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UNCLASSIFIED

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

CARIBBEAN REGIONAL

PROJECT PAPER

POPULATION AND DEVELOPMENT
(Amendment # 1)

AID/LAC/P-329 &
DR/P-082-3

Project Number: 538-0039

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE
 A = Add
 C = Change
 D = Delete
 Amendment Number One

DOCUMENT CODE 3

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

3. PROJECT NUMBER
538-0039

4. BUREAU/OFFICE
 LAC 05

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

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)
 MM DD YY
1/2/3188

7. ESTIMATED DATE OF OBLIGATION
 (Under 'B:' below, enter 1, 2, 3, or 4)
 A. Initial FY 8/2 B. Quarter 4 C. Final FY 8/6

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
AID Appropriated Total						
(Grant)	(500)	(-)	(500)	(3,100)	(1,566)	(4,666)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country					984	984
Other Donor(s)						
TOTALS	500	-	500	3,100	2,550	5,650

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		AUTHORIZATIONS 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) POP	PN	400	-	3,724.7	-	941.3	-	4,666	-
(2)									
(3)									
(4)									
TOTALS				3,724.7	-	941.3	-	4,666	-

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

11. SECONDARY PURPOSE CODE
 444

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

13. PROJECT PURPOSE (maximum 480 characters)

To reduce the number of unwanted pregnancies in the Eastern Caribbean

14. SCHEDULED EVALUATIONS
 Interim MM YY 1/08/4 | 0/58/5 | Final MM YY 0/98/8

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify) 935 for vehicles

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 102 page PP Amendment)

The purpose of this Amendment is to add \$941,300 and extend the PACD by two years to continue selected activities initiated under the original project.

17. APPROVED BY
 Signature: James L. Helweg
 Title: DIRECTOR, RDO/C
 Date Signed: MM DD YY 1/925/86

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

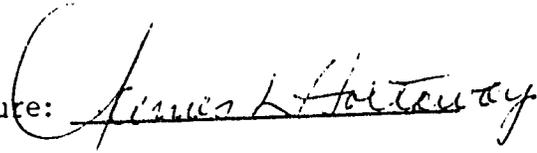
PROJECT AUTHORIZATION

AMENDMENT NUMBER TWO

NAME OF PROJECT: Population and Development

PROJECT NUMBER: 538-0039

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Caribbean Regional Population and Development Project was authorized on July 28, 1982 and amended on June 21, 1985. I hereby further amend said Authorization to add an additional Nine Hundred Forty-One Thousand Three Hundred United States Dollars (US\$941,300). This increases the total authorized amount to Four Million Six Hundred Sixty Six Thousand United States Dollars (US \$4,666,000). The Project Assistance Completion Date of December 31, 1986 is also hereby changed to December 31, 1988.
2. All other terms and conditions of the original Authorization, as amended, shall remain in full force and effect except as hereby specifically amended.

Signature: 

Typed Name: James S. Holtaway

Title: Director, RDO/C

Date: September 25, 1986

POPULATION AND DEVELOPMENT PROJECT
(538-0039)

PROJECT PAPER AMENDMENT NUMBER ONE
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LIST OF ACRONYMS
AND ABBREVIATIONS

BFPA	Barbados Family Planning Association
CARICOM	Caribbean Community Secretariat
CBD	Community Based Distribution (of Contraceptives)
CCSMP	Caribbean Contraceptive Social Marketing Project
CDC	Centers for Disease Control
CEO	Chief Executive Officer
CFPA Ltd	Caribbean Family Planning Affiliation Limited
CHA	Community Health Aide
CPS	Contraceptive Prevalence Survey
CRS/CSM	Commercial Retail Sales/Commercial Social Marketing
CSM	Contraceptive Social Marketing
DMO	District Medical Officer
EC	Eastern Caribbean
ED	Enumeration District
FLE	Family Life Education
FP	Family Planning
FPA	Family Planning Association
FY	Financial Year
IAPG	Inter-American Parliamentary Group
IEC	Information-Education and Communication (in Family Planning)
INOPAL	International Programs for Latin America (Division of the Population Council)
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD/IUCD	Intra-Uterine Device
IUSSP	International Union for the Scientific Study of Population

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JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LD	Low Dose (Oral Contraceptives)
LDC	Lesser Developed Countries
MDC	More Developed Countries
MCH	Maternal Child Health
MOH	Ministry of Health
NPTF	National Population Task Force
OB/GYN	Obstetrics/Gynecology
OC's	Oral Contraceptives
OR	Operations Research
OTC	Over-the-Counter (Non-prescription Drugs)
PAC	Project Advisory Committee
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
PRB	Population Reference Bureau, Inc.
RAPID	Resources for the Awareness of Population Impact on Development
RDO/C	Regional Development Office/Caribbean
SOMARC	Social Marketing for Change (The Futures Group)
ST/POP	Science and Technology Bureau/Office of Population
UNFPA	United Nations Fund for Population Activities
UWI	University of the West Indies
UWIDITE	University of the West Indies Distance Teaching
UFWI	University of the French West Indies
UNECLAC	United Nations Economic Commission for Latin America and the Caribbean
WRA	Women of Reproductive Age (15 - 44)

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I. RECOMMENDATION AND SUMMARY

A. Recommendation

The A.I.D. Regional Development Office/Caribbean (RDO/C) recommends authorization of a \$941,300 Amendment to the Population and Development Project (538-0039). FY 86 population account funds are requested to continue the International Planned Parenthood and Operations Research Components. It is also recommended that the Project Assistance Completion Date (PACD) be extended by two years, from December 31, 1986 through December 31, 1988.

B. Management Strategy

During the period of the 1986 Mission Action Plan review in AID/W, it was recommended that RDO/C take steps to reduce its number of management units. Subsequently, RDO/C made a decision to combine its on-going and future population activities into one project: the Population and Development Project. This amendment represents the first phase of this management consolidation effort.

It is anticipated that this Project will be amended again in FY 87 to add those activities presently designated in the FY 87-88 Action Plan under the Privatization of Family Planning Project (538-0143) and to formally review cost effectiveness assumptions for all components. It is also anticipated that the second amendment will add information, education and communication activities currently being undertaken under the Family Planning Information, Education, Communication and Training Project (538-0116) upon its scheduled PACD of June, 1987.

C. The Original Project*

The Population and Development Project (538-0039) was authorized by the RDO/C Mission Director on July 28, 1982. It was designed to reduce the number of unwanted pregnancies in the region through the adoption of better policies and the provision of improved services. It is being implemented by four major organizations and operates in all the normal RDO/C client countries

* Please refer to the Project Paper for the RDO/C Population and Development Project (538-0039), dated 7/28/82, available through RDO/C in Bridgetown, Barbados or LAC/DR in Washington, D.C.

and Belize. Monitoring and evaluation exercises have documented the success of the project which includes the introduction of new policy initiatives and the expansion of access to family planning services.

Throughout the life of the project, implementation has been coordinated by a Project Advisory Committee. At the last Project Advisory Committee meeting in February, 1986 it was concluded that, despite numerous achievements during the Project, its work will not be complete at the current project assistance completion date. Community-based distribution programs require further technical assistance and support to be fully institutionalized. There is a need for more clinic renovation and community health aide training. Follow-up contraceptive prevalence surveys (CPSS) are needed. Operations Research has been an effective and cost-efficient method for targetting host country programs and policies, however there are more topics which need to be studied and a capability for this type of work needs to be institutionalized in the corps of new researchers that has been developed.

This Project is thus at a juncture which can boast the success of several significant efforts. The institutionalization of appropriate innovations on a long-term basis and the convergence of the various activities into viable, cost-effective national family planning programs will require reinforcement and consolidation.

D. The Amended Project

This Amendment will allow for the continued refinement and monitoring of family planning activities only initiated during the previous four years. These efforts will be aimed at developing integrated national family planning systems which provide full coverage of services at the lowest possible cost and are sustainable within the country's financial and human resource capabilities.

Project Amendment activities will include: providing training opportunities for physicians, nurses and community health aides who have not benefitted from the training conducted to date; providing technical assistance and training to family planning associations in St. Lucia, St. Vincent and Dominica which have young community based distribution (CBD) programs initiated under this Project; conducting minor renovations and providing limited equipment to additional health clinics; and conducting operations research activities to test and compare service delivery methods for cost-effectiveness and client preference. To accomplish these continued objectives, the Amendment will provide approximately \$690,500 to IPPF for services delivery, training and commodities; and \$350,000 to the Population Council for operations research activities. CARICOM will be given a no additional cost grant.

extension of nine months to September 30, 1987 to finalize the work of the remaining National Population Task Forces. The Caribbean Contraceptive Social Marketing Program will continue in the current program countries and expand its reach to other islands in the region with funding provided by the SOMARC project (ST/POP).

At the end of the two year extension the following objectives will have been achieved:

- o Medical policies on contraceptive services will have been established in each territory. National Population Task Forces will have shepherded national population policies through four or five more governments (in addition to St. Lucia which has a Cabinet-approved policy and Dominica which has a policy pending approval).
- o Geographic and psychological accessibility to government family planning services, which has been significantly improved in Barbados, Montserrat, St. Lucia and St. Kitts and Nevis, will be improved particularly in Dominica, St. Vincent and Grenada.
- o Family planning service delivery training for Ministry of Health physicians, nurses and community health aides will be completed.
- o Contraceptive logistics management will be strengthened in all Project countries and coordinated with the Regional Pharmaceuticals Management Project (538-0134).
- o Community-based distribution programs will be firmly established in at least seven Project countries.
- o Contraceptive social marketing will be established in five of the Project Countries, i.e., Barbados, St. Lucia, St. Vincent and the Grenadines, Antigua and Barbuda, and St. Kitts and Nevis.
- o Approximately 15 operations research (OR) activities will have been conducted and OR will be institutionalized as a management capability in at least three of the family planning associations in the region.

E. Financial Summary

(Thousands US\$)

<u>Component</u>	<u>Project To Date</u>	<u>This Amendment</u>	<u>New Total</u>
- POLICY	729	-0-	729
- SERVICES	2,781.7	591.3	3,373.0
- OR	166	350	516
- SOCIAL MARKETING	220*	-0-	220
- COMMODITIES	<u>293*</u>	<u>-0-</u>	<u>293</u>
	4,189.7**	941.3	5,131.0

* These figures differ from those presented in the original Project Paper. Subsequent to the publication of that document, \$5,000 was shifted from the commodities component to the social marketing component.

** Represents \$3,724,700 authorized by RDO/C, plus \$465,000 contributed to project by AID/W (Policy \$129,000, OR \$166,000 and Social Marketing \$170,000).

II. BACKGROUND

A. RDO/C Strategy

1. Management Strategy

The four million dollar Population and Development Project (538-0039) represents RDO/C's major effort in the population field. The only other on-going activity is an OPG (538-0116) authorized at less than one million dollars. A new privatization of family planning project has been planned for a FY 87 start. These three closely-linked activities are the only vehicles planned for the near future to implement the Mission's population strategy.

At the time of the FY 86 Action Plan review in AID/W, RDO/C was advised to reduce its number of management units. With this advice in mind, RDO/C has decided to combine its population activities into one management unit. The logical choice was to combine the activities under an amended Population and Development Project. This process will take the distinct phases or amendments. The first phase represented by this amendment will continue those activities that have proved sound and cost effective under the original project. The second phase will fold in privatization of family planning activities which are planned to be designed this fall. On-going activities will also be formally analyzed as part of the design process to confirm that they are cost effective. Finally, selected activities from the OPG which expires in the summer of 1987 will be added. It is hoped that a combined population project will lessen overall management burden and improve coordination between activities.

2. Population Sector Strategy

In the Eastern Caribbean the very limited land and resource base and high population densities place a particular urgency on population issues. The problems of unplanned pregnancies are particularly critical to young adults and to female heads of households. Since both groups comprise a significant portion of the workforce, unplanned pregnancies have detrimental implications for employment and economic growth. The RDO/C population strategy calls for creating and maintaining an appreciation by policymakers and leaders of the impact of population dynamics on the socio-economic development goals of each country and the region as a whole. This is coupled with giving active support to a wide variety of family

planning approaches, with a focus on strengthening institutions providing such services to ensure broad access by all members of these societies seeking services. These institutions will be helped to develop their capacities through training and technical assistance in management (especially contraceptive supply logistics) and the provision of equipment and commodities to renovated clinics. Concurrently, private sector family planning institutions will be strengthened through training, technical assistance in management, and non-clinical delivery programs in community-based distribution and contraceptive social marketing. Efforts to increase accessibility and measure effectiveness of alternative delivery systems include operations research activities and periodic contraceptive prevalence surveys. Improvements to the public and private sector delivery systems will be encouraged to the point where further progress can be self-sustained.

B. Background and Constraints

1. Demographic Background

Population dynamics in the Eastern Caribbean have been characterized in recent years by dropping birth, death and fertility rates and high rates of emigration. Birth rates peaked in the 1960s as did the rate of natural increase at 3 percent per year in some countries. In the 1970s the region was still facing average natural increase rates over 2 percent which, if maintained, translates to a doubling of the population in 35 years. As the original Project Paper suggests, "Excessive population growth has exacerbated the Eastern Caribbean countries' deep-rooted structural problems by having its dependent effect on high unemployment."

At their Seventh Meeting in July 1981, the CARICOM Ministers Responsible for Health re-emphasized these concerns. Quoting Caribbean Development Bank President William Demas, the Ministers noted the growth of population as one of the main factors contributing to the high level of unemployment:

"For communities living on islands with limited space and limited resources, rapid population growth is a serious problem. The pressure on health services, hospitals, school places, housing, and general well-being are all too evident."

While the Ministers Responsible for Health were beginning to become aware of the population problem facing the region, the issue was still a highly controversial one. A review of the extent of services available prior to the beginning of this Project shows the poor level of accessibility to current and potential contraceptors at that time.

Table 1

Availability of Family Planning Services
in the Caribbean, 1982

	<u>ANT</u>	<u>BAR</u>	<u>BEL</u>	<u>DOM</u>	<u>GRE</u>	<u>MON</u>	<u>StK</u>	<u>StL</u>	<u>StV</u>
<u>Governments</u>									
<u>Clinics</u>				*			*		*
<u>Family Planning Associations</u>									
<u>Clinics</u>	*	*			*	*	*	*	
<u>Community-based distribution</u>	*				*		*		
<u>IE&C only</u>				*					*

The above table shows that government services were available to some degree in three countries, although the quality and type of services were limited. In St. Kitts, for example, government-sponsored family planning services were available through clinics only two days per month. In most countries where family planning associations were offering services, these programs were also limited in terms of available, qualified staff, contraceptive supplies and community outreach.

It was recognized by the original Project design team that fertility rate reductions were already in motion to some degree in the region, although still far above replacement levels. The Project Paper correctly warns, however, that "even with further fertility decline, the populations of the LDSs will continue growing well into the next century because of their present youthful age-structure. The present pace of fertility decline to replacement fertility levels means that the populations will double in size before equilibrium can be reached."

Five years later that thought has not been lost even in the face of recent successes in family planning. At the Tenth Conference of Ministers Responsible for Health held in June, 1986 in Georgetown, Guyana, the CARICOM Ministers reported:

"A major problem of all the Caribbean countries in the next fifteen years will be the large numbers entering adulthood - those children now under fourteen years of age. Generally speaking, Member Countries are having great difficulty coping with those who have become adults in the last ten years. Even larger numbers are slated to become adults in the near future. Every possible means should be used to assist the countries to cope with this."

According to the 1980-81 population census of the Commonwealth Caribbean, there were approximately 190,000 women of reproductive age (WRA) in 1980. Projections of natural increase based on this census data suggest that by 1985 the number of WRA would have increased to over 230,000, to 270,000 by 1990, and more than 295,000 by 1995.

The above projections do not take into account the impact of emigration which in the past has had the effect of reducing the population growth by nearly 50 percent. Emigration has doubtlessly been a "safety valve" for population pressures on these small islands. It also represents a serious loss to these countries not only through the obvious drain on public sector resources which pay the bill for educating North American and British workers but also in terms of lost contribution to their own national economic development.

2. Problems and Constraints

Several key legal, political, physical, administrative/medical and cultural constraints were identified by the original Project design team as hindering the development of effective population efforts in the region. While the degree to which these impediments were manifest in each country varied somewhat by locale, these constraints were significant throughout the region.

a. Legal Impediments. Perhaps the most critical legal problem in the region was the presence of a prescription requirement for dispensing oral contraceptives. This requirement was de jure law in all of the Project countries with the exception of St. Lucia where it was a strict policy but not a de jure legal requirement.

b. Political Impediments. The greatest political constraint to effective family planning was identified as a lack of awareness of the importance of population growth on the development

strategies of the region. In several countries, family planning was a strongly controversial topic whether due to the influence of Catholic religious convictions (in Dominica, St. Lucia, and St. Vincent, for example), or the conservative nature of the society (e.g., Montserrat).

c. Physical Constraints. One of the greatest physical constraints to effective family planning programs consisted of poor accessibility to services and contraceptive products due to the limited number of family planning outlets and inadequate facilities of many outlets which existed. Where governments offered family planning services through health clinics, the physical layout of many of these facilities prevented the privacy required for client counselling and medical examinations. Inadequate and improper facilities was often cited by Ministry of Health officials as the reason governments could not introduce family planning into their maternal and child health clinics. Not only were physical plant layouts inappropriate in many instances, but necessary medical equipment was lacking and clinic staff were poorly (if at all) trained to provide family planning services.

In addition to poor or in some cases non-existent government-supplied services, physical (geographic) accessibility was limited to very few alternative systems for service delivery. While each of the countries could claim family planning associations, as the previous table shows, Dominica and St. Vincent were limited to information and counselling services, and only three FPAs (Antigua, St. Kitts and Grenada) offered non-clinical distribution programs. Although a myriad of contraceptives were available in commercial pharmacies, the small number of pharmacies in countries such as St. Vincent, St. Lucia, and Dominica (less than 10 in each), the tendency for pharmacies to be located primarily in the capital cities and the high cost of contraceptives (US\$5.00-12.00 per cycle of orals) limited the influence of the private sector in contraceptive delivery.

d. Administrative/Medical Constraints. One of the major administrative/medical constraints identified by the original design team was the Caribbean medical system "which requires excessive medical supervision and patient follow-up and fails to delegate responsibility to the appropriate level health worker". Thus, for example, only physicians were seen as capable of conducting routine medical examinations of potential contraceptive users, or of inserting IUDs. A second major impediment was seen to be out-dated medical protocols and knowledge gaps significantly behind current contraceptive technology and practice.

e. Cultural Impediments. The cultural impediments to successful population programming were seen to be certain prevailing attitudes which directly or indirectly countered family planning efforts. These include judgemental attitudes communicated verbally or nonverbally by clinic personnel to sexually active young people seeking services, male concerns that a contracepting girlfriend would be promiscuous and a widely-held belief that "free goods are poor quality goods". (These and other socio-cultural considerations in Project planning are further amplified in the social soundness analysis.)

C. Review of Project to Date

A synopsis of overall progress to date is presented below. A more detailed account may be found in Annex A.

The Population and Development Project (538-0039) was authorized by the RDO/C Mission Director on July 28, 1982. The goal of the Project, as stated in the original project paper, is to bring the populace of the Eastern Caribbean into better balance with available resources by limiting birth rates. The purpose of the project is to reduce the number of unwanted pregnancies in the Eastern Caribbean by systematically addressing the two major constraints to limiting population growth: (1) the lack of awareness among key leaders of the consequences of current demographic trends and out-moded medical procedures of family planning practices on socio-economic development; and (2) the current inability of countries to deliver adequate and timely family planning services.

The Project, as originally conceived and implemented to date, is the product of four major actors. The population policy and medical policy formulation components of the Project have been implemented by the Caribbean Community Secretariat (CARICOM). The contraceptive social marketing component has been executed by The Futures Group under its SOMARC Program and predecessor, Contraceptive Social Marketing (CSM) program. The operations research component has been managed by Tulane University. The services delivery and training components have been implemented by the Western Hemisphere Region Office of the International Planned Parenthood Federation (IPPF/WHR).

The original countries included in the Project were Antigua, Barbados, Dominica, Montserrat, St. Kitts and Nevis, St. Lucia and St. Vincent and the Grenadines. Belize has received limited support for population policy work. Following the intervention in Grenada, the IPPF/WHR grant was amended to bring Grenada fully into the Project.

Quarterly progress reports and the external evaluation report document the successes of the Project in introducing the new policy initiatives and expanding access to family planning services. A few of the "milestones" of the Project follow. The first regional "population awareness conference" held in the Caribbean was convened under the CARICOM component of the Project in April, 1984. The object was to instil an appreciation for the impact of population growth on the economic, political and social development of these island nations and to discuss with policymakers options they might consider in managing the demographic situation in their countries. This conference was followed up by a Caribbean Conference of Parliamentarians on Population and Development in June, 1985 which culminated in adoption of a "Caribbean Declaration on Population and Development". Under the Project each country has established a National Population Task Force (NPTF) which has carried forward the discussion of the impact of population growth on development, and has sought to develop national population policies. The St. Lucia NPTF formulated a national population policy which has been approved by Cabinet; in Dominica the NPTF has just submitted its draft to Cabinet. Other countries are still working towards this goal. Each of the countries has adopted an overall medical policy which establishes protocols for contraceptive use. All of the policy work noted above has been assisted by demographic research publications developed under the CARICOM component of the Project.

Under the service delivery component of the project, family planning services have been established within the public health systems of Grenada, St. Lucia, Antigua and Montserrat so that today all governments in the region offer family planning services. The first multi-country Contraceptive Social Marketing (CSM) program was established in this region (Barbados, St. Lucia and St. Vincent), and non-clinical community-based distribution (CBD) programs were established in Barbados, St. Vincent, St. Lucia and Montserrat. Contraceptive supplies have been provided to the clinic and non-clinic outlets providing both a certain and wider range of products for clients.

Eight operations research projects were successfully completed with the assistance of family planning associations and Ministries of Health throughout the region. Baseline Contraceptive Prevalence Surveys were conducted in each of the Project countries (except Belize) and follow-up surveys have been started in Antigua, Dominica, St. Lucia and St. Vincent. Family planning surveys focusing on male respondents were conducted for the first time in Barbados, St. Kitts and Nevis and Dominica.

Table 2 provides a comparison of the current status of family planning services with the status in Table 1. It also provides a country-by-country specific breakdown of other Project inputs.

Table 2

Availability of Family Planning Services
in the Caribbean and Project Inputs, 1985

	<u>ANT</u>	<u>BAR</u>	<u>BEL</u>	<u>DOM</u>	<u>GRE</u>	<u>MON</u>	<u>StK</u>	<u>StL</u>	<u>StV</u>
A. <u>SERVICES</u>									
<u>Governments</u>									
<u>Clinics</u>	+	+		*	+	+	*	+	*
<u>Family Planning Associations</u>									
<u>Clinics</u>	*	*		+	*	*	*	*	
Community-based distribution	*	+		+	*	+	*	+	
Adolescent Programs	+	+		+	+	+	+	+	
IE&C only					*				*
<u>Private Sector</u>									
Contraceptive social marketing		+						+	+
Community-based distribution									+
B. <u>OTHER PROJECT INPUTS</u>									
<u>Training (FPA and Gov't Staff)</u>									
Physicians	+	+		+		+	+	+	
Nurses	+	+		+	+	+	+	+	+
Community health aides							+		+
<u>Clinic Renovation and Equipment</u>	+			+	+	+	+	+	+
<u>Commodities</u>	+	+		+	+	+	+	+	+
<u>Contraceptive Prevalence Surveys</u>									
First round	*	*		*	+	+	+	*	*
Follow-up	+			+				+	+
<u>Operations Research</u>		+		+		+	+	+	+
<u>Policy</u>									
National population task forces	+			+	+	+	+	+	+
Population policies								+	
Medical policies	+	+	+	+	+	+	+	+	+
Demographic training	+	+	+	+	+	+	+	+	+

* = Existant prior to Project
+ = Added through Project

Table 3 is a matrix which matches inputs and the constraints they were meant to address. A review of this table and Table 2 shows that numerous efforts have been targeted to remove physical constraints by improving access to contraceptive products, equipment and facilities; to reduce medical constraints, specifically the perceived need for physician dominance of family planning delivery; and to remove political barriers by improving awareness of population matters.

The scorecard on removing constraints to date is mixed. At this point in Project implementation, most of the policy work has been successfully completed; and, by any measure, awareness of population impacts on development has been achieved. The Regional Medical Policy, adopted almost verbatim by all participating governments, has been successful in addressing three key constraints to more effective service delivery. First, while it did not remove prescription requirements for oral contraceptives, it recommends that "recognized field workers" be allowed to "prescribe" a three-month supply of orals to women who fit into a broadly specified low-risk description. During the three month period, women taking orals through such methods are to obtain a medical check-up. The medical policy strongly encourages the development of non-clinical, community family planning services and greater use of community health auxiliaries in delivering those services. Third, the policy clearly advises on the applicability of various contraceptive methods based on the most recent clinical trials and research.

In the area of cultural impediments, nurse training initiated under the Project is improving the professionalism of these clinic workers in dealing with prospective contraceptors, although more training will be required. Special service delivery and counselling efforts have been initiated to modify male attitudes which discourage contraceptive use. CSM and CBD programs which sell contraceptives at subsidized prices are making contraceptives available to those who have limited incomes but distrust free clinic goods.

A plethora of services and outlets have been opened to the region, although most of these programs are still too new to be judged on their long-term economic viability or programmatic effectiveness. It is expected that these activities can be brought to a reasonable state of operation in the coming year, at which time cost-effectiveness assessments will make good management sense.

Table 3

Inputs and Constraints Matrix

<u>INPUTS</u>	<u>CONSTRAINTS</u>										
	<u>Legal</u>	<u>Political</u>	<u>Physical</u>			<u>Admin/Med</u>		<u>Cultural</u>			
	<u>RX req</u>	<u>lack of awareness</u>	<u>poor access:</u>	<u>prod</u>	<u>equip</u>	<u>facil</u>	<u>MD dom</u>	<u>poorly trained</u>	<u>improper behavior</u>	<u>male atts</u>	<u>free goods = no good</u>
<u>Governments</u>											
<u>Clinics</u>			*			*					
<u>FPAs</u>											
<u>Clinics</u>			*	*		*					
<u>CBD</u>			*			*					*
<u>Adolescents</u>			*			*				*	
<u>Private Sector</u>											
<u>CSM</u>			*			*				*	*
<u>CBD (StV)</u>			*			*					*
<u>Training</u>											
<u>Physicians</u>							*	*			
<u>Nurses</u>							*	*	*		
<u>CHAs</u>							*	*	*		
<u>Clinic Renov</u>					*	*					
<u>Commodities</u>				*							
<u>CPSS</u>		*									
<u>OR Projects</u>	*		*			*	*			*	*
<u>Policy</u>											
<u>NPTFs</u>		*									
<u>Pop policies</u>	*	*									
<u>Med policies</u>	*	*	*				*	*	*		
<u>Demo training</u>		*									

III. THIS AMENDMENT

A. What The Amended Project Will Do

1. Rationale

The conclusion of the last Project Advisory Committee meeting in February, 1986 was that while the project has achieved many of its ambitious objectives, its work will not be complete when the current project assistance completion date arrives. Some of the innovations, e.g., community-based distribution programs, require further technical assistance and support to take them from the nascent stage to being effective, institutionalized components of the regional development effort. There is a need for more clinic renovation and community health aide training. Follow-up contraceptive prevalence surveys (CPSs) need to be done to provide a comparison with the baseline data collected through the first round of surveys in 1981 and 1982. Operations Research has been an effective instrument for gathering practical experience in a cost-efficient manner to use in targetting host country programs and policies. There are more topics which need to be studied and a capability for this type of work needs to be institutionalized in the corps of new researchers which has been developed.

This Project is thus at a juncture which can boast the success of several significant efforts. The institutionalization of appropriate innovations on a long-term basis and the convergence of the various activities into viable, cost-effective national family planning programs will require reinforcement and consolidation.

This Amendment will allow for the continued refinement and monitoring of family planning activities only initiated during the previous four years. These efforts will be aimed at developing integrated national family planning systems which provide full coverage of services at the lowest possible cost and are sustainable within the country's financial and human resource capabilities.

2. Goal, Purpose, Objectives, Strategies and Tactics

The goal and purpose of the Project Amendment remain the same as in the original Project Paper. The objective of the project during the continuation period is to provide further assistance to the Governments and family planning organizations of the Eastern Caribbean states to bring their populace into better balance with available resources and to help Governments and peoples of the Eastern Caribbean to reduce the number of unwanted pregnancies in the region.

The primary strategy during the continuation period will be the maximization of accessibility to family planning services and products at the lowest possible cost--allowing for sustainability within the countries' financial and human resources. Achieving this strategy, requires tactics which focus clearly and singly on each participating country and marry the efforts of both the public and private sectors.

During the extension period, the primary tactic is to target technical assistance to specific unmet needs as determined on a country-by-country basis. As the service delivery systems introduced by the Project gain more experience and history, they will be concurrently evaluated for their overall contribution to increased contraceptive accessibility and cost-effectiveness as measured against other delivery programs.

3. Expected Outputs

- a. National Demographic and Medical Policies - Acceptance by Cabinets and/or Legislatures of formal National Population Policies in at least six countries.
- Constitution of National Population Councils, provided with small budgets, to oversee implementation of population policies in at least four countries.
- Acceptance of revised, liberalized medical protocols dealing inter alia with wider accessibility of contraceptives in at least four countries.

- b. Increased family planning service availability through public and commercial sectors
 - Establishment in at least six (6) countries of a sufficient number of facilities, adequately appointed, equipped and staffed, at which clients can receive counselling and family planning services without fear of violation of confidentiality and without having to travel great distances.
 - Establishment, in at least five countries, of community-based distribution systems which provide good services at a cost which makes the service affordable to large numbers and yet profitable to the family planning associations, and establishment of trained retailers and managers who operate them.
 - Establishment, in at least six countries, of a social marketing system which will provide branded contraceptives to that segment of the market which research identifies to be unserved.
- c. Training provided to doctors, nurses and allied health workers
 - Doctors: Training of at least nine doctors through JHPIEGO (St. Vincent, Grenada and Antigua).

- Nurses and Community Health Aides:
Establishment of
formal, in-service training committees in at least six countries.
- Institutionalisation through in-service training committees of continuing nurses education courses in at least three countries, with self-instructional kits and other materials available in all countries.
- d. Commodity Supply and Distribution
 - Assumption, by the medical authorities responsible for ordering, storing and distributing pharmaceuticals, of responsibility for ordering, storing and distributing contraceptives, in at least four of the countries participating in the Regional Pharmaceuticals Management Project (538-0134).
- e. Improvement of Clinic
 - Approximately 65 clinics in at least six countries to be provided with basic family planning equipment and modest renovations.

- g. Operations Research - The development of operations research skills and techniques in design, data gathering, data processing and analysis, so that skills may be applied as management tools in making family planning organizations/programs more cost-effective. At least three countries/FPAs should acquire these benefits.

- f. Program Support - The carrying out of first round CPSs in Grenada, St. Kitts and Nevis and Montserrat, and follow-up contraceptive prevalence surveys in Barbados, St. Lucia, Antigua, St. Vincent and the Grenadines and Dominica.

4. End of Project Status

By the revised project assistance completion date, the medical directorates in the Ministries of Health in most of the territories will have adopted regional medical policies on contraceptive services and formulated protocols to address family planning issues.

The governments of all of the countries with the exception of Belize will have received draft population policies from the National Population Task Force they appointed. Some of them will have adopted these reports, disbanded the National Population Task Forces and in their places appointed National Population Councils to oversee the implementation of the approved population policies.

Government family planning services will be available in each of the countries and will be delivered to contraceptive users in approximately 65 well appointed and equipped clinical accommodations which afford privacy and facilities

acceptable both by the user and the staff delivering the services. The staff will be well trained in all aspects of family life and family planning, including basic counselling. The governments will continue to receive contraceptive supplies but will work towards improved pharmaceuticals logistical management, so that the addition of contraceptives to the list of pharmaceuticals would present no major problem.

In at least three territories, the local family planning associations, which have started community-based distribution programs, will, with further help and technical assistance, have these programs established to the point where they may generate some funds for the family planning associations, while widening the market and accessibility to over-the-counter contraceptives. The contraceptive social marketing program managed by The Futures Group will widen the accessibility of contraceptives, catering to its special segment of the market (young, working, but lower economic class individuals), with culturally-acceptable advertising of its contraceptive products.

The findings of nearly 15 operations research activities by the larger family planning associations will have led to increased contraceptive prevalence through the implementation of well-managed family planning activities, which have been proven to be most cost effective and acceptable to the program's clients.

5. Project Activities and Inputs

a. Population Policy

As reported previously, the implementation of the population awareness component of the Project has been nearly fully completed. The remaining activity to be completed by most governments is the formulation of national population policies. The CARICOM NPTF consultant will continue to work with four of the remaining eight territories which have not yet formulated a population policy. It is anticipated that by September, 1987, a minimum of five more governments will have joined St. Lucia in establishing a national policy for population matters. Detailed quarterly work plans will be submitted by the Grantee as will monthly progress reports.

b. Family Planning Services Delivery through IPPF

The family planning services delivery component under the Amendment will consist of four activities: (a) training, (b) non-clinical community-based distribution (CBD) and provision of commodities to the public sector, (c) improvements to clinic services and (d) program support.

(1) Training. A substantial amount of training has already been undertaken under the Project to assure a cadre of individuals capable of providing high quality family planning services. While a certain amount of training under the Amendment will be required to replace individuals no longer working in family planning, an important focus of training will be the improvement of services delivery and the reduction of delivery costs.

It is proposed that further training will be provided to at least nine (9) more doctors. All costs for participants, including round-trip economy airfares, maintenance allowances during training, course tuition fees and educational materials will be met from the ST/POP grant to JHPIEGO.

While physicians play an important role in family planning services delivery, nurses will continue to be the primary providers of family planning services. The training of nurses has had the effect of noticeably upgrading their family planning skills, which has led to an improvement in the quality of family planning services delivered. The need for continued training remains, not only to replace those nurses lost to the service through retirement and immigration, but also to help to further develop the local capability for family planning training.

To maximize the training effort under the extension, formal in-service training committees will be established in each country to evaluate training needs, advise on candidate selection, assisting in curricula and training materials development and placement of graduates. Two, one-day training and motivational seminars will be held for nurses in each of the Project countries.

Under the Project, IPPF will design and produce a self-instruction training kit for nurses on family planning service delivery and counselling. The kit should be applicable for use both by newly-trained nurses as well as nurses needing refresher training. It will contain a copy of the IPPF contraceptive technology manual and video cassettes prepared by CFPA. Six training kits will be provided to each beneficiary sub-grantee, who will ensure that additional copies are available for use by tutors in the region's schools of nursing.

Additionally, in recognition of the increasing role of community health aides in the provision of family planning in both clinical and community settings, IPPF will organize and conduct one-day training and motivational seminars for them. These seminars will be designed to follow immediately after the

nurses training programs and be conducted by the nurses trained. This design will assist the nurses in practicing the training and counselling skills they will have learned during their seminars. It will also help to strengthen the professional linkages between the nursing and community health aide fields for the improvement of family planning services. Nurses are the primary providers of family planning services. Family planning nurses in the region have had opportunities to meet only briefly at regional training seminars, but these opportunities did not allow of a sufficient time for a discussion of common problems and their solutions and the development of a professional body which could further their aims and objectives. The first Regional Conference of Nurses in Family Planning was held in St. Lucia, July 15 - 17, 1986 and was adjudged to be very successful. On their own initiative the nurses formed an action group for Caribbean nurses in family planning. In order to help maintain the high level of motivation evidenced at this first conference, the Grantee will arrange for a second conference to be held in the Region.

(2) Clinical and Non-clinical Distribution of Commodities. An overall management assessment of the CBD programs started under this project found several common problems plaguing all of the projects: inadequate coordination by managers, poorly trained or motivated retailers interfacing with consumers, the lack of promotional materials and inadequate institutional support.

Under the Amendment, it is anticipated that a thorough management assessment and marketing audit will be undertaken of all of the CBD programs started through the IPPF grant, which can reasonably benefit from further assistance, i.e., Dominica, St. Lucia, and St. Vincent and the Grenadines. Following this critical assessment, a detailed workplan will be established for the provision of technical assistance, training and materials development and dissemination. The workplan will delineate the need for country specific training and assistance and will identify opportunities for regional training where this level of intervention is warranted and would be most efficient.

It is expected that a majority, if not all, of the assistance and training can be conducted by program managers of the Barbados Family Planning Association's CBD program and other regional resource persons with marketing and promotion skills. This strategy should result in more relevant interventions targeted to the West Indian context and milieu, closer collaboration with counterparts and cost efficiencies in program interventions. It should also result in a further strengthening of regional resources and greater technical cooperation among Caribbean countries.

Technical assistance in Contraceptive Supply Management has been provided through an AID/Washington funded RSSA with the U.S. Centers for Disease Control. However, although there have been attempts by some sub-grantees to establish maximum and minimum supply levels, delivery schedules and the development of supervisory system, the development of uniform supply information and inventory control systems has not been satisfactory and estimates of contraceptive requirements remain tentative.

The Grantee with Technical Assistance from CDC, will organise a regional workshop in Contraceptive Supply Management. The workshop will be for national family planning services co-ordinators, the store-keepers responsible for contraceptive stocks and the senior nursing officer responsible for MCH/Family Planning clinics.

The Project Director and staff of the Regional Pharmaceuticals Management Project, based in St. Lucia, will also be invited to participate in planning and conducting the workshop, with a view to having the supply management of contraceptives added to the supply management of pharmaceuticals in the participating countries.

(3) Clinic Improvements. Clinic renovations completed to date under the Project have focused on the provision of additional examination and counselling space to facilitate the work of Ministry of Health family planning nursing and physician staff. Requests have been received from at least three of the Project countries for further assistance in clinic renovation and/or the provision of limited, specialized family planning equipment. All combined, the requests add up to the need for renovating an additional 25 clinics. As this number is beyond the scope of funds available for additional clinic renovation (\$60,000), the first task of IPPF will be to assess the relative needs as expressed by each government and devise a strategy for meeting the more critical needs.

This construction/renovation activity should be greatly facilitated by lessons learned assuring that all physical plant modifications can be successfully completed within the time available.

(4) Program Support. This component includes several important program elements, e.g., a contraceptive prevalence survey for Barbados, technical assistance and support for training consultants and a final project evaluation. The Amendment will provide the needed time to complete the CPSs already underway in St. Lucia, St. Vincent, Dominica and Antigua, and will provide the financial support to conduct a follow-up survey in Barbados.

The major objectives of these surveys are to determine and clarify levels of contraceptive use in the territories in which they are undertaken and to assess the relative effectiveness of information, education and delivery services in affecting patterns of contraceptive use in the various territories. More specifically the surveys will try to determine:

- o the socio-demographic characteristics of women associated with different rates of contraceptive use;
- o the barriers to and facilitators of use in terms of women's awareness of contraceptives and contraceptive outlets;
- o the internal and social sources of resistance to contraceptive use as determined by women's contraceptive experience, their religious convictions, the attitudes of their families, friends, partners and husbands; and
- o the reach of family planning programs and their impact on contraceptive use.

In pursuit of these objectives, appropriate questionnaires will be developed covering each of the topics and administered to representative samples of women aged 15-44 in the various territories. The Contraceptive Prevalence Surveys will be comprised of two or three-stage probability samples involving the random selection of enumeration districts (EDs) in some cases, the systematic sampling of households within each ED and the random identification of the eligible respondent within each household.

IPPF has arranged for the release of Dr. Tirbani Jagdeo from his duties as Chief Executive Officer of the Caribbean Family Planning Affiliation Ltd. to be the principal investigator in the conduct of the contraceptive prevalence surveys.

c. Operations Research

The Tulane OR Component improved family planning service delivery and generated data to improve and redirect RDO/C-supported activities. With the expiration of the centrally-funded Tulane OR Project, however, the outstanding OR needs will be met under the Amendment through existing ST/POP OR grant to the Population Council.

The principle objective of the new OR component will be to improve the cost effectiveness, accessibility and quality of utilization of family planning service delivery systems in the Eastern Caribbean. In the process of implementing the OR activity, it is expected that the benefits and methodologies of operations research will be crystalized in the local organizations implementing these new research undertakings. Where possible, those local resources which implemented the first round of activities in the Eastern Caribbean will be called upon to undertake the new work and a special effort will be made to undertake the data analysis and reporting locally.

A regional seminar on the results of operations research studies conducted by Tulane in April, 1986 identified several program areas which require examination during this Project Amendment period, including:

(1) New strategies for Reducing the Costs of Services. The cost of providing services in the Caribbean is still exceptionally high, particularly for services to special groups (e.g., \$14.49 per couple-month of protection for on-site distribution to factory workers in St. Lucia).

New strategies for reducing costs without seriously limiting the coverage or quality of services are urgently needed to assist service delivery systems in becoming more self-sufficient. Where previous research has demonstrated that a particular strategy is effective in delivering contraceptive services (e.g., the use of community volunteers), community health aides, home visits to women following a first birth, new variations should be tested which reduce or recover some of the costs of these efforts.

(2) Male Participation. Male attitude surveys conducted to date under the Population and Development Project suggest that the traditional view of male opposition to family planning should be reconceptualized in terms of a lack of motivation rather than an aversion to practice family planning. Programs which will enhance the male sense of responsibility for family planning which could lead to increased use of condoms and vasectomy are critical for improving contraceptive prevalence in the region. Systematic efforts to identify the most effective methods of gaining male participation are very few.

(3) Delaying Births/Birth Spacing. The first step in the analysis of programs to delay first or second births to young mothers was initiated under the Tulane OR Program with Barbados family planners. Increasing the cost-effectiveness of programs which follow-up on young mothers will be essential, however, if such activities are to be adopted by governments in the region. Further OR will be critical in fine-tuning such strategies.

(4) Improving Skills of Service Deliverers. Cost-effectiveness is needed not only in the contraceptive delivery systems. Greater proficiency in managing financial and human resources of the agencies delivering services will also lead to improved cost-efficiencies. This Project will examine a range of feasible management alternatives for cost and programmatic effectiveness to better equip service providers to maximize their management efforts and minimize program costs.

(5) Quality of Use of Contraceptives. Increased efforts are needed to test alternative information, education and communication (IE&C) strategies to improve the use of contraceptive methods, particularly focusing on the consumer's knowledge of proper use, potential side effects, what to do in case of problems.

Five major tasks will be undertaken in the implementation of operations research during this phase of the extended Population and Development Project:

Task Number 1: Assessment of Opportunities for OR. The first activity will be to review the operations research issues confronting Eastern Caribbean family planning service delivery agencies to gain a better understanding of the scope and commonality of problems facing these systems.

The opportunities identification process will consist of visiting all government and private family planning/maternal and child health service agencies and representatives of potential collaborating groups, e.g., CARICOM, UWI, PAHO, UNFPA and SOMARC, working in the Project countries, and consulting with RDO/C and Office of Population officers regarding regional needs. Based on this review, a data base of opportunities for OR will be developed and prioritized with the assistance of the RDO/C Health, Population and Education Division.

Based on a selection criteria, which will be developed jointly by the Population Council and RDO/C, 5-10 research opportunities will be selected from which 4-5 will be developed into complete proposals. This first task will serve as the basis for the first 12-month workplan and will be submitted to RDO/C six weeks following start-up.

Task Number 2: Preparation of OR Proposals. Once potential implementing organizations are evaluated, the Population Council will work with the selected organizations to prepare full proposals for consideration by RDO/C and the Office of Population. During the two years of the program, 4 or 5 activities requiring 12-18 months of implementation and ranging from \$20,000 to \$75,000 will be conducted. Activities will be implemented in at least three of the eight program countries.

All proposed research will be discussed jointly with the implementing organization and representatives of RDO/C during the preparation stage and submitted to RDO/C for approval. Once approved locally, the proposals will be sent to the Population Council's headquarters in New York and the OR Project office in Mexico as well as the ST/POP Technical Officer for review and finalization by means of subcontract with the implementing organization.

During this process, a one-day seminar for program managers, administrators and researchers will be organized to improve communications and strategy procedures, and provide in-service training of researchers. The primary goal of these seminars will be to give these key individuals hands-on experience in clarifying policy alternatives in the development of the proposals.

Task 3: Technical Assistance to Implementing Agencies. The implementation phase of each OR activity consists of a series of activities beginning with the design of data collection methodology and terminating with communication of results to policymakers. Technical assistance will be provided to the implementing agencies through each of the steps required to

implement the research activities, e.g., preparation of data-gathering materials; selection of units of study; data collection, processing, and analysis; communication between researchers, managers and policymakers; and report preparation. Every effort will be made to implement all phases of the activities locally. Assistance will be provided by the Population Council's resident staff associate who will be located in Barbados and by special short-term consultants as warranted.

Task Number 4: Integrating OR Techniques into Routine Program Management. While training conducted over the course of the component will be directed at implementation of the immediate activity at hand, the Population Council will provide training on the broader methods of gathering, analyzing and using data for decision-making to provide project managers and researchers with strategies and practical experience on integrating OR into routine management. While it is expected that most of the training will be conducted on-site, short-term third-country training may be considered for key project personnel, where required.

Task Number 5: Disseminating Project Results. To maximize the usefulness of this research and the approach, the results of the OR activities will be disseminated on three levels: national, regional and international.

At the local level, the results of the research will be communicated to members of the implementing agencies who might not have participated in the activity including, for example, directors of other divisions and programs, as well as to other relevant local organizations on the particular island who could benefit from learning about the research results and methodology. The mechanism for disseminating these results will be a local seminar at the close of the activity.

A regional conference will be held in Barbados when all of the activities are completed to disseminate the results of each of them in one forum. Following in the fashion set by the Tulane Caribbean OR component, presenters will be selected from the individual researchers who worked most closely on the activity, and the audience will consist of those who can most use the information gained.

Finally, the broadest level of dissemination will be undertaken through bi-annual reporting of the activities' progress in a specially-developed English language edition of the INOPAL newsletter Alternatives which will be provided to relevant parties throughout the region over the life of the Project.

d. Contraceptive Social Marketing. RDO/C has played primarily an advisory role in the development of the CCSMP, contributing only \$50,000 to its implementation. The majority of funding to date has come from the ST/POP contraceptive social marketing project.

CCSMP is the process of finalizing its fourth year (July 1986 to June 1987) marketing plan. Included in the marketing plan will be a complete discussion of the management and marketing strategies designed for "restaging" the CCSMP to most effectively meet the needs of the Caribbean region.

Two major issues to be addressed in the coming year of operation of the CCSMP are contraceptive product mix and geographic coverage. The product strategy to date has focused on condoms and two dosages of oral contraceptives. Internal AID commodity procurement problems suggest growing uncertainties with the future supply of CSM oral contraceptives. Additionally, from a strictly marketing perspective, CSM experience with orals sales to date suggests that, due to the ethical nature of the product, the cost of improving Perle and Perle LD sales in this relatively small potential orals market is probably unacceptably high. Finally, as the CSM program has proven more successful than CBD programs in selling over-the-counter (OTC) contraceptives (particularly to younger target age groups), it is anticipated that the CCSMP will focus future activities on OTC products, possibly including foaming tablets and an "ultra-thin" condom. Specialization on OTC contraceptives also ensures optimization of the CSM tenet of brand-specific mass media advertising as only OTC products are advertised in these countries.

With regard to geographic coverage, it is anticipated that during the coming year the CCSMP will have stabilized its marketing effort in the original three program countries, thus opening the possibility for expanding the program to further island nations. While the expansion strategy has not been developed yet, the most appropriate expansion countries are Antigua and St. Kitts and Nevis in the first instance, leaving the more conservative islands of Dominica and Grenada for the less visible clinic and CBD programming efforts. RDO/C funding for this activity may be required for these future expansion efforts. Additionally, should the success of this activity warrant continued support after SOMARC, RDO/C "maintenance level" support could be required.

6. Implementation Plan

a. Implementing Mechanism

Implementation of the project will continue to be a complex operation, notwithstanding the experience gained during the past three years.

The grant to CARICOM will be extended for nine months from December 31, 1986 to September 30, 1987 at no additional cost. The Co-operative Agreement with the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) will be extended for two years from December 31, 1986 to December 31, 1988 to allow IPPF/WHR to undertake some further training activities, the improvement of some more clinic services, the continued distribution of contraceptives and the provision of technical assistance. The Population Council will be contracted to implement the operations research component as a follow-on to what had been achieved previously under the operations research component by Tulane University. The Futures Group, under its centrally-funded SOMARC Project, will also continue its contraceptive social marketing activities.

It is proposed to continue co-ordination through a Project Advisory Committee (PAC) which will be composed of a representative of CARICOM (the contractor stationed in Barbados), IPPF/WHR (Caribbean Project Manager), F.B. Armstrong (Project Manager), The Population Council (Staff Associate, Operations Research in Maternal Child Health/Family Planning in the Caribbean) and AID (Chief, Health Population Education Division). The main functions of the PAC will be to provide guidance to project implementation and to address serious coordination difficulties. The PAC will meet at least once annually at a time to be determined by the members.

The USAID Health and Population Advisor(s) assigned as project officer(s) will be the primary focus for routine management co-ordination, in consultation with the Chief/HPE Division. It is estimated that between 60-70% of the project officers' time will be spent on project monitoring.

The roles of the implementing agencies will be spelled out in grant agreement amendments and project implementation letters, as appropriate. In general, however, the agencies will be responsible for the following areas of Project implementation:

(1) CARICOM

To enable CARICOM to complete the implementation of population policy formulation in the remaining

countries (Grenada, St. Kitts and Nevis, Antigua, Barbados, Montserrat, Belize and St. Vincent and the Grenadines) during the nine month extension period, CARICOM will employ the following staff members and/or consultants:

(a) It will extend the contract of the consultant hired for one year with effect from October 1, 1985 for a further period of one year from October 1, 1986 to September 30, 1987 on the same terms and conditions. The duties of the consultant will be the same as in the existing contract, i.e., in the main to assist the National Population Task Forces in the remaining countries to complete their tasks of formulating population policies for the respective governments of those countries.

(b) It will continue to employ the administrative assistant now employed on the project. The administrative assistant will work on project matters at the direction of the Chief of the CARICOM Health Section or such other officer as CARICOM may designate as project manager. The administrative assistant will be responsible for the coordination of the activities of the contractor and for providing the contractor with logistical support. She will also be responsible for the submission to USAID, through the Project Manager, of workplans, reports and answers to special queries, in a timely fashion.

(c) It will continue to employ a secretary/stenographer to assist the administrative assistant in the preparation of reports and the conduct of clerical and any other activities with respect of the Project that may be assigned by the Project Manager.

(d) It will continue to supply office equipment, materials and resources as may be required for the prudent completion of Project activities.

(2) IPPF/WHR

IPPF/WHR will implement its activities under the general supervision of its New York office, but specifically through its Caribbean office established in Barbados.

A Project Director in the New York office will be assisted by a Program Officer. The project director will be responsible for co-ordinating the work of the Caribbean office which will be staffed by a Project Manager, a Program Officer, a Program Assistant and a Secretary. The Caribbean Office project manager will be responsible for:

(a) Co-ordinating IPPF conducted activities with those being undertaken by CARICOM, the Population Council, the Futures Group (SOMARC) and CFFA Ltd.

(b) Negotiate and administer sub-contracts for training of physicians, nurses, and others working on improvements to clinics.

(c) Manage transshipment of commodities to government programs.

(d) Coordinate required technical assistance.

(e) Undertake equipment procurement and monitor clinic improvements.

(f) Coordinate other program support activities as required.

(3) Population Council.

The implementation plan for operations research builds closely on the system established by Tulane University. The principal person responsible for program management will be the Population Council's staff associate stationed in Barbados. She will devote 100% of her time to the Caribbean projects during the first 18 months of the program. Near the end of this period her contract will be reviewed to determine the level of effort required for the remaining 6 months of the program. The candidate proposed for this position demonstrated her capacity to comply with the requirements of the position in her previous role as field administrator with the Tulane OR Project from 1982-86.

The Population Council will be responsible for:

(a) Assessing OR opportunities in the region and prioritizing these opportunities in accordance with RDO/C population emphases.

(b) Preparing OR proposals and sub-grant agreements with local implementing agencies.

(c) Monitoring and providing technical assistance in implementation of OR activities.

(d) Integrating OR techniques into routine program management of the implementing agencies.

(e) Disseminating the OR activity results.

Technical supervision will be provided by the INOPAL Director stationed in Mexico. He will devote 15% of his time to support this activity particularly in the assessment of OR opportunities, preparation of proposals, monitoring of project implementation and dissemination of results. All contracting will be administratively managed by the Population Council staff in New York whose responsibilities will include ensuring that communication between AID/W, RDO/C and the Population Council on subcontracts, technical and financial reporting is expedited. Adequate secretarial support has been allocated in the New York and Barbados offices.

Up to one person-month of consultant time per year has been budgeted to support technical assistance to specific projects. Priority will be given to qualified resource persons in the region to assure timely provision of assistance. To facilitate identification of appropriate consultants, the OR program will participate on the Project Advisory Committee for the Population and Development Project. Finally, the program will receive the support of other Population Council programs operating in the region in the areas of women in development and contraceptive introduction.

The Barbados office will be shared with the IPPF at the existing facility in Oistins until plans for more permanent facilities can be arranged. It is hoped that office space closer to the AID Mission in Bridgetown can be obtained to facilitate inter-agency communications.

In addition to participation in the Project Advisory Committee, regular contact will be maintained with other international agencies working in the Caribbean. These will be identified during the initial visit and concrete plans for collaboration, communication and coordination will be developed. Given the relatively small size of most of the territories, this regular contact will be essential to maintain the integrity of research designs and to avoid duplication of efforts. These agencies will include but not be limited to UNFPA, SOMARC, IPPF and others. They will receive regular summaries of project developments as part of the routine dissemination effort.

(4) Contraceptive Social Marketing (SOMARC)

The management and administrative overview of the Caribbean Contraceptive Social Marketing Project has rested with The Futures Group under its centrally-funded SOMARC Project

since the inception of the activity in June, 1983. During this sponsorship, the CCSMP has gone through three local management systems, starting as a semi-autonomous entity of the Barbados Family Planning Association with offices in Oistins to its current structure of management by distributor and advertising agency subcontracts.

The current system is consistent with the present Agency strategy of direct collaboration with the private sector in the development process to the greatest extent possible. SOMARC has identified a Project Manager who is presently the Marketing Manager of Frank B. Armstrong, Ltd., a leading distribution firm in the Eastern Caribbean. Armstrong is responsible for the following activities:

(a) Developing annual marketing plans for the CCSMP.

(b) Implementing that marketing plan by coordinating the efforts of FBA inputs, including a detailer, sales and merchandizing staff, and administrative support.

(c) Collaborating with the advertising agency, McCann-Erickson, in the design of product advertising campaigns and promotional materials, and monitoring the implementation of the campaign.

(d) Developing annual program budgets and controlling budget costs.

(e) Liaising with SOMARC, AID/Washington and RDO/C staff and preparing required reports for donor and other agencies.

Given the relative recency of Mr. Armstrong's tenure as CCSMP Project Manager, The Futures Group has played a significant technical assistance role in restaging the activity. It is anticipated that over the Project extension period, the management skills and familiarity with CSM programming possessed by Mr. Armstrong will be developed to a sufficient degree that the oversight and consultative role currently being played by SOMARC will be greatly reduced.

7. Evaluation Plan

The original Project Paper presents a comprehensive evaluation strategy for the Population and Development Project. It is based on the collection and analysis of three types of

information: contraceptive prevalence surveys (CPSs), service and other program data and periodic evaluations. This same strategy will be preserved for the Project extension, and improved upon.

a. Contraceptive Prevalence Surveys

As mentioned in the original Project Paper, CPS baseline data were collected at the beginning of the Project for Barbados, Antigua, Dominica, St. Vincent, St. Lucia and Montserrat which will provide a first measuring point of contraceptive prevalence. Additionally, a CPS was undertaken in Grenada in early 1986. A second round of CPSs is currently underway in Antigua, Dominica, St. Lucia and St. Vincent. When these surveys are complete in early 1987, RDO/C will have the first opportunity to compare prevalence rates over the first four years of the Project in four countries and thereby assess one measure of Project impact. While the recency of the Grenada baseline survey precludes the opportunity to fund a second round under the Project extension, it is anticipated that the second round CPSs will be conducted for Barbados under the extension. CPSs are effective tools for measuring macro-level contraceptive prevalence changes. They also can indicate changes in prevalence within specific age cohorts, changes (if any) in preferred source of contraceptive supply, greater or lesser satisfaction with the accessibility (geographic and psychological) of supply sources, and, of course, preferred method of contraception. All of these have relevance for measuring the success of the various components of the Population and Development Project, and therefore a very close look at this second round of surveys is intended.

b. Service and Other Program Data

Under the rubric "service and other program data" come several types of project statistics including such things as:

- o numbers of clients served in a family planning clinic;
- o numbers of contraceptives sold through a CSM or CBD program or distributed through home visits by community health aides;
- o numbers of young adults attending an adolescent clinic;
- o numbers of teachers, nurses, doctors or community health aides trained in fertility management or family planning

counselling, and feedback from participants after each training effort, etc.

These can all be measures of final Project impact. Sub-grant agreements between IPPF and participating governments mandate that such service and program statistics be kept and reported on a regular basis.

More importantly, perhaps, the above statistics can be useful on-going indicators to managers of the program's effectiveness or lack thereof which should illuminate areas of possible design or implementation weakness. If collected and analyzed regularly by managers, such data can form the basis for making mid-course corrections and modifications to program implementation which not only assure immediate benefits but also help program planners to manage family planning resources most efficiently and will improve chances of program continuation after the PACD of the Population and Development Project.

It is therefore unfortunate that sub-grant reporting has been one of the weakest links in program coordination to date. This situation will be addressed directly by IPPF and SOMARC during the extension period not only to assure the availability of such data for final evaluation of the Population and Development Project, but more importantly as a specific technical assistance objective to improve family planning program management.

c. Periodic Project Evaluation

While the Project Paper specifically provides for a final evaluation of the Population and Development Project, it does not specifically indicate the necessity or timing of a formal interim evaluation. Nonetheless, a comprehensive mid-term evaluation of the IPPF and CARICOM components of the Population and Development Project was undertaken in the Autumn of 1984. The evaluation consisted of (1) site visits to the participating Project countries where formal and informal interviews were held with key government and/or program officials including staff of the various Ministries of Health and family planning associations; and (2) a review of Project documents including grant agreements, clinic records, work plans, quarterly reports, etc. The evaluation was conducted by a team of experts including a medical epidemiologist from Howard University, a director of community services for a Washington D.C.-based FPA, a social science analyst from AID/ST/POP/R and an RDO/C social scientist. Additionally, IPPF conducted their own in-house, mid-term evaluation of the Project.

which was shared with RDO/C. Together, the two mid-term evaluation efforts have been very useful in designing the two-year extension of the Project.

The original Project Paper does not address evaluation plans for the operations research component or the Population and Development Project and only gives cursory attention to the need for evaluating the CSM component of the Project. In fact, however, a mid-term evaluation of the Tulane University Operations Research Project was conducted in 1985 by an outside evaluation team. No final evaluation of the Tulane OR effort is anticipated.

The original Project evaluation plan speaks only to the review of sales data and annual marketing plans of the Caribbean Contraceptive Social Marketing Project as the means of assessing the impact and success of this activity. In fact, an evaluation of the first operational year was undertaken as one of the operations research activities conducted by Tulane University. This evaluation relied solely on a survey research design (similar to a CPS in terms of questionnaire design, if not sampling procedures) which was implemented in all three program countries. It did not review contraceptive sales data or assess the viability and implementation of annual marketing plans of the program.

Formal evaluation plans during the extension of the Population and Development Project include retaining the final evaluation strategy outlined in the original Project Paper with some modification. Specifically, the final evaluation will address not only the IPPF and CARICOM Project components, but will be expanded to also assess impact and success of the operations research activity as conducted by the Population Council and the CSM program component of The Futures Group SOMARC Program as well. This evaluation will employ a similar methodology as used for the IPPF/CARICOM mid-term evaluation and will be conducted by a multi-disciplinary team of experts identified in collaboration with all participating Project implementing agencies.

The evaluation strategy noted above is designed to assess the success of the Population and Development Project on several levels. At a basic level, the strategy will assess the efficiency and professionalism of Project implementing organizations in managing their components of the overall Project by reviewing the feasibility, logic and effectiveness of workplans and how well they were implemented. On a second level, service and other program statistics will provide RDO/C with quantifiable data on monthly and quarterly program activities which indicate the level of output, which results from implementing organization efforts. Additionally, the reports themselves will be indicators of the management.

expertise developed by the region's family planners as a result of their technical assistance and training efforts. Finally, on the macro level, through the results of CPSS, the evaluation strategy will indicate whether all of the activities and efforts have been successful in the ultimate goal of increasing prevalence of contraceptive use and reducing unwanted pregnancies by improving accessibility to family planning services.

d. Financial Review

At some time during the two year extension period, the RDO/C Controller may wish to initiate a financial review of the project. IPPF's amended contract will contain \$10,000 for evaluations, some of which could possibly be used to finance this review. If, however, the full \$10,000 is required to carry out the amended evaluation plan, as described above, PD&S resources will be used to fund the review.

B. Amended Analyses

1. Financial Analysis

a. Summary of Cost Estimates

The original cost of the Caribbean Population and Development Project, as amended, was \$5,073,700. This represents \$4,189.7 in AID grant funds (of which RDO/C provided \$3,724.7 and AID/Washington \$465,000) and \$884,000 contributed by CARICOM and the participating countries. Under the Amendment, AID (RDO/C) will contribute \$941,300 in grant funds and the counterpart contributions are estimated to be \$100,000

BUDGET SUMMARY
(Thousand U.S. Dollars)

	<u>Project to Date</u>		<u>Under Amendment</u>		<u>Total</u>	
	<u>AID</u>	<u>Counterpart</u>	<u>AID</u>	<u>Counterpart</u>	<u>AID</u>	<u>Counterpart</u>
Policy Service	729	140	-0-	27	729	167
Delivery	3,460.7	744	941.3	73	4,402.0	817
TOTAL	4,189.7	884	941.3	100	5,131.0	984

The \$941,300 to be added to the project under the amendment will be added to \$99,200 of previously authorized, but unobligated funds to make available a total of \$1,040,500 for obligations in FY 86. This available funding will be spread between two components. The allocation of these funds is as follows:

<u>Component</u>	<u>Amount</u>
1) IPPF	\$690,500
2) Pop Council	<u>350,000</u>
TOTAL	\$1,040,500

The CARICOM policy component and the Futures Group Contraceptive Social Marketing Component will continue to be implemented during the Amendment period, but without additional RDO/C financial support. The Tulane University Operations (OR) research component will be dropped from the project with OR activities being implemented under the new Population Council OR component.

b. CARICOM Policy Component

No new funds will be provided to this component. A no cost extension for nine months will be given to CARICOM to finalize the work of the National Population Task Forces on each island. The approximately \$100,000 which CARICOM should have left at the present PACD will be sufficient to fund the agreed-upon activities during the extension period.

c. IPPF Component

IPPF will be granted \$690,500 (\$591,300 in new money under the Amendment plus \$99,200 previously authorized, but unobligated funds) to finance its activities under the two year extension of the project. These funds will supplement the approximately \$272,600 which will be left over in the grant at the present PACD. Therefore, during the extension period, IPPF will have approximately \$963,100 to devote to activities during the two years. The following budget table illustrates the sources and uses of these funds:

IPPF BUDGET

(U.S. Dollars)

	<u>Balance at End of Existing Grant 12/31/86</u>	<u>Reallocation For Amended Grant</u>	<u>New Funds Added Under Amendment</u>	<u>Total Funds Available for Amendment Period</u>
Training	41,400	41,400	105,600	147,000
Commodities Clinic	8,800	8,800	107,200	116,000
Renovations Program	48,200	48,200	101,800	150,000
Support	119,600	119,600	38,400	158,000
Other	182,900	-0-	-0-	-0-
Administra- tion	<u>(128,300)</u>	<u>54,600</u>	<u>337,500</u>	<u>392,100</u>
TOTAL	272,600	272,600	690,500	963,100

d. Population Council OR Component:

The Population Council will be given \$350,000 to implement the operations research component. The funds will go for the following inputs:

Population Council Budget

(US Dollars)

Salaries	105,283
Consultants	12,000
Fringe Benefits	23,183
Travel and Transportation	47,364
Allowances	19,800
Other Direct Costs	37,870
Regional Conference	14,500
Subcontracts	<u>90,000</u>
TOTAL COSTS	<u>\$350,000</u>

e. Methods of Implementation and Financing

<u>Financing Mechanisms</u>		
<u>Component</u>	<u>Method of Financing</u>	<u>Amount</u>
1. IPPF	Amendment to Grant FRLC	\$690,500*
2. Population Council	AID Direct Contract Buy-In FRLC	\$350,000

* Represents the new money to be put into grant (\$591,300 in funds authorized by this PP amendment plus \$99,200 previously authorized, but unobligated funds).

The existing grant under the project with IPPF will be amended to add \$690,500 of additional funds and reprogram the approximately \$272,600 of unexpended existing funds. The existing FRLC will be used to disburse the new funds as well as the reprogrammed funds.

The Population Council component will be financed through a Mission buy-in to an existing AID/W contract. As with other buy-in's under the global AID/W contract, the Population Council's FRLC (TFCF No. 7200-1485) will be used for disbursement purposes.

2. Economic Analysis

a. Economic Effects of Population Assistance

The Caribbean, plagued by high unemployment, is already one of the most densely populated regions of the world. To the extent that future rapid population increases outstrip the rate of economic growth, it will place added burdens on governments' ability to provide basic services in areas such as health and education. Problems of unemployment will probably be exacerbated. Resources will be diverted from needed investment and the difficulties of launching a sustainable development program are increased. At the individual level, the health and nutrition of women and children are related to the ability to determine safe and effective ways of spacing pregnancy.

A.I.D.'s policy of enhancing the freedom of individuals to voluntarily choose the number and spacing of children therefore generates benefits that are diverse, and in many cases intangible: greater opportunities for women and children to avail

themselves of opportunities for education and training; improved possibilities for women to seek employment or careers; relief from the psychological burdens of strained family finances; better health and perhaps increased life expectancy as well as a general increase in the standard of living. The national consequences of these individual benefits are frequently manifested as increased national wealth and higher levels of employment.

b. Cost Effectiveness

Available data will not support a meaningful attempt to directly quantify the benefits of increased awareness of, and access to, methods of voluntary family planning. The economic analysis therefore takes the rather diverse package of interrelated benefits as given, and focuses on the cost effectiveness of attaining that package.

Unfortunately, the proposed budget is not fully broken down by intervention categories^{1/}. It is therefore not possible at this time to calculate updated cost effectiveness estimates by intervention, as was done in the original project paper. To compensate for this deficiency, therefore, the contractor should be urged to maintain records of both the costs of, and the number of beneficiaries from, each type of intervention in order to facilitate the end of project evaluation.

(1) Number of Females of Child-bearing Age

Female cohorts for 1980 were obtained from the 1980-81 Population Census of the Commonwealth Caribbean. A crude estimate of the number of women of child-bearing age in 1985, 1990 and 1995 was made by simple projection of the 1980 cohorts. The numbers for 1987 and 1992 were then estimated by interpolation. The numbers of women of child-bearing age by year were estimated to be: 1980, 190,848; 1985, 231,052; 1987, 246,641; 1990, 270,024; 1992, 281,594; 1995, 298,950.

(2) Contraceptive Prevalence

Accurate data on current rates of contraceptive prevalence are not available, but RDO/C Health and Population staff estimate that it is between 30 and 35 percent. A

^{1/} Training: of physicians, of nurses, other, family life education. Commodity supply. Clinic improvements.

rate of 32.5 percent was assumed for the calculations made here. Applying this prevalence rate to the number of women of child-bearing age yields a baseline estimate of 80,158 female contraceptive users for 1987.

To evaluate the cost effectiveness of the project, and estimate of the change in prevalence over time was needed. The 1987-88 RDO/C Annual Action Plan sets a target of a 25% increase in the prevalence rate between 1984 and 1990. The targets are shown below. The table shows that a 13 percentage point increase (from 12 to 25) is targeted between 1987 and 1990. In order to project beyond this period, it was assumed here that the rate of increase in prevalence from 1990 to 1992 would be the same as that for 1988 to 1990.

Even without intervention, there would be some increase in contraceptive use. RDO/C staff estimate that without the project the increase would be 5 percent by 1990, compared to 25 percent with the project. Again, the 1988-90 rates were extrapolated to 1992. The data are also shown in the table.

Cumulative Increase in Contraceptive Prevalence
(Percent)

	<u>1984</u>	<u>1985</u>	<u>1987</u>	<u>1988</u>	<u>1990</u>	<u>1992</u>
Increase with project:	2	5	12	16	25	34
Increase without project:	0.4	1	2.4	3	5	7

(3) Project Impact on Prevalence

The table above indicates a 13 percentage point increase in the prevalence rate from 1987 to 1990. Thus the predicted rate for 1990 is $(32.5)(1.13) = 36.725$. With an estimate of 270,024 women of child-bearing age for 1990, $(.36725)(270,024) = 99,166$ women would be practicing family planning. This represents an increase of 19,008 for the period 1987-1990. However, it is assumed that a 5 percentage point increase would have occurred between 1984 and 1990 (3 percentage points of which occur in 1987-1990) without the project. There would therefore have been 90,391 users in 1990 without the project, and the residual increase of 10,233 is attributable to the project.

If the project impact is assumed to extend for five years (i.e. to 1992), the with-project prevalence rate would be 39.325, or $(.3925)(281,594) = 110,525$ women, for an increase of 30,367 over 1987. However, under the assumptions used, the 1992 prevalence rate would be 4.6 percent higher than in 1987 (or 33.995) even without the project, equivalent to 95,728 women. The residual increase in usage attributable to the project is therefore estimated to be 14,797.

The project is estimated to result in an increase in the number of females practicing family planning by 10,233 or by 14,797, depending whether the time frame is 1987-1990 or 1987-1992.

(4) Cost Effectiveness Calculations

Two aggregate measures of cost effectiveness are utilized. The proxy measure for the number of beneficiaries is the number of new female users of family planning services during the project period, calculated alternatively as 1987-1990 and as 1987-1992. As noted in the previous section, the number of new users attributable to project activities was estimated to be 10,233 and 14,797 for the two respective time periods.

Two cost measures were used for comparison:

$$\frac{\text{Total Project Cost}}{\text{Number of New Users}}, \text{ and}$$

$$\frac{\text{Recurring Project Cost}}{\text{Number of New Users}}$$

As reported in the Financial Analysis section, Total project cost, including \$272,600 in reallocation from the original grant, is \$1,313,100. For the period 1987-1990, the total cost per new user is therefore,

$$\frac{\$1,313,100}{10,233} = \$128.32 \text{ for } 1987-1990,$$

or,

$$\frac{\$1,313,100}{14,797} = \$ 88.74 \text{ for } 1987-1992$$

If two overhead items, Program Support and Other Administration, are deducted from total cost, the new total becomes \$ 763,100, yielding unit recurrent cost estimates of:

$$\frac{\$763,100}{10,233} = \$74.57 \text{ for 1987-1990,}$$

or,

$$\frac{\$763,100}{14,797} = \$51.57 \text{ for 1987-1992}$$

The cost per new adopter of some specific budget items were also calculated. The results for the two time periods, respectively are: Training, \$14.37 and \$9.93; Commodities, \$6.45 and \$4.46; Renovations, \$14.66 and \$10.14; Program Support and Other Administration, 53.75 and \$37.17.

c. Internal Rate of Return Analysis

The stated benefits of the project are diverse and difficult to measure, since they include psychological as well as economic benefits. The costs of the project, however, are known. If the institutional development components of the project are successful, the benefits of the project will extend beyond the life of the project. It is assumed here that local governments or other agencies such as IPPF can carry on family planning activities beyond the two years of the grant, and that in this way project benefits will be felt over 10 years. The cost effectiveness of the project is greatly improved to the extent that it results in institutional development and sustainability. This is illustrated by the scenario below.

The cost of the project is \$656,550 per year. It is assumed that governments spend \$50,000 per year on family planning activities. Total expenditures are therefore \$706,550 per year. It is further assumed that to carry forward the effects of the institutional development aspects of the project will require expenditures by IPPF, governments, or other agencies, of \$75,000 per year. With these assumed costs, the value of gross benefits needed to generate a net benefit stream which would yield an internal rate of return (IRR) of 10% is calculated. The results are shown in the Table below.

Internal Rate of Return Scenario
Population and Development Project
Benefits Required to Yield IRR of 10%

Year	Cost (US\$000)	Needed Benefits (US\$000)	Net Benefits (US\$000)
1	706.55	253.3817	-453.1680
2	706.55	253.3817	-453.1680
3	75.0	253.3817	178.3817
4	75.0	253.3817	178.3817
5	75.0	253.3817	178.3817
6	75.0	253.3817	178.3817
7	75.0	253.3817	178.3817
8	75.0	253.3817	178.3817
9	75.0	253.3817	178.3817
10	75.0	253.3817	178.3817

NPV=0.0000000

The scenario shows that annual gross benefits valued at \$253,382 would have to accrue to the region in order to yield an IRR of 10%. Thus, if the project results in annual benefits (psychological, financial, or other) which each woman of child-bearing age in 1985 would value at \$1.10 per year, the project yields a reasonable economic return. If the benefits accrue only over the two years of the project, the gross needed value of annual benefits rises from \$253,382 to \$706,550, while for a five-year benefit stream the gross value of yearly benefits would need to be \$364,143 to yield the same rate of return. This is equivalent to \$3.06 and \$1.58, respectively, per woman of child-bearing age in 1985.

If one makes the more restrictive assumption that the benefits accrue only to those women who actually practice family planning rather than to all women of child-bearing age, and if the benefits accrue only over the two-year period of the project, the 10,233 additional users would each need to value the benefits

they receive at \$69.05 per year. If the benefits accrue over a five year period, the 14,797 new users would each have to value the additional benefits at \$24.61 per year in order for the project to yield at 10 percent IRR.

d. Conclusion

The relatively high costs associated with this project in part reflect the inability to take advantage of economies of scale with such small populations and numbers of potential beneficiaries. They are to some extent unavoidable if family planning activities are to be carried out in the region. The contractor should be urged to focus on OR, marketing techniques, institution-building, or on other specific interventions that are specifically aimed at reducing long run delivery costs to the minimum attainable, in order to provide some assurance that the provision of services is sustainable by the countries in the long run without continued project support.

This conclusion is reinforced by the internal rate of return analysis, which indicates that the efficiency of the project is substantially improved by increasing the period over which the benefits can be generated. Relative cost effectiveness therefore is a function of the degree of success in the institution building elements of the project.

3. Social Soundness Analysis

a. Introduction

At the start of the project in 1983 (the Project Authorization was signed on July 28, 1982 but there were delays in getting implementation started) it was held to be socially sound, based on AID required criteria elaborated in the Social Analysis of the Project Paper. During the almost four years of project implementation, additional quantitative and qualitative data have become available against which the social soundness of the project can be judged.

b. Sociocultural Acceptability of the Project

This Social Soundness Analysis has three distinct but related aspects: (i) the compatibility of the project with the sociocultural environment in which it works (its

sociocultural feasibility); (ii) the likelihood that the new practices or institutions introduced among the initial project target population will be diffused among other groups (i.e., the spread effect); and (iii) the social impact or distribution of benefits and burdens among different groups, both within the initial project population and beyond.

A population project funded by an external donor is not new to the English-speaking Caribbean. First efforts at family planning programs in the Region began over 20 years ago in the larger nations. The idea of restricting fertility has received official and social approval as demonstrated by government support for family planning and the general fertility decline observed in recent decades. In general, the high fertility norms of earlier generations have been eroded though not totally overturned. Fertility levels are still considerably above replacement level and the ultimate goal of this project is to see women achieve the lower fertility levels they desire through the provision of better information on and access to resources. The Region is not able to support prolonged population growth even at moderate rates.

c. Fertility Desires

This project does not have to overcome the social resistance often faced by "first stage" population programs in countries where the whole idea of restricting fertility has yet to take root. This project is not trying to change fertility desires; it is seeking to help people achieve the fertility desires they already have. Women in the Caribbean are still having a large number of unwanted children because they lack access to services.

In two of the more recent Contraceptive Prevalence Surveys carried out in St. Kitts and Nevis and Montserrat in 1984, the following data on fertility desires are presented:

(1) Desire for More Children - St. Kitts-Nevis

The future fertility intentions of women in St. Kitts/Nevis - how many women wanted more children and how many wanted no more are given in the Table below. It presents the data on desire for more children among women 15 to 44 by age and parity of women.

Desire for More Children Among Women Aged 15 - 44
By Age and Parity - St. Kitts-Nevis CPS 1984

Desire for more Children

Characteristics of Women	Want More	Not Sure	Want No. More	Total %	N
Age 15-24	69.7	10.0	20.3	100.0	77
25-29	42.1	20.3	37.6	100.0	90
30-34	29.0	6.0	65.0	100.0	62
35-44	1.7	15.9	82.4	100.0	43
Parity					
0-1	72.0	11.1	17.0	100.0	73
2-3	42.1	14.0	43.9	100.0	117
4+	9.4	14.3	76.3	100.0	83
All	39.8	13.3	46.9	100.0	273

The Table shows that desire for more children is inversely related to age and parity. In other words, younger women are more likely to want more children than older women and low parity women are more likely to want more children than high parity women. This is what one would normally expect of the fertility intentions of women. Since younger women are less likely to have actualised their fertility desires than older women, we expect a larger proportion of the former to want more children. Seventy per cent of 15-24 year olds want more children compared to 2 per cent for women over 35. The same logic explains the relationship between desire for more children and parity. As we can see, 72 per cent of the low parity women wanted more children compared to 9 per cent of the high parity women, women with more than four children. Since age of women and parity are inversely related, it is probable that the observed relationship between parity and desire for children is higher among younger women.

(2) Desire for More Children - Montserrat

The Table below presents data on desire for more children among women in Montserrat aged 15-44 by age and parity of women.

Desire for More Children Among Women
Aged 15 - 14 By Age and Parity
Montserrat CPS, 1984

Desire for More Children						
Characteristics of Women	Want More	Want No More	Not Sure	%	Total N	
All Ages	37.0	49.3	13.7	100	106	
Age						
15-24*	46.5	26.3	27.2	100	28	
25-29	46.2	42.3	11.5	100	26	
30-34	45.0	43.8	11.3	100	25	
35-44	11.7	84.4	3.9	100	24	
Parity						
0-1	63.1	25.4	11.5	100	40	
2-3	26.3	56.9	16.8	100	44	
4+	11.8	76.3	11.8	100	22	

The pattern emerging in the Table indicates that women 15-24 were no more likely to want more children than women aged 25-29 and 30-34. This is surprising because one would have thought that younger women at the beginning of their fertility careers would be more likely to want more children than older women. This finding, however, can be explained by two factors. First, the data

* The collapsing of women aged 15-19 and 20-24 into one category obscures the fact that 63 per cent of all teenagers wanted more children. The observed low levels of desire for more children here reflect the fertility preferences of women aged 20-24.

on those 15-24 years old obscured the fact that 63 per cent of teenagers wanted more children. Second, women aged 15-24 were twice as likely to be unsure of their future fertility preferences than women aged 25-29 and 30-34. If this "unsure" category were more clearly resolved into definite fertility intentions, it is very likely that the incidence of the desire for more children would have been higher among the younger women. As expected, desire for more children decreased with parity, with 63 per cent of low parity women wanting more children compared with 26 and 12 per cent of those with 2-3 and four and more children respectively.

In an earlier Table of the Contraceptive Prevalence survey not reproduced here, it was shown that 44 per cent of the women with 3-4 children said that their last pregnancy had occurred when they no longer wanted any more children. But in the preceding sentence it was stated that only 26 per cent of women with 2-3 children desired more children. What is seen here is the emergence of a small family norm in Montserrat. Women today seem to want fewer children than conventional wisdom has supposed. It is unfortunate that over one-third of these women have already exceeded their fertility preferences.

A similar Contraceptive Prevalence Survey has been carried out in Grenada and the results will be published in the near future. Plans are also underway for conducting similar follow-up surveys in the four countries: Antigua, Dominica, St. Lucia and St. Vincent and the Grenadines which had some baseline surveys conducted in 1980-81. There is also to be a survey in Barbados in 1987.

(3) Project Significance and Fertility Desire

It may well be asked what is the significance of carrying out these contraceptive prevalence surveys? What do they tell us that is important for programs aimed at reducing fertility levels and are they worth the cost? The significance is that the surveys enable us first to determine and then to understand the patterns of contraceptive prevalence among women. As has been demonstrated, what conventional wisdom supposes to be the fertility preference of women may be substantially in excess of their expressed desires. Unfortunately, the numbers of children desired are often considerably exceeded. Reliance on conventional wisdom is costly. To know and to understand patterns of contraceptive prevalence must surely be less costly.

The extended project seeks to continue to bring population growth into line with resources by reducing the levels of unwanted fertility. It will continue to operate in a

favourable social climate. It is to be regretted that the lack of comprehensive benchmarks of contraceptive prevalence rates in the region before the initiation of project activities makes it difficult to measure and ascribe the degree of impact of the interventions made by the project. However, it is to be hoped that by the end of the extended project when the results of the follow-up CPS are published that some measurement of the impact may be possible.

d. Contraceptive Use

In the two most recent Contraceptive Prevalence Surveys in St. Kitts and Montserrat, 40% of all sexually active women aged 15-44 in St. Kitts-Nevis and 53% in Montserrat, were using a contraceptive at the time of the survey. Contraceptive use was below average among women aged 15-19 (30% in St. Kitts-Nevis and 48% in Montserrat of women aged 15-24) and zero parity women (25% in St. Kitts-Nevis, 42% in Montserrat). Only 38% of women with secondary education in St. Kitts-Nevis used contraceptives and although there is no comparative figure for Montserrat, the survey notes that use was relatively low among better educated women; but this is explained by the fact that better educated women tended to be younger women.

In both countries the most frequently used method was the oral contraceptive pill particularly among women aged 15-29 years. The IUD and tubal ligations were high in the list of methods preferred in both countries. In St. Kitts-Nevis 38% of contraceptive users were not sure that their current method was reliable and in Montserrat although it was a lower percentage, 20%, it is still relatively high.

In St. Kitts-Nevis only 13%, and in Montserrat only 6% of all women used a method of contraception at first intercourse, while 57% and 59% respectively waited for more than one year before starting on a method. In Montserrat it was reported that teenagers seem more willing to use a method at first intercourse than teenagers of a generation ago. In both countries it was revealed that a critical event in contraceptive decision-making processes was the birth of a child. In St. Kitts/Nevis 41% of current users started to use a contraceptive only after the birth of their first child.

On the basis of the evidence of these surveys the prime target groups that emerge as requiring information and access to contraceptive use are teenagers, zero parity women, rural women, and unemployed women.

What emerges from among the findings of the Contraceptive Prevalence surveys is the continuing need for Family Planning Associations (FPAs) to arrange programs in Information Education and Communication not only to dispel doubts about the alleged inefficacies of some methods, but to emphasize the very positive benefits, in terms of health of mother and child, of their continuing to contracept. A clear implication of the findings is that the efforts of all the agencies must be to target the young women in the 15-24 age groups.

Figures from the 1980 census figures of the nine territories (7 OECS, Barbados and Belize) show that there were over 99,000 women aged 15 - 24 years of a total of 191,000 women of reproductive age (15 - 44 years) or some 52% at that date. In projections made from the 1980 census figures (in which no adjustments were made for survivorship rates or migration) the numbers of women of reproductive age (15 - 44 years) in 1985, were estimated to be about 231,000 of which some 111,000 or 48% were in the age group 15 - 24 years.

A similar projection for the year 1990 estimated that the number of women aged 15 - 24 years in this year would number about 114,000 or 42% of women reproductive age (15 - 44 years), estimated to be about 270,000.

Although the proportion of the two age groups (15 - 19; 20 - 24) of the total of women of reproductive age (aged 15 - 44 years) continues to decline, it is still quite high. It is believed that, without access to information and to contraception devices and mechanisms, continuing high fertility rates can be predicted with all the difficult social and economic consequences of population growth outstripping economic resources in the national economies.

e. Male Attitudes

The same surveys elucidated a most important fact. Despite prevailing beliefs, there is little or no evidence of male opposition to family planning in St. Kitts-Nevis and Montserrat. Most women had discussed family planning with their partners, most of whom encouraged the idea and practice of contraception.

In another survey, a Male Family Planning Survey conducted in St. Kitts/Nevis, Barbados and Dominica, by Westinghouse Public Applied Systems in 1982, 41% of the men surveyed believed that contraceptive decisions should be made by both partners, and nearly three-fourths (74%) of the men who knew of at least one family planning method believe that men should be involved in family planning decision making.

The Male Family Planning Survey also found misinformation about the effectiveness of condoms as a method. This suggests that educational programs might increase their acceptability and utilization. However, the condom as a method was preferred 6 to 1 over the withdrawal method.

The programmatic and policy implications coming out of these surveys stand out clearly. The Caribbean male is capable of being educated to accept responsibility as a father, to share the burden of parenting with his mate(s) and to share decisions as to family size and the contraceptive means to be adopted to keep within the limits of their choice of size. Males must be targetted programmaticly and the best and most cost effective methods of reaching males must be resolved empirically.

f. Cultural Variation Within the Region

The primary countries covered by this project are Antigua, Barbados, Dominica, Montserrat, St. Kitts-Nevis, St. Lucia and St. Vincent. Whilst a fair degree of cultural heterogeneity exists there are some important variations among the territories which the project recognizes.

It should be noted that Grenada was brought into the project on June 21, 1985 when the sum of two hundred twenty-four thousand and seven hundred dollars was subgranted by IPPF/WHF Inc. to the Ministry of Health of the Government of Grenada to initiate a National Family Planning Program.

Belize, also after a change of government, has been participating to a larger degree in the project activities. It will have a Medical Contraceptive Policy Seminar and has sent participants to a CARICOM organized population policy formulation training course.

(1) Religion

The countries that are participants of this project display a startling degree of religious heterogeneity. Christianity is the major theology in all cases but within that an array of established and informal religious sects operate. Dominica, St. Lucia and Grenada are predominantly Roman Catholic; the other islands have populations that are mainly Protestant with the major affiliation being the Anglican Church. The Catholic islands are considered first.

In St. Lucia over 95% of the population is Roman Catholic. While in many Latin American countries this may become a major form of resistance for family planning projects, (given the church's pronounced attitude to artificial contraception), the reality in St. Lucia is quite different.

St. Lucia has had a long exposure to both the concept of "Planned Parenthood" and the details of contraceptive technology through the promotional and service delivery activities of the IPPF affiliate. The St. Lucia Planned Parenthood Association has fought for and has been successful in winning the acceptance of the people, the government and the Church. Difference over choice of contraceptive method still exist. The Church employs two trained family planning nurses to promote the Billings (natural family planning) method, which is endorsed by the Vatican. Tolerance and mutual respect for artificial contraceptive users, however, are still very much the order of the day. In St. Lucia, the Government seems to have made an accommodation with the Roman Catholic Church to the extent that several high ranking Government officials have spoken out publically about the pressing need for family planning and limiting births if there is to be any economic development.

In Dominica the service delivery of family planning is the sole responsibility of a Roman Catholic government. The promotion of family planning is cautious and conservative but the full range of contraceptive techniques are available free of charge through Ministry of Health clinics.

In Grenada, the government has only just begun embarking in a national family planning program and it is therefore too early to judge whether the Church will support or oppose the programs.

At the popular level too the religious element does not impede the acceptance of contraception. The Contraceptive Prevalence Surveys showed as high acceptance and usage rates in the Catholic as in the non-Catholic countries.

Education in these countries was hitherto dominated by the Church. In recent years the State has taken over control of most schools. It is now up to government to develop curricula and in most countries there are positive steps being taken to introduce a full scale Family Life Sex Education Program.

The religious picture in the other islands is more diverse. A nominal majority commitment to the Church of England disguises a proliferation of non-established low church sects of a predominantly revivalist nature. Formal policy statements on contraception are being increasingly made. Public debates between Church groups and Family Planning Associations take place but few groups directly oppose the idea of family planning or of the use of contraceptive technology. The major exception to this is probably the Rastafarian movement which is still a small group in the Eastern Caribbean.

In general there has been little or no objection raised to mass media advertising of contraceptives on religious grounds. There have been some on aesthetic grounds when the patois expressions have been considered not to have been in good taste. It has not been a major obstacle over the past twenty years of family planning nor is there any reason to expect that there will be any great resistance encountered.

(2) Socio-economic Variation

The different socioeconomic levels across the Region and within each country are recognized in the design of the project. Differential access to services are compensated for by the provision of a range of alternative systems of distribution. Commercial Retail Sales (CRS) of contraceptives pre-supposes a market capable of supporting such a venture. Disposable income to purchase commodities is available to a large enough group in the targeted countries.

A CRS activity will appeal to hitherto unreached populations for whom the financial cost of purchasing contraceptives is lower than the true costs and the psychological costs of visiting a family planning clinic are mitigated.

It was against this background of assumptions that the CRS program of sales was launched in February 1984. Price-subsidized Panther Condoms, Perle, and Perle LD oral contraceptives were offered for sale through pharmacies and other retail outlets. The launch of sales was preceded by orientation marketing programs for physicians and government health personnel in Barbados, St. Lucia and St. Vincent. Press, radio and T.V. Campaigns were also launched, except that in St. Lucia, the Roman Catholic Church objected to the mass media advertising.

An evaluation one year later found that sales figures in the CRS program compared favorably, but were not better than other distribution programs. After a change in the management of the program, marketing operations resumed normalcy in February 1986. Sales of condoms shows a strong increase in all three countries, but sales of orals are disappointing. In St. Vincent the community-based distribution program has not yet begun to distribute contraceptives.

(3) Variations in Government Involvement in Family Planning Programs

Family planning services have been established with the government health clinic systems in Grenada, St. Lucia, Antigua and Montserrat for the first time ever. In St. Vincent, Dominica, and St. Kitts-Nevis, the Government Ministries of Health are the primary family planning providers. The contraceptive social marketing programs established in Barbados, St. Lucia and St. Vincent proceed with the tacit support of the governments of these countries. In Barbados and St. Lucia, the family planning associations play a large role in the delivery systems with governments' involvement and co-operation.

It is part of the "colonial" heritage for the populaces in these territories to expect Governments - whether central or local Governments, to provide every variety of social service, including maternal or child health clinics, - at which advice or counselling and the supply of contraceptives were provided free of charge. Out of this heritage therefore, there has developed the expectation that Governments have to provide these clinics and services to large numbers of persons.

f. Social Impact

(1) Effect on Government Policy and Programs

Presently all of the countries have established National Population Task Forces which have been mandated by the Governments, through the efforts of the project, to formulate national population policies. CARICOM recruited a consultant in

October, 1985, who has been working almost exclusively with the Task Forces. In two training programs designed and conducted by the demographic unit of UNECLAC, about thirty participants from all of the countries have been trained to participate with the Task Forces in population policy formulation. Since one of the key features in the training courses was to get participants into the mental habit of "factoring in" population into all sectoral development planning, it will be seen that even in the course of producing population policies, there will be considerable social impact, and the final documents when adopted and implemented under the guidance and direction of National Population Councils, will have an even greater impact.

The full-time consultant received some training on making computer presentations on the effects of population growth on various sectors - labor force, school age children, etc. These presentations use data gathered by PRB specific to each country. These presentations are made to groups of persons at all levels of leadership in all of the islands. In St. Lucia where a rapid presentation was made to the Prime Minister and his cabinet colleagues, the impact has been almost dramatic, in that the Prime Minister has become a very vocal protagonist for family planning. It can safely be predicted that the Government will be supportive of the FPA and its programs of information, education and communication. Increased financial support to these efforts is less certain given the growing financial constraints.

(2) Effect on Regional Medical Policies

Medical Contraceptive Policy Seminars were held in all of the countries. At these seminars members of the medical profession and allied health workers discussed and adopted a model "regional" contraceptive policy. The greatest social impact which may be expected to arise will be improved health of mothers and children as a result of improved and more accessible maternal and child care health services.

The "model" Regional Contraceptive Policy Document is instructive and tries to give advice in perspective. A few examples from the document will have to suffice: The medical profession has endorsed usage of steriodal oral contraception, cautioned on generalized use of oral contraceptives for teenagers, and spoke to the reduction of pelvic inflammatory disease among adult users of oral contraceptives.

Secondly, the project paper drew specific attention to the Caribbean Medical System requiring "excessive medical supervision and patient follow-up". It was felt that the system failed to delegate responsibility to the appropriate health worker and "many patients have to wait to submit themselves to over qualified physicians". As a result of this project the Medical Steering Committee of eminent West Indian obstetricians and gynecologists are positively disposed to the adoption of less conservative attitudes. In dealing with the insertion of IUDs in the model, they stated "evidence from many countries suggests that properly trained non-doctor personnel can insert IUDs as well as doctors". This practice is now increasing throughout the islands.

These two examples serve to indicate that the adoption of more liberal up-to-date medical policies on contraceptive services can have a real social impact in improving contraceptive delivery services.

g. Spread Effects

The spread effect of many particular elements of the project will continue long after the end of the project life. As indicated above, the benefits likely to be derived from the development and implementation of population policies can be wide-spread.

The improvement of the physical plant of health centers and the installation of equipment and the provision of training doctors and nurses who staff the clinics in these centers, will have a beneficial effect on the delivery of family planning services. If the nurses and their assistants become proficient in counselling and providing services at the clinics, we could expect an increase in the numbers of new acceptors, a decrease in drop-outs, an increase in the contraceptive prevalence rate, and in time, a reduction in the total fertility rate. Two-thirds of the sixty (60) health centers to be renovated have been completed. More than 50 doctors have been trained under JHPIEGO auspices and 250 nurses have also received training. Twenty-four adolescent health clinics have been established, with all of them offering family life education and some of them providing contraceptive services as well. The peer counsellors among adolescents have been trained and it is hoped that some of them, will continue to work in their youth groups.

4. Institutional Analysis

The following analysis examines the current activities of the regional and international agencies which will be involved in the execution of this project. The agencies are: IPPF/WHR, Inc. and the Population Council.

a. International Planned Parenthood Federation/Western Hemisphere Region, Inc.
(IPPF/WHR)

(1) Legal and Financial Status

IPPF/WHR, Inc. is incorporated in the state of New York pursuant to the Not-For-Profit Corporation law and is a Private Voluntary Organization registered with AID. The membership of the corporation consists of affiliated Family Planning Associations (FPAs) in the Western Hemisphere Region which embraces North, South, and Central America, and the Caribbean. The central purpose of the Corporation is "to advance the acceptance of family planning and responsible parenthood in the interest of family welfare, community well-being, and international goodwill."

IPPF/WHR, Inc. functions as one of the six regional offices of the International Planned Parenthood Federation (whose headquarters is in London) and receives its primary support through an allocation from IPPF London. Partial funding is also received for support services as executing agency for specific support earmarked grants, as in the case of the RDO/C OPG for the CFFPA program. (538-0116). Staff operations in the corporation (WHR) are performed through the Regional Office headquartered in New York. Their management and staff, of which a significant number are West Indian, are highly committed to expanding Family Planning services throughout the Eastern Caribbean region.

(2) Technical and Mangement Capability

IPPF/WHR monitors approximately \$12 million of grants to it's member associations. In addition it manages the implementation of three USAID grants totalling approximately \$5 million, one for the Caribbean Family Planning Affiliation, another for family planning activities in Ecuador, and a third for leadership education on population in selected Latin American countries. Its familiarity with USAID project implementation requirements is therefore substantial.

The range of programs implemented by WHR affiliates shows considerable variation and reflects the diversity of IPPF/WHR's 27 years of experience in family planning. Some associations maintain networks of family planning clinics or supervise distribution posts that deliver community services. Some direct themselves primarily toward improving the national policy atmosphere vis-a-vis family planning. Others concentrate on information and education in support of government programs of service delivery.

(3) Pioneer Work of IPPF/WHR

Programmatic approaches such as community based distribution that are now being elaborated on a global basis were developed originally by associations in this region. Many recent developments in the family planning movement have been tested and improved by associations during the past two decades in the Western Hemisphere. These include the use of mass media to deliver family planning messages, systems of commercial distribution, the development of networks of cooperating doctors, the use of paramedical personnel where medical doctors are in short supply, delivery systems that bring family planning to homes and working places, the promotion of sex education in and out of schools, and the integration of family planning activities with other developmental activities such as agricultural extension, community development and programs encouraging adult literacy. It can be seen that there already exists within IPPF/WHR substantial technical expertise in policy, commodity supply, financial management, medical policy and other areas.

(4) Compatibility with Government Programs

Due to the size of most Eastern Caribbean islands, work in family planning conducted by the private family planning associations and WHR has been both visible and coordinated with government efforts. Many associations have been the primary source both of commodities and technical services for the delivery of family planning. Thus little difficulty is foreseen in moving WHR into a more substantial role of assistance to governments in the delivery of Family Planning services. The general trend desired by most governments within the region has been to become more actively involved in actual service delivery placing emphasis for the FPA's in roles of promotion, information and education. The role of WHR in developing this collaborative effort is crucial.

(5) Leadership Capability

IPPF is considered both willing and capable of undertaking the substantial role of leadership for government involvement in the delivery of Family Planning services throughout the Eastern Caribbean, with a demonstrated ability to select and administer contracts, attract competent professional staff and undertake overall responsibility for a complex program in seven countries. For these reasons the use of WHR as a primary implementing agent for a substantial portion of this project is considered both feasible and desirable.

b. Population Council

(1) Legal and Financial Status

The Population Council, an international scientific and professional organization, is a non-governmental, non-profit institution established in 1952. It is governed by a board of trustees whose members come from eleven countries. The council is committed to the enhancement of human welfare and works in the following areas: family planning, health, and other population related programs to enhance relevant local, national and regional capacities; human reproductive biomedicine aimed at the development and improvement of contraceptive methods, social science research useful to the understanding of public policy issues bearing on population, publications for researchers policymakers, and the concerned public, and advanced training for future generations of population specialists. For the past several years, the annual budget has averaged US\$20,000,000. Council resources are allocated to programs and projects throughout the world, but especially to those in or related to developing countries in Africa, Asia and Latin America and the Caribbean.

(2) Organizational Structure and Technical Capacity

The council's multidisciplinary work is carried out by three of its divisions - the center for biomedical research, the center for policy studies and international programs - supported by a fourth division of program support and services, which includes the office of communications. This proposed Caribbean Operations Research Project in Family Planning/Maternal and Child Health Delivery Systems will be managed by the Council's international programs division.

International programs brings the council into working partnerships with people of developing countries through its participation in key population related activities. As a fundamental mechanism for collaboration, the Council maintains regional offices in Bangkok, Cairo, and Mexico City. In the Latin American and Caribbean Region, the Council also maintains field offices in Brazil, Colombia and Peru which report to the Regional Office in Mexico City. This network helps identify program initiatives and assist local, national, and regional institutions in the design, implementation, and evaluation of research and action programs. Council researchers, technical advisors, and representatives reside in eleven countries and have collaborative

arrangements in more than a score of others. A multidisciplinary professional staff in New York provides interregional support and serves as liaison with internationally oriented donors, the Council's own scientific research centers, and other experts.

(3) Related Program Activities

The recent focus of international programs activities includes increasing contraceptive practice through improvements in the design of family planning programs and related operations research and through introduction of council-developed contraceptives, improving the chances of child survival through a better understanding of the determinants of child mortality and changes in infant feeding practices, facilitating the incorporation of population factors in the development process through a better understanding of population and development interactions, and enhancing women's participation in economic activities. Information dissemination through publications, workshops, and seminars forms an integral part of program activities.

c. Country-by-Country Institutional Analysis -
Institutionalization Efforts

Antigua: The main service delivery and Information/Education/Communication activities in Antigua were initiated and remain the responsibility of the Antigua Planned Parenthood Association (APPA). The APPA has a clinic/office in St. John's which provides clinical services twice weekly. The rest of the island is served by their CBD program which uses a limited number of outlets. These do not reach to all communities on the island.

The Government's involvement in Family Planning has been restricted to granting permission for their Public Health Nurses to participate in the CBD program. Some nurses with links to the APPA do distribute commodities out of their clinics. This operates on a haphazard basis in about one third of the clinics. Commodities are free.

The APPA is currently running a sex education program in selected government schools. The Ministry of Health's own educational program is run through the Health Education Unit. Contraception is not a major focus of their activities. The Ministry of Education is planning to introduce Family Life Education into the school curriculum shortly.

31% of all women in Antigua are currently using a contraceptive. This is the lowest of the countries surveyed in Contraceptive Prevalence surveys.

Barbados: The Barbados Family Planning Association's (BFPA) headquarters in Bridgetown is the major provider of family planning services in Barbados. Their clinic provides a daily service. Commodities are sold at a subsidized rate, in a well-organized community-based distribution system, through almost 100 outlets island-wide. The BFPA also runs a series of I-E-C activities in the community and with a range of institutions: Parent Teacher Associations; youth clubs; factories, etc.

The Ministry of Health is developing plans to provide family planning services within their polyclinic system. Currently the BFPA and the Ministry of Health cooperate so that the association provides post-partum services to mothers who deliver at the major hospital. The BFPA also provides limited services through the polyclinics. The Ministry of Health assists the BFPA with their running costs.

Sex education in schools is done on an ad hoc basis. The Ministry of Education is committed to expanding Family Life Education as a formal part of the curriculum.

Thirty-eight per cent of women in the fertile age group in Barbados are currently using contraceptives. A follow-up Contraceptive Prevalence survey is targetted for 1987.

Dominica: Family planning services in Dominica are primarily the responsibility of the Ministry of Health. Family planning is an integral part of the Maternal and Child Health program. Clinics across the island distribute commodities free of charge. These commodities have up to now been supplied by UNFPA, but IPPF/WHO now also supplies commodities. There are seven comprehensive clinics where full family planning services are provided. Women who wish to start on a method have to travel to these comprehensive clinics.

The Dominican Planned Parenthood Association distributes some commodities but does not operate a clinic. Its major role is in I-E-C activities. Thirty-seven per cent of all women in the fertile age groups are using a contraceptive method. A follow-up Contraceptive Prevalence Survey is targetted for 1987. A draft population policy is about to be submitted to Cabinet by the National Population Task Force.

Montserrat: Family planning in Montserrat has to date been the responsibility of the IPPF affiliate, the Montserrat Planned Parenthood Association. They operate a clinic in Plymouth where subsidized commodities and free services are provided. The government has a network of clinics across the island which have not previously been used for family planning distribution or services. A recent Contraceptive Prevalence Survey (1984/5) stated that 53% of exposed women were using a contraceptive at the time of the survey.

St. Kitts-Nevis: Family planning services in St. Kitts-Nevis are provided by the Ministry of Health through its Maternal and Child Health program. Twelve clinics provide family planning services typically on a twice monthly schedule. There are insufficient trained nurses to operate a more flexible schedule. Commodities are available free of charge from all clinics.

The St. Kitts-Nevis Planned Parenthood Association has an office in Basseterre and runs a clinic in Sandy Point. Its activities include a CBD program and I-E-C. A recent CPS (1984/5) stated that 40% of women-in-union were using contraceptives at the time of the survey, but there is some suggestion that contraceptive prevalence was under-reported.

St. Lucia: The St. Lucia Planned Parenthood Association is the primary provider of family planning services in a combined program with the Ministry of Health. The Planned Parenthood Association has a clinic in Castries and channels commodities to government health clinics throughout the island. The government also offers Family Planning services in twenty-eight health centers. Government support for family planning has increased, with strong public statements from the Prime Minister and other ministers. There are cooperative arrangements over staff between Ministry of Health and the Planned Parenthood Association.

Thirty-four percent of St. Lucia women in the fertile age groups are currently using contraceptive. A follow-up Contraceptive Prevalence Survey is targeted for 1987.

St. Vincent: The National Family Planning program in St. Vincent is the major provider of family planning services. This program is run under the Ministry of Health's overall clinic activities but is separately administered. There is a daily clinic at the hospital in Kingstown and family planning is available on certain days at the other clinics. Commodities are free. The St. Vincent Planned Parenthood Association has no service delivery role; its activities are restricted to Information/Education/Communications. The Family Life Education in schools is very restricted.

Contraceptive prevalence in St. Vincent is currently thirty-three percent of all women in the fertile age group. A follow-up Contraceptive Prevalence Survey is targetted for 1987.

PROGRESS TO DATE OF ORIGINAL PROJECT

Mindful of the demographic environment and the region-wide constraints to effective population programming, a two-pronged Project was designed which included both policy and service delivery components. The population policy and medical policy formulation components of the Project have been implemented by the Caribbean Community Secretariat (CARICOM). The services delivery and training components have been implemented by the Western Hemisphere Region Office of the International Planned Parenthood Federation (IPPF/WHR). The service delivery work of IPPF has been augmented by a contraceptive social marketing component executed by The Futures Group under its SOMARC Program and predecessor CSM program, and an operations research component which both introduced and tested several alternative service delivery methods managed by Tulane University.

The original countries included in the Project were Antigua, Barbuda, Barbados, Dominica, Montserrat, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines. Belize has received limited support for population policy work. Following the intervention in Grenada, the IPPF/WHR grant was amended to bring Grenada fully into the Project.

The following section details the effort of the Project to date.

1. Policy

a) Demographic Policy. This CARICOM-managed component of the Project focused on raising the level of awareness and knowledge of policymakers about population problems of the region by means of (i) establishment of National Population Task Forces whose jobs it has been to prepare and secure government approval of National Population Policies, (ii) preparation of country population reports, (iii) convening of two regional conferences on population issues, (iv) development of a regional RAPID presentation, and (v) demographic training for population technicians in the region.

(i) National Population Task Forces. Each of the Project countries with the exception of Barbados and Belize have appointed NPTFs. A St. Lucia policy has been approved by the Cabinet, and a National Population Council has been appointed to oversee its implementation. The Dominica NPTF policy awaits Cabinet consideration.

(ii) Population Reports: The Population Reference Bureau produced nine country population reports. These reports provide historical, current and projected data on national demographic conditions and have been used as reference guides by academics, NPTFs, policymakers and lay audiences.

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(iii) Regional Awareness Conferences: Thirty-one national delegates (including 13 from some of the dependencies and the MDC's which are not beneficiaries of the Project) attended the First Regional Awareness Conference in St. Lucia, April 30-May 1, 1984. Presentations and discussion focused around Project-commissioned papers on migration, adolescent fertility, national population policies, and contraceptive policies. A RAPID presentation was made by a representative of The Futures Group.

The first Caribbean Conference of Parliamentarians on Population and Development was held in Barbados June 14-15, 1985, under the auspices of the Inter-American Parliamentary Group with financial and programmatic assistance by CARICOM. This meeting constituted the second Regional Population Awareness Conference and was attended by nearly 75 Cabinet-level parliamentarians from CARICOM countries, the United States and Canada. The Conference passed a "Caribbean Declaration on Population and Development" which called on Parliaments and Governments in the Caribbean consider population and development factors in development planning, to establish National Population Councils in each country, and to increase budgetary allocations to population and development programs.

(iv) The RAPID Presentations: A RAPID presentation developed for the region by The Futures Group has been given before several audiences including both Awareness Conferences, the National Population Task Forces, the Caribbean Family Planning Affiliation Annual General Meeting, and governments. The CARICOM NPTF consultant has developed the competence to give RAPID presentations and to update the software as required.

(v) Demographic training: With the establishment in 1985 of a Demography Unit in ECLAC, a training course was developed in population policy formulation for NPTF members, statisticians, policymakers and planners. The first 10-day training course was held in St. Kitts and Nevis in October, 1985. The Project sponsored a total of 15 participants representing Dominica, Montserrat, St. Kitts and Nevis and St. Vincent and the Grenadines. The main objective was to improve understanding by NPTF members of the interrelationship of population and development to assist in formulating population policies. A final product of the course was the first draft of an explicit National Population Policy for each of the four participating countries developed by the trainees. A second 10-day course was held in Barbados July 7-18, 1986 with 20 representatives from Antigua and Barbuda, Barbados, Grenada, St. Lucia and Belize.

Project funding also provided for the participation of CARICOM Demographer O. Daly-Hill in a conference of the International Union for the Scientific Study of Population in Florence, Italy, June 5-12, 1985.

(b) Medical Policy. A series of regional and national seminars were convened and observational training was arranged to facilitate the development of contraceptive medical policies in each of the Project countries.

(i) Steering Committee and Regional Seminar: A Medical Steering Committee convened under the Project developed a "Medical Policy on Contraceptive Services" which addressed medical procedures, techniques, drugs and equipment related to the provision of family planning services. It also provided a framework for the development of national policies to be prepared under the Project. The draft regional policy was presented at the first Regional Population Awareness Conference.

The Regional Medical Policy was successful in addressing three key constraints to more effective service delivery. First, while it did not remove prescription requirements for oral contraceptives, it did recommend that "recognized field workers" be allowed to "prescribe" a three-month supply of orals to women who fit into a broadly specified low-risk description, within which time the new contraceptive would obtain a medical check-up. The policy strongly encouraged the development of non-clinical, community family planning services and greater use of community health auxiliaries in delivering those services. Third, the policy clearly advised on the applicability of various contraceptive methods based on the most recent clinical trials and research.

(ii) National Seminars: Medical seminars were held in eight of the nine countries to date and most of them produced medical policy documents.

(iii) Observational Training: The Chairman of the Medical Steering Committee, an Obstetrician/Gynecologist from Dominica, attended a seminar/workshop in Santo Domingo in 1984. This was the only occasion on which provision for short-term observational training was utilized.

2. Service Delivery.

The majority of service delivery under the Project has been managed by IPPF/WHO. This Project component includes training; commodity supply and distribution to government clinic-based programs and non-clinical community-based distribution programs; improvement of clinic services; adolescent extension programs; and program support (including contraceptive prevalence and male attitude surveys).

CFPA Ltd has produced much of the teaching material which has been used by Family Planning Associations and to Ministries of Education for teaching FLE including videos, slides, textbooks, and posters. These are made available on request at a small charge to users.

(b) Commodity supply and distribution. Under this activity, contraceptives were provided to government clinic-based family planning programs and community-based distribution (CBD) programs were launched in St. Lucia, Barbados, Montserrat, Dominica and St. Vincent and the Grenadines.

The Barbados CBD project, operated through the Barbados Family Planning Association, was by far the most successful of the five IPPF-assisted projects. The success of this project can be attributed to three major factors: (1) the laudable efforts of the full-time CBD coordinator who was successful in establishing nearly the total grant-specified number of contraceptive outlets across the island, and through her hard work, keeping those shopkeepers and owners motivated to stay with the program; (2) the excellent administrative, professional, and technical support provided to the coordinator by the BFPA; and (3) the fact that this project did not rely on retailing only the contraceptive supplies provided by IPPF for the CBD project, but rather, promoted brands available in the BFPA clinic. This last point is particularly important given that the CBD products were new in the market and therefore had no established client base, and that by using the regular BFPA contraceptives, the CBD project served to truly expand the reach of BFPA clinic programming. Additionally, as the CBD project as designed by IPPF, would be funded for only two years, the CBD project was able to focus on the supply of contraceptives which the BFPA regularly stocked and would therefore have available after project funding expired.

The remaining four CBD projects have been far less successful in meeting their objectives. An analysis of these projects suggests that they all suffer from similar problems: (1) part-time, ill-prepared, unmotivated coordinators; (2) poorly-trained retailers; (3) the absence of promotion or use of mass-media materials; (4) poor institutional support. Nonetheless, the potential role of CBD in these islands is as viable as in Barbados although not as firmly established. These efforts represent the first attempts to introduce non-clinical delivery services in St. Lucia, St. Vincent and Montserrat.

(c) Improvement of clinic services. This activity consisted of providing modest renovations to 39 existing health facilities (except in Barbados) and providing limited supplies and

equipment. This renovation and equipment activity resulted in the establishment of family planning services under the sponsorship of the Ministries of Health in government health clinics in Grenada, St. Lucia, Antigua, and Montserrat for the first time.

(d) Adolescent extension programs. In keeping with the Agency's strategy of expanding family planning services to unserved populations and with particular reference to the widespread concern in the region over the large number of teenage births, the Project developed a program of adolescent clinics, and youth outreach programs through family life education and peer counselling.

Twenty adolescent health clinics have been established (3 in Dominica, 4 in St. Vincent, 4 in Montserrat, 3 in St. Kitts/Nevis, 2 in Antigua, 5 in Barbados, and 3 in St. Lucia). The actual design and focus of each of the adolescent clinics vary by community, however all of them consist of a mixture of family life education and family planning services. The clinics have been more successful in providing counselling services than contraceptives.

Youth outreach programs also varied by community consisting of off-site family life education programs to youth groups, uniformed services, professions, and in some cases, youth conventions. These programs have met with limited success, being most effective in the more community-active countries, e.g., St. Lucia and St. Kitts, and less effective in Antigua.

Probably the least successful of the adolescent programs has been the peer counsellor activity. Students and other youth were trained in family life education and contraceptive methods. The role of these students in the provision of family planning services and counselling was never clearly defined, however. As with the above two programs, the success of the peer counsellors depended heavily on the specificity of the role defined for the peer counsellors and the motivation and interest in the established family planning network to make maximum use of these individuals.

Despite the outstanding need to effectively address young adult family planning needs, given the mixed success of some of the vertical interventions and the need to provide access to services and information to at least 30 percent of the population, adolescent services will be integrated into mainstream programming.

(e) Program support. Under the grant, baseline CPSs were completed for each of the OECS countries and Barbados. These surveys provide useful project descriptions of the numbers and ages of contraceptors, the most popular methods, the reasons people did or did not contracept, and the prevalence provided through the various delivery approaches. Follow-up surveys which will measure

the impact of the family planning programs initiated under the Project are currently being undertaken in St. Lucia, St. Vincent, Dominica and Antigua. These surveys will not be completed before the current PACD. No follow-up survey is scheduled for Grenada within the extension as the first round was only conducted in 1985. No second round is anticipated for Montserrat due to its size and limited population growth. A second round CPS for Barbados is proposed during the extension period.

As CPSs usually target a female audience of respondents, the Project funded three studies which sought information from Caribbean men. The result was three male attitude surveys conducted in Dominica, St. Kitts and Nevis, and Barbados.

3. Operations Research.

The Tulane University Caribbean OR Program was developed to complement the service delivery and policy activities with three main objectives: (1) to improve the delivery of family planning services and to identify effective approaches to increasing contraceptive use, (2) to demonstrate to and sensitize administrators and decision makers as to the benefits of operations research for improving program effectiveness, and (3) to strengthen the research and evaluation departments of government agencies and private organizations by providing on-the-job training in operations research.

Over the course of the program, nine family planning service delivery strategies in the region were the subject of OR projects. Six of the research activities were conducted in collaboration with Ministries of Health or Education; two were carried out by private family planning associations; and a ninth activity was conducted in three countries in collaboration with two Ministries of Health and an FPA.

With the exception of a Dominican teen clinic project which was terminated early due to implementation problems, the OR projects were very successful in providing quantitatively-supportable information on the cost, preferability and effectiveness of service delivery alternatives. In St. Lucia, for example, the OR project analyzed the cost and programmatic effectiveness of two contraceptive delivery systems for factory distribution: one using twice-monthly visits by a nurse to screen new users and provide contraceptives, and a second in which the nurse's work was augmented by a factory worker (distributor) who was trained to answer basic family planning questions and provide contraceptives in the nurse's absence. The results suggest that the treatment group which employed the services of an employee distributor not only gained more acceptors of family planning but did so at a much lower cost per couple month of protection than the

health personnel in each of the three participating islands and coincided with the introduction of a press, radio and television campaign in Barbados. Radio advertising was added later in St. Vincent although pressure from the Roman Catholic Church in St. Lucia precluded mass media advertising there.

The CCSMP was evaluated after one year of product sales as one of their operations research activities. The objectives of the study were to (1) measure the extent to which the target population could recall the CCSMP messages, and if they recalled them, how well and correctly they were received; (2) to determine the percentage of the population that had ever purchased the products; (3) to measure impact vis-v-vis contraceptive prevalence; and (4) to determine whether "brand switching" had occurred to any great extent.

The evaluation found that (1) there was significant recall and appeal to the mass media CCSMP product advertising in particular and generally for family planning messages; (2) approximately 10 percent of the population in each country reportedly had purchased CCSMP products; (3) prevalence rates had not measurably increased in any of the target countries when compared to 1981 CPS data; and (4) brand switching was not readily apparent. A comparison of sales figures for CCSMP with the St. Lucia factory distribution program show comparable results obtained (3,274 "couple-months-of-protection" through factories versus 2,999 through the CCSMP) over the same period.

The project was initially designed to be an activity of the Barbados Family Planning Association and this management design was followed until approximately six months after the departure of the resident advisor. In November 1985 management was fully assumed by Frank B. Armstrong Ltd. As of February 1986 the CCSMP has begun to resume normal marketing operations.

Panther sales during this period have continued to show a steady increase. Sales of Panther in the second year increased in all three countries by 64 to 250 percent, and in the third year in two countries by 27 to 63 percent. Sales of orals have been less rewarding. Strongest sales are reported in St. Lucia which not only has the strongest distribution organization but where the lower price of Perle and Perle LD is perceived to be a greater benefit than detraction to consumers. A comparison of the CSM project distribution against the IPPF CBD projects in these islands suggests that the CCSMP has done 300 percent better than the Barbados FPA CBD project in condom sales although less well in orals; and about 15 percent better than the St. Lucia condom-only CBD project. The St. Vincent CBD project has not yet begun to distribute contraceptives and thus affords no possibility for comparisons.

DEMOGRAPHIC PROFILES

Antigua and Barbuda

No census has been taken in Antigua and Barbuda since 1970, making more definitive statements about population growth very difficult. In 1970 a total 64,794 persons lived in Antigua and Barbuda and the U.N. estimated a mid-1980 population of 75,200, which is comparable with government estimates but takes no account of emigration. If this estimate is correct, it would suggest an average natural increase of 1.5 percent. Guadeloupan Demographer Jean-Pierre Guengant estimates a population of 66,000 in 1980 where emigration has dampened the natural increase by 70.4 percent for an annual growth rate of 0.47 percent.

Total fertility was estimated to be a low 2.65 live births per woman at the end of the 1970s, somewhat above replacement level over the long run. Life expectancy is estimated to have increased from 62 years in 1970 to 65 by 1980. The crude death rate also is estimated to have fallen from 7.5 to 6.0 per 1000. Infant mortality is estimated to be 32 per 1000 live births in 1980, down from 40 in 1970.

In 1980 it was estimated that the median age was 21; the proportion under age 5 was 32 percent, and the over 65 cohort at about 6 percent.

According to the 1980 estimates of population, at that time there were approximately 14,800 women of reproductive age (WRA) in Antigua with 28 percent of this number falling into the 15-19 age group. The size of this cohort approximates the number of births to women under age 20 or 27 percent of the total 1,400 births per year.

The 1981 contraceptive prevalence survey (CPS) reported that 30.2 percent of the WRA were practicing family planning at the time of the survey, leaving approximately 7 out of 10 women of reproductive age unprotected. The percentage of users among "exposed women" (i.e., women in union status who are not sterile or pregnant at the time of the survey) equals approximately 45 percent. Of the exposed women currently contracepting, 86 percent were using a "modern method" including 40 percent who were using the pill, 22 percent using sterilization; 5 percent using condoms; and 5 percent using "inefficient methods" of rhythm, withdrawal, etc. Of the exposed women not practicing family planning, fully 24 percent of them said they did not want more children.

Family planning services are available through government clinics, the family planning association, and a non-clinical FPA community based distribution program.

Barbados

A total of 248,938 persons were enumerated in the 1980 census. This represents an increase of approximately 9,000 over the 1970 census resulting in a low average annual rate of growth during the decade of 0.47 percent. The natural increase during this period was 27,000 which would translate into approximately 1 percent rate of natural increase; however net emigration of about 18,000 over the decade kept population growth to half that amount.

The fertility declines since 1970 have nonetheless been dramatic, arriving at 1.94 level in 1980. At this level and assuming no emigration, the rate of growth would still be below replacement. A 1980 mortality rate of 8 per 1000 was recorded and infant mortality fell from 46 per 1000 in 1970 to 23 by 1980. Life expectancy is also comparable to developed countries, averaging about 70 years. The 1980 emigration rate of 7.5 per 1000 persons is high by international standards, but considerably lower than emigration rates in past years.

Significant changes in fertility and migration and the improvement of mortality during the 1970s contributed not only to a small increase in numbers, but also to a variation in the age distribution. The population aged slightly from 21.2 as a median age in 1970 to 24.5 in 1980. The percent under age 5 fell from 10.9 to 8.6 while the 65+ cohort increased from 8.3 to 10.5 percent. The dependency ratio dropped from 82.9 in 1970 to 78.6 ten years later.

The stabilization in Barbados' population is due to several factors, not the least of which should be considered the work of the local family planning association, the second oldest FPA in the world. Despite this work it should be pointed out that with 585 persons per square mile Barbados is still the second most densely populated country in the world and two to three times more densely populated than its neighboring island states. Population stabilization, therefore, is not only a desirable objective, but a necessity for Barbados' 250,000 people.

In January 1980 Barbados reported a total of 56,700 women of reproductive age, of which 24 percent were between the ages 15 through 19. This young cohort also represented 24 percent of the 4,400 annual births in Barbados.

A 1981 CPS stated that 37.2 percent of all WRA were contracepting at the time of the survey. Exposed women practicing family planning equalled 51.2 percent, leaving nearly one in two exposed women at risk of pregnancy. Of the 37.2 percent contracepting, 78 percent were using modern methods including 36 percent on the pill, and 30 percent using sterilization. Eleven percent of the women relied on condoms, and 4 percent used rhythm/withdrawal. Of exposed women not contracepting (nearly half of all exposed women), 45 percent did not want further children, and the rest wanted a child sometime in the future, but not at present. Thus a large number of women are at the risk of unwanted pregnancy.

Barbados has family planning coverage through its 8 poly clinics, through the FPA, and two non-clinical (CBD and CSM) island-wide programs.

Belize

Belize's population grew from 119,934 to 145,208 over the decade from 1970 to 1980. This increase represents an annual growth of 1.9 percent. The fertility rate is approximately 5.8.

Mortality rates are reported to have fallen substantially during the 1970s from 7 per 1000 in 1970 to 5 per 1000 in 1980 and the life expectancy of the average Belizean has been estimated to be 70.9 years. The result of continued high fertility and low mortality is a high rate of natural increase -- well over 3 per year.

Migration, both in and out, has played a significant role over several years in Belize, primarily resulting in significant racial changes over the period. Thus, while almost 60 percent of the population spoke English in 1946 and 22 percent spoke Spanish, by 1980 the respective proportions were 50 and 32.

The age distribution changed very little over the decade. The median age increased from 15 in 1970 to 16.5 in 1980; the proportion under age 15 fell from 49.3 to 46.1 in 1980. The dependency ratio fell from 115 in 1970 to 107 in 1980, the result of an increase in the working-age population from approximately 77,500 in 1970 to 95,900 in 1980.

The demographic situation in Belize is different from the other countries in this section in that at 6 persons per square mile it does not face the population density problems or cautions which face the island countries. Indeed being sparsely settled, Belize could accommodate further growth, although planned growth would place undue burdens on the public sector in the near future.

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Dominica

Despite earlier years of fairly rapid population growth, the population of Dominica grew at a very low rate of 0.5 percent from 1970 to 1980 resulting in a population of 73,337 in 1980. A major contributor to this low rate was the drop in the crude birth rate from 39.0 in 1970 to 21 in 1979. This low figure is attributed to the after effects of hurricane David in 1979 when many Dominicans left the island. This rate has been on the upswing in recent years, increasing to 24.5 in 1980 and 27.6 in 1981.

The total fertility rate in 1980 was estimated to be 3.4. Mortality fell during the period from 10 per 1000 in 1970 to 6.5 in 1980 with a life expectancy of about 65 years. Infant mortality also dropped sharply from 119.6 per 1000 live births in the 1950s to 67 in the 1960s and 27 in 1977.

The median age in Dominica increased from 15.4 percent in 1970 to 18.5 in ten years. In 1970 about 6 percent of the population was over 65, resulting in a dependency ratio of 122. By 1980 the age composition picture changed so that 40 percent of the population was under age 15, the elderly accounted for 7.2 percent of the population, and the dependency ratio had dropped to 89.

Despite the drop in fertility, emigration has continued to play a major role in the reduced growth levels in Dominica. Emigration has remained at high levels throughout the period. The rate of approximately 1.8 percent of the population leaving the island annually puts Dominica among the highest "emigrating nations" in the Eastern Caribbean, comparable to St. Kitts (1.8 percent) and Grenada (2.3 percent).

In January 1980 Dominica reported a total of 14,600 women of reproductive age, of which 32 percent were between the ages 15 through 19. This young cohort also represented 27 percent of the 4,400 annual births in Dominica.

A 1981 CPS stated that 35.8 percent of all WRA were contracepting at the time of the survey. Exposed women practicing family planning equalled 56.3 percent, leaving nearly one in two exposed women at risk of pregnancy. Of the 56.3 percent contracepting, 88 percent were using modern methods including 34 percent on the pill, and 30 percent using sterilization. Seven percent of the women relied on condoms, and 4 percent used

rhythm/withdrawal. Of exposed women not contracepting (nearly half of all exposed women), 35.8 percent did not want more children, and the rest wanted a child sometime in the future, but not at present. Thus a large number of women are at the risk of unwanted pregnancy.

Grenada

Grenada's estimated 1980 population is 93,000. While population data are sketchy, demographers estimate that the population of Grenada has not increased significantly since the 1960s, due to the effects of net emigration. In fact, it has been estimated by Guengant that a negative rate of growth of 0.1 percent occurred during the 1970s, a period of very high emigration during which an estimated 2.3 percent of the population left the island annually.

The birth rate remained in the middle to high 20s during the decade (e.g., 28.5 average for 1975-1979), reaching a low of 22.8 per 1000 in 1982. Crude death rates have stabilized at about 7 per 1000, and life expectancy is estimated to be 65 years. The median age in 1970 was 16.5; 47 percent of the population was estimated to be under age 15 and 5.8 percent above 65 with a dependency ratio of 112. By 1980 it is estimated that the median age increased to 18; the proportion under 15 dropped somewhat to 41.5 percent and the elderly remained at 5.8 percent with a dependency ratio of 90.

While the very high migration rates have characterized this population for several years, resulting in negligible overall growth, recent U.S. government interventions in the country to improve its economic status may have the impact of reducing the desire or ability to emigrate among young Grenadians. Should this in fact be the case, population pressures can be expected to increase in this island nation during the coming years.

The 1981 census reported approximately 20,000 women of reproductive age, including 6,200 women between the ages of 15 and 19. This cohort represents 31 percent of the WRA, however they account for 29 percent of the estimated 2,700 annual births.

Unfortunately prevalence data are not available at this time as the CPS is in the final stages of analysis at this writing.

Montserrat

The population in 1980 was estimated to be 11,606. During the period 1970 to 1980, the population of Montserrat grew by 0.34 percent annually. Like the majority of its neighbors, Montserrat relied on net emigration to cancel the balance of more births than deaths each year.

Crude birth rate has dropped from 25 per 1000 in 1970 to 19 per 1000 in 1980 although it increased slightly in 1981 to 19.3. In contrast to birth rates, the crude death rate did not drop during the period, stabilizing at about 11 per 1000. Life expectancy at birth also stabilized at about 70 years for women and 63 for men.

Despite the stabilization of population growth over the decade, age distribution did undergo changes: the under 5 age group fell from 13.5 percent to 8.2 percent of the population; the "active population" (15-64 age group) increased from 49 to 56 percent; the elderly population grew from 10.8 percent to 12.9 percent; and the dependency ratio fell from 101 in 1970 to 82 in 1980.

Montserrat had a total of 2,400 of WRA in 1980, of which there were 700 young women between the ages of 15 and 19. This young cohort accounts for 27 percent of the WRA but 35 percent of the 200 births each year. Thus, this age group represents about one-fourth of the WRA but produces one-third of the annual births.

The recently completed CPS reported that the percentage of exposed women using contraceptives equals 53 percent. Of the exposed women currently contracepting, 58 percent were using the pill; 3.1 percent relied on sterilization, 6 percent use condoms; and 0.5 percent using rhythm/withdrawal methods. Of the exposed women not practicing family planning, fully 49.3 percent reportedly do not want more children, and 34 percent did not want more children at the time of their last pregnancy.

Family planning services are available through the FPA, and more recently through the government clinics and a CBD project.

St. Kitts and Nevis

According to the 1980 census, the population of St. Kitts and Nevis was 43,309 with 78.2 percent of the population residing in St. Kitts and the remainder in Nevis. Over the past decade the country actually recorded a drop in the population size by 3.5 percent. This historically stable growth is not the result of zero

(or below) population growth rates, but rather the result of high net emigration. According to official government estimates, natural increase for the three years 1978 through 1980 totalled 1,952 while net emigration amounted to 1,901. It has been estimated that the emigration rate is upwards of 30 per 1000. In fact, emigration accounted for 117.6 percent of the total natural increase for St. Kitts and Nevis between the years 1970 and 1979. With the exception of Grenada's nearly equal (104.9 percent), this rate is 40-60 percent higher than all of the other Eastern Caribbean states.

The fertility rate in St. Kitts and Nevis was calculated to be 3.6 in 1980 compared with 5 in 1970 although recent trends show the fertility rate on the increase again. Even at the 1980 level of fertility, however, if emigration were to be stopped completely, the population would triple in 50 years, suggesting that the export of the country's human resources is its major escape from severe overpopulation.

Over the decade from 1970 to 1980, the crude birth rate actually increased from 9.7 to 11 per 1000, attributable mostly to the aging of the population. In 1980 37 percent of the population was under age 15, a drop from 58.7 percent in 1970, but still an uncomfortably high figure. The 65+ cohort accounted for 7.8 percent of the population in 1970 but 9.5 percent in 1980. The dependency ratio fell over the decade from 126 dependents per 100 working-age persons in 1970 to 88 in 1980.

While historically high emigration has provided a safety valve from an otherwise problematic population growth, the question must be asked: can St. Kitts and Nevis afford to continue educating and providing medical coverage to a population which will be required to emigrate for lack of local opportunity? The relatively low GNP per capita (\$560) despite a fairly constant population level suggests that the outflow of human resources has truly been a double-edged sword for St. Kitts and Nevis.

According to a the 1980 census, at that time there were approximately 9,100 women of reproductive age (WRA) in St. Kitts and Nevis with 31 percent of this number falling into the 15-19 age group. The cohort is responsible for approximately 36 percent of the 1,200 births each year.

The recent contraceptive prevalence survey (CPS) reported that 40 percent of the women in union were practicing family planning at the time of the survey, leaving approximately 6 out of 10 women in union status unprotected. Of the women in union currently contracepting, 48 percent were using the pill, 6.4 percent were relying on sterilization; 14 percent were using condoms; and 8.9

percent were using "inefficient methods" of rhythm, withdrawal, etc. Of the exposed women not practicing family planning, fully 46 percent of them said they did not want more children at any time in the future. One third of the women reported that their last birth was unplanned and unwanted.

St. Lucia

According to the May 1980 census of St. Lucia, the population was estimated to be 120,300. This marks an increase of about 20,000 (19.2 percent) over the 1970 figure yielding an average annual rate of growth during the decade of 1.4 percent. The statistical office of St. Lucia estimates that the population increased to about 124,000 by mid-1982, an average growth rate of 1.5 percent since 1980. The population thus grew at rates which are among the highest in the Eastern Caribbean.

In St. Lucia, despite a long history of net emigration, population growth rates have been surprisingly high. During the 1970s the estimated net emigration rate was 18 per 1000. This suggests that about 1200 - 1400 more people left the country than entered it in any given year.

The birth rate fell between 1970 and 1980 from about 45 to 29.3 per 1000. More telling is the decline in the total fertility rate from 6 in 1970 to 4.3 in 1980. Although this is a significant drop, fertility is nevertheless still high. According to the statistical office, fertility has increased since 1980 so that today St. Lucia continues to have one of the highest fertility rates in the region. In 1982 it is estimated from provisional data that the crude birth rate was 32.6 per 1000 with 3405 recorded births, the highest rates since the early 1970s. As a result total fertility increased from 4.3 to 4.7 in 1981. It is estimated to have increased again to 4.9 in 1982.

The crude death rate in St. Lucia has continually dropped in recent years, standing at 7.5 per 1000 in 1980, with a life expectancy of males of 67.4 years at birth; 71.8 years for females. In 1982 life expectancy was estimated to be 68.7 and 72.4 respectively. These levels are much more typical of developed rather than developing countries. Infant mortality has also dropped significantly in recent years. Provisional 1982 data indicate an infant mortality rate of 22.4 per 1000. The combination of a young population and considerable success in prolonging life expectancy has resulted in an extremely low crude death rate which is expected to remain low for the foreseeable future.

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Continued high fertility and relatively constant levels of net emigration have combined to keep the age structure relatively constant during the 1970s. In St. Lucia the median age crept up from about 15.5 in 1970 to 16.5 in 1980, giving St. Lucia one of the youngest populations in the Eastern Caribbean. The proportion of the population under age 15 was 49.4 percent in 1970 and 49.6 percent in 1980. The 65+ group increased from 5.1 to 5.3 percent. The dependency ratio stands at 122. St. Lucia's demographic future is uncertain. There is widespread agreement that the population cannot increase much more given its growing density and mountainous terrain. Although possible, a population of 200,000 seems too large, but with persistently high fertility, a doubling of the population in 50 years is likely even with high emigration.

In January 1980 St. Lucia reported a total of 23,800 women of reproductive age, of which 30 percent were between the ages 15 through 19. This young cohort also represented 26 percent of the 1,800 annual births in St. Lucia.

A 1981 CPS stated that 35 percent of all WRA were contracepting at the time of the survey. Exposed women practicing family planning equalled 49.2 percent, leaving nearly one in two exposed women at risk of pregnancy. Of the 49.2 percent contracepting, 83 percent were using modern methods including 49 percent on the pill, and 25 percent using sterilization. Nine percent of the women relied on condoms, and 4 percent used rhythm/withdrawal. Of exposed women not contracepting (nearly half of all exposed women), 34.6 percent did not want further children, and the rest wanted a child sometime in the future, but not at present. Thus a large number of women are at the risk of an unwanted pregnancy.

Family planning services are available through the FPA, in each government clinic, and through CBD and CSM programs.

St. Vincent and the Grenadines

The 1980 population of St. Vincent and the Grenadines was set at 97,845, which represents an annual growth rate of 1.2 percent over the 1970 census. Throughout the 1970s the crude birth rate continued to fall, reaching 35.7 in 1980. The total fertility rate was 4.7. The death rate fell from 8.3 in 1970 to 8 per 1000 in 1980. Infant mortality dropped from previous levels to 39 deaths per 1000 live births.

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Annual net emigration over the decade stood at 1.8 percent of the population, thus reducing the impact of the very high fertility rate. While the rate of emigration has decreased somewhat over the decade, the "rate of return" to the country on its provision of social and educational services is still poor and represents a real impediment to national development.

Age structure has changed over the decade. The median age increased from 14.5 to 16.5, which is still among the lowest in the world. While 51.2 percent of the population was under 15 and 4.8 percent over 65 in 1970, by 1980 the under 15 group accounted for 43.7 percent (still problematically high) and the over 65s accounted for 5.7 percent. This resulted in a drop in the dependency ratio from 127 in 1970 to 98 in 1980. According to the 1980 census, at that time there were approximately 20,200 women of reproductive age (WRA) in St. Vincent and the Grenadines with 31 percent of this number falling into the 15-19 age group. This young adult cohort is responsible for 29 percent of the 3,400 births annually.

The 1981 contraceptive prevalence survey (CPS) reported that 32.5 percent of the WRA were practicing family planning at the time of the survey, leaving approximately 7 out of 10 women of reproductive age unprotected. The percentage of users among "exposed women" (i.e., women in union status who are not sterile or pregnant at the time of the survey) equals approximately 49 percent. Of the exposed women currently contracepting, 72 percent were using a "modern method" including 31 percent who were using the pill, 28 percent using sterilization; 20 percent using condoms; and 5 percent using "inefficient methods" of rhythm, withdrawal, etc. Of the exposed women not practicing family planning, fully 44.1 percent of them said they did not want more children ever, while 53 percent did not want a child at the present.

Family planning services are available through government clinics, and a non-clinical CSM project.

Caribbean Region

While the demographic evolution has varied from country to country, a general regional pattern is discernable. Crude death rates have dropped from roughly 25 in 1950 to around 10 in 1970. Crude death rates hovered around 40 per 1000 into the 1960s, however, resulting in an accelerating rate of natural increase from about 1 percent in 1920, to 2 percent in the 1940s, and up to 3 percent in the 1960s. Although birth rates began dropping after reaching their peak in the 1960s, the natural increase continues to range from 6.6 per 1000 in Montserrat to 28.8 in St. Lucia and 33.1 in Belize. (See Table 1.). The table also shows that the rates of natural increase in the region translate into "doubling times" from 116 years in Montserrat to 21 years in Belize and 24 years in St. Lucia.

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While further declines in the rates of natural increase are possible, it is not possible for rates to continue to decline as rapidly as in the 1970s. Indeed, for all of the CARICOM countries the arrival at the reproductive age of the female cohorts born in the 1950s will have the effect of boosting the number of births. Increases in the crude birth rate are already being observed in Belize and St. Kitts and Nevis and may continue for the next two decades based on population dynamics. (See Table 2)

Fertility rates have also been dropping over the last few years as shown in Table 1 and Graph 1, however, they are still significantly above replacement level in most countries. Age-specific fertility rates for the region (Graph 2) illustrate that pregnancies are occurring too early, at too young an age, and are taking place when women are well beyond their most favorable childbearing years.

Perhaps as important an impact on population growth for the region has been the export of human resources through emigration. Between 1950 and 1980 the CARICOM countries lost almost 1.5 million people through emigration. Nearly 300,000 left during the 1950s, 600,000 in the 1960s and as many again in the 1970s. In the 1970s net emigration amounted to at least half of the natural increase in all of the CARICOM countries with the exception of Bahamas, reducing the growth rate to an average 1 percent per year against a natural increase well above 2 percent. (See Table 3.)

Contraceptive use in the region has been growing over the last several years according to Table 4. Prevalence rates for "exposed" women, i.e., women who are in union, are not pregnant or infecund, ranges from 40 percent in St. Kitts and Nevis to a high of 62.6 percent in Trinidad and Tobago. The most popular methods are orals, sterilization (primarily female sterilization) and condoms.

TABLE 1

BIRTH RATES, DEATH RATES AND RATES OF NATURAL INCREASE
ANNUAL AVERAGES IN CARICOM COUNTRIES FOR 1975-79

Countries	AVERAGE FOR 1975-1979				
	CRUDE BIRTH RATE per 1,000 (1)	CRUDE DEATH RATE per 1,000 (2)	NATURAL INCREASE per 1,000 (3)=(1)-(2)	FERTILITY RATE	DOUBLING TIME PER NATURAL INCREASE
1. Jamaica	29.9	6.8	23.1	3.4	30
2. Trinidad & Tobago	26.8	7.0	19.8	2.9	36
3. Barbados	18.1	8.8	9.3	1.94	77
4. Guyana	32.2	7.3	24.9	3.3	28
A = More Developed Countries	28.8	7.1	21.7		
5. Grenada	28.5	7.8	20.7	2.9	33
6. St. Vincent	35.7	8.0	27.7	4.7	25
7. St. Lucia	36.3	7.5	28.8	4.9	24
8. Dominica	24.5	6.5	18.0	3.4	38
B = Windward Islands	31.9	7.5	24.4		
9. Antigua	21.6	7.1	14.5	2.65	46
10. St. Kitts-Nevis	26.6	10.8	15.8	3.6	43
11. Montserrat	17.5	10.9	6.6	-	116
C = Leeward Islands	23.0	8.8	14.2		
12. Belize	38.8	5.7	33.1	5.8	21
13. Bahamas	23.6	5.5	18.1	2.9	39
TOTAL CARICOM	29.0	7.1	21.9		31
14. United States	16	9	7	1.8	100

Notes: Rates are weighted for the sub-groups and for the Total CARICOM.
The rates for Antigua and Guyana are estimates in the absence of recent data.

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TABLE 2

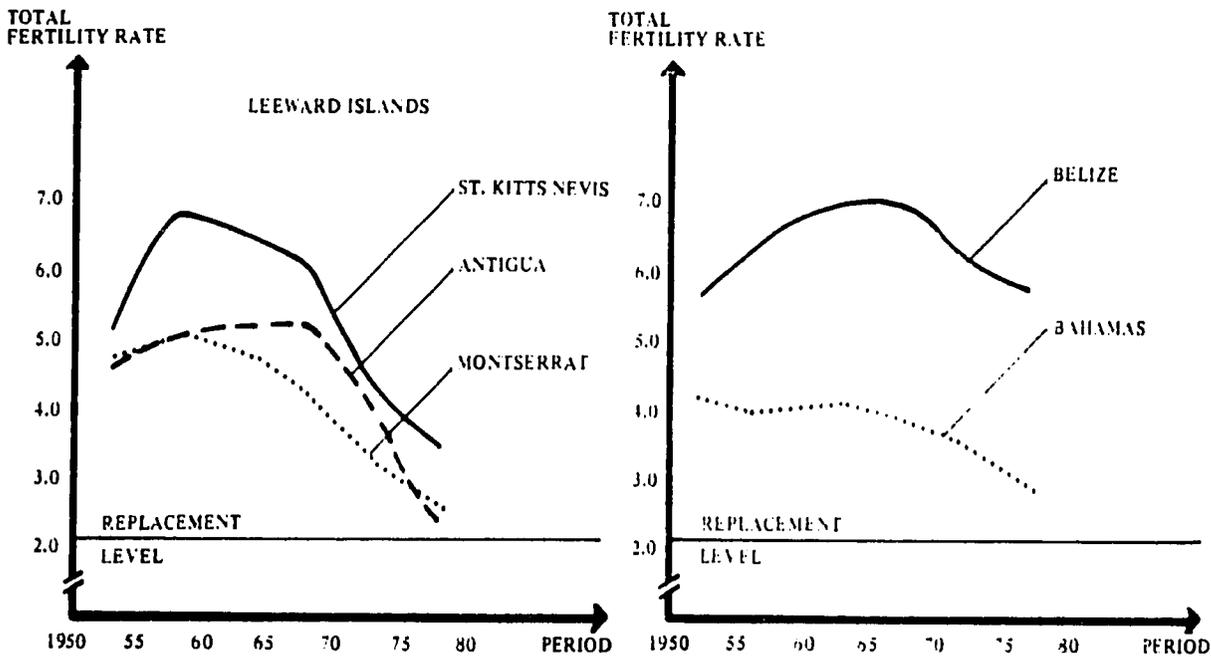
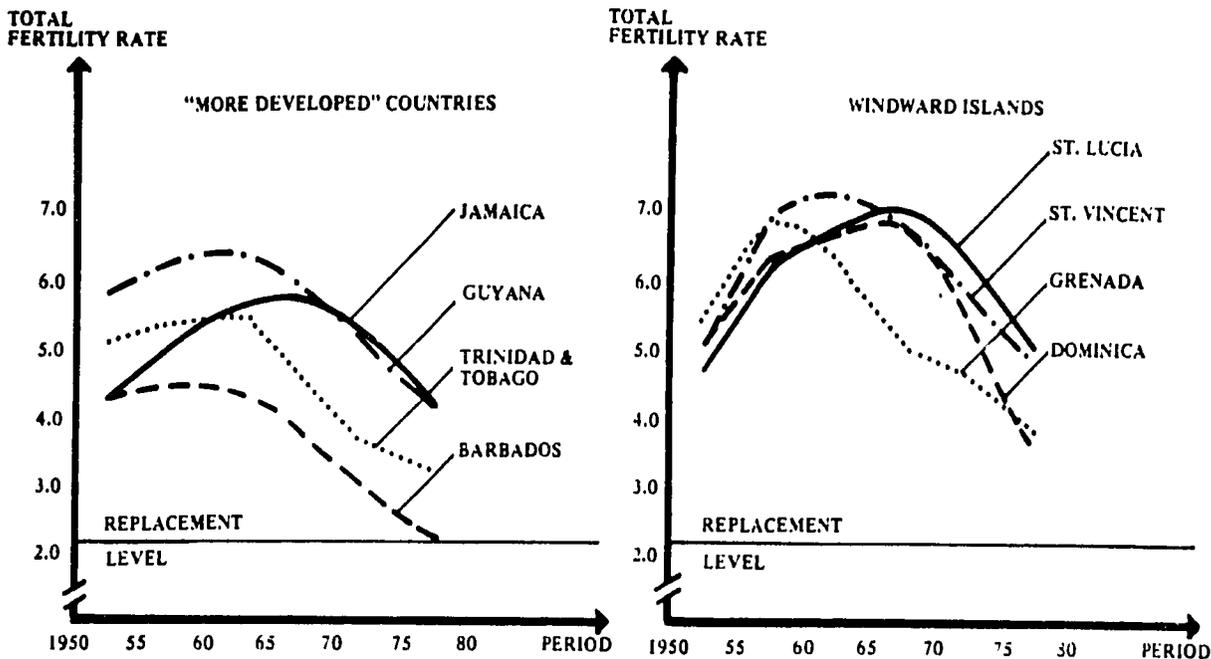
NUMBERS OF TEENAGE WOMEN AND WOMEN OF FERTILE AGE IN 1980
AND TOTAL BIRTHS AND BIRTHS FROM TEENAGE WOMEN
ANNUAL AVERAGES FOR CARICOM COUNTRIES IN 1975-79

Countries	Number of Women Aged 15-44 Years Jan. 1980 (Thousands) (1)	Women Aged 15-19 Years Jan. 1980 (Thousands) (2)	Proportion of Women Aged 15-19 Years Among 15-44 Years (3)=(2)÷(1)	AVERAGE 1975-79		
				All Births (Thousands) (4)	Number of Births at Less Than 20 Years (Thousands) (5)	Proportion of Births at Less Than 20 Years (6)=(5)÷(4)
1. Jamaica	434.0	141.5	33%	60.0	17.0	28%
2. Trinidad & Tobago	249.6	65.3	26%	27.5	5.4	20%
3. Barbados	56.7	13.7	24%	4.4	1.1	24%
4. Guyana	171.8	48.9	28%	24.2	5.5	23%
A = More Developed Countries	912.1	269.4	30%	116.1	29.0	25%
5. Grenada	19.7	6.2	31%	2.7	0.8	29%
6. St. Vincent	20.2	6.3	31%	3.4	1.0	29%
7. St. Lucia	23.8	7.1	30%	4.1	1.0	26%
8. Dominica	14.6	4.6	32%	1.8	0.5	27%
B = Windward Islands	78.3	24.2	31%	12.0	3.3	27%
9. Antigua	14.8	4.1	28%	1.4	0.4	27%
10. St. Kitts-Nevis	9.1	2.8	31%	1.2	0.4	36%
11. Montserrat	2.4	0.7	27%	0.2	0.1	35%
C = Leeward Islands	26.3	7.6	29%	2.8	0.9	31%
12. Belize	27.7	8.7	31%	5.4	1.3	24%
13. Bahamas	50.7	13.6	27%	4.7	1.0	21%
TOTAL CARICOM	1,095.1	323.5	29%	141.0	35.5	25%

Notes: Numbers of women and teenage women estimated in accordance with census results (Antigua, Bahamas and Jamaica excepted.)
Numbers of total births and births from teenagers have been estimated for Guyana.
Numbers and proportions of births from teenagers have been estimated for Dominica and Montserrat.

GRAPH 1 .

ESTIMATES OF TOTAL FERTILITY RATES FROM 1950-54 TO 1975-79



GRAPH 2

ESTIMATES OF AGE-SPECIFIC FERTILITY RATES, 1975-79

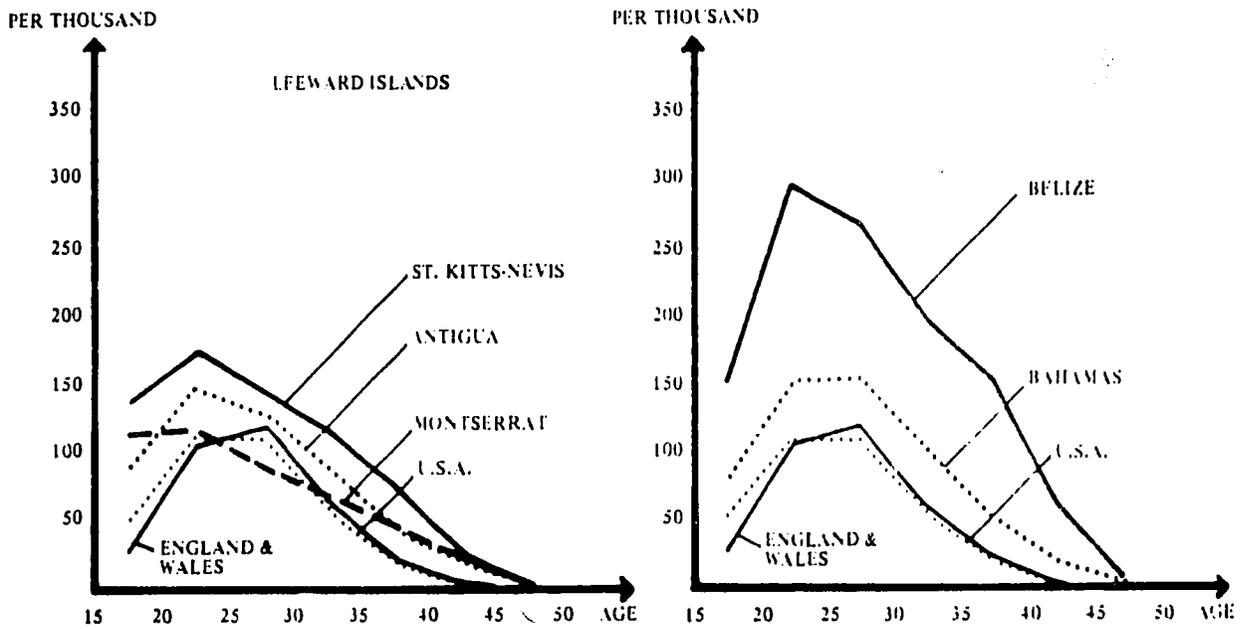
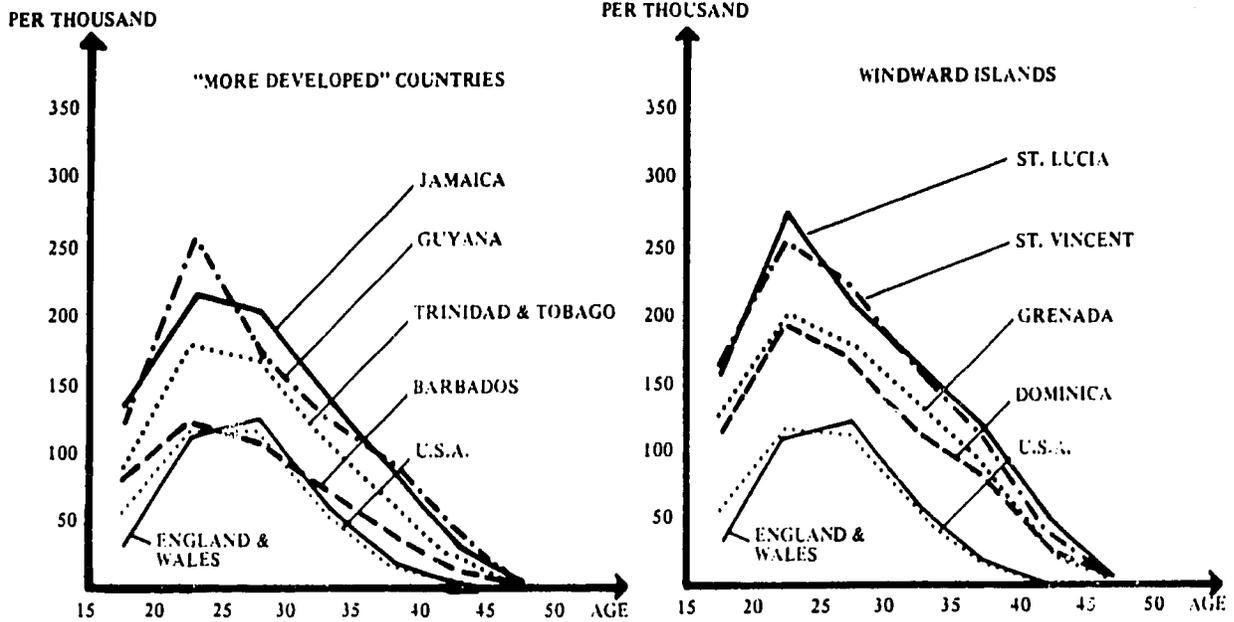


TABLE 3

NET EMIGRATION AND NATURAL INCREASE (IN THOUSANDS)
AND RATES OF EMIGRATION AND POPULATION GROWTH
IN THE CARICOM COUNTRIES IN THE 1970s

Countries	Population Jan 1980 (Thousands) (1)	1970-1979		Emigration Natural Increase per 100 (4)=(2)+(3)	Annual Rate of Growth per 100 (5)	Annual Net Emigration as a % of the 1980 Population (6)	Doubling Times per Pop Gr.
		Estimated Net Emigration (Thousands) (2)	Natural Increase (Thousands) (3)				
1. Jamaica	2,053	271	481	56.3	1.08	1.3	65
2. Trinidad & Tobago	1,055	94	197	48.1	1.03	0.9	67
3. Barbados	249	15	26	56.3	0.47	0.6	148
4. Guyana	759	130	191	68.0	0.84	1.7	83
A = More Developed Countries	4,116	51.0	895	56.9	0.99	1.2	70
5. Grenada	93	21	20	104.9	-0.11	2.3	n.a.
6. St. Vincent	98	15	26	57.1	1.23	1.5	56
7. St. Lucia	116	19	34	55.6	1.38	1.6	50
8. Dominica	74	12	16	78.2	0.49	1.7	142
B = Windward Islands	381	67	96	70.2	0.78	1.8	90
9. Antigua	66	7	10	70.4	0.47	1.1	148
10. St. Kitts-Nevis	44	8	7	117.6	-0.27	1.8	n.a.
11. Montserrat	12	1	1	67.6	0.34	0.7	205
C = Leeward Islands	122	16	18	87.9	0.18	1.3	388
12. Belize	145	20	44	44.4	1.86	1.3	37
13. Bahamas	208	(4)	36	-	2.16	-	32
TOTAL CARICOM	4,972	609	1,089	55.9	1.02	1.2	69
14. United States	241,000	n.a.	7	n.a.	0.7	n.a.	100

Notes: The 1980 populations were estimated on the basis of recent census results (except Antigua)
Natural increase has been estimated for Guyana in the absence of data.
Migration data for the Bahamas means net immigration, means not applicable.

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TABLE 4

"EXPOSED" WOMEN BY TYPE OF CONTRACEPTIVE METHOD

Method Currently Used	Fertility Surveys ¹			Contraceptive Prevalence Surveys ²				
	Jamaica 1975/76	Trin. & Tob. 1977	Guyana 1975	Barbados 1980/81	St. Vincent 1981	St. Lucia 1981	Dominica 1981	Antigua 1981
Pill	14.9	22.3	11.8	18.6	15.3	24.3	19.0	18.6
I.U.D.	2.3	2.6	7.0	4.5	2.7	1.2	2.3	5.3
Injection	7.9	1.3	0.4	2.5	3.2	2.7	11.3	5.2
Sterilization (Female & Male)	9.0	4.9	9.5	15.0	13.8	12.4	16.9	10.1
A = "ANY MODERN METHOD"	34.1	31.1	28.7	40.6	35.0	40.6	49.5	39.2
Other Female Scientific	1.8	6.0	2.4	2.9	1.7	1.3	0.7	1.5
Condom	8.2	18.5	3.7	5.6	9.7	4.5	4.1	2.2
B = "ANY EFFICIENT METHOD"	44.1	55.6	34.8	49.1	46.4	46.4	54.3	42.9
Rhythm	0.4	2.8	1.1	1.1	1.1	0.9	1.2	1.2
Withdrawal	1.7	3.4	1.3	0.8	0.7	1.7	0.8	0.7
Other "Inefficient" Method	0.4	0.8	1.2	0.2	0.5	0.2	-	0.2
C = "ANY INEFFICIENT METHOD"	2.5	7.0	3.6	2.1	2.3	2.8	2.0	2.1
TOTAL USERS	46.6	62.6	38.4	51.2	48.7	49.2	56.3	45.0

Notes: (1) % calculated for women 15-44 years as given in the published results
(2) % calculated after deduction of estimated users not in union by methods

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PROJECT CHECKLIST

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

CROSS REFERENCES: IS COUNTRY CHECKLIST UP-TO-DATE? Yes

HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolution Sec. 524; FAA Sec. 634A

Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;

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2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes

3. FAA Sec. 611(a)(2). 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 action required

4. FAA Sec. 611(b); FY 1986 Continuing Resolution Sec 501 If for water or water-related land resource construction, has project met the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.) N/A

5. FAA Sec. 611(e). 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. FAA Sec. 209. Is project susceptible to 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. This is a regional project

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; and (c) encourage development and use of cooperatives, and credit N/A

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.

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A
9. FAA Sec. 612(b), 636(h); FY 1986 Continuing Resolution Sec 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. N/A
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

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12. FAA 1986 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A
13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Yes
- Does the project or program take into consideration the problem of the destruction of tropical forests? N/A
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)? N/A
15. FY 1986 Continuing Resolution Sec. 536. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? None
16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, None

historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FAA Sec. 102(a), 111, 113, 281(a). 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 basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions;

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

(c) support the self-help efforts of developing countries;
(d) promote the participation of women in the national economies of developing countries and the improvement of women's status, (e) utilize and encourage regional cooperation by developing countries?

- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? Yes
- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? N/A
- d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country)? This requirement does not apply to regional projects

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- e. FAA Sec 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? Yes
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? Yes
- g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. The project utilizes local resources (manpower) to the maximum extent possible and was developed jointly with host governments and other local institutions