID and AID-financed organizations such as the Association for Voluntary Sterilization (AVS), Pathfinder Fund (PF), American Public Health Association (APHA), American Home Economics Association (AHEA), etc. have provided the major share of external assistance to Jamaica's population and family planning efforts. Over 7 out of 10 dollars of all external assistance in this sector is provided by AID either directly or through the above mentioned intermediaries. The Mission strategy is to enlist the support of these intermediaries to fund components of the National Family Planning Program for which their special expertise gives them a relative advantage. For example, the AVS has been instrumental in helping the NFPB and the MOH carry out their strategy to meet the demand for voluntary sterilization. AVS is expected to become NFPB's major contributor (outside of USAID's bilateral program) with a large grant to help establish adequate MOH facilities and equipment necessary to meet the demand for voluntary sterilizations.

In the broadest sense, all of USAID's development support to Jamaica is related to this project and contributes to reaching its goal. This is because of the well established direct relationship between "modernization" and reduction of fertility. That is, as social and economic improvements spread through society, persons tend to take advantage of options to personal and material gratification other than child bearing. Therefore, to the extent that AID projects in agriculture, education, energy, etc. contribute to increasing the standard of living overall, they will also be contributing to fertility reduction, which is the specific goal of this project.

USAID projects in the health sector include a nutrition project (Regional Nutrition Project - Caribbean Food and Nutrition Institute) and a primary health care project (Health Management Improvement).

The Health Management Improvement project has several mutually supporting features in common with this project. Its stated purpose is "to improve the health and nutritional status of the Jamaican population by improving the efficiency, effectiveness and equity of the primary health care delivery system". In order to accomplish this purpose the project provides a loan of \$7.4 million and a grant of \$350,000 for commodities, technical assistance and other support in the areas of manpower development and training, health planning, health information systems development, supply management, equipment for health centers, health center renovation and nutrition action programs. Inasmuch as the majority of acceptors enrolled in the national family planning program receive contraceptive supplies and services through Ministry of Health hospitals and clinics, improvements in the capacity of the Ministry to effectively deliver health services will have an important positive benefit on this project as well.

3. Activities of Other Donors

Other bilateral and international donors (some of which also receive financial support from AID) also support Jamaica's national family planning program. (Annex F also contains a summary of population and assistance from these donors). For example, the International Planned Parenthood Federation (IPPF) provides major budgetary support to their local affiliate, the Jamaica Family Planning Association (JFPA), to carry out an array of activities best suited for the private sector.

There also has been a division of labor among other donors. The Federal Republic of Germany has provided significant assistance in the past with a three year grant of \$734,000 to the University of the West Indies to assist in construction of the Center for Advanced Training and Research in Fertility Management. Sweden (CIDA) has provided funds for a sex education program among labor groups. The International Bank for Reconstruction and Development (IBRD) has provided US\$8.8 million since 1970 for two "Population Project" loans to the GOJ. However, despite the word "population" in the project title, only a small amount of these funds has been used for family planning. Most of the funds have been used for hospital, maternity center and health center construction, together with support activities designed to strengthen the service delivery capacity of the primary health care system in Cornwall County. AID, through the Caribbean Development Facility, has also provided \$2 million as counterpart support to Jamaica for the IBRD loans.

The only other international donor of major importance to Jamaica's national family planning program is the United Nation's Fund for Population Activities (UNFPA). UNFPA has been providing depo-provera to the NFPB, which is the contraceptive method of choice for approximately 25% of all family planning acceptors in the national program. UNFPA funded the World Fertility Survey in Jamaica (1975) and has provided support for carrying out the decennial Jamaican census. UNFPA has also made significant contributions to UWI for a Family Health project and supports the Center for Advanced Training and Research in Fertility Management and a Worker's Education Project. Unfortunately, current indications are that projected levels of UNFPA support to Jamaica will be reduced drastically. IPPF has also advised JFPA of forthcoming reductions in its grant to that organization.

The probable reduction in overall levels of UNFPA support, together with the limited level of external support for fertility reduction programs from other donors, highlights the importance of AID's maintaining and expanding its commitment to support for family planning and population in Jamaica. No future bilateral assistance in population is expected from countries other than the U.S. nor has the World Bank or other multilateral lending institutions indicated their willingness to support future population activities in Jamaica.

PART II C

C. Constraints to Addressing Jamaica's Population Problem

Despite the family planning services described in Part II(B), Jamaica's population problem remains. The total fertility rate is 3.8 and life expectancy is about 70 years. There are too many people for the economy to adequately support and the numbers are growing too fast. The general unemployment rate is estimated to be in excess of 26% and the average real per capita income has been declining for over 8 years. There is great pressure to emigrate particularly to the U.S. (legally or illegally). The economic, social and other problems

associated with the steady increase in Jamaica's population are described in greater detail in Part II (A) and in the Economic and Social Soundness Analyses of this paper.

Elimination of the problem is not realistic, at least in the near term but mitigation through expanding the coverage and increasing effectiveness of contraceptive services delivery is a valid and valuable objective. Additionally, special problem groups need to be addressed, e.g. adolescents and the less accessible and more resistant rural population.

Despite Jamaica's long history of involvement in family planning, its extensive network of public clinics and retail supply outlets and the support it has received in the past from AID and other international donors, its family planning program has not been as successful as it should have been. A number of constraints inhibit Jamaica's ability to effectively address its population problem. The most serious constraints are an ineffective system of services delivery compounded by the lack of policy and planning to make these services more effective. Socio-cultural barriers also impact greatly on the delivery of contraceptive services.

1. Constraints Within Contraceptive Services Delivery System

The MOH through its hospitals and PHC clinics is by far the largest organization delivering contraceptive services in Jamaica. Shortfalls in its effectiveness are demonstrated by the one-third drop out rate amount women who initiate contraception*. Many of those who do practice contraception do so ineffectively or with the intention of bearing more children at a later date. Ineffective services, high drop out rates and the inability to recruit large numbers of new clientele result from several causes: (1) Many clinics lack the full complement of medical personnel, to provide family planning services and, therefore, no services or sporadic services are offered at such clinics; (2) Many clinic personnel lack the needed skills and the services are, therefore, unavailable or of poor quality, e.g. many clinics are unable to perform IUD insertions; (3) The clinics with the appropriate and properly skilled staff are too over-burdened and quality suffers; (4) The MOH does little outreach work and followup and individual counseling is generally non-existent or of poor quality because staff are unskilled or over-burdened. In addition, many clinic staff have poor attitudes towards their clients, and especially adolescents, which does not encourage greater demand for services.

Compounding these problems are a number of bureaucratic obstacles to efficient delivery of services. For example, the MOH tends to be over-centralized in its decision-making process which makes it very difficult for field managers and operators to develop and carry out programs. As a result, long delays are encountered in starting even high priority activities. This also has a demoralizing effect on staff. Another problem is the relatively low pay for civil servants which makes it difficult to attract and retain qualified people. Additionally, built-in obstacles to career mobility make it difficult to move into a new job even when the "permanent" incumbent has been absent for months or even years. In addition, staff (especially non-professional) are often under-utilized. For example inadequate use of the Ministry's 1,100 community health aids is made for family planning information and services. Likewise, midwives and auxiliary nurses could do much of the work of registered nurses (of which there is an acute shortage) were they allowed to do so.

* Jamaica Family Planning Drop Out Study (Powell 1980)

Poor management is a problem throughout the system. Because there is no well-managed "central focus" for coordinating all of the MOH's family planning activities, there are long implementation delays in initiating new programs; and problems at one level in the system do not get communicated or resolved at other levels. Lack of an overall program planning process and lack of a family planning information system have created a tendency to act precipitously without adequate analysis of the consequences on overall objectives of the program.

A serious institutional problem which also has an adverse effect on NFPB's ongoing management performance is confusion over the role and responsibility of NFPB vis-a-vis the MOH. This problem has its roots in the previous described "integration" of NFPB with the MOH which is now in the process of being reversed. Until the new policy is promulgated which clearly spells out the respective roles and responsibilities of the NFPB and MOH, there will continue to be this problem resulting in confusion and inefficient program development and implementation. However, if NFPB, as expected, is again granted a major role in the supervision of clinical services, it could have a very positive effect on upgrading the quality of MOH services as well.

Finally, an institutional problem of some importance is the weakness of the private sector in influencing the development of population policy and the delivery of family planning services. This seems to be changing somewhat, (e.g. in the addition of private sector members to the NFPB policy board) but the system continues to be characterized by a predominance of public sector influence at both policy and program levels.

Not all of the problems outlined above can be corrected by the AID project, and some are most effectively addressed through organizations other than the MOH. For example, public education activities and services for youth may be performed better by organizations like the MYCD, the MOA, JPPA, NFPB, etc.

The system for supplying contraceptives to the MOH is functioning satisfactorily. This is expected to continue, so long as it is handled by the NFPB. It is important, therefore, that AID continue its support to NFPB for the procurement and distribution of contraceptives, so that the operation does not lapse.

2. Policy Constraints

Specific policies, regulations, laws and programs within the public sector inhibit an expanded and more effective contraceptive services delivery and certain ones probably have a pro-natalist effect. For example CHA's are prohibited from distributing contraceptives. If these restrictions were removed, CHA's could serve as valuable 'physician extenders' or relieve the pressure on over-burdened clinic personnel at higher levels and reach large numbers of clients at the household level who for one reason or another do not frequent clinics.

Paternal child support obligations are "on the books", but largely unenforced in Jamaica. Thus, realistic and fair burdens are not attached to parents of children born out of wedlock, the group in which the problem of lack of parental responsibility is more prominent, and which makes up the majority of total children born in Jamaica.

The maternity leave entitlements in the public and private sector are considerably in excess of those generally provided in developed countries, e.g. the U.S., and, at least, should be analyzed to see if they have a pro-natalist effect. Other areas, such as the relationship of present tax laws and social benefits to fertility, require examination.

A causal relationship has been demonstrated in many developing countries between the establishment of a national population policy and reduced fertility. Jamaica, as yet, lacks such a policy which would serve to focus national attention and enable a more organized and effective application of resources.

Many years ago the GOJ recognized the problems inherent in rapid population growth. In 1967, the NFPB was created and in the National Family Planning Act of 1970 empowered to "prepare, carry out and promote the carrying out of population and family planning programs" in Jamaica. Family planning at the board policy level has been largely apolitical, with both the People's National Party (PNP) and the JLP giving strong support to the goal of fertility reduction. Nevertheless, there are policy issues which have impeded rapid fertility decline. While giving explicit support for family planning, the GOJ has not yet promulgated an explicit, comprehensive multi-sectoral population policy which would establish demographic goals for the country, include demographic implications in decisions regarding public resource allocations and promote legal and administrative measures consciously designed to limit population growth. A population policy document has in fact been drafted by an Interagency Task Force on Population Policy and is awaiting action by the Cabinet. This document sets forth a population policy for Jamaica and would establish a high level interagency committee headed by the NPA to promote and coordinate population planning activities in Jamaica.

3. Socio-Cultural Constraints

Despite Jamaica's fairly rapid rate of fertility decline since the early 1960's there remain important socio-cultural characteristics of the Jamaican population which limit the extent to which small family norms and contraceptive practices are adopted. Foremost among these characteristics is the widespread pattern of family unions wherein young women begin sexual activity at a fairly young age and progress through their child-bearing years having children by a series of different men. Out-of-wedlock births are the norm in Jamaica, where only about a third of women currently in union with men are legally married. Men contribute to the problem by often insisting on their mates having children by them, even though the family may already contain children brought about through a previous relationship. Sociological research done through the UWI (see Annex E) suggests that women would have significantly fewer children were it not for this prevailing union pattern, all other factors being equal.

Yet the typical desired family size (almost four children) remains high and is bolstered by myths surrounding motherhood. One of the most prevalent is that a young girl must produce a child lest she be looked upon as a "mule" by society. Another is that a woman must "have out her lot", no matter how many children that turns out to be. Similarly, men place strong emphasis on their ability to produce children as a measure of their manhood. There certainly are no near term prospects of any significant male sterilization activity. Poor contraceptive education also leads to widespread myths concerning the ill effects of contraceptives and contributes to high drop-out rates.

Though most Jamaicans practice some form of religion, there is little organized religious opposition to family planning. Nor is there significant ideological opposition except from small sub-groups such as the Rastafarians, and even among them opposition to family planning is not uniform nor absolute.

The migratory nature of so many Jamaicans is another powerful factor which has a major influence on the population equation. In very few countries of the world is emigration massive enough to cut the new population growth rate almost in half as it does in Jamaica. This phenomenon is not expected to continue into the late 1980's however since a combination of improved economic conditions at home and more restrictive immigration policies of countries abroad are expected to significantly reduce the rate of emigration.

It is difficult to assess the impact of these socio-cultural characteristics of the Jamaican population on fertility. At first glance these characteristics appear to be formidable constraints to fertility reduction. And yet fertility has declined and contraceptive prevalence is increasing. How far and how rapidly this trend can continue given these negative factors is an open question. So far the advantages of smaller families have over-riden tendencies in the opposite direction, but more needs to be known about these tendencies and programs developed specifically to overcome them.

PART II (D)

D. RATIONALE AND STRATEGY

As indicated in preceding sections and in the Economic and Social Soundness Analyses, Jamaica has a population problem despite a relatively high level of public sector family planning activities assisted by AID and, to some extent, by other donors. Unemployment is over 25% and real per capita income has been declining for almost a decade. The increase in population is expected to continue to outstrip the rate of economic improvement.

Relief for Jamaica historically and somewhat uniquely has come in the form of emigration, previously, to the U.K. and now, to the U.S. The desire and pressure to emigrate (legally or illegally) is probably as great now as it has ever been. For example, large numbers of Jamaicans arriving in the U.S. on non-immigrant visas remain there illegally, despite a 60% refusal rate by the U.S. Consular Office in Kingston. Jamaica is one of only five countries around the world which actually fills the standard annual quota of 20,000 non-affinity immigrant visas. The other countries such as Mexico, have populations vastly larger than Jamaica's.

Expanding and increasing the effectiveness of Jamaica's population and family planning activities, particularly the contraceptive services delivery system, will facilitate Jamaica's long term development and improve the welfare of its population.

AID assistance in this most critical of all areas must be viewed as part of a continuing effort, following and expanding its previous family planning services project. This project should also be viewed as the predecessor to at least one additional project, which it will probably be well into the 1980's before Jamaica is able to provide the necessary level of family planning services without external support.

Jamaica's degree of success in reducing its population growth rate has been achieved through a complementary system of public clinic-based services and private commercial retail sales of contraceptives supported by large scale educational efforts. This system will be maintained and supported in the Project.

USAID is in a unique position with respect to the substantial support it has given this sector since the creation of the National Family Planning Board fourteen years ago. While the current USAID project is broad based, this is a natural result of the maturity of the program which has led to a division of labor and specialization of functions undertaken by the various specialized agencies. Coordination of the large number of agencies is to be accomplished by the NFPB. In its historical context, this new project contains and strengthens the successful elements of past projects while adding new elements shown to have significant potential.

The Project clearly is manageable. Jamaica is an island of approximately two million people with a fairly homogeneous population and well dispersed network of public health clinics offering family planning services, which makes the development and implementation of a comprehensive project of this nature quite feasible.

There is now a high degree of commitment on the part of the GOJ to move forward rapidly to meet many of its population objectives. This Project seeks to exploit this receptivity, especially in areas with major potential impact on the project goal. For example, the GOJ and leading private social service organizations recognize the serious social and demographic problems created by high rates of adolescent fertility (one of the highest in Latin America and the Caribbean) and are committed to lowering these rates substantially. The Project thus provides significant inputs for adolescent fertility programs designed to meet that objective. There is no other age cohort which has such a potentially high positive demographic rate of return in terms of future reduction of the nation's birthrate. Similarly, there is great interest in establishing an explicit population plan and policy for Jamaica, since research has demonstrated that countries with such population policies have far greater success in reducing their population growth rates.

Finally, there are no feasible alternatives open to the GOJ if it wishes to pursue its goal of rapid fertility reduction. There is no other international donor with AID's resources and commitment to this program. Without the Project, the minimum impact would be a severe reduction or absence of essential contraceptive supplies and other commodities and further deterioration of the delivery system brought about by a lack of staff training. Moreover, proposed new initiatives of other public and private agencies could not go forward as planned.

Fertility reduction is not a single path taken by a single input to reach the desired end. It is more often a case of a variety of inputs taking a number of different paths, all mutually reinforcing the necessary to reach the common goal. For instance, it is not enough to simply supply contraceptives in order to achieve fertility reduction. People must be motivated and educated to use them and staff trained to administer them properly. Moreover, not all agencies are equally equipped to reach the primary target population of over 280,000 Jamaican women potentially at risk of pregnancy. For example, many family planning acceptors are most appropriately reached

through Ministry of Health clinics, but many others are best reached through community outreach programs such as those involving home economics extension agents of the Ministry of Agriculture (MOA) and community outreach workers of the Jamaican Family Planning Association (JFPA). Still others prefer not to go to clinics or receive services through any agency, but prefer direct contact with commercial establishments which sell contraceptives. In addition, a variety of approaches are needed to appeal to special target groups which have important demographic impact. Thus, there is a need for specially tailored family planning programs for teenagers and for males.

Assistance under the project can be categorized in a variety of ways. In one sense they can be divided into two categories of activities which will promote increased contraceptive prevalence, reduce fertility and lower birth rates by expanding the coverage and improving the effectiveness of the contraceptive services delivery system.

First, there are those activities designed to directly increase levels of contraceptive use. Second, there are those which, through motivational/educational means or through public policy interventions, are expected to have a major long term impact on fertility reduction. In addition, certain support activities are necessary for both direct and indirect project activities.

1. Direct impact activities support public and private education and service delivery. Major elements include:

- a. Training, equipment, supplies, improved management and other support to expand and improve the comprehensive family planning clinic service program available island-wide largely through the Ministry of Health's integrated primary health care services system and proposed clinical services of the NFPB. Assistance to the clinic program will also emphasize improved counseling and motivational efforts.
- b. Continued support for the commercial contraceptive distribution system as a backup and consumer alternative to the clinic program.
- c. Development and maintenance of an extensive public family planning information and sex education program utilizing a number of organizations and media. This program will utilize community and group contact, be extended through the mass media, employ individual contact by outreach workers, health educators, etc.
- d. Special programs in areas of critical importance such as:
 - adolescent educational service programs,
 - male and female voluntary surgical contraceptive programs,
 - integrated multisectoral service delivery programs.

2. Indirect impact activities are designed to influence family size preferences. They deal primarily with motivational factors including socio-cultural barriers rather than accessibility factors emphasized above. It has been well documented that reduction of family size preference comes not only from direct educational efforts, but also from improvement in economic levels, educational attainment, social status, and health care. Population policy development activities also fall within this category of indirect impact activities, and establishment of a policy, planning and monitoring apparatus and improved planning will enable better development and implementation of family planning activities and use of resources.

3. Support activities, though not primary contributors to fertility reduction, are essential to provide the tools necessary to reach that goal. They consist of such activities as:

- assistance in development a viable country vital registration system, as well as a working client information system;
- special surveys and studies on contraceptive prevalence, clinic dropouts, method use preference and other operational research.

PART III

1. PROJECT DESCRIPTION

The program or sector goal is to improve the health, social and economic status of the Jamaican people by reducing the rate of Jamaica's population growth. Other factors, outside the scope of this Project, e.g. satisfactory economic conditions and economic management, appropriate public administration and social programs, the level of emigration, etc., also will have a critical effect on the population growth rate.

The project goal is to significantly reduce the crude birth rate over the next 20 years. Achievement of this goal will have the single most direct effect and greatest impact on reducing the rate of population growth. Quantitative measures of achievement include reducing the present crude birth rate of 27/1000 to 24/1000 by 1986 and to 20/1000 by 1990. This goal is consistent with the "low projection estimates" contained in Population Dynamics and Prospects: a 1981 Assessment for Jamaica. If this goal is met, and assuming the continuation of present levels of emigration and life expectancy, the population will increase from approximately 2,170,000 in 1980 to 2,355,000 in 1990 and 2,583,000 in 2000. This projection is admittedly optimistic in that it assumes a rapid fertility decline and continued high emigration, during a period of continuing increase in the numbers of women in their prime child bearing years (20-29). However, if the present crude birth rate is reduced only moderately again assuming the same life expectancy and emigration levels, the population would be at least 2,500,000 in 1990 and over 3,000,000 in 2000.

The project purpose is to expand the coverage and increase the effectiveness of the contraceptive services delivery system, including motivational and educational efforts. The quantitative target is to increase the rate of contraceptive prevalence from 58% of women now-in-a-union in 1980 to 70% by the end of 1986. This is expected to result in a further 30% reduction in the total fertility rate by 1986.

A significant increase in the rate of contraceptive prevalence is necessary to meet the project goal. It is difficult to determine precisely the required level because use of contraception does not translate directly into births averted. The equation is complicated by large numbers of contraceptors who are child-spacing only, who are using methods of contraception which have high failure rates or who "drop out" of the program relatively early, thus exposing themselves to the risk of pregnancy. An increase of contraceptive prevalence from 58% of women now in a union to 70% by the end of 1985 will probably require the enrollment of between 40,000 to 50,000 new contraceptive acceptors nationwide. If this target is reached, and if contraceptive user continuation rates are considerably improved through better program management, the birth rate should be reduced as planned.

2. PROJECT ACTIVITIES

In order to overcome the institutional, policy and socio-cultural impediments to achievement of the project purpose and goal, this project will emphasize three major areas of activity: (a) strengthening and expanding physical

delivery systems; (b) development of a population policy and plan and institutionalizing a policy, planning and monitoring apparatus and (c) expanding family planning motivational and educational network. These activities will result in expanding the coverage and improving the effectiveness of contraceptive services delivery.

(a) Strengthening the Expanding Physical Delivery Systems

This activity is the major emphasis of the Project, since a strong delivery system is essential in increasing contraceptive prevalence and reducing fertility. Activities within the public sector include: provision of technical assistance to improve management effectiveness of the NFPB, MOH and other agencies as well as the design and development of specific programs such as voluntary sterilization, adolescent fertility, male motivation, etc.; training of all MOH health workers in the PHC system and in other relevant agencies in contraceptive technology and family planning techniques including client recruitment, counselling and follow up; expansion of family planning education, counselling and contraceptive service availability through "special project" support to the MYCD and MOA; provision of contraceptive supplies and related equipment necessary for effective service delivery.

Within the private sector AID will provide supplies and logistical support for the commercial retail sales of contraceptives program of NFPB and will expand the range of service coverage by providing budgetary support for JFPA, Operation Friendship and the YWCA to carry out community-based rural and urban adolescent fertility programs.

(b) Development of a Population Policy and Plan and Institutionalizing a Policy, Planning and Monitoring Apparatus

Project activities falling under this component include: budgetary support to the NPA and DOS for the formation of Population Units within those agencies; long term technical assistance from the Population Council to aid in the ongoing development of the population policy and plan for Jamaica and to support the work of the Population Policy Coordinating Committee and the demographic studies program of the UWI; budgetary support to the UWI to establish a demographic studies program and to carry out fertility-related research; and budgetary support for the RGD to improve the national vital registration system.

(c) Expanding Family Planning Motivational and Education Networks

This activity is essential to the success of the Project, since only by this means can myths and other socio-cultural barriers to acceptance of family planning be overcome. Specific activities include: support for research on socio-cultural determinants of fertility, training of health workers, family planning educators and outreach workers in proper methods of family planning counselling; expansion of large-scale public information and education programs through the mass media (funded through NFPB counterpart contributions); support for expansion of community outreach programs of NFPB, JFPA and Operation Friendship; development and dissemination of client-oriented educational materials; seminars and short-term training sessions for secondary school principals, social workers and others in similar professions.

SUMMARY OF PROJECT INPUTS

I. <u>National Family Planning Board</u>	(\$000)	
	AID	HOST COUNTRY
Technical Assistance		
The Population Council - 10½ PM	150	59
In-country Training		
7535 training weeks for 3255 participants in management, IF&C, and general family planning orientation	105	59
Overseas training		
36 training weeks for 16 participants in program/policy development, male motivation, research/statistics and training of trainers	34	0
Commodities		
centrally procured contraceptives, other medical supplies and equipment, 2 mobile units and 2 vans	2,071	1,063
Other Costs		
Personnel Services		
for top management salaries, subsidies, NFPP/MOH trainer and male motivation program	74	2,362
Evaluation		
Baseline survey update, mid-project and end of project evaluation	100	177
Voluntary Surgical Contraception		
for salaries and supplies at \$28/procedure	200	1,890
Adolescent Resource Center		
Commodities		
educational equipment & supplies; office equipment	51	118
Other Costs		
Salaries and consultant fees for project staff; postage and miscellaneous	109	178
Administrative and Service Delivery Costs		
	2,894	5,906

		(\$000)	
II. <u>Ministry of Health</u>		AID	HOST COUNTRY
Teen Scene Program			
salaries & benefits for project personnel; local consultants		75	
commodities and refurbishing of clinic		8	
In-country Training			
training of Parish PHC teams, MOH's mental health officers and peer counselors		74	300
Commodities			
medical and educational supplies and equipment		101	100
Acostrad (VD Prevention and condom Promotion)			
consultant fees, local training costs, education and promotion, supplies & equipment		50	75
Administrative and Service Delivery Costs (salaries, rental, utilities etc.)			4,022
		308	4,497
<hr/>			
III. <u>Ministry of Youth and Community Development</u>			
Women's Center Family Planning counselor		11	0
Youth Project			
- Technical Assistance			
short-term local consultants		4	0
- In-country Training			
Youth Club Volunteers, project and SDC staff		15	0
- Commodities			
educational equipment and supplies three (3) vehicles and spare parts		76	0
- Other Cost			
salaries for project staff		187	775
Administrative and Service Delivery Costs			41
Sub-total		293	816
<hr/>			
IV. <u>Ministry of Agriculture</u>			
In-country Training			
family planning home economics officers; male agricultural workers and rural teenagers		64	65
Commodities			
educational equipment & supplies, cooking utensils cutlery, pots and plates, spare parts of vehicles		25	0

(\$000)

	AID	HOST COUNTRY
Other Costs		
servicing, licensing and fuel costs for vehicles	5	0
Administrative and Service Delivery Costs		188
Sub-total	94	253
<u>V. National Planning Agency</u>		
Commodities		
statistical and office supplies and one passenger vehicle	28	12
Other Cost		
salaries of project personnel	84	205
Administrative Costs		44
Sub-total	112	261
<u>VI. Department of Statistics</u>		
Technical Assistance		
long-term consultant services for senior demographer	38	0
Overseas Training		
short-term courses in demography and statistics	24	0
In-country Training		
training for middle level statistical officers, and management training seminars	1	0
Computer facilities	0	60
Commodities		
statistical supplies and station rv	13	0
Staff Salaries	0	105
Administrative Costs	0	5
Sub-total	76	170

(\$000)

VII. Registrar General's Department

Technical Assistance

The National Center for Health
Statistics consultant - approximately
8 pm

AID

HOST COUNTRY

77

Training

vital statistics registration for local
registrars

11

Commodities

office equipment & supplies, statistical
supplies

7

Other Cost

vital statistics conference and publicity
campaign

15

Administrative Costs

343

Sub-total

110

343

VIII. Jamaica Family Planning Association

Technical Assistance

short-term local personnel

6

0

Training

contraceptive methods, reproductive health
& communications skills for new and old
outreach workers

7

11

Commodities

stationery & general supplies and one
vehicle

16

14

Other Cost

salaries for personnel under the project
administrative and Service Delivery Costs

183

9

10

Sub-total

212

44

(\$000)

IX. Operation Friendship

	AID	HOST COUNTRY
Technical Assistance		
short-term consultants	17	8
In-country training		
family life education programs for teenage boys and girls	3	0
Commodities		
medical supplies, educational equipment, one mobile clinic and spare parts	37	12
Other Cost		
salaries and allowances for project personnel, postage and fuel costs	232	30
Administrative and Service Delivery Costs		30
Sub-total	289	80

X. Young Women's Christian Association

Other Cost		
salaries and related expenses for nursing staff	32	0
Staff Salaries		
(director and office personnel)	0	18
Administrative and Service Delivery Costs	0	20
Sub-total	32	38

XI. UWI - Sociology Department

Salaries - teaching fellow and research assistant to assist in developmental teaching a diploma course in Population Studies	56	
Consultant fees (local)		
research costs - migration and fertility determinants	13	
In-country Training		
staff development training	4	
Commodities		
book, office equipment and supplies; typing services	18	
Contingency	7	

(\$000)

	AID	HOST COUNTRY
Other Cost		
to carry out research and surveys on:		
(a) determinants for fertility)	14	
(b) internal migration and Occupational Mobility)		
UWI overhead and Administration	28	
Administrative Costs		14
Sub-total	140	14
Contingency	440	
GRAND TOTAL	5,000	12,422

Estimated AID-financed technical assistance to be provided in connection with the Project is summarized, below. Tabular summaries of training and commodity procurement are contained in Annexes C and D, respectively.

<u>T.A. ORGANIZATION</u>	<u>TYPE OF AGREEMENT</u>	<u>FUNDING SOURCE</u>	<u>PROJECT MANAGING INSTITUTION</u>	<u>PERFORMANCE (PERSON MONTHS)</u>
Pop. Council	Host Country Contract	Grant \$100,000	NFPB	10½
NCHS	PASA	Grant \$76,000	NFPB/RGD	8
AVS*	Centrally funded contract	Grant \$20,000	NFPB/USAID	2
DAI*	"	" \$80,000	"	8
Pathfinder*	"	" \$20,000	"	2
APHA*	"	" \$72,000	"	8
JHPIEGO*	"	" \$20,000	"	2

* rough estimates only - actual use dependent upon local needs and AID/W priorities.

B. PROJECT ACTIVITIES BY INSTITUTION

1) National Family Planning Board (NFPB)

The Project will provide funds to strengthen the capacity of NFPB to manage and coordinate Jamaica's national family planning program, carry out a variety of direct service activities and participate in the development of Jamaica's population policy and plan. Assistance to NFPB will impact on all aspects and components of the Project. NFPB, as the lead agency of government responsible for population and family planning activities is the central coordinating agency for this Project. All Project funds will be administered by NFPB either in support of its direct activities or provided to other agencies for "special projects" which NFPB and USAID have agreed to finance. The agreements for these sub-projects will be approved in advance by A.I.D.

Included among direct NFPB activities receiving AID assistance is NFPB's new Adolescent Fertility Resource Center which will receive \$160,000 over a three year period. The Center will serve as a central focus for Jamaican agencies providing contraceptive education, counseling and services to adolescents. It's services will include information analysis and distribution, technical assistance, promotional activities (including adolescent fertility workshops and conferences) and research and evaluation. AID and the GOJ will provide funding for educational and office equipment and supplies and for salaries and operating costs.

NFPB also plans a substantial increase in public information activities through its Information, Education and Communications (IE&C) Division and approximately \$60,000 in AID Project funds will be used for commodities to support this activity.

An additional \$74,000 in AID funds will finance certain personnel costs including the salary of a "male motivation" officer at NFPB for one year, the salary of a trainer for two years to organize and carry out family planning training for MOH personnel delivering family planning services, and salary supplements for the two top managers at NFPB for three years.

NFPB also plans to initiate a pilot rural community-based contraceptive distribution program. Two mobile units at a cost of \$25,000 in AID project funds will be provided to support this activity.

Training in areas of skill shortage is a high priority for this Project and for NFPB. A detailed training schedule is presented in Annex C. AID Project funds in the amount of \$105,000 will be used by NFPB to carry out a variety of family planning training activities for its own staff and the staff of other agencies. In addition, Development Associates, Inc., (DAI), the primary consulting firm on project training, will provide additional support under a centrally-funded AID project. This support is expected to exceed \$60,000 at no cost to the Project. Services include technical assistance in training course design and implementation, consultants for training sessions, evaluation of training, training in program management and overseas observation visits.

In addition to these direct activities, NFPB will provide administrative and support services to other agencies, as follows:

- a) NFPB will procure and distribute from its central warehouse all project commodities totalling

\$2.4 million in AID financing. This includes contraceptives (\$1.6 million) drugs, medical supplies vehicles, educational equipment and materials etc. (see Annex D for Procurement Schedule).

- b) AID project funds in the amount of \$200,000 will also be provided to assist with fees and supplies for those entities (primarily MOH hospitals) providing voluntary sterilization services. This is in addition to a planned expenditure of up to \$840,000 in counterpart funds contained in NFPB's budget submission for institutional reimbursement for sterilization services. These funds are required to meet NFPB's ambitious goal of increasing the annual number of sterilizations performed from approximately 3,000 to 10,000. It also assumes additional grant support from AVS of up to \$500,000 for the next two years, primarily for supplies and facilities renovation.
- c) NFPB will coordinate a variety of project technical assistance services. NFPB will have a contract with the Population Council, at a cost of \$150,000 from the Grant, to provide a variety of technical experts who will make an estimated 21 two-week trips to Jamaica. These experts will work closely with representatives of the NFPB, Department of Statistics, National Planning Agency and University of the West Indies and will provide assistance in the areas of institution building, specialized technical consultation, and training and research to assist these agencies in establishing the national population policy and plan and the related organizational planning apparatus.
- d) NFPB will also coordinate a large amount of AID technical assistance not financed under the Grant. This form of technical assistance comes through world-wide "centrally-funded" AID contracts with the American Public Health Association, Development Associated, Inc., The American Home Economics Association, The Association for Voluntary Sterilization, U.S. Center for Disease Control and several others (see Annex F for complete list). Centrally-funded technical assistance will be used for design of adolescent fertility and other special projects, staff training, design and participation in conferences and workshops, design of family planning information systems, consultation on research, analysis of NFPB stores operations and project management and evaluation.

No AID project funds have been earmarked for NFPB's extensive commercial distribution of contraceptives (CDC) program aside from contraceptives totalling approximately \$350,000. This program has been successful in reaching large numbers of persons outside of the clinical program. Recent product price increases have made the program virtually self-sustaining. That is, revenue from sales of contraceptives are sufficient to cover costs of the program (advertising, merchandizing, packaging, etc.) except for the contraceptives themselves. It is expected that by the end of the Project, the program will be sufficiently solvent to also cover the contraceptives as well.

Related to but outside the specific activities of this Project, NFPB has submitted a large budget request to the GOJ for 1982/83 which, if approved, will result in a five-fold increase over its current level of expenditures (J\$1.5 m) for its family planning program, particularly in the area of clinical services and public information and education. The Board plans to spend up to J\$500,000 for a publicity campaign to support the two-child family planning concept as well as advertising for the commercial retail sales of contraceptives program. Up to J\$400,000 has been allocated to "a massive educational campaign addressing such areas as teenage pregnancy, parenthood education and male responsibility". In addition to the aforementioned J\$1,500,000 request for the sterilization program, NFPB is requesting up to J\$1,170,000 to remodel and furnish 15 clinics which will provide comprehensive family planning services in each parish. Locally-procured contraceptives, drugs and medical supplies have been budgeted at J\$622,000 and an additional sum of J\$145,000 for research and statistics. A large increase in staff is planned to carry out this ambitious program. NFPB is requesting almost J\$2,000,000 in personal emoluments for a total of 201 staff members.

2) The Ministry of Health (MOH)

The main emphasis of assistance to the MOH will be on the expansion and improvement of clinical contraceptive services. The MOH has declared its very strong support for family planning, but a variety of management problems, inadequately trained staff and other problems have hindered effective implementation of the MOH's efforts. The Project will provide specific inputs targeted to overcome those problems.

NFPB has hired a full-time family planning trainer to concentrate exclusively on organizing and carrying out training for approximately 2,400 MOH physicians, nurses, midwives, community health aids, health educators and other categories of health workers. \$74,000 in AID project funds are provided to cover local costs of this training.

Commodities totalling approximately \$100,000 will be provided for the Ministry's post-partum nurse educator program in hospitals and for family planning educational activities of the Bureau of Health Education. The post-partum program provides full-time nurse educators in 22 MOH hospitals with maternity services. These nurses provide family planning education to large audiences and recruit large numbers of new acceptors. Many of them also assist in voluntary sterilization operations.

AID will continue to support the MOH's pilot adolescent fertility project (Teen Scene) in downtown Kingston at a cost of \$83,000 over the life of the Project which will finance a local training consultant, supplies, equipment, staff training and renovation. This is a comprehensive activity combining community outreach, counselling and a full range of educational and clinical services. It is expected that it will result in successful approaches to reaching adolescents that can be incorporated into the MOH's extensive network of hospitals and clinics throughout the island. The Teen Scene is expected to reach a minimum of 20,000 adolescents with family planning educational clinical services over the next three years.

AID will provide approximately \$50,000 to ACOSTRAD over a two year period in the form of educational supplies and equipment, consultant fees and local training costs to assist it in carrying out its program of education on sexually transmitted diseases in the public school system and among community groups. Promotion of the use of condoms as a prophylactic as well as a birth control method is an integral part of the ACOSTRAD program and is expected to

result in a large increase in condom usage, especially among adolescents.

3) Ministry of Youth and Cultural Development (MYCD)

MYCD programs offer an excellent opportunity to expand outreach and contraceptive services delivery to sexually-active adolescents.

AID will finance US\$187,000 of the costs of a large scale family life education and contraceptive services program for youth. This special project will be managed through a "National Coordinators" office in the central Ministry and is designed to reach over 30,000 youth (2/3 males) with family planning information and services over the next four years. The overall objective is to reduce adolescent fertility while improving the economic potential of adolescents. A number of different strategies will be employed to reach this objective. In addition to the National Coordinator, four full-time family planning counsellors/trainers will be employed at the central level. The National Coordinator's staff will assist the various divisions in the development of implementation plans for their respective family planning programs.

In the case of the MYCD's Social Development Commission which already has a family life education program in its nine Youth Centers, technical assistance and training will be provided to Center staff by The National Coordinator to upgrade the quality of contraceptive education and to add the distribution of non-prescription contraceptives to sexually active youth. In the case of institutions with no family life educator presently on staff such as industrial training centers, 4-H Clubs and Child Care Institutions, the Ministry plans to identify suitable resident personnel who will be trained by staff from the National Coordinator's office. Until such time as these individuals are located and trained, the National Coordinating staff will play a direct role in providing family life education counselling, contraceptive distribution and follow up in these institutions. It is anticipated that approximately half of the proposed 229 target centers belonging to these institutions will be able to carry on project activities with in-house staff by the end of the project with periodic monitoring and back up from the National Coordinator staff. For the almost 1,300 youth clubs with no assigned professional staff, National Coordinator's staff will provide training to fifteen (15) volunteers who will carry out a program of family life education and contraceptive distribution in these clubs.

AID project support for this special project will consist of \$187,000 for staff salaries \$76,000 for commodities, \$15,000 for training and \$4,000 for technical assistance (local). It is the stated intention of the MYCD to continue the sub-project out of its own budgetary resources after the PACD. The MYCD contribution during the Project's life will total an estimated \$816,000, almost entirely for salaries.

Also, falling under the general aegis of the MYCD is the "Women's Center" program of the Women's Bureau. The Center was established to provide formal education and home craft skills training to high school age children forced to drop out of school because of pregnancy. With over 100 girls enrolled, the Center has done an excellent job of reintegrating these children back into the formal school system after the birth of their children. AID will finance the salary of a full-time family planning counsellor for one year at a cost of \$11,000 who will attempt to prevent repeat pregnancies among center clientele and provide family planning information and services to other youth frequenting the Center. The Center will absorb the position within its ongoing operating budget in FY 83.

4) Ministry of Agriculture (MOA)

The MOA is one of the largest government ministries with an extensive program of extension services to farmers which provides a potentially valuable means of reaching the less accessible rural population. Under the previous AID financed Family Planning Services Project, the MOA was given four mobile units to allow the Ministry's home economics extension workers access to persons residing in deep rural areas. The Ministry's home economics officers were also trained in innovative outreach methods combining family planning education and contraceptive distribution with nutrition education and methods of food preparation using the Working with Villagers materials developed by the American Home Economics Association.

The MOA will receive \$94,000 in AID project support over the next four years to carry out a large scale in-house family planning training program for MOA staff and for adolescents in rural areas. \$64,000 is allocated for continuing training of regional home economics officers, for training of almost 6,000 male agriculture extension officers and to finance regional workshops in family planning/nutrition education for teenagers. Commodities and other costs incident to carrying out this training program will total \$30,000 in AID-provided project funds. The MOA will contribute an estimated \$65,000 for training costs and \$188,000 to transport extension agents.

It is expected that the activities to be carried out by the MOA under the Project will have a major long-term impact on increasing contraceptive prevalence and lowering birth rates. Ministry extension workers will be reaching elements of the population which often lack access to social and health services because of their physical isolation and who tend to harbor larger family size preferences than the population as a whole.

Extension agents will refer prospective clients to local MOH family planning clinics, but will also provide contraceptive supplies themselves where appropriate and necessary. The MOA's approach combining family planning with nutrition education also makes the former much more acceptable to the rural farm population. Moreover, emphasis on male agricultural extension agents for imparting family planning information, primarily to other males, is an important step in overcoming male resistance to family planning.

5) Jamaica Family Planning Association (JFPA)

This component will avail the Project of the capabilities of the JFPA in reaching rural adolescents in three parishes. It will continue activities begun under the "Youth-to-Youth" project for an additional two years at a cost of \$166,000 in AID funds. It will also provide \$96,000 over three years to allow JFPA to expand its successful house-hold contraceptive distribution program to rural communities in the parishes of Trelawny and St. Elizabeth. Most of the funds (\$183,000) will be used for salaries of project staff, (\$7,000) will be used to finance in-service staff training, (\$16,000) for commodities and (\$6,000) for local costs of technical assistance and evaluation. The JFPA will contribute an estimated \$42,000 for these activities.

Specific activities are directed at enrolling large numbers of rural sexually active youth into JFPA's family planning program and expanding the general coverage of the Association's rural outreach program to seven rural communities in St. Ann and Trelawny parishes. Activities include face-to-face counselling and recruitment of potential contraceptors by outreach workers at the householdlevel, conducting of group family life and sex education sessions

for youth in schools, community centers, youth clubs, etc., and contraceptive distribution.

6) Operation Friendship (OF)

Operation Friendship, probably more than any other Jamaican organization, has demonstrated its ability to provide large scale outreach and clinical services for adolescents in poor urban areas.

Operation Friendship will receive a total of \$289,000 in AID financing for two additional years of its ongoing adolescent fertility program in Western Kingston and to initiate a new mobile unit which will bring family planning services to the nearby urban communities of Braeton, Passage Fort and Independence City and to rural communities of Linstead and others. A total of 30,000 new and 27,000 continuing family planning acceptors are expected to be recruited into the national family planning program as a result of Operation Friendship's efforts. Over the life of the Project AID will finance \$232,000 for salaries and allowances for personnel as well as miscellaneous postage and fuel costs. \$17,000 will be used for local short-term consultants, \$3,000 for family life education seminars for teens and \$37,000 for commodities, including a mobile unit. OF will provide an estimated \$80,000 for these same costs. Contraceptives will be provided through NFPB.

An assessment of OF's progress since the initiation of its current adolescent fertility project in late 1979 reveals that substantial progress has been made in meeting the contraceptive needs of adolescents in Western Kingston. Records indicate that OF is on schedule in reaching its target of 10,000 clients a year with contraceptive education, counseling the clinical service. Four project outreach staff (Community Health Aids) are actively working in the surrounding urban getto areas educating youths and recruiting them into the OF program. A full-time project family life educator offers daily courses in sex education, contraception, early child development, parental responsibility, etc. for up to 40 teenagers. A full-time project obstetrician/gynaecologist and other clinical staff offer a full range of medical family planning services for up to 30 clients a day.

The importance of maintaining and expanding project support to OF lies in the fact that it operates a highly credible and successful multi-service program in one of the most crowded and depressed areas of the country where the rate of teenage pregnancy (45% of all births) and low age of first pregnancy (15 to 16 years) is much more serious than in any other part of the island. OF is demonstrating that despite conditions of abject poverty, high crime, unemployment and general lack of adequate social services, a successful community-based family planning program can be implemented that will eventually have a major impact on lowering birth rates, especially among adolescents. OF is convinced of the long-term need for this program and has pledged to continue it through a combination of funds from the GOJ and generated through their own local efforts when AID funds are no longer available.

7) Young Women's Christian Association (YWCA)

At an estimated cost of \$32,000 AID will finance the services of a full-time nurse health educator and six part-time nurses for the YWCA over the next two years. The YWCA will contribute \$38,000 for related salaries and administrative costs. Contraceptive supplies will be provided by NFPB. Activities to be carried out include family planning education, counseling and contraceptive

distribution to sexually active teen members of the six Y Teen Centers and three YWCA School Leavers Institutes located throughout the island. In addition, these services will also be made available to at least ten secondary schools which are affiliated with the YWCA Teen Program. The full-time nurse educator will travel extensively to these sites for periodically scheduled visits. The part-time nurses will be recruited from local communities where services are delivered.

This component is part of a larger YWCA Adolescent Fertility (NEET) Project funded by the Pathfinder Fund in 1980, with additional support from AID for minor renovations of Y facilities. The activity was originally envisioned as a comprehensive, in-depth residential counseling and contraceptive service effort, but a variety of internal management and policy problems of the YWCA resulted in poor project performance after the first year. As a result, Pathfinder terminated funding as of December 1981.

However, NFPB and AID have decided to continue to support the clinical element of the original activity which has just been getting underway, since it now appears that management and policy problems have been resolved. The YWCA is a very highly regarded organization with a number of socially prominent Jamaican women on its Board of Directors. The Y's continued active involvement in this project is an important addition to the national family planning program in that it provides contraceptive services to a special adolescent population in need of subsidized care and establishes credibility for adolescent fertility efforts within important levels of Jamaican society.

8) National Planning Agency (NPA)

In terms of governmental acceptance of population policy initiatives, NPA represents the most critical component of a policy and planning system.

NPA's new responsibilities in relation to population policy and research are to be initiated by a new Population Planning and Research Unit with the assistance provided under this Project and are summarized below:

1. Monitor the implementation of the Population Policy in the various sectors, while at the same time reassessing it and making modifications where necessary.
2. Coordinate the work of the various agencies involved in population matters through a committee chaired by the Head of the National Planning Agency.
3. Prepare for the National Development Plan -
 - a) the Population Section incorporating the Population Policy;
 - b) the population data necessary for the various sector plans;
4. Provide planning assistance to the ministries to integrate population planning into sector planning.

5. External Migration -

- a) Collaborate with the Department of Statistics who tabulate this data to-

provide the type of detail necessary for meaningful analysis;

bring the processed data as up-to-date as is feasible;

provide data for all migration points to and from Jamaica.

- b) In-depth analysis will then be made as to the characteristics and numbers of the migrants.

6. Fertility and Mortality -

Collaborate with the Registrar General's Office, Ministry of Health and Department of Statistics to update the registration system so that -

- a) the registration for infant births and deaths is more reliable;
- b) accidental and violent deaths are registered without prolonged time lag;
- c) current calendar year deaths are available by sex and age.

7. Prepare the year's demographic analysis for the Annual Economic and Social Survey Publication of the Jamaican government.

8. Carry out small scale in-depth surveys to supplement any demographic analysis related to the Comprehensive and Integrated Rural Development Programs.

9. From January 1983 the Unit will begin to focus on data emerging from the Population Census scheduled for June 1982 and will perform the following tasks:

- a) Analysis of Internal Migration data looking at pattern of movement and demographic characteristics of moves
- b) Analysis of Fertility Data emerging from the census.
- c) Compute new population projections using the recent data in cooperation with the Department of Statistics
- d) Collaborate with the Manpower Unit of the National Planning Agency and the Department of Statistics to prepare manpower projections based on updated population projections.

- e) Give special emphasis to analysis of data in areas from the census which are part of the comprehensive and Integrated Rural Development Programs.

To enable NPA to carry out its expanded role, AID will assist in financing the establishment of the Population Planning and Research Unit in order to make population planning an integral part of national development planning. One result will be the coordination of population policy objectives and the population growth rate with the goals and targets of economic and social development.

AID will provide \$112,000 to NPA to support this unit over a three year period. This will finance two senior staff positions (population planners) (\$84,000) and provide necessary commodity support (\$28,000) to allow the unit to carry out its new responsibilities. Technical assistance in various aspects of population policy development will be provided to NPA through NFPB's AID-financed contract with the Population Council. Technical assistance from the Population Council will be in the areas of demographic methodology, the preparation of population projections and analysis of migration. The GOJ will provide approximately \$261,000 for these same costs.

9) Department of Statistics (DOS)

Policy and planning and the related organizational apparatus will not be effective without the data base and reference materials which should be provided by the DOS. With assistance from this Project, the DOS proposes to create a Population Unit within the Department with responsibility for the timely production of demographic information required by NFPB, NPA and other agencies. AID will provide \$75,000 to the DOS over a three year period in the form of salary support for a senior demographer (\$36,000), staff training (\$25,000) and commodities (\$13,000). Short-term consultant support will also be provided by the Population Council to the Population Unit. The GOJ contribution is estimated at \$170,000.

The establishment of the Population Unit will overcome a major obstacle to population planning, the timely collection, analysis and distribution of demographic data. The senior demographer who will head the Unit will carry out population projections in collaboration with the GOJ's Central Data Processing Unit and respond to requests for other demographic information from the NPA, NFPB and other agencies. The DOS will also use its facilities and resources to carry out selective surveys and research in such areas as external migration. Finally, the establishment of the Unit will be an important contribution to strengthening the Department as it prepares to tackle the massive job of carrying out the decennial census of the population this year.

10) Registrar General's Department (RGD)

The Project will provide assistance to enable RGD to assume the role of producing vital statistics data inputs for the DOS to analyze and for the organizations directly involved in population policy and planning. Vital statistics are one portion of the raw material needed for effective planning.

AID will provide a total of \$110,000 to the RGD over a two year period to assist it in upgrading its capacity to register, process and analyze vital statistics and to provide NFPB and other agencies with timely data on mortality and fertility. \$76,000 will be used to continue technical consulting services

of experts from the National Center for Health Statistics (NCHS) formerly funded under the now defunct VISTIM project. These experts will provide advice and assistance on systems for collection, processing, tabulating and analysing vital events. They will also design and help carry out in-service training of NGD staff and data users. \$11,000 has been earmarked for training of local registrars, \$7,000 for commodities and \$15,000 for a publicity campaign and national conference to educate the public on the importance of timely registration of births and deaths. The corresponding GOJ contribution is an estimated J\$610,000 for administrative costs.

Project support will contribute to strengthening institutional capability of the RGD to process in a timely manner the large volume of ongoing requests for certified copies of vital events. It will also enable the RGD to do annual tabulation of vital statistics, which until the advent of the VISTIM project had not been produced since 1964 because of demands on staff time for production of certificates.

NCHS under a PASA with AID will provide a course for personnel of planning organizations on techniques of statistical analysis and joint conferences for the producers and users of data. Short courses will also be arranged in each parish for District Registrars, hospital medical records personnel and others involved in the registration process. A primary emphasis will be raising the coverage of the registration process through this training and through the island-wide publicity campaign.

11) University of the West Indies (UWI)

AID will provide \$140,000 to the UWI Sociology Department for the establishment of a nine-month graduate diploma course¹⁶ in demographic studies. This course will be a valuable asset to NFPB, NPA, DOS and other agencies needing to establish a capability in demography. Also included in the grant is \$13,000 to fund two project-relevant studies on emigration and the determinants of fertility. The result will be a significant increase in the institutional capacity of the Department to provide demographic training and population research important to the achievement of the project goal and purpose.

The Department will also benefit from the technical expertise of Population Council consultants under its contract with the NFPB to be financed by AID. Population Council consultants will assist in its teaching program and in the design and execution of research. Since a contraceptive prevalence survey will be used to provide baseline data, AID will also finance a mid-project and end of project contraceptive prevalence survey by the Department at an estimated cost of \$100,000 in order to evaluate the impact of increasing contraceptive prevalence and decreasing fertility.

The Department will also play an important role in the development and implementation of Jamaica's population policy through the participation of its Chairman on the Population Policy Coordinating Committee chaired by the head of NPA. The Department will bring to the Committee a vital reservoir of information on practical consequences of fertility related programs based upon its extensive knowledge of sociological research in this area. Moreover, staff members of the Department are frequently called upon to participate in preparing baseline studies and family planning project evaluations at various community and national levels and, thus, have developed an intimate knowledge of family planning program operations.

PROJECT ANALYSES

A. Financial Plan and Analysis

1. Summary

The total cost of this project will come to \$17.4M. The USAID contribution consists of US\$5M grant aid. The host country contribution will total an estimated \$12.4M which will be used primarily to cover administrative and service delivery costs. Of this contribution, \$12,182 (98%) will be provided by the GOJ and \$260,000 by Jamaican voluntary organizations.

2. GOJ Cost Analysis

The NFPB has submitted a budget request to the Ministry of Finance for \$7.9M in JFY 82/83. This represents more than a five fold increase over NFPB's present budget. Of this amount, approximately J\$3.5M (US\$2.0M) constitutes a contribution to this project. Whether the request will be approved in its entirety is uncertain at this time, but there is little doubt that amounts allocated to NFPB over the life of the project will exceed its intended contribution to the project together with its present level of operating expenses extended over the next four years and increased for inflation.

The decision on NFPB's request will also affect the size of the MOH budget for family planning. With major NFPB increases, the total MOH family planning budget is expected to remain relatively static at approximately J\$4M/yr and may decline slightly. The total amount of NFPB and MOH counterpart support has been calculated at \$10.4M or roughly one half of the estimated total family planning budget of these agencies as the portion attributable to activities undertaken under the project. Other agency counterpart support costs were originally calculated either liberally (MYCD) or conservatively (MOA), depending upon policies and practices in force at the particular agency. The following table summarizes GOJ project support costs by institution. In some cases agency estimates have been adjusted to achieve a realistic level of internal consistency. Under any circumstances, however, the GOJ counterpart contribution estimated at 71% will remain far in excess of the 25% required of AID-funded projects.

TABLE 6
Summary of Host Country Expenditures by Institution

(J\$ 000s)

Institution	Year				
	I	II	III	IV	Total
MOH	2,000	2,000	2,000	2,000	8,000
NFPB	3,500	3,000	2,000	2,000	10,500
MOA	75	100	125	150	450
MYCD	325	350	375	400	1,450
NPA	151	150	164	-	465
DOS	100	101	101	-	302
RGD	280	330	-	-	610
YWCA	34	34	-	-	68
OPER. FRIEND.	43	47	52	-	142
UWI	12	13	-	-	25
JFPA	20	25	30	-	75
Total J\$(000s)	6,540	6,150	4,847	4,550	22,087
US\$(000s)	3,678	3,459	2,726	2,559	12,442

The following tables summarize project expenditures by component and project life.

TABLE 7
Summary of Expenditures by Input Category

(US\$000s)

	AID		HOST COUNTRY	
	FX	LC	LC	TOTAL
Technical Assistance	235	78	67	380
Training	28	328	435	791
Commodities	2,347	110	1,319	3,776
Other	-	1,433	10,601	12,034
Contingency	196	245	-	441
TOTAL	2,806	2,194	12,422	17,422

Table 8
Expenditure by Project Life
(US\$ 000s)

Year	AID		HOST COUNTRY	
	FX	LC	LC	TOTAL
1	773	733	3,678	5,184
2	776	636	3,459	4,871
3	643	490	2,726	3,859
4	614	335	2,559	3,508
Total	2,806	2,194	12,422	17,422

3) RECURRENT COST ANALYSIS

Project recurrent costs are considered to be those incremental costs generated for the implementing organizations after the PACD as a result of the Project. They represent the costs of continuing activities initiated during the Project which are intended to be continued after the PACD and are not included in the project contributions provided during the LOP. Project inputs of technical assistance, for example, are provided during the LOP and do not continue after the PACD, whereas additional personnel necessary for an activity intended to continue after the PACD, e.g. additional clinical personnel, would be an incremental recurrent cost generated by the Project. Recurrent costs of the Project are estimated below and consist almost entirely of the cost of additional personnel and of maintaining or replacing commodities financed under the Project.

<u>Organization</u>	<u>Expense</u>	<u>1st Year</u>	<u>2nd Year</u>	<u>Percentage of</u>
		<u>Post PACD</u>	<u>Post PACD</u>	<u>Estimated</u>
		US\$000's	US\$000's	<u>Annual Budget</u>
NFPB	Personnel	250	275	14%
	Commodities	600	660	15%
MOH	Personnel	200	220	Negligible - less than 1%
	Commodities	70	77	
MOA	Personnel	20	22	Negligible - less than 1%
	Commodities	10	22	
MYCD	Personnel	50	55	Negligible - less than 1%
	Commodities	15	16.5	
NPA	Personnel	30	33	Negligible - less than 1%
	Commodities	5	5.5	
DOS	Personnel	20	22	Negligible - less than 1%
	Commodities	5	5.5	

<u>Organization</u>	<u>Expense</u>	<u>1st Year Post PACD</u> US\$000's	<u>2nd Year Post PACD</u> US\$000's	<u>Percentage of Estimated Annual Budget</u>
RGD	Personnel	30	33	Negligible - less than 1%
	Commodities	5	5.5	
YWCA	Personnel	-	-	Negligible - less than 1%
	Commodities	-	-	
Operation)	Personnel	-	-	Negligible - less than 1%
Friendship)	Commodities	-	-	
UWI	Personnel	-	-	Negligible - less than 1%
	Commodities	20	22	
JFPA	Personnel	20	22	Negligible - less than 1%
	Commodities	5	5.5	
		<u>\$1,400</u>	<u>\$1490.5</u>	

In order to estimate the impact of the recurrent costs, they have been compared with the estimated budgets of the organizations concerned. These budgets were projected at their current levels which were increased by 10% p.a. nominally to allow for inflation. As indicated above, with the exception of the annual cost of contraceptives distributed by the NFPB, the recurrent costs in every case will represent a de minimis portion of the organizational budgets, less than .1%. By no means do they represent any significant burden on the host country institutions, and in every case the organizations have agreed to meet these costs. The contraceptive supplies to be procured and distributed by the NFPB, obviously, are of absolutely critical importance for Jamaica's family planning program, and USAID/Jamaica feels justified in assuming that donor assistance, if needed to help the GOJ with these costs, will be forthcoming.

8. ECONOMIC ANALYSIS

1. Introduction

The objective of the project is to lend support to the long-term goal of improving "the health, social and economic welfare" of the people of Jamaica through a reduction of the crude birth rate from an estimate 27/1000 now existing to 20/1000 or less by 1991. The project will attempt to increase the level of contraceptive prevalence from 58 percent in 1981 to 70 percent by 1985 and also support the development and implementation of a comprehensive population policy and continuing planning apparatus for Jamaica.

2. Project Output

The specific target which has been set for the project is to increase the rate of contraceptive prevalence among females at risk in the 15 - 49 age group by 1986. It is estimated that in 1986 the number of females in this group will be approximately 568,000. On the assumption that two thirds of this total will be at risk and also given the project target of achieving 70 percent contraceptive prevalence, the program should be geared to service the contraceptive needs of approximately 265,000 women, including most of the 160,000 being served by the clinic network and those being re-supplied through commercial channels.

A somewhat less direct output of the project will be to increase the continuation rates and reduce client turnover so that the ratio of new acceptors to total continuing user should fall. The current ratio for the clinic program is estimated at 1:5 and as a result of the project it could be lowered to 1:6 by 1985. The number of program users projected at 160,000 would imply 27,000 new acceptors by 1986.

Other indirect outputs of the project will include a steady increase in the percentage of females who know about some method of contraception but have never practiced. Increasing the number of females in this category is a necessary condition for achieving further increases in contraceptive prevalence.

In the final analysis the most tangible outcome of the project will be the expected reduction in the birth rate from 27/1000 to 20/1000 by 1990.

In 1980 approximately 200,000 women were estimated to be continuing users of contraceptives in Jamaica. In that year it is estimated that approximately 26,000 births were averted under the previous program*. This would suggest that for every 8 contraceptive users there is one birth averted. This ratio indicates a very inefficient and sporadic use of contraceptives. The project targets imply some 265,000 users by 1986 at which time it is expected that the ratio of births averted to the number of users would be reduced through a more effective program to 1:7.

* (See Annex G, Calculation of Births Averted)

Assuming 7 continuing users for each birth averted by 1986, given the projected number of users (265,000), the number of births averted will be 38,000.

In Table 11, the projection of births averted are based on population projections (low) done by Tomas Frejka of the Population Council in 1981 and assuming continuing fertility decline with immigration.

The projection of births averted between 1982 and 1985 is comprised of two components: the incremental births averted annually, being the difference between the births which would have occurred if the 1980 general fertility rate remained unchanged compared to the births projected with a declining general fertility rate; and the continuing difference in births as a result of the role of the new program in maintaining part of the total accomplishments of the previous program. The rationale being that if the program was not continued some of past accomplishment would be lost and the general fertility rate would rise.

On the assumption that without the program which is being planned, the accomplishment of the previous program in lowering the fertility rate would level off at the 1981 level, between 1982 and 1985 one half of the implied births averted as a result of the achievement of the previous program is attributed to the presently planned program. The rationale being that if the new program was not to be implemented this degree of past achievement would have been lost.

The total of births (net) which will be averted as a result of the program each year is estimated at 26,151 by 1986, with 9,200 being new accomplishment, the net cumulative births averted by 1985 being 79,300. For 1991 the respective figures are 12,664 and 140,102. After 1985 when financing from this project is scheduled to be completed, the total births averted used in the analysis is again put at one half of the projected total, employing the same rationale as above.

It was considered unrealistic to use the total projected births averted as a result of this project and so two refinements were carried out. This involved taking only 90 percent of births averted and then applying a constant mortality rate (16/1000) throughout to arrive at a figure for net births averted. This last refinement is based on the principle that not all projected births averted would have resulted in live births which would survive early years of infancy.

3. Quantification of Benefits

The economic benefits of the program for all practical purposes, are equated to the benefits attached to a birth averted. For each birth which is averted the following costs which are avoided by society, as a result, should be calculated.

- (a) The present value of the stream of consumption by or investment in the marginal person, which society would have incurred over his lifetime.
- (b) Present value of the stream of congestion costs attributable to the marginal person throughout his lifetime.
- (c) Present value of the stream of environmental pollution costs attributable to the marginal birth throughout his lifetime.

Only brief examination will show that it is almost impossible to measure streams (b) and (c) while stream (a) will present great difficulty but not an impossibility. The benefits of a birth averted is here equated with the stream of consumption or investment in the marginal person and which Society avoids.

Each birth which will be averted would have represented a claim against Society for some level of support in terms of food, shelter and clothing, in addition to resources for providing health care, education and other social services.

To facilitate the quantification of benefits, the savings per birth averted are calculated using national income data (1980) relating to (total) per capita final consumption (private plus public). The total final consumption per capita for 1980 is US\$1077. This is taken as a measure of the annual consumption or investment in the marginal person which Society would have incurred for each birth which takes place. Since this is a per capita measure and given the skewed distribution of income it was necessary to adjust this level of final consumption to reflect a more realistic measure of the per capita consumption of the income class which this project is expected to affect the greatest. The adjustment weight used was the ratio of annual minimum wage to per capita compensation to employees for 1980, 0.63. A further adjustment to reflect the fact that consumption is likely to be lower in the early years of life (0-15) was made by allocating only one half of the calculated final consumption figure to these years.

The annual savings per birth averted is therefore US\$679 during adulthood and US\$339 for years (0-15). In order to convert 1980 dollars to constant 1981 dollars, a factor 1.15 is applied; anticipating annual inflation of 15 percent between 1980 and 1981. The savings per birth averted, expressed in constant 1981 US dollars is US\$780 and US\$390 respectively.

The benefits of each birth averted are counted over a twenty year period only and not for the entire expected life. This will be further explained in the section dealing with program costs.

Table 11 shows the projected net births averted under the project and the undiscounted savings per birth averted each year 1982 - 1991.

Year	Projected Births Averted	Net Births Averted	(000 Constant 1981 US\$)	
			Discounted Benefits Per Birth Averted	Total Discounted Benefits
1982	17,300	15,320	3,786	58,000
1983	21,200	18,774	3,410	64,000
1984	25,900	22,937	3,073	70,485
1985	31,900	28,251	2,771	78,284
1986	6,650	5,889	2,496	14,699
1987	8,150	7,220	2,249	16,238
1988	9,550	8,457	2,026	17,134
1989	10,900	9,653	1,825	17,617
1990	12,350	10,937	1,644	17,980
1991	14,300	12,664	1,481	18,756
				373,193

4. Project Costs

The total cost of the project consist of the implementation costs (investment) and those costs which Society would incur as a result of the project's existence. This latter cost would represent the value of the future net expected value produce stream of the marginal person whose birth is averted and therefore the benefits which Society will have to forego as a result. It is, however, extremely difficult to measure this benefit foregone: a task which is equivalent to measuring the future contribution which a "person" whose birth is averted today would have made to total output in 15 to 20 years from now.

While some attempt at measuring the output foregone should be made, the necessity for doing so is removed by the role of the discounting process in the analysis. Project benefits were not considered after the twentieth year when the discounted value of the stream of benefits per birth averted was calculated in the previous section. The same could be done for future net expected contribution foregone as a result of each birth averted. There is not much error in this approach since it is reasonable to expect that for the project target group net contribution to output would be quite close to their consumption. Furthermore, this analysis makes no allowances for future levels of unemployment and the likelihood that any or all of those births averted, would have resulted in individuals who would be productively employed. However the main rationale for ignoring the costs foregone is net contribution to output, of the births averted rests on the fact that the net benefit/cost of these individuals in the years of adulthood would be insignificant in terms of discounted values. Therefore the only costs included in

this analysis is the direct cost of implementing the program, US\$17.422 Million.

5. Cost Benefit Analysis

a. Economic Benefits

The benefits of the project were derived in table 11. In order to reduce these benefits to economic benefits it is necessary to arrive at an estimate of the foreign exchange component of these benefits. A fairly rough approximation is used here, 30 percent. In reducing the benefits of the project to economic benefits this portion of total benefits is shadow-priced, attaching a premium of 12 percent to the market value of the US dollar visa-vis the Jamaican dollar, i.e., US\$1 = J\$2.

TABLE 12

Foreign Exchange Impact of Project

(000 Constant 1981 US\$)

<u>Year</u>	<u>Total Benefits</u>	<u>F/C Impact</u>	<u>Economic Benefits</u>
1982	58,000	17,400	60,088
1983	64,050	19,200	66,356
1984	70,485	21,146	73,022
1985	70,284	21,085	72,814
1986	14,699	4,408	15,228
1987	16,238	4,871	16,823
1988	17,134	5,140	17,751
1989	17,617	5,285	18,251
1990	17,980	5,394	18,627
1991	18,756	5,627	19,431

b. Economic Costs

Only the foreign exchange component of the project cost is shadow-priced. The labour cost was not so treated although in a project of this nature it is rather a premium which would have to be added to the market value of the personnel. However, the unavailability of disaggregated personnel costs, makes it almost impossible to achieve this refinement.

Table 13

Project Cost (000 US\$)

<u>Year</u>	<u>Total Costs</u>	<u>F/E Component</u>	<u>Economic Costs</u>
1982	5.184	0.773	5.279
1983	4.871	0.706	4.956
1984	3.936	0.643	3.936
1985	3.508	0.614	3.582

c. Benefit/Costs Calculations

Economic costs and benefits are discounted at the rate of 11 percent per annum. Table 14 shows detailed benefit costs calculations.

The results of the Benefit/Costs Calculation is a B/C ratio of 24 indicating that the Population and Family Planning Services project is an extremely worthwhile undertaking. However, a word of caution is in place.

A high benefit costs ratio, as has been calculated for this project, is typical for population projects. The cause is related to the difficulty in measuring the full economic costs of these projects result in some costs being ignored (as was done in this analysis for the cost of output foregone) and the fact that the measured benefits of such programs start accruing very early in the analysis while costs are delayed.

6. Cost Effectiveness

On a cost effectiveness basis, the program appears to be feasible. The task of reducing the birth rate by 7/1000 by 1991 is an ambitious target but one which could be reached given an effective program. The projection of net births averted as a result of this project compared to the incremental costs of the project suggest a cost per birth averted of US\$90. This is a reasonable cost per birth averted and given the state of institutional and technological development in the Jamaican Society, there is hardly any alternative type of program which could achieve or even approach the target set at this level of costs.

BENEFIT/COST CALCULATIONS

(000 Constant 1981 US\$)

<u>Year</u>	<u>Total Costs</u>	<u>F/E Component</u>	<u>Economic Cost</u>	<u>Present Value of Economic Costs</u>	<u>Total* Benefits</u>	<u>F/E Impact</u>	<u>Economic* Benefits</u>	<u>Present Value of # Economic Benefits</u>
1982	5,184	0.773	3,589	5,279	58,000	17,400	60,088	60,088
1983	4,871	0.706	3,397	4,465	64,050	19,215	66,356	66,356
1984	3,859	0.643	3,060	3,175	70,485	21,146	70,032	73,022
1985	3,508	0.614	2,873	3,582	70,284	21,085	72,814	72,814
1986					14,699	4,408	15,228	15,228
1987					16,238	4,871	16,823	16,823
1988					17,134	5,140	17,751	17,751
1989					17,617	5,285	18,251	18,251
1990					17,980	5,394	18,627	18,627
1991					18,756	5,627	19,431	19,431

PV Costs = 15,558

PV Benefits = 378,391

$$B/C = \frac{378,391}{15,558} = 24$$

* Already discounted. See Table 1.

Costs and benefits discounted at 11% per annum.

C.

SOCIAL SOUNDNESS ANALYSIS1. Family Structure and Relevant Belief Systems

Jamaican women participate extensively in conjugal relationships and motherhood. According to data contained in the 1970 census 82% of all women in the 14-64 age group either were in or had been in a conjugal union. Of these 88% were mothers.

Jamaican women tend to commence their childbearing at an early age. Usually when this occurs in the teen years, the young mother tends to remain in the home of her parents or other relatives, usually the parent is her mother. The dominant feature of the Jamaican family life cycle is that women begin their fertility career under the influence of their mothers. Mothers at this stage exert firm influence on the family and related behavior of their young daughters now in their new status of mothers.

Typically, the second stage in the family building cycle begins when a young mother moves out of her parent's home to set up her own household. This is usually brought about by a new pregnancy. The structure of the household depends in part on whether or not the young woman decides to assume the role of a single parent or to enter into a common-law or married relationship. It also depends on whether or not the woman takes her earlier offspring with her into this new setting or, as is frequently done, leaves them with her own mother or other female relative. Women in this second phase tend to be somewhere within the range of 25 - 44 years. In consensual or married unions influence shifts from her mother or female relative to her partner. With the patriarchal system found in Jamaican society, a woman in the second phase of the family life cycle, with young dependent children, is at the most dependent phase of her life and as such may be least likely to make decisions on critical issues affecting her own life. Her participation in non-family roles is likely to be restricted and her socio-economic condition could be compromising. It is in this phase that women are also most likely to have the experience of a pregnant daughter who continues to live with her even after the birth of her child. A three generation family therefore comes into being.

In later life, say 45 and over, women move towards becoming single again. As their children grow older, the child-bearing responsibilities of women become lighter. They find it easier to participate in non-familial activities and with the greater possibility of assistance from grown children their economic situation tends to improve. They may head their own families and again experience relative independence. One-third of Jamaican families are headed by women.

The above model does not, of course, apply in all cases. This is especially true of minority groups representing the middle and upper classes. In such groups more often than not legal marriage is the basis of family formation and child bearing. Nevertheless, the family cycle experience of the average Jamaican woman, is characterized by youthful pregnancies primarily in the parental home, child-rearing in the middle years with the woman largely in a conjugal union, and in the later years, the family setting may be largely consanguine with the male conjugal partner absent.

The fluidity and flexibility of these familial arrangements are important considerations in the design of family planning programs in Jamaica. It requires that emphasis be placed upon "birth" planning as opposed to "family" planning in the traditional sense, and that educational, motivational, and service programs be designed to reach men and women at a very early age.

2. Cultural Norms, Values and Beliefs

A number of deep-seated cultural and psychological barriers to program implementation and success also exist in Jamaican society. Religious beliefs strongly influence family and contraceptive behavior. The situation in Jamaica is somewhat unusual in that there is very little evidence of differences in contraceptive practices between Catholics and non-Catholics. However, groups belonging to more fundamentalist religions and sects with very strong normative controls, like the Rastafarians, seem to be more resistant to population control programs. Even persons with no obvious formal religious links often cite religious rationalizations for their objection to some methods of birth control. In a very general sense there is an underlying religious sentiment in the Jamaican population which seems to influence decision making regarding family building activities. The popular belief that a woman should have all the children that God ordains her to have is nurtured in this prevailing religious influence. This is also associated with the belief that "barrenness is a curse" and may explain why even a young, pregnant teenager is afraid of selecting the abortion option, as there is no guarantee that she may conceive again.

The strong value placed on male virility as an indication of being a "real man" and the dependence on paternity to prove this is another serious obstacle to project success and will take time to modify. Implications for this project are that large-scale efforts at public education will have to be undertaken to influence these values and beliefs towards smaller family size preferences and that such efforts must be developed and implemented in a way which enlists the support of religious and other important social institutions.

3. Impact on Status of Women and Project Beneficiaries

The effect of the project on status of women will be significant. Traditionally, Jamaican women from an early age have been tied to children. Fertility begins early which structures nearly all the other options or life choices open to women. Young women with a child are less likely to complete their education, and consequently less able to qualify for non-menial jobs. This tends to increase their dependence on a male and lead to a renewed sexual union which in turn is likely to result in more children. The escape route from this dismal low-status high-fertility life history is for females to avoid the early first pregnancy and gain education and independent labor force skills. By targeting, in particular, the age group 15 to 19 the present project should make a major contribution to this goal.

Project activities will be primarily directed at women in the child-bearing years 15 to 44. Several components of the project will focus specifically on teenage women. In addition, because of their influence on decision making in the areas of family formation and childbearing, young males will be included in the target population of some project activities.

According to recent population estimates (1980) the number of women in the childbearing years 15-44 totalled over 456,000. Within this group women between the ages of 15 and 29 are the most significant contributors to total fertility. This age group also suffers from very high rates of unemployment. High rates of fertility are often found to be closely related to levels of unemployment, so the prevailing high level of unemployment among women in Jamaica poses a potential obstacle to the success of the program.

Project support for private voluntary organizations may reduce this problem somewhat. These organizations often provide skills training which can greatly increase employment opportunities for young women. Because demand for contraceptive services is believed to be directly related to the perception by women of viable and satisfying alternatives to childbearing an improved employment situation may provide young women with some tangible reason for wanting to use contraceptives.

Women between the ages of 15 and 19 will receive special attention through the project. The Adolescent Fertility Resource Center will establish and maintain contact with all agencies working with adolescents or whose work has implications for adolescent fertility. It will keep relevant agencies informed of developments in the field and will provide assistance to improve their effectiveness in providing services for adolescents. Since many of these agencies deal almost exclusively with an adolescent clientele the project will have a significant impact on this group.

Additional project support will be directed at identifying contraceptives that are suitable for adolescent females and at increasing the new acceptorship rate among women under 20 years of age. All of these activities, if successful, are expected to have a major impact on young women.

A disproportionate number of women of childbearing age reside in urban areas. Special care will be taken to ensure that the project's greater concentration on urban residents does not result in neglect of rural women. Through extensive use of radio, television and the press project support for educational/motivational services will reach a broad spectrum of society, even including people in deep rural areas.

In addition, the island's male population will also come under the influence of the project. In Jamaican society men exercise a great deal of influence over decisions relating to family and childbearing. Consequently, youth programs, intensive education campaigns and other efforts designed to promote the concept of family planning will be directed at males between the ages of 15 - 29.

There are important social benefits that will occur as a result of this project which are linked to the previously discussed economic benefits. That is, the resource needed to raise the quality of life of the people of Jamaica, the public sector funds required to raise educational standards and to focus more attention on environmental and cultural factors are all threatened by rapid population growth.

Furthermore, the emigration "drain" from Jamaica, which now plays a vital role in holding actual annual increments to manageable proportions also entails an unwanted social cost to Jamaica. The potential talents and energy which these immigrants could represent for Jamaica are lost. There is considerable evidence that, in fact, these people represent the more alert, talented and motivated of their generation. Lower rates of population growth in Jamaica, the goal of the present project, will reduce employment pressures and make for greater opportunity for young Jamaicans at home.

The social as well as economic benefits from the population program are in fact widely perceived and distributed in Jamaican society. This is attested to by the fact that no major group or segment or political faction in Jamaica is opposed to the program. Its "social soundness" appears clear to most Jamaicans.

In sum, this project represents a sound, socially relevant and acceptable approach to fertility reduction. It was designed and developed with the benefit of other 2000 in-depth client interviews on prevailing contraceptive attitudes and practices in Jamaica (see Annex E). It embodies a strategy which has proved itself over time in overcoming certain pro-natal beliefs and practices held by the population. That these beliefs and practices are amenable to change is attested to by the rapid decline in the total fertility rate by about a third during the 1970's. There is no reason, from a sociological point of view, why this rate of decline should not continue into the 80's and 90's and beyond, to achieve the project's target of 70% contraceptive prevalence and lowering of the birth rate to 20/1000 by 1990, especially given the broadening of institutional and program efforts this project envisions.

D.

TECHNICAL ANALYSIS

1. Demand for Family Planning Services

Recent studies of the Jamaican population confirm the fact that a high level of unmet demand still exists for family planning services, despite the extensive and long-standing national family planning program carried out by the NFPB and MOH. While large-scale promotional activities in both the public and commercial sectors have made "family planning", "Perle" and "Panther", virtually household words to the great majority of the Jamaican population, this high level of awareness does not translate into a correspondingly high level of effective contraceptive practice. For example, in the aforementioned UWI study (Powell, 1979), 40% of the women sampled did not want their last pregnancy and 30% said that it was mis-timed.

In addition to the high level of sporadic and ineffective contraceptive usage, slightly less than half of the women currently in-a-union are not using contraceptives and approximately 70% of these non-users are undecided as to whether they wish to use a contraceptive method at this time. There is no simple explanation for this ambivalence. For example, it is widely believed that many more women in Jamaica would adopt contraception were it not for the union pattern which results in a woman seeking the support and protection of different men as she moves through her life cycle, with each man wanting his "own" children by her. Whatever the reason, it is clear that a large unmet

demand for family planning services continues to exist, among women who lack access to services, who are becoming pregnant through ignorance or misuse of contraceptives or who are ambivalent about it but who could presumably be recruited through a motivational campaign designed to overcome their fears and inhibitions.

2. Contraceptive Technology

This project will provide a wide array of contraceptives which have proven their safety and effectiveness in family planning programs throughout the world. The large majority of contraceptives provided through the project consist of orals and condoms which are used in clinical programs and are repackaged for sale in the commercial distribution program. In addition, the project will supply smaller quantities of intra-uterine devices, diaphragms, foams and creams. Equipment necessary for performing voluntary surgical contraception will be made available through JHPIEGO and AVS, with the project providing funds for institutional support to facilities where the procedures are done.

In addition to these contraceptives, the UNFPA provides NFPB with the injectible contraceptive Depo-Provera. Depo is very popular in Jamaica, accounting for over 25% of all new acceptors and an increasing number of continuing acceptors. Jamaica was one of the first countries to adopt Depo for its national family planning program. Over 14 years of experience with the method has demonstrated its safety and reliability, not to mention its popularity, despite the unpleasant side effects the method sometimes causes.

3. Delivery of Services

The service delivery system is organized to meet the demand in a manner which emphasizes the relative advantages of the contraceptive methods available. For example, all methods are available through MOH hospitals and clinics, though not all hospitals and clinics offer the full range of methods. This project is designed to plug the gaps in the delivery system which are widely recognized. NFPB is developing a large-scale sterilization program involving facilities renovation, provision of medical equipment and supplies, staff training, institutional reimbursement and public education and promotion. The objective is to create a demand for this service and to create the machinery necessary to meet the substantial demand that already exists which can be met through over 20 government hospitals where this service is not now readily available.

In addition, NFPB plans to establish a minimum of fifteen comprehensive family planning clinics throughout the country which will also serve as centers for training and supervision of staff of other clinics in adjacent areas, with the result of increasing the quality and availability of family planning services island-wide. While the proposed NFPB clinics should make a significant contribution to increasing contraceptive user continuation rates, the project will also attack this objective directly through a large scale program of training of health personnel in MOH and other clinics. Recognizing

that good education and counselling are essential to the success of the program, these areas will be stressed. Also receiving attention will be the area of contraceptive technology, including training of nurses in intra-uterine device (IUD) insertion.

Support will also be provided through this project for non-clinical methods of contraceptive service delivery. Contraceptives will be provided for the commercial distribution of contraceptives program to help meet the demand for large numbers of clients who rely on commercial outlets. NFPB will meet other costs of the program - advertising, merchandizing, packaging, etc., through revenues generated through sales of the products.

Finally, support will be provided for community-based distribution (CBD) of contraceptives programs operated by JFPA, Operation Friendship and MOH extension workers. These programs rely primarily on house-to-house face-to-face contact. Though no study has yet been done to measure the effectiveness of this approach, it is widely believed that contraceptive continuation rates are higher than in either the clinical or CDC program because of greater access to supplies and more thorough counselling available from community workers. Though the previous AID-financed family planning project envisioned community health aids (CHAs) of the MOH being trained to distribute contraceptives in their clinic catchment areas, this program was never implemented. Hopefully, the MOH will allow the CHAs to distribute contraceptives sometime in the near future, since this would have a significant impact on fertility reduction nationwide.

E.

INSTITUTIONAL ANALYSIS

1. Introduction

Section IV, E, details the institutional problems which inhibit the effective implementation of family planning programs in Jamaica. Briefly, these problems center around shortages of key service delivery personnel, especially doctors, nurses and project managers, as well as inadequately trained personnel at several levels of the delivery system. A number of bureaucratic systematic obstacles (low pay, recruitment and promotion policies, etc.), compound the personnel problem and poor management is a problem throughout the system. Confusion over the new role and responsibilities of the NFPB, especially vis-a-vis the MOH, continues to exist and will persist until the new policy is promulgated which clearly spells out that role.

The purpose of this analysis is to consider these problems in terms of the managerial administrative environment within which this project will be implemented. The administrative capability of the NFPB, MOH, other family planning service providers, and agencies concerned with population policy and program development are assessed in terms of their organizational mandate and structure, quality of leadership and commitment, available resources, record of performance and external environmental issues affecting the organization.

2. National Family Planning Board

The NFPB is the agency of the GOJ with responsibility for overall direction and management of all family planning activities in Jamaica. The National Family Planning Act of 1970 gives NFPB the "power to prepare, carry out and promote the carrying out of family and population programs in Jamaica and to act as the principal agency of Government for the allocation of financial assistance or grants to other bodies or persons engaged in the field of family and population planning in Jamaica". Thus, NFPB, in addition to its direct service delivery programs, will receive and distribute project funds to finance other agency family planning and population projects in accordance with project proposals mutually agreeable to NFPB, the executing agency and USAID.

NFPB has been in existence since 1967. However, because of "integration" or absorption, of most of its staff and service responsibilities by the MOH in the mid and late 1970's, it has only recently begun to rebuild the management organization it requires now that the policy of "integration" with the MOH has been reversed. Currently, the NFPB consists of 12 senior staff out of a total of 78 and is actively recruiting to fill existing vacancies in the IE&C, clinical and training areas. (See Figure 2, NFPB organization chart). A vigorous new policy board has been appointed which is actively making plans for major expansion of NFPB's direct service activities particularly in the clinical IE&C areas which would increase the staff to over 200. The Board is chaired by a private physician and consists of representatives from the MOH and other public and private agency representatives and other individuals. The GOJ has agreed to grant the Board a sizeable increase in its budget to carry out its expanded responsibilities.

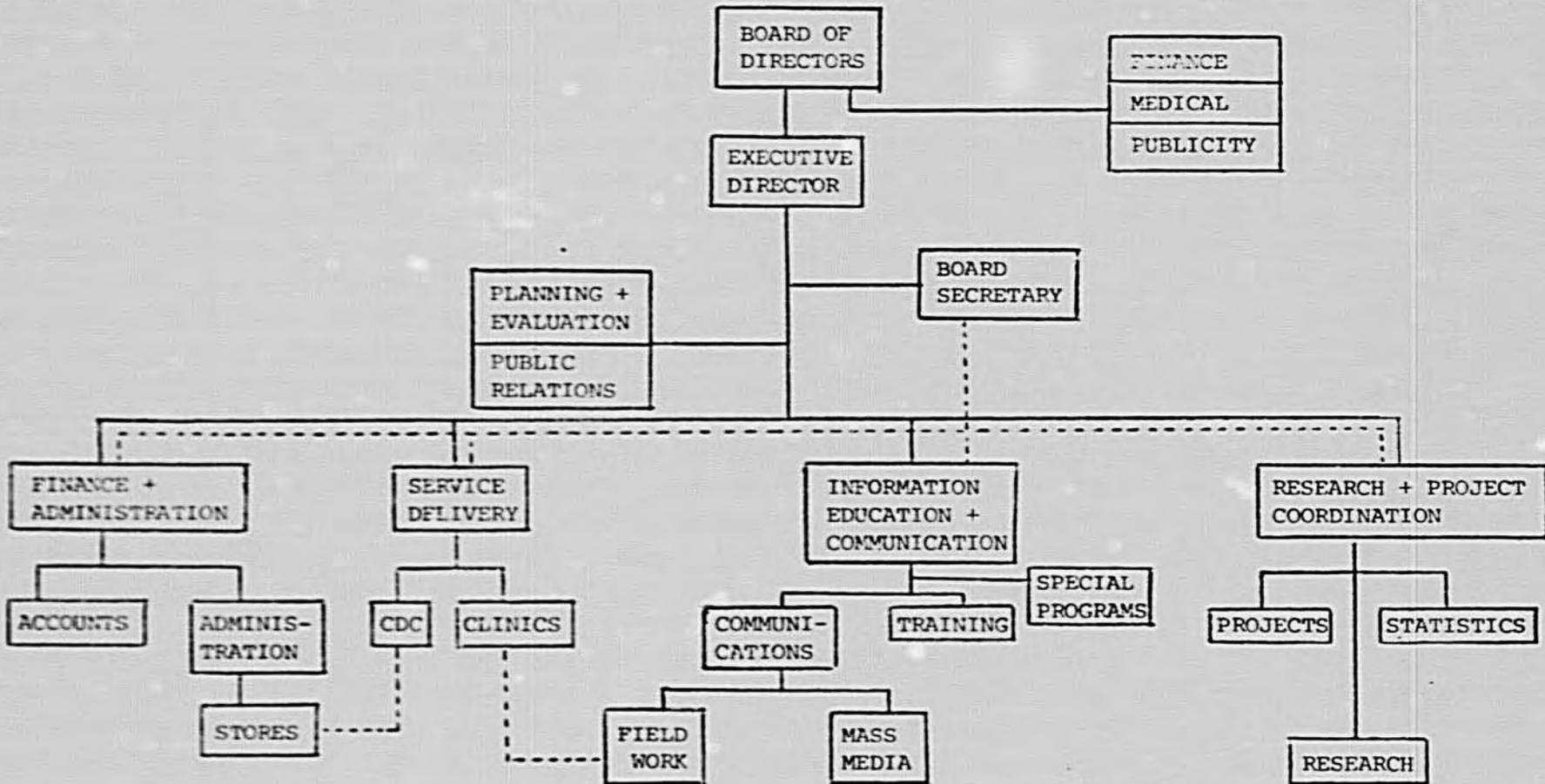
A distinguishing feature of the "new" NFPB is its dynamic leadership demonstrated by the new policy board and management team. The policy board has moved to regain NFPB's primacy in family planning through a new Ministry Paper which, once adopted, will officially confirm NFPB's role and eliminate much of the continuing confusion caused by the 1974 "integration" policy. In the program area the Board has moved vigorously ahead with previously described plans for a greatly expanded sterilization program, a direct service clinical program and a variety of public information and education efforts which include emphasis on male motivation, adolescent fertility behavior and parental responsibility. The new management staff, though largely inexperienced in family planning are also moving ahead vigorously to implement the Board's new programs.

Though NFPB shows great promise for the future, administrative problems remain that will have to be overcome for NFPB to realize its full potential. For example, key senior staff positions need to be filled and new staff trained in family planning program management. Personnel practices need to be written and installed. In addition, NFPB has not yet instituted an effective system of special project (those administered by other agencies) coordination, monitoring and evaluation. NFPB is aware of these short-falls in its present administrative structure and operation and has taken specific steps to overcome them. Once approved, NFPB's new official mandate and

National Family Planning Board

ORGANIZATIONAL STRUCTURE

(Proposed)



greatly increased budget will provide the authority and resources needed to carry out its program. Staff are being recruited and provision made in the project budget for ongoing staff training. In addition, a management needs assessment is scheduled to be carried out, which will pinpoint problems in the system and make specific actionable recommendations for their resolution. Part of this exercise will involve recruitment of a Jamaican management consulting firm to serve in a long-term consultative capacity to NFPB.

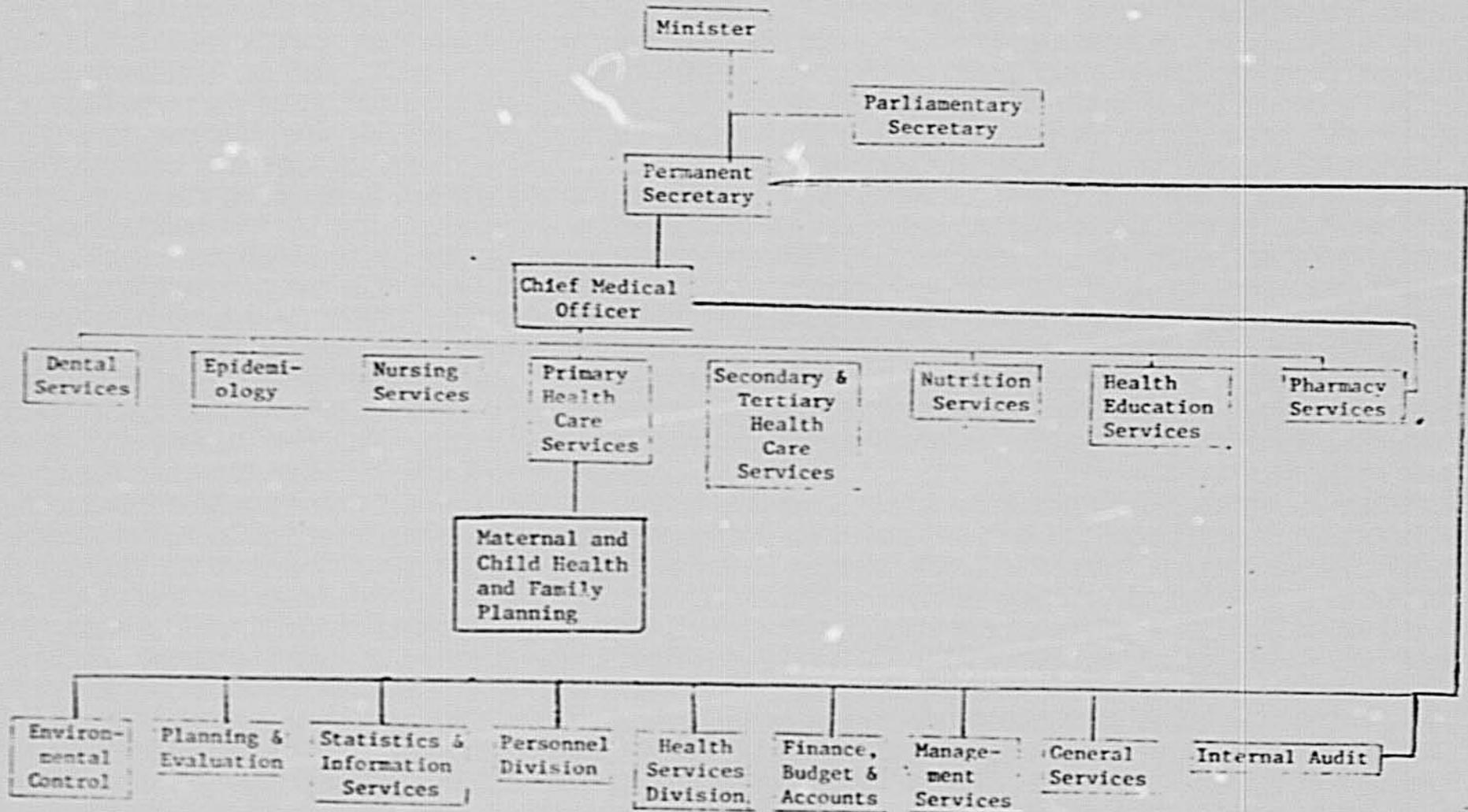
In sum the NFPB now has or will have in the near future, the legal and policy mandate, the policy and management personnel, the experience and the resources it needs to manage this project as part of a larger national family planning program. Furthermore, the project will also provide support for training NFPB staff in administrative and technical aspects of family planning program management. Finally, the external environment in terms of the high credibility of the NFPB and the general receptivity of the population to family planning messages and programs is most favorable to a significant increase in effort at this time.

3. Ministry of Health

The MOH is a large Ministry consisting of over 380 hospitals and clinics with more than 12,000 employees, at least 2,000 of which have some family planning delivery responsibilities, primarily through the primary health care (PHC) delivery system. The Ministry has been adversely affected by severe shortages of medical staff in recent years, particularly among MDs and nurses. However, there are indications this trend has been checked in recent months as the Ministry moves ahead with programs to rebuild the health delivery system and recruit additional physicians from abroad. Steps have also been taken to extend the post-graduate internship requirement for new UWI medical school graduates, which should also help ease the physician shortage.

Primary responsibility for planning, developing, implementing, monitoring and evaluating the MOH's family planning programs lies with the office of the Senior Medical Officer of Health (SMO) in charge of Maternal and Child Health and Family Planning. This office falls under the jurisdiction of the Primary Health Care Services Division (see Figure 3, MOH Central Office Organizational Chart). In practice, this arrangement has not been satisfactory for a number of reasons, chief of which is insufficient staff. The incumbent SMO is a pediatrician over-burdened with other responsibilities. There are no other senior staff at the central Ministry with exclusive responsibility for management of the family planning program, despite the fact that family planning accounts for at least 20% of all PHC services. A related institutional problem is the lack of coordination among separate MOH divisions (e.g. Bureau of Health Education and the Training Branch) with responsibility for some aspect of family planning service delivery. Additional administration problems include uneven levels of client care due to lack of overall program coordination, inadequate client counselling on family planning methods and absence of follow up, absence of an effective referral system among hospitals and clinics and among outside agencies.

ORGANIZATIONAL CHART-MINISTRY OF HEALTH (Central Office)



inadequately trained staff at various levels in the delivery system and restrictions which needlessly limit the extent to which certain categories of staff (particularly community health aids) can be used for delivery of family planning services. Reliable family planning service statistics are not readily available, though this situation is improving with installation of the Ministry's Monthly Clinic Reporting System which includes valuable information on family planning.

A priority for this project is the training of PHC personnel in the delivery of family planning services. The emphasis here will be on nurses, midwives and community health aids. Though technically part of their ongoing responsibilities, family planning has not received the priority it needs as compared with other PHC services because of inadequate staff training and poor management from the central ministry. The rejuvenation of NFPB, with increased responsibilities for training and administration of family planning services through MOH hospitals and clinics should help resolve this problem. No doubt, many of the aforementioned ongoing management problems of the MOH could be resolved with the addition of full time family planning staff at the Central Ministry with adequate authority to coordinate and manage the MOH's family planning programs. In fact the MOH agreed to this under the previous AID-financed family planning project in 1980, but it was never implemented. Given the importance to the overall success of the project of establishing a central focus at the MOH for managing its numerous family planning efforts, such will be a requirement for receipt of funds under this project.

The MOH ranks family planning among its top priorities in its 5 year Health Plan (1978-83) and senior MOH officials have consistently articulated broad support for population and family planning. Under the leadership of the MOH's Permanent Secretary (who was formerly Chairman of NFPB and now serves as Vice Chairman) an Interagency Task Force on Population Policy was appointed and chaired by the head of the MOH's Planning and Evaluation Unit. The Task Force produced the previously described Statement of National Population Policy for Jamaica which will soon be formally adopted by the GOJ.

Organizationally, the NFPB is a semi-autonomous statutory body which falls under the MOH; the Ministry of Health appoints the members of the NFPB policy board and approves and submits to the Cabinet and Parliament for approval rules governing the operation of NFPB. Thus a close relationship exists between the MOH and NFPB. NFPB's success depends heavily on the commitment of the MOH to family planning which to date has been unequivocal.

In sum, the MOH is the major provider of family planning services, and also exercises a strategic policy role through appointment of the NFPB policy board and promulgation of rules governing the operation of NFPB. The MOH is strongly committed to family planning which is an integral part of its primary health care delivery system. However, there are serious problems in the quality of the service delivery system brought about through poor management and lack of coordination of the various MOH divisions with family planning

responsibilities. AID's Health Management Improvement Project will make a significant contribution to overcoming basic management problems particularly in the PHC area. The addition of full-time family planning management staff at the MOH will also contribute to improved implementation of this project. In addition, NFPB's direct involvement in provision of family planning services through their own clinics will also serve to raise the standards of care of MOH clinics within their area of jurisdiction. Given these combined influences, the MOH will significantly improve its capacity to carry out its responsibilities under this project.

4. Other Family Planning Service Providers

Other family planning service providers receiving assistance under the project include the MYCD, the MOA, the JFPA, Operation Friendship and YWCA. Together they account for \$920,000 or 18% of the total AID project budget and an estimated 35,000 or 18% of total clients to be served under the project.

The MYCD and MOA are large well-established Ministries of government with adequate resources to carry out effective planning programs. As described in Section III the MYCD has established a national family planning coordinator's office which reports to the permanent secretary as the central focus for its project while the project head in the MOA is located in the Extension Division. Both are ideally located to implement the work required under their projects. The head of the MOA project has many years of experience in family planning program development integrated with nutrition education. The MOA under the previous AID supported family planning project has demonstrated its capacity to successfully train its field (home economics extension) workers and deliver family planning education and contraceptive services. While the MYCD has no previous experience in family planning, the establishment of a national coordinator's office as a top level of this Ministry speaks well for its commitment to this program. At the service delivery level, one of its divisions, the Social Development Commission, has been running family life education programs successfully for several years. In sum, while family planning is not a major activity for either the MYCD or the MOA, both Ministries have the commitment, the leadership, the institutional support within their Ministries and the resources to allow them to effectively implement those elements of the project for which they are responsible.

In contrast, JFPA, as previously mentioned, started family planning in Jamaica over 40 years ago and brings a wealth of proven experience to the task of implementing its share of this project. Despite its experience, however, JFPA has its share of management problems which result in long implementation delays and lack of full coverage for those in need of services. For example, the JFPA Kingston clinic renovation is months behind its planned completion schedule, and sterilization services at its St. Ann's Bay clinic is far below capacity. Part of the difficulty stems from the fact that JFPA until recently had no senior executive staff to carry out planning and management functions for the agency. Ongoing program management has been steadily improving as new senior executive staff make their presence felt, though

problems of volunteer board vs. paid staff roles and responsibilities continue to create difficulties. On balance, however, JFPA has no serious institutional or administrative problems which would prohibit the successful implementation of its share of this project.

Operation Friendship is a community-based organization similar to JFPA in that it is governed by a policy board under which comes an executive director who manages the staff of the organization. However, Operation Friendship is a much larger urban based organization which offers a wide variety of social and health services (basic health and MCH services, child dental care, primary school education, community college, day care, trade training, etc.) for the poor community of Western Kingston. In 1979 Operation Friendship added family planning services for teenagers to its activities through a grant from NFPB and USAID. This grant has been administered effectively with no major problems - surveys have been undertaken, staff recruited and trained, services delivered, and targets met pretty much as planned. In addition, Operation Friendship has demonstrated a capacity to change its policies and programs rapidly in response to new demands or changes in the operating environment. The organization is deeply committed to family planning as part of the health services program and enjoys a high degree of credibility among its target population. Its leadership has been outstanding. In short, Operation Friendship has the institutional capability required to carry out its share of this project.

The YWCA will receive a small grant of \$32,000 to carry out a specific set of family planning educational and service activities with its organization and among selected secondary schools. In 1979 the YWCA made the decision to develop this program in response to the expressed needs and desires of its youth membership and last year made the decision to include distribution of contraceptives to its educational program. Though the YWCA in common with private voluntary organizations with limited resources, has had numerous administrative problems in the past, no major institutional problems are foreseen in the implementation of this small grant.

5. Agencies Concerned with Population Policy and Program Development

There are four agencies receiving project funds in addition to NFPB which fit under this category: NPA, DOS, RGD and UWI. NFPB will monitor population developments through its newly-created Research and Projects Division. NPA, DOS and the RGD are all long-established GOJ agencies each with recognized legal responsibilities in this sector, whereas the UWI has for several years carried out training and research programs in demography and population planning.

The NPA is the lead agency of government charged with development and implementation of Jamaica's population policy within the framework of overall social and economic development planning. However, prior to the advent of this project, NPA has not made the institutional commitment required to effectively carry out its assigned role. This was primarily due to the lack of

human and financial resources available to the agency and the heavy demands on it for economic planning and analysis. Nevertheless, the agency has the mandate and has stated its commitment to assume the leadership in population planning for Jamaica. This commitment has thus far taken two forms

(1) Agreement by the head of NPA to chair an intersectoral committee on Population Policy (2) submission to the GOJ for approval of a revised organizational plan which creates a Population Unit within the NPA. This unit will be partially funded through the project for a period of three years; after which it will continue with 100% GOJ financing. Given this high level of commitment and the appropriate design and staffing of the Population Unit, there are no foreseeable administrative impediments to implementation of this element of the project.

Similarly, DOS is a Jamaican agency of Government with specific legal responsibilities for the collection and analysis of demographic data relating to population planning. High staff turnover and demands on existing staff for economic data has limited the extent to which DOS has been able to respond to the need for data for population planning. However, there are no inherent institutional weaknesses within the DOS which would prevent it from carrying out its legal responsibilities for demographic data analysis were it given the necessary resources to do so. This project will also finance the creation of a Population Unit within the DOS to consolidate and rationalize its currently disparate population activities carried out by the Demographic and Social Statistics Section, the Censuses and Surveys Division and the Computer Processing Unit. This will have the effect of strengthening the institutional capacity of the DOS to respond to data requirements of NFPB and other agencies concerned with population planning.

The RGD has made significant improvements in its organizational capacity since the implementation of the Vital Statistics Improvement (VISTIM) project in 1978. The registration process has been streamlined and for the first time since the early 1960's annual tabulations of vital statistics are being produced. Since this project builds upon the proven success of the VISTIM project no major institutional problems are anticipated.

The UWI Department of Sociology has, for many years, been the country's major source of research and training in population planning and demographic studies. This project will build upon the existing institutional framework of the Department, providing it with additional human and material tools it requires to continue and expand its work. Since the Department has a long track record of proven success and since this project makes no institutional demands outside of the existing scope of Department or University activities, no administrative problems are foreseen. Planning is going forward for University approval of the planned project financed diploma course in demographic studies which will be offered in the fall of 1982. In sum, USAID concludes that UNI will be able to successfully implement its share of this project.

IMPLEMENTATION ARRANGEMENTS

V.

A.

IMPLEMENTATION PLAN1. Implementation and Monitoring Responsibilities

Project Implementation will be the responsibility of the National Family Planning Board (NFPB). For special projects carried out by other agencies and ministries under this project, NFPB will have responsibility for providing assistance in project design and preparation, project approval (jointly with USAID), project monitoring and evaluation. Responsibility for overall project monitoring and backstopping will be assigned to the USAID Project Manager from the Health/Population/Nutrition Division. A joint NFPB/USAID Project Implementation Committee will meet quarterly to review progress and problems based upon information contained in comprehensive quarterly reports, which will be prepared by NFPB staff on a reporting format to be provided by USAID. (See Annex B for Implementation Schedule).

Advance AID approval of sub-project agreements and implementation plans will be required. In most instances these will be intra-governmental administrative agreements.

2. Financial Management

USAID will make disbursements directly to NFPB based upon approved requests for advances of funds to meet local currency costs of goods and services included in the approved project budget. Such advances may not exceed 60 days estimated expenditure. Expenditures must be properly reported and documented to USAID on monthly financial reports in form and substance acceptable to AID before further advances and approved. The foreign exchange cost of eligible goods and services procured by host country institutions generally will be financed under direct or bank letters of commitments.

3. Procurement

AID-funded commodities will be procured in accordance with AID and host country contracting procedures and requirements. Detailed procurement information will be provided to the National Family Planning Board as an attachment to implementation Letter No. 1, the text of which will also explain the application of AID requirements.

Standard Government of Jamaica procurement procedures, which are not substantively at variance with AID requirements except as to such special concerns as source/origin, cargo preference, AID approvals, etc., will be followed.

The National Family Planning Board, with the assistance of USAID, will be responsible for all procurement under the project. However, coordinators of special projects implemented through other agencies will assist NFPB in carrying out procurement actions for their special projects including formulation of specifications and obtaining quotations from at least two suppliers for all local procurement.

Ten (10) motor vehicles, including two equipped as mobile clinics, will be required over the life of the project. Of this number, five (5) will be four-door passenger vehicles and five (5) will be van-type vehicles. Solicitations will be sought from manufacturers of American vehicles in order to acquire fuel efficient, economical, and durable passenger units and vans.

The National Family Planning Board will arrange for port clearance of all imported commodities and for direct delivery of commodities to the sub-projects.

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

Certain items on the AID ineligible list will be procured for one of the special projects. These items are cutlery, forks, spoons and tents which are needed for the integrated, nutrition and family planning, education and services project of the Ministry of Agriculture.

4. Training

As a significant step toward the institutionalization of both population policy development and family planning service delivery, TRAINING is an important component of the programs supported by this 1982-85 project. As with the overall program, the training activities reflect the priorities established for the project:

- A. The development of a positive, broad-based population policy by all significant GOJ entities including training in:
 - problem-awareness for public sector decision-makers
 - policy-related demographic research
 - vital statistics registration and utilization
- B. The delivery of family planning information and services to two special target groups, adolescents and males, including training in:
 - family life curriculum development and implementation
 - peer-counselling
 - male program initiatives
- C. The strengthening of the full range of family planning services delivered by both public and private sector providers, including training in:
 - community outreach
 - clinical skills
 - communication and education skills

Training activities are presented in Annex C by institution, type of training, number of participants, course duration, year of training and cost. The NFPB, unlike other institutions shown on the schedule, will coordinate and carry out training not only for its own staff, but for a large number of other individuals employed by a variety of public and private sector agencies.

Overall, the project will finance 211 weeks of training for 13,817 participants at a total cost of \$356,000.

B.

EVALUATION PLAN

Evaluations will be carried out at various stages of project implementations. The Survey of Contraceptive use in Jamaica, 1979, including selected unpublished tabulations will be used as a baseline to measure changes in fertility. Contraceptive prevalence, etc. following project implementation. Allowances will be made as appropriate to account for the nearly two years which will have elapsed between the end of the survey and the start up of a new project.

During the life of the project special evaluations will be conducted to measure the effect of selected, high priority activities such as adolescent fertility. Additional studies on determinants of fertility, internal and external migration, etc. will provide valuable information as to how the project strategy should be modified, if at all.

Separate evaluation exercises are included in each special project activity. These interim evaluation will usually be conducted at annual intervals. Where possible, comparisons will be made with the 1979 baseline data to measure progress. Up-to-date data on utilization of family planning clinics, birth rates, sales of contraceptives, etc. will be readily available through the NFPB and MOH and other agency records. The interim evaluations will provide valuable guidance concerning the effectiveness of the various special projects and the need for changes in the allocation of project resources, administration, etc.

An overall mini-project evaluation will be carried out between the 18th and 24th month of the project. In addition, a major in-dept impact evaluation will be carried out between one year and six months prior to the project assistance completion date to determine the need, if any for a follow on project. The impact evaluation will include an island-wide survey which will provide information on fertility rates, changes in knowledge, attitudes and practices related to contraceptive use, family size, etc. The results of the survey will provide hard evidence of progress made toward attainment of the project goal and purpose. The evaluation will also investigate technical, administrative and managerial matters that have a bearing on the project and make recommendations for the design of future projects.

It is anticipated that the GOJ, Department of Statistics and the University of the West Indies will cooperate fully in project evaluations. USAID will also participate in all project evaluations and will provide foreign expert consultant evaluators to work with local experts on project evaluation teams. A total of \$100,000 has been provided in project funds for evaluation, most of which will be used to pay for survey costs of the end-of-project impact study.

Achievement of the project goal will not be the major focus of project evaluation. This is because of the difficulty, if not impossibility, of measuring the "impact" of the project on health, social and economic status. There are so many important external variables which affect these outcomes (e.g. government policy, good availability, political unrest, etc.) that cannot be properly controlled in the evaluation design. Moreover, the problem is compounded by the generally accepted notion that low fertility may be a necessary pre-condition but is not, in itself a determinant of improved social and economic status. Finally, looking only at that part of the goal statement which deals with reduction of the birth rate, it is possible that if fertility does not decline as rapidly as hoped for, there could actually be a temporary increase in the birth rate in the mid-80's. This is because of the larger numbers of women entering into their prime child-bearing years during this period, and does not necessarily mean that fertility is not declining, only that it is declining at a slower rate than expected. This must be kept in mind when looking at data on birth rates at the completion of the project.

The major focus of project evaluation will be on project purpose and output achievement. This can be quite straightforward measured by the aforementioned contraceptive prevalence survey and in the case of the "population" project purpose, by official GOJ records indicating the extent to which relevant agencies have built up their institutional capacity to produce and have indeed produced and implemented population policies and plans. Other measurement criteria and indicators of project achievement are detailed in Annex A (Logical Framework).

VI. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

The standard conditions precedent to initial disbursement of the Grant will apply. These involve the designation of official GOJ representatives and the provision of specimen signatures and of a legal opinion confirming the validity of the Grant Agreement.

Special conditions precedent to disbursement will include the following:

- a) Prior to any disbursement of Grant funds the GOJ will be required to submit evidence that the NFPB has been given authority and responsibilities appropriate for its direction and implementation of the Project.
- b) Prior to disbursement of Grant funds for MOH activities the Grantee will be required to provide evidence of its intent to establish and fill a post within the Ministry for a full-time Family Planning Coordinator with adequate authority to coordinate the planning and implementation of all Project activities carried out directly by the various branches and divisions of the MOH.
- c) AID approval of a comprehensive plan to improve NFPB's personnel, financial and physical resources management will be required prior to disbursement for any activity to be implemented by NFPB.
- d) AID approval of a sub-project agreement and implementation plan will be required prior to disbursement for each respective sub-project or activity to be implemented by any organization other than NFPB. A comprehensive implementation plan covering all proposed activities of the Grantee's Adolescent Fertility Resource Center is also required prior to disbursements for this sub-project.

Project Title Population and Family Services,

Number: 512-0069

Narrative Summary	Objectively Verifiable Ind	Means of Verification	Important Assumptions
<p>Program or Sector Goal:</p>	<p>Measures of Goal Achievement:</p>		
<p>To improve the health, social and economic status of the Jamaican people</p>	<ol style="list-style-type: none"> 1) Increase in real per capita income 2) Decrease in demand on public health services 3) Decrease in rate of unemployment 4) Increase in percentage of children enrolled in the public schools. 	<ol style="list-style-type: none"> 1) MOH Reports 2) MOE Reports 3) Registrar General Department reports 	<ol style="list-style-type: none"> 1) The economy will begin to show growth by 1982 2) The GOJ will maintain a strong priority and commitment to vigorous National Family Planning programs. 3) External funding for family activities will be maintained at current levels or increased. 4) Small family norms will be accepted. 5) Continued high rate of migration.
<p>Project Goal:</p>	<ol style="list-style-type: none"> 1) Reduction in CBR to 24/1000 by 1986 and to 20/1000 by 1990 	<ol style="list-style-type: none"> 1) Registrar General Department Records 	
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of Project Status:</p>	<ol style="list-style-type: none"> 1) NFPB/MOH service statistics 2) NFPB records 3) UWI survey 4) Special Projects records 5) Other GOJ plans and public reports 	<ol style="list-style-type: none"> 1) GOJ will provide adequate financial support 2) MOH & NFPB will improve their capacity for project implementation 3) NFPB will continue to assume a leadership role in coordinating the National family planning program
<p>To expand the coverage and increase the effectiveness of contraceptive services delivery</p>	<ol style="list-style-type: none"> 1) Increase rate of contraceptive prevalence from 58% in 1980 to 70% in 1986 2) 50% increase in number of new and continuing family planning acceptors by 1985 		

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
<p>Output</p> <p>1) Trained indigenous staff functioning at all levels of the family planning delivery system</p>	<p>3) 25% increase in sales of contraceptives through the CDC program</p> <p>Magnitude of outputs:</p> <p>1) At least 2,000 PHC workers trained in family planning</p> <p>2) At least 16 family planning administrators and other specialists will have received short term overseas training</p> <p>3) At least 4 senior employees of DOS and other agencies will have received long-term training in demography at UWI</p>	<p>1) MOH, NFPB, DOS, Ministry of Agriculture & AID records</p> <p>2) Site visits</p>	<p>4) The GOJ will adopt a national population policy</p> <p>1) NFPB and MOH will carry out training according to the project training plan</p> <p>2) GOJ will free up staff from other duties for training</p> <p>3) Out-migration of skilled medical personnel will be checked.</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAME WORK

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
2) Increased availability of family planning services through MOH and NFPB clinics and through the commercial distribution of contraceptives program	<p>4) 6,000 agricultural extension agents will have received training in family planning</p> <p>1) All non-specialty MOH hospitals and clinics (approx. 370) offer a full range of family planning services by 1985.</p> <p>2) At least 8,000 voluntary sterilizations performed annually by 1985</p> <p>3) 25% increase in the number of commercial outlets in the CDC program by 1985</p>	<p>1) MOH & NFPB records</p> <p>2) Site visits</p>	<p>1) NFPB will receive the new financing necessary to carry out clinical program</p> <p>2) MOH will increase its commitment to family planning service delivery</p> <p>3) Overall economic conditions will continue to improve</p>
3) Research carried out on determinants of fertility, migration and contraceptive prevalence	<p>1) Research study produced which identifies causes of fertility among general population and sub-groups such as males and adolescents</p> <p>2) CPS carried out island wide utilizing a sample of 2,000 respondents</p>	<p>1) UWI records</p>	<p>1) Staff at Department of Sociology will remain available for the planned research</p>

PROJECT DES 1 SUMMARY
LOGICAL FRAME WORK

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
<p>4) Population policies adopted at both national and sectoral levels and policy, planning and monitoring apparatus established</p>	<p>1) National Population Policy and plan developed and adopted by parliament by 1983</p> <p>2) Population/Demographic research units established at NPA and DOS</p> <p>3) Diploma course in demography established at UWI</p> <p>4) Interagency Population Policy Committee established</p> <p>5) Population analyses included in long-term sector plans for Jamaica</p> <p>6) Population plans produced as part of sectoral plans for at least three GOJ ministries - Health, Education and Agriculture</p>	<p>1) GOJ and UWI records</p>	<p>1) Technical resources will remain available through The Population Council to assist in population policy development</p>
<p>Inputs:</p> <p>a. <u>Technical Assistance</u></p> <p>1) population policy development</p> <p>2) registration and vital statistics</p> <p>3) development and coordination of training programs</p> <p>4) family planning management</p> <p>5) program development and evaluation</p>	<p>10½ PM from Population Council over 4-year life of project</p> <p>Approximately 8 PM from Nat'l. Center for Health Statistics in 1982 and 1983</p> <p>Approximately 15 PM centrally-funded TA (non-project financed) from APHA, DAI, CDC, AHEA, AVS JHPEIGO, Pathfinder Fund, and the Futures Group in form of short-term consultancies as required</p>	<p>Reports, evaluations, site visits and inspection by NFPB, GOJ, AID and/or</p>	<p>Timely procurement of commodities and consultant services by NFPB/AI</p> <p>Continued funding by AID/W of agencies providing centrally funded technical assistance</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAME WORK

Narrative Summary	Objectively Verifiable Ind.	Means of Verification	Important Assumptions
<p>b. <u>Training</u></p> <p>1) US and other overseas participant training</p> <p>2) Local training and agency orientation in all aspects of family planning program development, management and implementation</p>	<p>36 weeks of short-term overseas training by 16 participants</p> <p>211 weeks of short-term training by 13,817 participants</p>		
<p>c. <u>Commodities</u></p> <p>1) Centrally-procured condoms and oral contraceptives</p> <p>2) Other contraceptive supplies medical equipment and supplies and vehicles (8) and other supplies</p>	<p>15,500 condoms and 1950 cycles of oral contraceptives over the LOP (approx. \$1.4M)</p> <p>Approximately 1M in other commodities to be purchased over LOP</p>		
<p>d. <u>Other</u></p> <p>Salaries, local consultant services, research costs, per diem and other local costs of special projects of:</p> <p>NFPB MOH MYCD Women's Center. YWCA MDA JFPA Operation Friendship NPA DOS TWT RGD ACOSTRAD</p>	<p>All other costs total approximately \$1.4M for services to be delivered primarily in first three years of the project</p>		

PROJECT DESIGN SUMMARY
LOGICAL FRAME WORK

Narrative Summary	Objectively Verifiable Ind.				Means of Verification	Important Assumptions
	1982	1983	1984	1985		
<p><u>st Country</u></p> <p>Budgetary support for the MOH/NFPB including NFPB staff and administration, overhead, etc.</p> <p>Provision of all health facilities including hospitals, health centers and clinics etc., to provide family planning service and surgical procedures</p> <p>Warehouse maintenance, distribution and control of commodities (contraceptives, audio-visual equipment etc.), furnished by the project</p> <p>Training of medical/para medical personnel and other out-reach programs etc.</p> <p>Office space for counterpart and administrative support</p>	3,678	3,459	2,726	2,559	<p>1) GOJ reports and records</p> <p>2) Site visits</p>	<p>1) GOJ will maintain a high level of public commitment to family planning</p> <p>2) Public funds will remain available to finance family planning programs</p>
<p><u>her Donors</u></p> <p>Though not considered a part of this project <u>per se</u> the assistance of the following other donors will also contribute to goal and Purpose achievement</p> <p>UNFPA AVA Pathfinder APHA IPPF AHEA FPIA DAI JHPEIGO Federal Republic of Germany IBRD/World Bank</p>	See Annex F for summary of other donor assistance in the family planning sector				Agency Records	External support to Jamaica from other donors will be maintained at current levels

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
<u>National Family Planning Board</u>		
1. Project Authorization	March 1982	USAID
2. Project Agreement Signed	April 1982	USAID
3. First Disbursement of Funds	April 1982	USAID/GOJ/NFPB
4. Procure Project Commodities	on-going	NFPB/USAID
5. Observation Trips for 6 Family Planning Administrators and Policy Makers (2 each year)	August 1982 August 1983 August 1984	NFPB/USAID
6. Two Conferences for Administrators & Government Ministries & Private Sector on NFPB objectives & policies	September 1982 September 1983	NFPB
7. Inservice Training for NFPB staff & Board Administrators	on-going	NFPB
8. Training for NFPB clinic staff	on-going in 83,84,85	NFPB
9. Joint NFPB/USAID Quarterly Reviews	on-going	NFPB/USAID
10. Joint NFPB/USAID Quarterly Reviews with Agencies	on-going	NFPB/AID/Agency
11. Mid-Term Evaluation	August 1983	NFPB/AID/UWI
12. End of Project Evaluation	August 1985	NFPB/AID/UWI
<u>SUB-PROJECTS</u>		
<u>Jamaica Family Planning Assoc.</u>		
13. Project Approval	April 1982	NFPB
14. Project Agreement Signed	April 1982	JFPA/NFPB

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
15. Residential Training and orientation of recruits and current outreach workers	May 1982	JFPA/NFPB
16. Submit Quarterly Project Progress Report	on-going	JFPA
17. End of Project Evaluation	December 1984	JFPA
<u>YWCA</u>		
18. Project Approved	April 1982	NFPB
19. Project Agreement Signed	April 1982	NFPB/YWCA
20. Provide contraceptive information and service to YWCA students	on-going	YWCA
21. Submit Quarterly Project Progress Report	on-going	YWCA
22. End of Project Evaluation and Report	December 1983	YWCA
<u>MOH "Teen Scene"</u>		
23. Project Approved	April 1982	NFPB
24. Project Agreement Signed	April 1982	MOH/NFPB
25. Procure Project Commodities	June 1982	MOH/KSAC/AID
26. Recruit full complement of project staff	January - June 1982	MOH/KSAC
27. Orientation & Training of all staff	July 1982	MOH/KSAC
28. End of Project Evaluation and Report	December 1984	MOH/KSAC
<u>Operation Friendship</u>		
29. Project Approved	April 1982	NFPB
30. Project Agreement Signed	April 1982	OF/NFPB

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
31. Procure Project Commodities	June 1982	OF/USAID
32. Recruit 15,000 new family planning acceptors	on-going	OF
33. Joint meeting with AID/NFPB to develop project evaluation schedule	March 1982	OF/NFPB/USAID
34. Annual Project Evaluation	January '83 & '84	OF
35. End of Project Evaluation	December 1985	OF/NFPB
<u>Ministry of Youth and Community Development</u>		
36. Project Approved	April 1982	NFPB
37. Project Agreement Signed	April 1982	MYCD/USAID
38. Procure Project Commodities	June 1982	MYCD/AID/NFPB
39. Recruit full complement of Project staff	March 1982	MYCD
40. Appointment of Coordinating Committee	1982	MYCD
41. Provide 32,000 youth with family planning information and services	on-going	MYCD
42. Submit quarterly project progress report	on-going	MYCD
43. Attend quarterly project review meetings with AID / NFPB	on-going	MYCD/AID/NFPB
44. Conduct Annual Evaluations	December '83 & '84	MYCD
45. End of Project Evaluation	December 1985	MYCD/NFPB
<u>Ministry of Agriculture</u>		
46. Project Approved	April 1982	NFPB
47. Project Agreement Signed	April 1982	MOA/NFPB

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
48. Train Agricultural Extension Officers	on-going	MOA
49. Submit quarterly project progress reports	on-going	MOA
50. Attend quarterly project review meetings	on-going.	MOA/NFPB/AID
51. End of Project Evaluation and Report	December 1985	MOA/NFPB

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
POPULATION DEVELOPMENT PROJECTS		
<u>Population Council</u>		
52. Technical Assistance contract signed	April 1982	NFPB/AID
53. Provide Technical assistance to NFPB, NPA, UWI, & Department of Statistics in the area of population institutional building, Training and Research	on-going	PC
54. Provide Technical assistance to the GOJ inter-agency coordinating committee for population planning and development	on-going	PC
55. Prepare and submit Quarterly progress reports to NFPB and AID	on-going	PC
<u>Department of Statistics</u>		
56. Project Approved	April 1982	NFPB
57. Project Agreement Signed	April 1982	NFPB/DOS
58. Procure project commodities	June 1982	DOS/NFPB/AID
59. Employ consultant to manage population unit	May 1982	DOS
60. Prepare and publish demographic report	on-going	DOS

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
61. Prepare population projections	on-going	DOS
62. Submit quarterly project progress reports	on-going	DOS
63. Attend quarterly project review meetings	on-going	DOS/NFPB/AID
64. End of Project Evaluation	December 1984	DOS/NFPB
<u>Registrar General's Department</u>		
65. Project Approved	April 1982	NFPB
66. Project Agreement Signed	April 1982	NFPB/RGD
67. Project Agreement Signed (NCHS)	March 1982	NFPB/RGD/NCHS
68. Training of 120 local Registrars	on-going	RGD
69. Conference on Vital Statistics	July 1982	RGD
70. Provide Technical Assistance to the RGD	on-going	NCHS
<u>National Planning Agency</u>		
71. Project Approved	April 1982	NFPB
72. Project Agreement Signed	April 1982	NFPB/NPA
73. Procure project commodities	June 1982	NPA/NFPB/AID
74. Employ full complement of staff for Population Unit	May 1982	NPA
75. Monitor Implementation of the Population Policy	on-going	NPA
76. Coordinate the work of the sectors involved in population matters	on-going	NPA

IMPLEMENTATION SCHEDULE

MAJOR ACTION	ESTIMATED MONTH	RESPONSIBLE ORGANIZATION
77. Submit quarterly project progress reports	on-going	NPA
78. Attend quarterly project review meetings	on-going	NPA/NFPB/AID
79. Mid Term Project Evaluation and Report	September 1983	NPA/NFPB/AID
80. End of Project Evaluation and Report	December 1984	NPA/NFPB/AID
<u>University of the West Indies</u>		
81. Project Approved	April 1982	NFPB
82. Project Agreement Signed	April 1982	NFPB/UWI
83. Establish graduate diploma course in Demographic Studies	on-going	UWI - Dept. of Sociology

II.

TRAINING SCHEDULE

Institution	Type	Number of Participants	Course Duration	Courses/Year				Cost
				1	2	3	4	
Various (Overseas Participant)	Male Motivation (NFPB)	4	2 weeks	X	X			3,200
	Research/Statistics (NFPB)	2	1 month	X	X			6,000
	Training of Trainers (NFPB MOH)	2	6 weeks	X	X			9,000
	Program/Policy Development (various agencies)	8	1 week	X	X	X	X	16,000
Sub-Total		16	10 weeks					34,200
NFPB	Administrators- Managers family planning program	200	2 - 1 day	X				3,486
	Male Motivation	1100	13 - 1 day	X	X	X	X	6,184
	Medical Team Contraceptive Update	160	5 - 1 day	X	X	X	X	1,293
	Industrial nurses & welfare officers (infor- mation/motiva- tion	500	4 - 1 day	X	X	X	X	9,726
	Principals of Tertiary Insti- tutions (infor- mation/motiva- tion	120	4 - 1 day	X	X	X	X	3,261
	Principals of Elementary schools	200	4 - 1 day	X	X	X	X	4,498
	Principals of Secondary schools	200	4 - 1 day	X	X	X	X	4,498

Institution	Type	Number of Participants	Course Duration	Courses/Year				Cost
				1	2	3	4	
	In-service training (NFPB staff)	120	8 - 1 day	X	X	X	X	3,148
	Family Planning Clinical training (NFPB new staff)	60	3 - 10 days		X	X	X	12,930
	Family Planning clinical training (NFPB staff)	60	12 - 1 day	X	X	X	X	7,421
	Commercial Distribution of Contraceptives Retailers (Information/Motivation)	400	30 - 1 day	X	X	X	X	11,244
	Adolescent Program Management	8	1 - 3 weeks	X				12,000
	Demography	4	2 - 9 weeks		X	X		7,000
	Project Management	3	1 - 1 week	X				
	Family Planning Management	40	2 - 2 week	X	X			12,409
	Information/Education and Communication	80	3 - 3 days	X	X	X		6,072
	Sub-Total	3255	48 weeks					105,170
Ministry of Health	Clinical & Community Training for Parish PHC teams	2400	100 - 2 days	X	X	X	X	55,050
	Family Planning Clinical Training for Medical Officers of Health	40	2 - 2 days	X	X			6,803

Institution	Type	Number of Participants	Course Duration	Courses/Year				Cost
				1	2	3	4	
	Family Planning for nurses and dietitians	1400	69 - 1 day	X	X	X	X	5,004
	Family Planning training for Mental Health Officers	20	1 - 2 day		X			1,237
	Family Planning training for Peer Counsellors (Pre-service)	15	1 - 2 week	X				4,216
	Family Planning training for Peer Counsellors (Update)	15	6 - 1 day		X	X	X	1,517
Sub-Total		3890	58 weeks					73,827
Registrar General	Vital Statistics Registration for local Registrars	160	4 - 2 days	X				11,190
Sub-Total		160	2 weeks					11,190
ACOSTRAD	Health Educators Workshop on STD	40	1 - 4 days	X				5,622
	Teacher Trainers Workshop on STD	40	1 - 5 days	X				6,746
	Teacher Trainers Workshop on STD	40	1 - 2 days	X				2,811
Sub-Total		120	2 weeks					15,179

Institution	Type	Number of Participants	Course Duration	Courses/Year				Cost
				1	2	3	4	
Jamaica Family Planning Association	Contraceptive Methods, reproductive health & communication skills for outreach workers	40	1 - 4 days					(DAI funded)
	Family Planning Outreach update	11	3 - 5 days					5,500
	Advanced Family Planning Skills for Outreach Workers	11	6 - 1 day					1,500
	Sub-Total	62	5 weeks					7,000
Ministry of Agriculture	Family Planning for Home Economics Extension Workers	160	2 - 2 weeks	X	X			20,000
	Adolescent Fertility for Rural Teenagers	120	4 - 2 days	X	X	X	X	17,000
	Family Planning for Male Agricultural Extension Workers	6,000	100- 2 days	X	X	X	X	27,000
		6,280	46 weeks					64,000

Institution	Type	Number of Participants	Course Duration	Courses/Year				Cost
				1	2	3	4	
Operation Friendship	Family Planning Outreach and Clinical skills	6	4 - 1 week	X	X	X		3,000
Ministry of Youth & Commu- nity Develop.	Family Planning/ Family Life Education for project staff	16	8 - 1 week	X	X	X	X	15,000
Department of Statistics	In-service and short-term over- seas training in statistics and demography	3	6 - 4 week	X	X	X		25,000
University of the West Indies	Population Analysis staff development	4	2 - 2 week	X	X			4,000
	GRAND TOTAL	13,817	211 weeks					\$ 356,190

Estimated AID Commodity Procurement Schedule

Annex D - 1

	YEAR I		YEAR II		YEAR III		YEAR IV	
	FX	LC	FX	LC	FX	LC	FX	LC
<u>A. National Family Planning Board</u>								
1. Contraceptives								
- Orals	140,140		153,725		169,455		185,680	
- Condoms	193,600		208,550		243,802		275,903	
- Other	15,236		57,444		37,346		37,436	
2. Drugs & Medication	29,215		29,215		29,215		29,215	
3. Medical Equipment & Supplies	3,370		1,780	750	2,060		1,340	500
4. Clinical Supplies	20,295		11,393		12,445		12,445	
5. Other Equipment & Supplies	1,796		159		318			
6. Educational Equipment & Supplies	10,919		7,525		6,684		7,430	
7. Vehicles & Spare Parts	24,000		2,400		14,400		12,000	
8. Miscellaneous Insurance & Freight Cost for all Commodities except Orals & Condoms	19,455		19,455		20,704		21,202	
<u>B. NFPB Adolescent Resource Center</u>								
5. Other Equipment & Supplies		13,000		5,000		5,000		
6. Educational Equipment & Supplies	6,000	5,000	5,000	3,000	5,000	4,000		
SUB-TOTAL	464,026	18,000	496,646	8,750	541,427	9,000	582,651	500

	YEAR I		YEAR II		YEAR III		YEAR IV	
	FX	LC	FX	LC	FX	LC	FX	LC
I. Ministry of Health Special Projects:								
A. <u>Adolescent Fertility</u> <u>(Teen Scene)</u>								
5. Other Equipment & Supplies		4,000		500		500		
6. Educational Equipment & Materials	1,000	1,000		500		500		
B. <u>Bureau of Health</u> <u>Education</u>								
6. Educational Equipment & Supplies	9,708		6,590		4,710		2,994	
7. Miscellaneous	735		562		513		488	
C. <u>Government Laboratory</u>								
3. Medical Equipment & Supplies	297		297					
4. Clinical Equipment & Supplies	19,242	2,096	11,676	2,096	11,187	2,096	9,237	2,096
D. <u>Post Partum Program</u>								
6. Educational Equipment & Supplies	9,071		3,295		1,258		322	
8. Miscellaneous	256		6		25			
E. <u>ACOSTRAD</u>								
5. Other Equipment and Supplies		3,000						
6. Educational Equipment and Supplies	5,000	2,000	5,000	2,000				
SUB-TOTAL	45,309	12,096	27,426	5,096	17,693	3,096	13,041	2,096

	YEAR I		YEAR II		YEAR III		YEAR IV	
	FX	LC	FX	LC	FX	LC	FX	LC
II Other Special Projects:								
A. <u>Ministry of Youth</u>								
5. Other Equipment Supplies	2,000	9,000		1,500		1,500		1,500
6. Educational Equipment & Materials	17,000		3,000	2,500	3,000	2,500	1,000	1,000
7. Vehicles & Spare Parts (3)	17,000		9,000		3,000		1,500	
B. <u>Ministry of Agriculture</u>								
5. Other Equipment & Supplies	2,000	2,000	2,500	2,000				
6. Educational Equipment & Supplies	4,000		4,500	2,000				
7. Spare Parts for Vehicles	2,000		4,000					
C. <u>Operation Friendship</u>								
2. Drugs & Medication	2,000		2,000		2,000			
3. Medical Equipment	3,000							
5. Other Equipment & Supplies		2,000		3,000		2,000		
6. Educational Equipment & Supplies	3,000		2,000		2,000			
7. Vehicles & Spare Parts (1)	14,000							
D. <u>JFPA - Youth Associates</u>								
5. Other Equipment & Supplies	3,000	2,000	3,000	2,000				
7. Vehicles & Spare Parts (1)	6,000							

	YEAR I		YEAR II		YEAR III		YEAR IV	
	FX	LC	FX	LC	FX	LC	FX	LC
. <u>UWI - Department of Sociology</u>								
i. Other Equipment & Supplies	1,000	3,000		3,000				
. <u>Registrar General's Department</u>								
i. Other Equipment & Supplies	4,000	570	2,000	540				
. <u>Department of Statistics</u>								
i. Other Equipment & Supplies	6,000	2,000		1,895				
i. Educational Equipment & Supplies	2,000		2,000					
. <u>National Planning Agency</u>								
i. Other Equipment & Supplies	6,500	13,000						
7. Vehicles & Spare Parts (1)	8,500							
SUB - TOTAL	103,000	33,570	34,000	18,435	10,000	6,000	2,500	2,500
GRAND-TOTAL	612,335	63,666	558,072	32,281	569,120	18,096	598,192	5,096
TOTAL ALL YEARS	\$2,456,858							

SURVEY OF CONTRACEPTIVE USE IN JAMAICA, 1979Summary

The study of Contraceptive Use in Jamaica focused on women 14-44 years who represent the largest possible target group for family planning programmes. The total number in the sample is 2198. Not all of these women are however at risk of becoming pregnant, since they might currently enjoy various forms of non-exposure to risk. Not all the women may be fertile, some may be temporarily or permanently outside of a sexual union, and others may be using effective methods of family planning for example, sterilization. In presenting this report some sections deal with the wide target group of the sample, while other sections deal with women who have ever been in a union. Areas which deal with fertility and actual contraceptive practice exclude women who have never been in a union.

Knowledge of Contraception

Knowledge of contraception was exceptionally high, with over 90% of the sample knowing at least one method of contraception. The pill, the condom, the injection (adepe provora) and the I.U.D. were the most frequently mentioned methods. Educational level was found to be directly related to number of methods known. Women with high school education could name a larger number of contraceptive methods, than could women with primary education. Knowledge was also found to be related to union status. Married women had the highest average of methods known, and single women, the lowest. The majority of women named only the more recognised methods of contraceptives.

While knowledge of contraceptives obtained through the conventional question of methods known can be superficial and not

indicative of knowledge about methods, it gives a clear indication of the level of awareness about contraception. Awareness is the first step to the acquisition of real knowledge and the use of contraception. The important fact for the Jamaican woman is that more women have indeed become aware of family planning. The 93% spontaneous response compares to 87% of the 1972 Fertility Survey,² and one could indeed confidently say that the national programme is largely responsible for the spread of family planning information among Jamaican women.

Women must now be taken to a new level of knowledge about contraceptive methods. They need to be presented with carefully prepared information on specific methods of contraceptives and the working of these methods in relation to their own body process. The aim of this thrust in education should be to develop understanding and acceptance of family planning as an important part of the health preparedness of the individual, and a right to which she is entitled like any other aspect of the health delivery system. Of course the machinery necessary to provide this kind of education widely would require the working out of new management strategies to monitor the needed organizational and staff structures.

Attitude to Contraception

Approximately 11 percent of the women felt that contraceptives were harmful to a woman's health, while 36% felt there was no harm. There were however problems associated with specific methods which were of concern to the women. For example excessive bleeding associated

with the pill, and menstrual problems associated with the injection were frequently mentioned.

The fact that the women seemed so health conscious could be an asset to the family planning programme. Working from where the client is, is always a good problem-solving maxim. If health is valued, then there should be little difficulty in convincing individuals that rational and efficient planning of family is an intrinsic aspect of one's total health responsibilities.

With regards to specific methods, perhaps the strongest negative attitude was directed against sterilization as a method of contraception. Nearly 6 out of 10 women did not approve of sterilization for themselves, and 7 out of 10 would not approve it for their spouse. The irreversible nature of sterilization was the prime concern. This was tempered by religious scruples, 'it is against God's will'. Older women were more concerned with the religious consideration and younger women more with the finality of the method. The women strongly felt that the decision about the use of sterilization was largely theirs, rather than their spouse's.

Women who already had their desired number of children were more approving of sterilization than those who wanted more children. It was therefore not surprising to find that women with 6 or more children were more approving than those with fewer children.

Since attitudes can be the most potent barrier to the acceptance and success of a family planning programme, it is extremely important that programme personnel take seriously, findings relating to attitudes, and plan deliberately to work with sub-groups of women in an effort to

counteract negative attitudes. Most studies have shown that attitudes much more than knowledge are consistent with practice.

Practice of Contraception

Just over one-third of the total sample of women and 50.5% of the over union women were currently practicing contraception. The pill is the most popular method known and used. More than one in five of over union women were using the pill. Ten percent were using the injection, 9% reportedly sterilized and 6% using the condom. Relatively few women used other methods, for example nearly 2% use the I.U.D., 1% withdrawal and under 1% the cream/jelly type methods.

The pill and the condom are favoured by younger women and the sterilization and I.U.D. by older women. There was hardly any age cluster with respect to the injection.

Other identifiable sub-groups are married women and women with primary education favouring the I.U.D. and sterilization. This suggests intercorrelation between age, education and union with respect to the use of particular methods.

Women who are never users of contraceptives make up the majority of the women who were pregnant at the time of the survey.

Source of Contraceptive Methods and Contraceptive Information

The public sector emerged as the single most important source of contraceptive methods. More than 60% of current contraceptive users obtain their supplies from government hospitals and clinics. The commercial sector provides 27% of the products needed by current contracepting women, with pharmacies being the most important group in this sector. Private sources (hospitals and physicians) supply

just 7% of the needed contraceptives.

With reference to source of supply for specific methods, more than 40% of the users of the pill and the condom got their supplies from pharmacies. Twenty percent of women with the I.U.D. use private physicians and a slightly smaller proportion of sterilized women use a similar source. It can be said that the government clinic/hospital setting is the major supplier of all methods. Further, with the government's role in commercial distribution of contraceptives, it certainly controls the distribution of contraceptive materials to a large segment of Jamaican women in the child-bearing age.

Health-related staff (clinic and hospital nursing personnel and physicians) constitute the most important source of information about contraceptive methods, accounting for over 60% of sources of information. The media and primary groups (friends) are almost equal with about 14%. Urban women tend more than rural women to have gotten information from clinic and hospital personnel. While this is also the most important source for rural women, they tend more than urban women to also have heard from private physicians and the media.

Access to Contraceptive services

Public transportation is the most important means of reaching contraceptive outlets. More than 50% of contraceptive users travel this way, one-third walk to the outlets and just over 10% use private transportation. Most urban women walk and most rural women use public transportation. Yet, walking women in the urban area take a shorter time to reach outlets, than is the case with rural women. Seventy-seven percent of urban women take 30 minutes or less. Nearly 4 out of 10 rural women take half an hour or longer.

Access is a critical aspect of the success of a contraceptive programme. The data suggests rural-urban differentials with the rural woman no doubt at a disadvantage. She takes a longer time to reach outlets, and they tend to use private and commercial sources much more than the urban woman. Knowing the usually more strained economic conditions in the rural areas, one cannot explain the rural woman's behaviour in terms of more favourable economic conditions. The explanation points to access. The topography of rural areas often tend to isolate some rural women. Public transportation is more limited. To add to this, clinic hours are usually less available. The rural woman therefore suffers several disadvantages and so have less access than their urban counterparts to family planning outlets. This statement is quite policy relevant. Efforts need to be directed at improving the conditions of access for rural women, at least up to the level which now obtains in the urban setting. Every urban centre in Jamaica has at least one clinic which offers family planning services throughout the working day for five days per week. This type of service exists in some rural areas, but need to spread more rapidly to other rural areas. .

Pregnancy and Childbearing

The women represented here we must recall, are at varying stages of the childbearing period. Some have not yet begun childbearing, some are mid-way, while others are nearing completion. Approximately 17% of the over-union women have never been pregnant. The group turned in an average pregnancy rate of 3 pregnancies per woman. There is a positive relationship between time since initiation of union and number of pregnancies. Women who initiated union 25 years or more have a mean of 7.5 pregnancies. Women whose unions were initiated under 5 years ago have a mean of 1-2 pregnancies.

The average family size is under 3 children per woman. For women 40-44 the mean is 5.5 children. This cohort is nearing the end of the childbearing period, so this rate is of special significance as it gives the nearest indication of possible completed fertility. Women 30-34 who are about mid-way the childbearing span have an average of 3.2 children per woman. The rates would be higher if mothers rather than women were used as the base. Period since first union again highlights the extent of cumulative fertility. Women who began their initial union for more than 25 years have a cumulative fertility of 6.9 children per woman. This is relatively high, considering that none of the women have reached the end of the childbearing period. Women currently married have a larger mean size of family than women in other union types, and women with primary education have larger size families than women of higher levels of education. There was some indication of convergence of the means for urban and rural women.

Women tend to begin childbearing at an early age. Two out of every three women had their first child before age 20. The average age of first birth is 18.8 years.

Twenty-one percent of the over-union women are childless. These are mainly women under 25 years.

The summary position is that the level of cumulative fertility is high, with only a relatively small proportion of women remaining childless as they approach the end of the childbearing period.

Family Size Preferences

These questions relate to the full sample of women. Two out of three women said they did not yet have the number of children that they wanted. More than half of the women wanted a total of 4 children. Apart from women with one child, women tend to state the number of children they already have. The majority of women under 25 would like 2-4 children, while the majority of those over 35 would like a total of 5 or more children. Relating the additional children women said they wanted with the numbers they already have, it seems that the intended family size for women 14-29 years is 4. The intended size for older women appears to be larger than 4 children.

There is some evidence of convergence between urban and rural women, while education and union type both distinguish women with small and large size aspirations. Married women and women with primary education tend to favour large size families.

A combination of high levels of cumulative fertility and a tendency towards preference for medium or large size families, seen chiefly among older women, is a critical condition for future fertility. The important consideration here is not so much if women

will carry out their intention, but rather, whether those who want no more children, do take effective steps to prevent childbearing.

Unwanted Pregnancies

Forty-three percent of over-pregnant women said they did not want their last pregnancy, and 31% said they wanted the pregnancy at a later date. This means that approximately 74% of the last pregnancies were unplanned. Women under 25 and women that are unmarried are more likely to have had unplanned pregnancies.

Despite the high level of unwanted pregnancies there was little evidence of preventive action. More than 80% of the women with unwanted or mis-timed pregnancies were not contracepting at the time of conception. More than half of the women who had accidental pregnancies were using the pill at the time they became pregnant. At the time of the interview, 85% said they did not desire to become pregnant at all.

There is a close link between the areas just discussed. With regard to fertility, the problem seems to be the inability of women to prevent pregnancy and childbearing in their youthful years. So that having had a certain number of children this forms the basis for their expressed family preference. The high incidence of unwanted and unplanned pregnancies seems to go contrary to expressed desire for children. It seems also that the contraceptive habit is lacking or those who do practice tend to be inefficient practitioners.

Family planning education and counselling efforts will need to be directed at helping childbearing women to bring family size preferences more in line with their contraceptive habits.

Family Planning Information and Communication

With regard to mass-media communication, the radio is the most popular source of information on family planning. Printed materials (pamphlets, posters, etc.) were the second most important information means, newspaper was third and television the least of all. Proportions in each were however relatively high ranging from 91% to 46%. The radio was equally important for both urban and rural women.

Less than one half of the sample of women felt that they were favourably influenced by the communication through the above sources. Six out of 10 women have seen the pill on sale at some time or other, and a slightly lower proportion has seen the condom. Rural women more than urban women felt they were favourably influenced by the display of methods. A large proportion of women states that they are uninfluenced one way or the other by either the communication forms or the display of contraceptives. However, over 90% of the sample of women felt that the type of packaging of contraceptive methods does help the sale of methods.

Pro-Natal and Post-Partum Care

The majority of over-pregnant women have had pro-natal care most often from the government clinics. The period of pro-natal care varied with 59% of the women doing so for less than 4 months and about one-third for 4-6 months. Seven out of 10 women received post-partum care. Lack of post-partum care was highest among women under 25 years.

Policy Implications

In considering policy implications of the contraceptive survey, its findings have to be aligned with those from the Drop-Out study reported earlier, the Male Survey as well as the findings and recommendations from the study conducted by Jones et al. There are three specific considerations which will be treated briefly.

Demographic Consideration

The higher user rate of contraceptive use observed among ever union women is no doubt consistent with the vibrancy of the national family planning programme over the last decade and a half, and also with the declines in the crude birth rate that have been occurring over the last decade. Factors associated with declines in fertility are complex and not at all easy to disentangle the effect of programme factors from what we may call developmental factors. The two sets of factors interact to modify those values which influence fertility behaviour.

For example one cannot say whether the high proportion of women who want no further pregnancies are reacting to the impact of modernization or they are merely responding to the appeals made by the family planning programme.

Perhaps one of the most important demographic facts emerging from the study is the tendency towards what seems like a four-child family norm. The absence of interest in one or zero parity is also of demographic interest. Backed by the high cumulative fertility of the ever union women the need for continued vigorous family planning efforts along with increasing modernization, cannot be over-emphasized. The relative paucity of childless women in older ages is also of some

significance for future fertility trends. When this is viewed against the large proportion of unplanned and unwanted pregnancies, it becomes clear that there is often discrepancies between preferences, intentions and eventual action. The fact that a woman wants no more children does not necessarily mean that she will take action to ensure that she does not become pregnant. The fact that prevalence of contraceptives increases with age and with parity suggest either a concentrated effort to satisfy family size desires or a lack of contraceptive discipline to prevent the unwanted pregnancy. If programme effort is to guarantee its demographic impact then action must begin to focus on sub-groups of women who are high pregnancy risks. Particularly, public policy should be directed at discouraging early entry into unions, which is the crux of the matter in its long term effect on fertility.

Service Consideration

(a) Contraceptive Methods

Clearly the pill is the most popular method in use, and no doubt the most strongly promoted by the programme. While it is recognized that it is a highly effective method, it is known that it must be taken properly to be effective. If accidental pregnancies are to be avoided, then, efforts have to be intensified to ensure efficient contracepting. Efficient use of the pill could cut accidental pregnancies by one-half, based on the findings from the survey.

Perhaps it's now time for the programme to begin to promote other methods. Medium parity women who want no more children could be potential acceptors of sterilization. The I.U.D., also a quite

effective method is now little used. With the incidence of reported problems on the pill and the injection, it seems it could be fruitful to now explore other methods. An appropriate method for teenagers is still a problem.

Acceptance of contraception does not mean continuation. The high incidence of discontinuation was brought out in the Drop-Out Study. The end effect of this was shown in the contraceptive survey, where it was found that past users of contraceptives made up the largest group among the currently pregnant women. As was recommended in the Drop-Out Study, it would be useful to reduce the in-take of contraceptive acceptors and try to achieve higher continuation rates. This may be more cost-effective than a high rate of acceptance and high rate of discontinuation.

Based on the findings from the Drop-Out Study, from the contraceptive survey and the recommendations from Jones et al particularly relating to organization and management, it seems opportune to suggest further the need for the development of new programme strategies to creatively use para-medical personnel in the family planning programme.

Women in the survey were favourable to receiving contraceptive services and counselling from the traditional clinic nurse and the physician. The district midwife and the community health aide were favoured. The kind of one-to-one communication/counselling on specific methods which now seems most necessary can hardly be accommodated within the existing over loaded clinic setting. Expansion and strengthening this setting is just part of the answer. Perhaps what is more desirable at this time is an emphasis on community based

contacts now so ably filled by District Midwives and Community Health Aides in the delivery of health services. Family planning is an important aspect of the broader health concern, and with women so anxious about the health implications of family planning, amplifying its place in health can only but be advantageous. One of the most identifiable features of a population policy is the Family Planning Programme. The design and implementation of this programme can either make or break a population policy. The programme is not peripheral to such policy, it is central to it. High fertility is a problem and the Family Planning Programme has to ensure that it builds up its capacity to deal with fertility - related problems. This involves much more than contraceptive delivery. It confronts the values of individuals, important forces in contraceptive behaviour.

SUMMARY OF POPULATION ASSISTANCE FROM DONORSIN OR SUPPORTIVE OF FAMILY PLANNING

AGENCY	PROJECT TITLE	CENTRAL OBJECTIVES	DURATION	\$US FUNDING AMOUNT
1. <u>Multilateral Donors</u>				
International Bank for Reconstruction & Development (IBRD/World Bank)	First Population Project (JPP I)	To construct and equip ten rural maternity centers, a new wing at Victoria Jubilee Hospital, and to expand post-partum facilities at VJH.	1970-74 JPP I	\$ 2,700,000
	Second Population Project (JPP II)	To provide vehicles, equipment and facilities for construction of 57 health centers in the country of Cornwall. Also to train and equip midwives and Community Health Aids and to expand the Ministry's post-partum program.	1976-80 JPP II	6,800,000
United Nations Fund for Population Activities (UNFPA)	Family Health Care in the Caribbean: Development of Community Based Training, research & delivery of services (UWI)	To prepare research guidelines for the study of health problems of adolescents and youth.	1979-1982	800,000
	Advanced Training and research in Fertility Management (UWI)	To aid in the expansion of coverage and quality of care of family planning programs in the Caribbean region by providing training in Fertility Management.	1979-1982	650,663
	Family Life Education for Youth and Community development in 8 communities	To improve the health & social situation of the youth in eight participating communities in Duhaney Park, Kingston	1979-1982	242,004

AGENCY	PROJECT TITLE	CENTRAL OBJECTIVES	DURATION	FUNDING AMOUNT \$US
	Primary Health Care and Family Planning in 8 communities	To improve the health of the residents of the 8 communities through the promotion of health practices and responsible parenthood in Duhaney Park, Kingston.	1979-1982	976,400
	Workers Population Project	To create an increased awareness of population problems in relation to general social and economic development in Jamaica.	1977-1981	545,632
	Purchase of contraceptives for the National Family Planning Board	To provide the Depo-Provera contraceptive for the National Family Planning Program.	ongoing	676,680
2. <u>Bilateral Donors</u>				3,891,379
Federal Republic of Germany	Support to the Advanced Training & Research in Fertility Management (UWI)	To support the Fellowship and group training components of the Fertility Management project as well as the salaries of selected project personnel.	1979-1982	893,330
3. <u>Centrally-Funded AID/W Projects</u>				
Development Associates (DAI)	Family Planning	To provide technical assistance and to strengthen and expand family planning service delivery by providing training through local and regional training institutions.	ongoing	20,000/yr.
Johns Hopkins University Program for International Education in Gynaecology and Obstetrics (JHPIEGO)	Family Planning	To improve reproductive health care by training physicians and other health professionals to more effectively participate in local programs relating to reproductive health.	ongoing	10,000/yr.

AGENCY	PROJECT TITLE	CENTRAL OBJECTIVES	DURATION	\$US FUNDING AMOUNT
Center for Disease Control (CDC)	Family Planning	To provide support to family planning programs in the development of family planning service statistics.	ongoing	\$ 8,000/yr.
Bureau of the Census (BUCEN)	Health Management Improvement	To provide support in Health information systems development and training programs in population statistics and demographic analysis.	ongoing	15,000/yr.
American Public Health Association (APHA)	Family Planning	To provide a wide-range of technical consultation services in all aspects of family planning program development, management and implementation.	ongoing	18,000/yr.
American Home Economics Association (AHEA)	Family Planning	To provide technical assistance and training in an integrated family planning nutrition education program.	ongoing	12,000/yr.
The Futures Group	Family Planning Commercial Retail Sales Program	To assist in the development and expansion of commercial retail sales of contraceptives programs.	ongoing	12,000/yr.
The Pathfinder Fund	Women's Center	To provide an intervention program aimed at delaying pregnancy amongst young women.	ongoing	36,518
	Women in Development	To promote small scale female skills training as an alternative to child-bearing.	1982-1984	60,000
Association for Voluntary Sterilization (AVS)	<ol style="list-style-type: none"> 1. Beth Jacobs Clinic (JFPA) 2. Kingston Clinic (JFPA) 3. Spanish Town Hosp. 4. Victoria Jubilee Hospital 5. Glenn Vincent Poly Clinic 6. NFPB 	To support the renovation of the 6 centers (listed in previous column) to perform voluntary sterilization procedures and to conduct an information and education campaign to promote these services.		339,540

AGENCY	PROJECT TITLE	CENTRAL OBJECTIVES	DURATION	FUNDING AMOUNT \$US
International Planned Parenthood Federation (IPPF)	7. Establishment of repair and Maintenance (RAM) Center (MOH & NFPB)	To establish a repair and maintenance center capable of servicing all publicly-donated equipment in Jamaica.	1979-1981	\$ 44,417
	8. Advanced Training & Research in Fertility Management (UWI)	To provide audio-visual component for the project.	1978-1979	64,000
	Jamaica Family Planning Association	To assist JFPA in the execution of the Association's aims and objectives.	ongoing	60,000/yr.
	Women's Center	To assist in the support of the Women's Center program for adolescent mothers.	1978-1980	36,000

POPULATION AND JAMAICA'S FUTURE

A Statement of National Population Policy

- I. Goals of the National Population Policy
- II. The Process of Formulating the National Population Policy
- III. Past Population Trends
- IV. Future Population Trends
- V. Population Policy Measures
- VI. Institutional Arrangements for the Implementation and Evaluation of the National Population Policy

UNITED NATIONS DEFINITION OF A POPULATION POLICY (1972)

Measures and programmes designed to contribute to the achievement of social, economic, demographic, political and other collective goals through affecting critical demographic variables:

- a) mainly size and growth of the population,
- b) its geographical distribution (local and abroad),
- c) and its demographic characteristics.

POPULATION POLICY TASK FORCE DEFINITION (6 February 1980, from minutes)

A coherent set of national policy goals and objectives for the future that sets forth national priorities in terms of optimal size and growth of the population, consistent with sustained social and economic growth and development.

I. GOALS OF THE NATIONAL POPULATION POLICY

The Population Policy Task Force

- o having analyzed the social, economic, and demographic causes and consequences of Jamaica's population growth over the past several decades;
- o having explored the likely trends of population growth for the remainder of the twentieth century;
- o having come to the conclusion that past demographic trends present considerable obstacles to achieving goals of social and economic development and that future demographic trends will continue to affect Jamaica's development;
- o having taken into account Jamaica's economic and social development outlook and with a basic concern for the enhancement of the material and spiritual well-being of all Jamaicans,

has decided to suggest to the Government of Jamaica a comprehensive National Population Policy. This policy can truly be called a National Population Policy because both the Government and the Opposition, as well as Unions, public and private organizations, were involved throughout the process of policy development and formulation. Our comprehensive National Population Policy has the following basic goals:

(1) To ensure that the population of Jamaica will not exceed 3 million inhabitants by the year 2000. Achievement of this goal will provide favorable conditions for economic and social development of the country in the coming two decades.

(2) To promote a continued improvement in the health status of the nation. Success in this undertaking will prolong the average length of life, most notably by further diminishing infant mortality. A minimum goal is to increase average life expectancy at birth from its present level of approximately 70 years to around 73 years by the year 2000.

(3) To ensure access to high quality family planning services for all Jamaicans of reproductive age who wish to use them. This should ensure continuation of the nationwide fertility decline and, in line with the requirements of economic and social development, enable a thorough education and preparation for life of our next generation and contribute to the full emancipation of women in our society. Given achievement of these objectives, the average number of children per woman, which declined from almost 6 in the late 1960s to 4 by the late 1970s, should further decline to approximately 2 children per woman by the late 1980s, thereby realizing the goal of replacement level fertility.

(4) To create new and additional employment opportunities in sufficient number to correspond to the natural growth of the population of labor force age, through the vigorous development of our agriculture, industries, and services. This will permit a substantial reduction of unemployment and underemployment. Success in this task should result in a rapid increase in real

incomes of our population and in the reduction of the volume of outmigration from Jamaica, particularly of skilled manpower.

(5) To promote balanced rural, urban, and regional development in line with the national settlement strategy of the National Physical Plan 1970-1990 (revised 1978-1998), thereby achieving optimal spatial distribution of the population.

(6) To ensure the satisfying of basic human needs and the improvement of the quality of life in such areas as housing, nutrition, education, and environmental conditions. Success in this undertaking will facilitate the achievement of all the previously outlined goals.

The implementation of the National Population Policy will be the result of sustained and broad support and involvement by the entire Government of Jamaica. The following considerations were important when formulating our population policy:

(1) The goals of our population policy are being pursued not only because we wish to achieve certain patterns of demographic change but primarily because we wish to achieve those demographic trends that make the best contribution toward satisfying human wants.

(2) The goals that in the present context appear as population policy goals are an integral part of our general development goals.

(3) The involvement of the various agencies of the Government of Jamaica in implementing and monitoring our population policy should be broadened. For some institutions, serving the objectives of population policy will be a major, or even exclusive, activity. For others, it will be a subsidiary but important task.

(4) Although the general goals of our national population policy are not expected to change in the foreseeable future, the specific features of the policy to be implemented should be considered flexible, subject to continuous monitoring and evaluation and to possible redesign if warranted by new developments.

II. THE PROCESS OF FORMULATING THE NATIONAL POPULATION POLICY

The concern of the public and of governments in Jamaica over matters of population is longstanding. Private efforts to provide family planning were initiated in the late 1930s and major government undertakings took place in the 1960s and 1970s. The present process of reevaluating demographic trends in the context of Jamaica's development was started in February 1980 when the Permanent Secretary of the Ministry of Health appointed a Population Policy Task Force in which numerous institutions were represented.¹

During the sixteen months of its existence, the Task Force held various meetings and organized a Population Policy Development Workshop (16 October 1980) and the Jamaica Population Policy Development Conference (18-19 June 1981). The 1980 Workshop and the 1981 Conference were attended, respectively, by over 40 and 100 representatives from government, from academic institutions, and from other public and private agencies. Extensive documentation was prepared both for the Workshop and, particularly, for the Jamaica Population Policy Development Conference.²

1. The following institutions were represented on the Population Policy Task Force: National Planning Agency, Ministry of Health, Ministry of Social Security, Ministry of Agriculture, Department of Statistics, Town Planning Department, National Family Planning Board, National Secondary Students Council, and the University of West Indies. Representatives of the United Nations Fund for Population Activities, and USAID were also invited to participate in the work of the Task Force.
2. The documents for the Conference included the following: A Principal Document entitled "Population Policy and Development in Jamaica: Issues for the 1980s," and a series of six background documents (1) Population Dynamics and Prospects: A 1981 Assessment for Jamaica; (2) Social and Cultural Factors of Fertility Change; (3) Population Policy and Demographic Trends in Jamaica; (4) Implications of Population Growth in Selected Social and Economic Areas; (5) The Status of Demographic Research and Training in Jamaica; and (6) Demographic Data: Availability and Needs. The Base Research Document prepared for the Population Policy Task Force on the implications of population growth for social and economic development was also submitted.

At the 1980 Workshop the keynote address was delivered by the then Minister of Education, Youth and Sports, Dr. Phyllis McPherson-Russell and at the 1981 Conference by the Minister of Health, Dr. Kenneth Baugh. The substantive deliberations of the Conference were introduced by the Director of the National Planning Agency, Dr. Headley Brown. Significant portions of both the Workshop and the Conference were conducted in working groups of participants, which produced reports of suggestions and recommendations. All of this material was used to prepare this National Population Policy Document.

III. PAST POPULATION TRENDS

Jamaica is now well along in its demographic transition. Further major gains in health and further reductions in mortality can still be achieved, but both health and mortality are approaching conditions broadly comparable to those in developed countries. In the late 1970s, the crude death rate was around 7 per thousand and average life expectancy at birth was around 70 years. The crude birth rate has been declining throughout the 1960s and 1970s from a peak of over 40 around 1960 to about 27-28 in 1979. The rate of natural increase, which was over 3 percent per year around 1960, had declined to a little over 2 percent per year by the late 1970s.

At the same time, during the last two decades alone, almost half a million people emigrated, and among those who remained many tens of thousands were unemployed or underemployed. Although Jamaica's emigration and unemployment patterns are the result of factors outside the demographic sphere, population growth has aggravated rather than eased employment and emigration problems. High rates of population growth have also made it more difficult for the government to provide social services in adequate quality and quantity, notably in education and health care.

Jamaica's public and its governments have long realized that rapid population growth can constitute an important obstacle to improving living conditions and the quality of life of Jamaica's people. As early as 1939, the first family planning clinic was established, and in the mid-1960s, nationwide efforts to provide family planning services were organized. Such services would

have had only limited demographic effects had there not been a profound economic and social transformation under way. The transformation has manifested itself in many ways: fewer than 30 percent of the population now derive their main income from agriculture compared to 45 percent three to four decades ago. About one-half of the population now live in towns and cities compared to less than one-third only 20 years ago. And, most importantly, economic conditions and personal relationships within families are changing; children, who used to be economic contributors to the family at an early age, no longer fulfill that function, and parents increasingly perceive adequate educational investment in their children to be a precondition of personal advancement. Reflecting these changes, fertility and average family size have been declining at a rapid rate during the 1970s. The total fertility rate, a measure approximating the number of children born per woman, has declined from a value between 5.5 and 6.0 in the 1960s to around 4.0 at the end of the 1970s.

IV. FUTURE POPULATION TRENDS

Given the profound structural changes in Jamaican society, the change in parental desires toward lower fertility is likely to continue in the future. Although the exact path of fertility change cannot be predicted, it is possible to prepare alternative projections of fertility decline that bracket the upper and lower bounds of likely future trends. Such projections were recently computed as part of the background documentation for the Jamaica Population Policy Development Conference, 18-19 June 1981.

According to these projections, which include assumptions of considerable fertility decline, Jamaica is likely to have a population of under 3.1 million in the year 2000. Throughout the remainder of the century, the rate of natural increase is likely to be around 2 percent per year and the population growth rate between about 1.0 and 1.5 percent per year with emigration accounting for the gap between the two rates.

Despite the recent declines in fertility and in the crude birth rate, Jamaica's population is very young. In 1980 about 40 percent of the population was under age 15, and almost 25 percent were between the ages of 15 and 24. During the 1980s those in their 20s will be growing faster than any other age group. If fertility continues to decline about as rapidly as it did in the 1970s, the population under age 15 will stabilize in size during the next two decades. As the large age groups of those currently in their late teens and early 20s make their way up through the age structure, their social and economic

Impact will be felt throughout Jamaican society. Most obviously, this large age group, when in the prime childbearing years, will place an upward pressure on the crude birth rate, and in the labor market they will increase the demand for scarce jobs.

The results of these projections underline the urgency of the need to adopt and implement the population policy measures outlined in this document. The changes in the size of the young adult age groups are a virtual certainty because these people are all presently alive. A shortfall in generating employment and income opportunities could lead to a sustained high out-migration from the country and could cause undesirable patterns of internal migration. Failure to ensure conditions for a sustained fertility decline would prolong the period of high rates of population growth, and at the end of the century Jamaica's population could be significantly more than 3 million inhabitants, perhaps as much as 4 million. If this were to occur, population growth would continue at rates significantly above 1 percent per year even beyond the turn of the century.

V. POPULATION POLICY MEASURES

Numerous existing features of Jamaican social and economic policy will make a contribution to the implementation of the National Population Policy. Other policy measures will need revision so as to strengthen their contribution. Yet other policies and measures will have to be newly designed to serve the objectives of the National Population Policy.

Although policy measures that indirectly have a demographic impact by promoting health, generating conditions for a fertility decline, preventing out-migration to other countries, or creating a desirable internal population distribution, are extremely important for the implementation of the National Population Policy, the primary focus of such policies is on the achievement of other goals—in education, housing, social security, protection of the environment, agricultural development, and so on. It shall be the responsibility of the various agencies of the government, and in particular of the National Planning Agency, to ensure that the implementation of all population-sensitive economic and social policies of the Government of Jamaica is supportive of the objectives of the National Population Policy.

In the present document only population policy measures directly aimed at implementing the National Population Policy will be outlined. These policy measures are yet to be worked out in detail. Individual ministries and the National Planning Agency will have to ensure that their elaboration and

Implementation reflect the spirit both of the discussions that led to the formulation of the National Population Policy and of the recommendations set forth at the June 1981 Jamaica Population Policy Development Conference.

Several measures may require legislative changes that will have to be brought up for deliberation in Parliament.

(1) The promotion of health will continue to be the responsibility of the Ministry of Health. In line with the World Health Organization objective of "health for all by the year 2000", the Ministry of Health should improve its network of health facilities while creating optimum conditions for the private sector and for voluntary organizations to complement the activities of the public system. The Ministry of Health will continue to devote special attention to maternal and child care and to the delivery of health care to the neediest strata of the population and to persons living in remote rural areas.

(2) Delivery of family planning services will be reorganized as a comprehensive program under the leadership of the National Family Planning Board. In ensuring access to family planning services for all those who want them, the Board shall devote special attention to improvement of services to adolescents and young adults and to persons living in remote rural areas. It shall also encourage and promote participation of voluntary organizations in providing family planning services and shall seek other ways to enhance the contribution of the private sector, for example, by facilitating the distribution of contraceptives through commercial channels. Among the services offered by the National Family Planning Board will be voluntary sterilization and, under appropriate legal safeguards, pregnancy termination.

(3) A population planning and research unit, to be set up within the National Planning Agency, will carry out a study of existing economic incentives and disincentives that bear on parental decisions concerning fertility and on decisions concerning migration. Based on this study, the National Planning Agency will prepare recommendations on modifying such incentives and disincentives as may be needed to accelerate the decline of fertility and to affect the pattern of internal and external migration in socially desirable directions. Measures to be considered should include adjustments in tax policy, extension of the scope of the pension system, and preferential development of services and infrastructure (e.g., piped water and rural electrification).

(4) The National Population Policy as a whole and all its various details should be widely disseminated through the communications media and in the educational system. Family life and family planning education should receive broader attention than heretofore in public and private schools, in programs of the Ministry of Youth and Community Development, and in literacy programs. Within the framework of family life and family planning education, particular attention should be paid to the beneficial consequences of stable conjugal unions and to pointing out the rights and obligations of men and women in responsible parenthood. Special attention should also be devoted to health education, in particular to the need for immunization of all children and to the health and nutritional advantages of breastfeeding. Teacher training programs need to cover all aspects of the National Population Policy in their curricula. The broadcasting media, radio and television, and the press should be supplied with materials (statistical data, research publications, etc.) needed for informed discussion of population issues in Jamaica.

(5) The system providing statistical and other information needed for the implementation and monitoring of the National Population Policy should be improved. In particular, the quality of the registration of deaths and births should be upgraded and the potential of sample surveys to generate information on health, family planning, and migration (both internal and international) should be better utilized.

(6) Evaluation and research activities relating to the National Population Policy should be strengthened. These activities should be carried out — if necessary, through collaborative arrangements — in particular, at the National Planning Agency, the National Family Planning Board, the Department of Statistics, and the University of West Indies.

VI. INSTITUTIONAL ARRANGEMENTS FOR THE IMPLEMENTATION AND EVALUATION
OF THE NATIONAL POPULATION POLICY

The entire Government of Jamaica accepts the responsibility for the implementation of the National Population Policy. The following agencies will assume specific responsibility in the process of implementing and monitoring the National Population Policy.

(1) The National Planning Agency will ensure the integration of the goals of the National Population Policy in development plans and monitor activities of other agencies in matters of population policy.

(2) The National Family Planning Board will ensure delivery of family planning services and coordinate the activities of all agencies in this field and in matters relating to family life and family planning education.

(3) A coordinating and advisory Population Policy Committee will be formed comprised primarily of senior representatives of the National Planning Agency, National Family Planning Board, the Department of Statistics, and the University of the West Indies. It is recommended that membership on the Committee be kept to a small number.

(4) Research and evaluation activities at the National Planning Agency, the Department of Statistics, and at the University of West Indies, relating to Jamaican population and development trends and to programmes aimed at achieving the objectives of the National Population Policy will be strengthened.

CALCULATION OF BIRTHS AVEPTED

The estimates of past (and future) averted births are based on official Jamaican government data on population and births to 1980, on stated program targets, and on a new, official set of population projections for Jamaica (Frejka, 1981). The general fertility rate (GFR) (births per 1,000 females, 15-49) was used to allow for the changing age structure of the Jamaican population. Between 1970 and 1980, the GFR declined 28 percent; this was roughly comparable to the 25 percent decline in the crude birth rate, from 35.0 to 27.0. In the period 1970 to 1980, both measures of the change in fertility thus yielded the same results. Reduction in fertility itself, however, will make this less true in the 1980s. Females, 15-49, all of whom were born before fertility began to decline, will become a larger proportion of the total population. Thus, the crude birth rate, which relates annual births to total population, will not necessarily be parallel to, for example, the GFR, a measure more sensitive to age structure. Births per female might continue to fall, but because the number of females giving birth is increasing in relation to the total population, the ratio of births to total population might rise.

Specific steps were followed that make the logic clear.

1. Table A-1 contains the official data on annual births for the period 1971 to 1980, the official estimate of the mid-year population, and the estimated female population, aged 15 to 49. The general fertility rate that is implied is shown also. The program's impact during the period can be estimated as the difference between births which did occur and births which would have occurred had the GFR remained constant at its 1970 level. This calculation also is shown in Table A-1; the results are the series presented in Table 1 in the text.
2. The estimated number of future births to be averted is derived in much the same way (see Table A-2). The estimated total population is based on the new official projections of rapid fertility decline with immigration (Frejka, 1981). The target for the crude birth rate, which is set by the plan, is used to obtain a rough estimate of births which would occur in the target years 1985 and 1990. These births are then related to the estimated female population, aged 15 to 49 (the same official projections are used), to get the implied GFRs.
3. The projected number of births averted between 1980 and 1990 should be considered in two ways, as the number of incremental

births averted annually (this is the difference between the births which would occur if the 1980 GFR remained unchanged compared to the births projected with a declining GFR) and as the continuing difference in the births which would occur if the GFR were at its pre-program, 1970 level compared to the actual 1980 level. As explained in the text, if the program were not continued, some of this accomplishment (about half) would be lost and the GFR would rise. Thus, the author calculated the births which would occur between 1980 and 1990 to females, 15 to 49, at the 1970 GFR (170) compared to the births which would occur at the 1980 GFR (117); half the annual difference is an output of the program from 1981 to 1990 (see Table A-3). In the author's judgment, it is appropriate to calculate the total number of births averted to assess costs per birth averted.

The implication is that, were the program eliminated, the current birth rate would rise to half its pre-program (1971) level. Similarly, were the program not expanded, the birth rate would level off at its current (1980) level. Because the project is intended to maintain existing program effort (and achievement), and also to extend and increase program effort (and achievement), it is appropriate to count both kinds of achievements as outputs of the project. The total comes to 28,000 births averted per year by 1984, the end of the project period; the cumulative total would be some 88,000 births averted.

Table A-1
BIRTHS AVERTED, 1971-1980

Year	Mid-Year Population (In 000s)	Females, 15-49 (In 000s)	Birth Rate	General Fertility Rate (Births per 1,000 Females, 15-49)	Annual Births	Constant 1971 GFR Births	Annual Births Averted	Cumulative Births Averted
1971	1,901	390	34.9	170	66,300	66,300	--	--
1972	1,932	396	34.3	167	66,200	67,300	1,100	--
1973	1,972	404	31.4	153	61,900	68,700	5,400	6,500
1974	2,008	412	30.6	149	61,500	70,000	8,500	15,000
1975	2,043	422	30.1	145	61,400	71,700	10,300	25,300
1976	2,072	437	29.3	139	60,700	74,300	13,600	38,900
1977	2,097	453	28.8	133	60,400	77,000	16,600	55,500
1978	2,123	470	27.4	124	58,200	79,900	21,700	77,200
1979	2,149	484	27.1	120	58,300	82,300	24,000	101,200
1980	2,170	497	27.0	118	58,600	84,500	25,900	127,100

Sources: (1) Annual births from MDH data.
(2) Populations: 1970 Census, 1975 and 1980 estimates from new official projections. Other years are interpretations, assuming constant growth rate between benchmark years.
(3) Other columns computed using method described in text, Appendix A.

Table A-2

PROJECTED INCREMENTAL BIRTHS AVERTED,
1980-1990

Year	Mid-Year Population (In 000s)	Females, 15-49 (In 000s)	Birth Rate	General Fertility Rate (Births per 1,000 Females, 15-49)	Annual Births	Constant 1971 GFR Births	Annual Births Averted	Cumulative Births Averted
1980	2,170	497	27.0	118	58,600	58,600	--	--
1981	2,192	511	26.3	113	57,600	60,300	2,700	2,700
1982	2,213	524	25.6	108	56,700	61,800	5,100	7,800
1983	2,235	539	24.9	103	55,700	63,600	7,900	15,700
1984	2,257	553	24.3	99	54,800	65,200	10,400	26,100
1985	2,275	568	23.6	95	53,700	67,000	13,300	39,400
1986	2,290	582	22.9	90	52,400	68,700	16,300	55,700
1987	2,305	595	22.2	86	51,100	70,200	19,100	74,800
1988	2,320	608	21.5	82	49,900	71,700	21,800	96,600
1989	2,336	621	20.8	78	48,600	73,300	24,700	121,300
1990	2,355	639	20.0	74	47,100	75,400	28,300	149,600

Source: See text, Appendix A.

Table A-3

PROJECTED CONTINUING BIRTHS AVERTED,
1980-1990

<u>Year</u>	<u>Births at 1980 Fertility Level (GFR = 113)</u>	<u>Births at 1970 Fertility Level (GFR = 170)</u>	<u>Annual Difference</u>	<u>Annual Births Averted (% Difference)</u>	<u>Cumulative Births Averted</u>
1980	58,600	85,000	26,400	--	--
1981	57,600	86,900	29,300	13,200	13,200
1982	56,700	89,000	32,300	14,600	27,800
1983	55,700	91,600	35,500	16,100	43,900
1984	54,800	94,000	39,200	18,000	61,900
1985	53,700	96,600	42,900	21,500	83,400
1986	52,400	98,900	46,500	23,200	106,600
1987	51,100	102,000	50,900	25,500	132,100
1988	49,900	103,400	53,500	26,700	158,800
1989	48,600	105,600	57,000	28,500	182,300
1990	47,100	108,600	61,500	30,700	213,000

STATUTORY CHECKLISTA. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? **Yes**
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully? **No**
3. FAA Sec. 520(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? **COJ is not controlled by the international Communist movement**
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? **No**
5. FAA Sec. 620(n)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? **No**

6. FAA Sec. 620(a), 620(f); FY 79 App. Act, Sec. 108, 114 and 506. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?

No

I-2

7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?

No

8. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?

No

9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, convertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?

An investment guaranty agreement is in effect.

10. FAA Sec. 620(n); Fishermen's Protective Act of 1967, as amended, sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters:

No such action by Jamaica

a. has any deduction required by the Fishermen's Protective Act been made?

b. has complete denial of assistance been considered by AID Administrator?

11. FAA Sec. 620; FY 79 App. Act, Sec. 603. (a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds?

No

12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the

Approximately 2% of recent budgets has been used for military expenditure. Approximately \$300,000 in FX has been spent for military equipment in the past 12 months. No sophisticated weapons systems have been procured. USG has authorized foreign military sales of US\$1.5 million for FY 81.

amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking into Consideration" memo: "Yes, as reported in annual report on implementation of Sec. 620(s)." This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

Not in arrears

15. FAA Sec. 620A, FY 79 App. Act, Sec. 607. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No

16. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

No

17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977, although not a "nuclear-weapon State" under the nonproliferation treaty?

No. Jamaica is not a "nuclear-weapon State".

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

N/A

a. FAA Sec. 102(b)(1). Have criteria been established and taken into account to assess commitment progress of country in effectively involving the poor in development, on such indexes as: (1) increase in agricultural productivity through small-farm labor intensive agriculture, (2) reduced infant mortality, (3) control of population growth, (4) equality of income distribution, (5) reduction of unemployment, and (6) increased literacy?

B.1.

b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

N/A

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights?

b. FAA Sec. 533(b). Will assistance under the Southern Africa program be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

N/A

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N/A

d. FY 79 App. Act, Sec. 113. Will assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

No

e. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

N/A

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT?

A. GENERAL CRITERIA FOR PROJECT

- | | |
|---|---|
| 1. <u>FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A.</u> (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)? | AID/W has submitted Congressional Notification. |
| 2. <u>FAA Sec. 611(a)(1).</u> Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? | Yes |
| 3. <u>FAA Sec. 611(a)(2).</u> If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? | No legislative action required |
| 4. <u>FAA Sec. 611(b); FY 79 App. Act Sec. 101.</u> If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973? | N/A |
| 5. <u>FAA Sec. 611(a).</u> If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? | N/A |
| 6. <u>FAA Sec. 209.</u> Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. | No |

A.

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

N/A

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

N/A

9. FAA Sec. 612(b); Sec. 616(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

No

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

Yes

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

N/A

12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

N/A

4. FAA Sec. 102(b); 111; 113; 201a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

9.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

Yes

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

No

A handwritten scribble, possibly a signature or initials, is located in the lower-left quadrant of the page. Below it are three horizontal lines, likely intended for a signature or name, but they are currently blank.


NATIONAL FAMILY PLANNING BOARD

Annex J
 5 SYLVAN AVENUE,
 P.O. BOX 287,
 KINGSTON 5, JAMAICA.

October 22, 1981

Ref. No.....

Mr. Glen Patterson
 Director
 US AID Mission to Jamaica
 United States Embassy
 2 Oxford Road
 Kingston 5

Dear Mr. Patterson:

The National Family Planning Board requests the assistance of the United States Agency for International Development to finance the Population and Family Planning Services Programme for the four year period 1981-85.

The Board is indeed grateful and appreciates the tremendous assistance that US AID has provided in the past and looks forward to your continued support in the future.

Please accept our kind regards.

Sincerely yours,

R. E. D. Thwaites

Dr. R.E.D. Thwaites
 CHAIRMAN

/ad

DATE RECD: 11/3	
ACTION OFFICE: HNP	
INFO TO:	
DOM	ARDO
EA	HNP
PRC	EDUC
CAP	GDO
MGT	CAR
CONT	PER
RHO	GSO
DUE BY: 11/13	
ACTION TAKEN: NAM 11/3/81	

10/26/81



Department of State
INCOMING
American Embassy Kingston

TELEGRAM

UNCLASSIFIED

ON. NO.:

10 DEC EC 15 43z

R 100711Z DEC 80
FM SECSTATE WASHDC
TO ANEMBASSY KINGSTON 5417

UNCLAS STATE 326661

ADM AID

E.O. 12065: N/A

TAGS:

SUBJECT: DAEC REVIEW OF REVISED PID FOR JAMAICA POPULATION AND FAMILY PLANNING SERVICES PROJECT

BASED ON DAEC REVIEW OF SUBJECT PID, 11/19/80, MISSION MAY PROCEED WITH DEVELOPMENT OF PROJECT PAPER AND PROJECT AUTHORIZATION, TAKING INTO ACCOUNT THE FOLLOWING CONCERNS:

A. PROJECT FOCUS: PROPOSED PROJECT DESIGN IS QUITE BROAD, ENCOMPASSING SUPPORT FOR A RANGE OF FAMILY PLANNING ACTIVITIES IN BOTH PUBLIC AND PRIVATE SECTORS. WHILE BUREAU UNDERSTANDS MISSION'S DESIRE TO BE RESPONSIVE TO THE NATIONAL FAMILY PLANNING BOARD'S NEW DIRECTIONS FOR THE EIGHTIES, INTENSIVE REVIEW SHOULD RE-EXAMINE THE VARIOUS CONTEMPLATED ACTIVITIES TO ENSURE THAT MOST CRITICAL FACTORS IMPEDING THE REDUCTION OF FERTILITY RATES AND GREATER CONTRACEPTIVE PREVALENCE ARE, IN FACT, ADEQUATELY ADDRESSED UNDER PROJECT. RATIONALE FOR EACH PROJECT ACTIVITY, IN TERMS OF ITS IMPACT ON ACHIEVING PROJECT PURPOSE, SHOULD BE CLEARLY SET FORTH IN PP.

--B. INSTITUTIONAL CAPACITY OF NFPB AND MOHSS: MISSION SHOULD CAREFULLY ASSESS ADMINISTRATIVE AND TECHNICAL CAPABILITIES OF NFPB AND MOHSS TO CARRY OUT THEIR RESPECTIVE RESPONSIBILITIES UNDER PROPOSED PROJECT. AS A RESULT OF THIS ASSESSMENT, MISSION SHOULD DETERMINE ADEQUACY OF CONTEMPLATED TRAINING AND TECHNICAL ASSISTANCE (FROM WHATEVER FUNDING SOURCE) TO PROVIDE THESE INSTITUTIONS WITH SUPPORT NECESSARY TO EFFECTIVELY EXECUTE THEIR PROJECT-RELATED RESPONSIBILITIES.

--C. RELATIONSHIP OF TASK FORCE TO NFPB: IT SHOULD INDICATE MANDATE OF INTER-AGENCY TASK FORCE ON POPULATION POLICY AND EXPLAIN RELATIONSHIP OF TASK FORCE TO NFPB AND, WHERE APPROPRIATE, PROJECT ACTIVITIES.

RECD:			
TO	ACT	INT	INT
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POI			
ECOM			
ITD			
DAC			
ALM			
PER			
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GSC			
KTL			
CSL			
HRG			
CCP			
SEA			
NS			
PC	5		
WJA			
FF			
STAN			

(5)

UNCLASSIFIED

--D. PROJECT FUNDING:

---1. FINANCIAL ANALYSIS SECTION OF PP SHOULD DETAIL WHICH PROJECT-SPECIFIC INPUTS WILL BE FINANCED BY THE GOJ AND WHICH WILL BE FINANCED UNDER A.I.D. GRANT.

3/2
1184

---2. TO AVOID PROBLEMS REGARDING SEC. 611 (A) OF FAA, MISSION SHOULD ESTABLISH A REASONABLY FIRM ESTIMATE OF ALL PROJECT COSTS TO BE COVERED BY A.I.D., INCLUDING THE SPECIAL PROJECT DEVELOPMENT ACTIVITIES CONTEMPLATED WITH PVOS.

-E. COMMODITIES: MEDICAL EQUIPMENT AND SUPPLIES FUNDED UNDER THE PROJECT MUST BE RELATED TO FAMILY PLANNING, AND ANY AUXILIARY EQUIPMENT ASSOCIATED WITH THE USE OF DEPO-PROVERA MAY NOT BE FUNDED UNDER THE A.I.D. GRANT GIVEN CURRENT USG POLICY CONCERNING THIS CONTRACEPTIVE. PP ANNEX SHOULD LIST PROJECT-FINANCED EQUIPMENT.

--F. STERILIZATION PROGRAM: WHILE BUREAU RECOGNIZES NEED FOR STERILIZATION PROGRAM, WE WOULD PREFER THAT AVS OR SOME OTHER APPROPRIATE INTERMEDIARY PROVIDE THE NECESSARY SUPPORT IN THIS AREA. DS/POPULATION HAS AGREED TO EXAMINE AVS FUNDING AVAILABILITIES FOR THE JAMAICA PROGRAM AND, BY SEPTTEL, WILL PROVIDE INFORMATION TO MISSION. THE ESTIMATED DOLS 200,000 COMPONENT FOR VOLUNTARY STERILIZATION IS INCLUDED IN THE PROJECT IN CASE AVS OR OTHER DONOR SUPPORT IS CONSIDERED INSUFFICIENT TO MEET PROGRAM NEEDS.

PLEASE ENSURE THAT PP INCLUDES QUOTE INFORMED CONSENT UNQUOTE PROCEDURES AS PART OF THE VOLUNTARY STERILIZATION PROGRAM. PP SHOULD CLARIFY THAT SESSIONAL ARRANGEMENT IS REQUIRED IN CONTRACT WITH MEDICAL PERSONNEL, INSTEAD OF CASE-BY-CASE BASIS, IN ORDER TO GUARANTEE MAXIMUM ATTENTION AND COUNSELING OF PATIENT. (SEE PD-70 GUIDELINES OF USG DTD 6/14/77, AND A.I.D. CIRCULAR 393 OF 10/27/77).

-G. HEALTH MANAGEMENT IMPROVEMENT PROJECT. PP SHOULD DISCUSS RELATIONSHIP OF PROPOSED HEALTH MANAGEMENT PROJECT TO SUBJECT PROJECT, PARTICULARLY MUTUALLY SUPPORTIVE FEATURES.

2. PER MISSION REQUEST, BUREAU PROPOSES TO SEND REPRESENTATIVE FROM OUR POPULATION DIVISION TO PARTICIPATE IN REVIEW OF PP.

3. WHEN DETERMINING THE NEED FOR TECHNICAL ASSISTANCE, BUREAU REQUESTS THAT MISSION GIVE THOROUGH CONSIDERATION TO THE USE OF MINORITY CONTRACTORS TO PROVIDE SUCH SERVICES. CHRISTOPHER

BT
#6661

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
 AGENCY FOR INTERNATIONAL DEVELOPMENT
 WASHINGTON D C 20523

ASSISTANT
 ADMINISTRATOR

LAC/DR-IEE-81-2

ENVIRONMENTAL THRESHOLD DECISION

Location : Jamaica
 Project Title : Population & Family Planning Services, 532-0069
 Funding : \$1,200,000 FY 81
 : \$4,940,000 FY 81-84
 Life of Project: Four years (FY 81-84)

Mission Recommendation:

Based on the Initial Environmental Examination, the Mission has concluded that the project will not have a significant effect on the human environment and therefore recommends a Negative Determination.

The Development Assistance Executive Committee of the Bureau for Latin America and the Caribbean has reviewed the Initial Environmental Examination of this project and concurs in the Mission's recommendation for a Negative Determination.

AA/LAC Decision:

Pursuant to the authority vested in the Assistant Administrator for Latin America and the Caribbean under Title 22, Part 216.4a, Environmental Procedures, and based upon the above recommendation, I hereby determine that the proposed project is not an action which will have a significant effect on the human environment, and therefore, is not an action for which an Environmental Impact Statement or an Environmental Assessment will be required.



 Acting Assistant Administrator for
 Latin America and the Caribbean

Oct 10, 1980

 Date

Clearances:

LAC/DR: Environmental Advisor: Rotto CFE
 DAIC Chairman: MBrown _____

B. Description of the Project

The overall goal of this project is to improve the health, social and economic status of the Jamaican population by lowering the crude birth rate from an estimated 26/1000 in 1980 to 20/1000 by 1990.

This will be accomplished through a considerable intensification and expansion of support to the GOJ, primarily the Ministry of Health and Social Security and National Family Planning Board, which has legal responsibility for coordination of all elements of the national family planning program. Another major area of project support will assist the Government of Jamaica in the development and implementation of a comprehensive population policy and plan which will bring population impact considerations into development of activities of all major sectors of Jamaican society.

Specific AID-provided project inputs include funds for commodities (primarily contraceptive supplies), personnel (technical assistance and a limited number of local project staff), training (both local and overseas), and a variety of specially targeted activities and programs (mass media education, social science research, male motivation and adolescent fertility programs, etc.) in population and family planning.

C. Identification and Evaluation of Environmental Impacts

This project will have no deleterious effects on the environment. In fact, this project is - in the broadest sense - an environmental improvement project in that it seeks to promote adoption of policies and practices designed to bring the population of Jamaica in balance with its economic and physical resources.

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-Areas

Impact
Identification and
Evaluation ¹

A. LAND USE

1. Changing the character of the land through:

- a. Increasing the Population..... N
- b. Extracting Natural Resources..... N
- c. Land Clearing..... N
- d. Changing Soil Productive Capacity..... N

- 2. Altering Natural Defenses..... N
- 3. Foreclosing Important Uses..... N
- 4. Jeopardizing Man or His Works..... N

¹ N - No environmental impact.
L - Little environmental impact.
M - Moderate environmental impact.
H - High environmental impact.
U - Unknown environmental impact.

B. WATER QUALITY

- 1. Physical State of Water..... N
- 2. Chemical and Biological States..... N
- 3. Ecological Balance..... N

C. ATMOSPHERIC

- 1. Air Additives... .. N
- 2. Air Pollution..... N
- 3. Noise Pollution..... N

D. NATURAL RESOURCES

- 1. Diversion, Altered Use of Water..... N
- 2. Irreversible, Inefficient Commitments..... N

E. CULTURAL

- 1. Altering Physical Symbols..... N
- 2. Change of Cultural Traditions..... N

F. HEALTH

- 1. Changing a Natural Environment..... N
- 2. Eliminating an Ecosystem Element..... N

G. GENERAL

- 1. International Impacts..... N
- 2. Controversial Impacts..... N
- 3. Larger Program Impacts..... N

DRAFT ACTIVITY DATA SHEET

A. BASIC DATA

1. Population and Family Planning Services
2. Population Planning
3. (a) FY 82 - 1,089
- (b) LOP - 5,000
4. 532-0069 - Grant
5. New
6. FY 1981 Congressional Presentation: Annex III
Latin America and Caribbean, p. 251
7. FY 1982
8. FY 1983
9. FY 1984

B. PURPOSE

To assist the Government of Jamaica to meet its population and family planning objectives by expanding the coverage and increasing the effectiveness of the contraceptive services delivery system.

C. BACKGROUND/PROJECT DESCRIPTION

Despite the substantial progress Jamaica has made over the past decade in reducing its birth rate, the population continues to grow at a pace which exceeds the capacity of the economy to support it. In addition, there are three major constraints which limit the effective delivery of family planning services; (1) absence of a population policy; (2) institutional weakness; and (3) socio-cultural barriers. The project will finance the human and physical resources required to help overcome these constraints.

The goal of this project is to reduce the birth rate from approximately 27/1,000 in 1980 to 20/1,000 or less by 1990. In order to accomplish this goal 40,000 to 50,000 new family planning acceptors will be recruited. The project will also support the development and implementation of a comprehensive population policy and plan for Jamaica. The target population includes men and women of reproductive age located in both urban and rural areas. In addition, funding will be made available for special projects designed to reduce high rates of fertility among adolescents. Training will be provided for over 13,000 health workers, educators and other personnel involved in the dissemination of family planning information services.

E. RELATION OF PROJECT TO AID COUNTRY STRATEGY

This project is consistent with the AID development strategy which, over the past several years has placed high priority on assisting Jamaica to reduce fertility to levels compatible with sustained social and economic development. The GOJ also has played an active role in family planning since the establishment of the National Family Planning Board (NFPB) in 1967. With the assistance of AID and other donors a series of family planning projects have been implemented resulting in a lowering of the birth rate from 40/1000 in the late 1960's to approximately 27/1000 in 1980. The current goal of the NFPB is to reduce the rate to 20/1000 before the end of the decade. AID expects to continue to support Jamaican family planning activities designed to achieve this goal.

F. BENEFICIARIES

Jamaica's entire population will benefit to the extent that a reduction in family size will make possible an improvement in the overall quality of life. The primary beneficiaries will be the estimated 250,000 acceptors who will receive contraceptive services. Within this group major emphasis will be placed on reaching an estimated 50,000 teenagers through family planning information and services. In addition, approximately 13,000 health workers, educators and other personnel involved in the dissemination of family planning information will benefit from training programs financed under the project.

G. HOST COUNTRY AND OTHER DONORS

The GOJ will provide approximately \$12.4 million over the life of the project primarily to cover administrative and service delivery costs.

The United Nations Fund for Population Activities has provided approximately \$3.9 million for the period covering 1977-1982. This amount provided support to several family planning projects including the provision of funds for dept-provera, the World Fertility Survey in Jamaica, a family health project, support for the Center for Advanced Training and Research in Fertility Management and a Worker's Education Project at the University of the West Indies. The International Planned Parenthood Federation provides \$60,000 annually for budgetary support to the Jamaica Family Planning Association and another \$36,000 to support the Women's Center program for adolescent mothers.

H. MAJOR OUTPUTS

<u>OUTPUTS</u>	<u>ALL YEARS</u> <u>(\$000)</u>
Trained indigenous staff functioning at all levels of the family planning delivery system.	356
Increased availability of family planning services through MOH and NFPB clinics and through the commercial distribution of contraceptives program.	4,052
Research on determinants of fertility, migration and contraceptive prevalence.	114

Population policies adopted at both national
and sectoral levels, and policy, planning and
monitoring apparatus established

478

TOTAL

5,000

I. AID FINANCED INPUTS

(\$000) Life of Project

(a) Technical Assistance	345
(b) Commodities	2,770
(c) Training	390
(d) Other Costs	<u>1,495</u>
TOTAL	5,000

J. FINANCIAL DATA

	Obligations	Expended	Unliquidated
Throughout September 30, 1980	-		
Estimated JY 1981	-		
Estimated Through 9/30/81	-		
Proposed JY 1982	1,089		
Future Year Obligations	3,911		
Estimated Total Cost	5,000		

K. PRINCIPAL CONTRACTORS OR AGENCIES

NFPB

MOH

Population Council