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**STUDY OF SUSTAINABILITY
FOR THE
NATIONAL FAMILY PLANNING BOARD
IN JAMAICA**

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PREPARED BY:

OPTIONS II PROJECT

**Maureen E. Clyde
Tennyson D. Levy
Joanne Bennett**

**THE FUTURES GROUP
ONE THOMAS CIRCLE
SUITE 600
WASHINGTON, D.C. 20005-5608**

202 775-9680

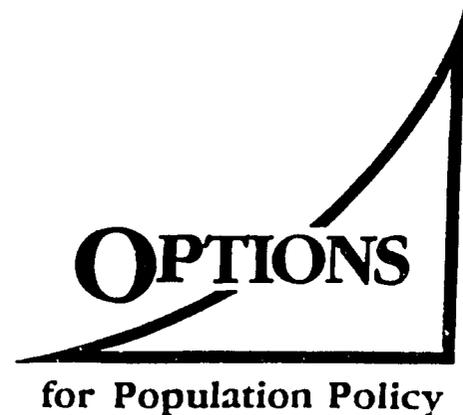


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List of Abbreviations

Cost, Insurance, and Freight	CIF
Commercial Distribution of Contraceptives	CDC
Contraceptive Prevalence Rate	CPR
Contraceptive Prevalence Survey	CPS
Family Health Management Services	FHMS
Family Planning	FP
Family Planning Initiatives Project	FPIP
Freight of Board	FOB
Government of Jamaica	GOJ
Information, Education and Communication	IEC
International Planned Parenthood Federation	IPPF
Jamaica Family Planning Association	JFPA
Ministry of Health	MOH
National Family Planning Board	NFPB
Non-Governmental Organization	NGO
Planning Institute of Jamaica	PIOJ
Private Sector Organization of Jamaica	PSOJ
Private Voluntary Organization	PVO
Statistical Institute of Jamaica	STATIN
Total Fertility Rate	TFR
United Nations Fund for Population	UNFPA
United States Agency for International Development	USAID
Voluntary Surgical Contraception	VSC

I. EXECUTIVE SUMMARY

The strategies for family planning (FP) employed by the Government of Jamaica (GOJ) and the National Family Planning Board (NFPB) over the last two decades have been very successful and provide an excellent example for other countries in the Caribbean region. The Jamaica of today, however, is very different from that of twenty years ago when the program was designed. The FP program is faced with new and complex issues:

- 1) The GOJ has a stated demographic development goal of achieving replacement level fertility by the turn of the century.
- 2) USAID/Kingston is incrementally phasing-out all assistance for FP beginning in 1993 and ending in 1998.
- 3) Other donors including the UNFPA and World Bank are cutting back their family planning assistance.
- 3) The current method mix of contraceptive use is inefficient, with high use of supply methods (ie. pill and condom) rather than efficient long-term methods.
- 4) Legal, economic, regulatory and other operational barriers exist, which constrain FP program expansion, especially through the private sector.

A new implementation strategy is required to address these issues. This strategy must be designed to achieve specific goals, use resources more efficiently, and identify and mobilize new resources. Responding to new challenges while facing increasing resource constraints requires a strong commitment on the part of the Jamaican FP community. It must be prepared to make difficult decisions in the short-term in order to achieve long-run success. The NFPB is the organization with both the credibility and mandate to lead the FP initiative and spearhead the design and development of this new strategy.

The NFPB, as a leader of the Jamaican FP program, is presented with a tremendous opportunity to advocate renewed commitment to population among policy-makers, at the highest levels of government, and to provide overall policy direction to the FP program. As leadership advocates for FP, the NFPB is the broker between policy-makers in the public and private sectors and is charged with initiating dialogue and promoting support for FP. The NFPB must help public and private sector policy-makers identify economic, regulatory, and cultural barriers to the expansion of FP services and recognize the importance of removing such barriers. The onus is on the NFPB to place population and FP as a paramount issue on the GOJ policy agenda.

Cultivating support from both the public and the private sectors is critical to mobilizing new resources for FP. The NFPB needs to define and form a working partnership between the public and private sectors (including non-profit institutions, commercial organizations and private health providers). This includes removing policies such as importation duties and prescription requirements which constrain the private sector from providing FP services. This public - private partnership has not been pursued because of the success of delivering FP through the public sector system.

FP clients come from different socio-economic levels and value different aspects of FP service. Many are willing to pay for convenience, quality, and service. Service providers must be prepared to meet these client needs with a range of products and service outlets. The private sector has a very important role to play in meeting these needs. To date, the public sector has been the primary provider of FP for all consumers. This must change so that the public sector resources provide FP services for those users who can not pay for the services. The private sector then will provide services to users who can pay. This will diversify the burden for financing services as well as expand the pool of service providers.

Recommendations and Next Steps

This report sets out to assist the NFPB to determine the most appropriate approaches to achieve the nation's population goals and objectives and to deliver an effective, cost-efficient and sustainable FP system. There are three major issues involved, namely: 1) population targets to be served; 2) the role and function of the NFPB to reach and serve the various targets; and 3) how to sustain beyond the inputs from donors. The following recommendations address each of these issues.

A. Population Targets

Historically, the FP system was service driven. That is, clients had access to services and products that were available, and not necessarily what was most effective or efficient. The achievement of a replacement level fertility by the year 2000 will require not only maintaining current users in an economic climate that may test their consistency and commitment to FP, but also reaching the hardest-to-reach segment of the population, current non-users.

1) The NFPB should prioritize population segments to be served based on the TARGET Model analysis, which estimates the number of contraceptive users, by method, that would be required to achieve fertility targets.

2) Based on the illustrative TARGET Model analysis herein, it is recommended that the following segments be considered for priority emphasis in FP:

- * Females age 15-19 who are not currently using a contraceptive method. Data indicate that more than half of these females are sexually active, one-in-six are currently pregnant, and one-in-five of all females who have had a child, had that child between the ages of 15-19.
- * Women in union not currently using a method. Data indicate that one-third of these women were previous users who discontinued because of method dissatisfaction.
- * Current public sector users who can afford to use private sector sources. Data indicate that approximately 40% of current public sector users can afford to pay for contraceptive supplies.

3) The NFPB should adopt a strategy of emphasizing long-term and more cost-effective methods of contraception. This will require converting current users to other methods, particularly sterilization (female and male), IUDs and Norplant, and placing new users on the most appropriate method.

B. The Role and Function of the NFPB

1) Family Planning Advocacy

The continuation and further development of the FP system at the requisite level of impact will necessitate a meaningful and tangible level of national consensus and support that can only be generated through a major advocacy role. The NFPB is the organization uniquely qualified to play this role. The demands of the advocacy role, however, will require a single mindedness of purpose and a reorientation of the Board's energies and resources to effectively advocate for support for FP from among a wide variety of groups.

Implicit in the advocacy role will be the need for the Board to influence and shape policies that impact on the FP system. Specifically, the Board will need to address the legal, regulatory, and operational barriers to the growth and development of FP, which upon preliminary investigation include:

- * Waiving or reducing duties and taxes on contraceptives,
- * Reclassifying oral contraceptives on the drug list to allow for access to the method without a prescription;
- * Liberalizing the distribution of all contraceptives, to allow for sales to be expanded beyond pharmacies to include selected stores, particularly in rural areas; and
- * Permitting the advertising and promotion of all contraceptive methods in the mass media to provide consumers with the basis for an informed method choice.

2) Program Development and Demand Generation

The NFPB will need to go through a process of transition to meet the changed and changing needs of the system and its users.

- * The Board will need to change its role in the implementation process from being a major participant to being the director of the process by coordinating the roles and functions of other implementors.
- * The Board will need to change the management process to re-tool and refine the skills within the Board to play the leadership role to increase the efficiency of the FP system.
- * The Board will need to modify the interventions to be more responsive to the needs of the FP users.
- * The Board must direct demand generation through a strategy that realizes behavior change and motivates consistent and correct participation in FP.

3) Resource Management

The Board needs to assume the responsibility for garnering financial support for maintaining the FP system. This includes lobbying the Government for priority consideration at the macro level, harnessing private sector participation in FP, canvassing for additional donor support, and convincing FP clientele with the ability to pay the importance of a personal investment in FP.

The resources available to the NFPB from the Government have never been sufficient to meet the demands of the system and are now currently being reduced. There will also be a phased withdrawal of international donor support for FP in cash, commodities, and technical support. To better manage the resources of the FP system, it is recommended that:

- * The skills of the current staff should be reviewed to ensure the right mix of expertise to execute the new strategy of the Board. This may require the reclassification of posts, retraining of staff, and recruitment of more appropriate skills.
- * The size of the current staff should be reviewed, not only to be able to respond to the ravages of inflation and a reduced subvention, but to transfer a greater proportion of resources to critical areas, such as: policy, advocacy, communications, and management information systems.
- * The institutional structure and functions need to be reviewed so that human resources and infrastructure match the leadership role the Board will have to play.

C. System Sustainability

The issues and recommendations discussed above will undoubtedly contribute to the sustainability of the FP system. The following further recommendations will help to assure the realization of a sustainable system.

- * Commodity costs need to be shared more equitably between the public sector and the user through private sector access. Public sector commodities should serve only the safety net consumer, thereby reducing the Government's liability for commodity costs to more manageable levels.
- * The NFPB should retain responsibility for commodity forecasting, procurement, and logistics management for the public sector only; however, the GOJ will have to pay for the contraceptives in order to serve the indigent population.
- * The NFPB should immediately assign and/or hire a qualified full-time staff person to manage commodity logistics for the public sector.
- * The NFPB should contract with IPPF/FHMS for contraceptive procurement (for public sector commodities) on the basis of a two-year contract in the first instance, which would be renewed based on NFPB's satisfaction with the service provided.
- * The management of the social marketing program should be transferred immediately and entirely to the private sector. During the first two years of managing the social marketing program, the company should be provided with donated commodities (Panther and Perle) and marketing support through the Family Planning Initiatives Project (FPIP). After two years of support, the company should assume all costs for implementing the social marketing program.
- * The private sector company should be selected, not only on the basis of competitive pricing, but also on their demonstrated commitment to FP as a necessary and valuable social service. The NFPB's current partner in the CDC program, Grace

Kennedy Distributors, has been a longstanding, effective and loyal partner. Grace Kennedy also has the most extensive distribution network in the business, and is financially solvent and well managed. While the recommendation is to investigate opportunities to work with other companies, Grace Kennedy Distributors is, at this time, the preferred company.

- * The social marketing program should serve that segment of the population in the consumption deciles 4-7, and those who can afford an economical price for FP services.
- * The transfer of the social marketing program to the private sector should allow the Board to reallocate more than a million Jamaican dollars per year to other priorities.
- * More private sector participation needs to be encouraged so that private physicians and other private service providers should assume a greater role in FP, thereby improving system sustainability through "burden" sharing.

D. Next Steps

The NFPB needs to take swift action to move toward developing a sustainable FP program. Understanding of and consensus for the necessary strategic changes are fundamental to implementation. Once the overall program direction is agreed upon by the relevant players, the next steps include to:

- 1) Conduct a workshop to plan and coordinate technical assistance and program support available through the USAID/Kingston Family Planning Initiatives Project and the World Bank Project;
- 2) Develop a 5-year action plan for implementation;
- 4) Develop a 1-year work plan;
- 5) Review staff configuration to meet new strategy;
- 6) Select and transfer full responsibility for the CDC program to a private sector marketing company;
- 7) Develop staff re-orientation program, retraining plan, and, (if necessary), recruitment schedule;
- 8) Hire/assign a staff person to take immediate responsibility for public sector commodity management; and,
- 9) Develop commodity projections for next twelve months, arrange for GOJ funding, and place an order with IPPF for 20% of public sector commodity needs for 1993.

II. PURPOSE AND METHODOLOGY

In December 1991, The Futures Group received a request from the NFPB in Jamaica vis-a-vis USAID/Kingston/Kingston to "study the implications of sustainability including but not confined to the privatisation of the Social Marketing Programme and to make recommendations as to the best alternative direction for the National Family Planning Board given its mandate and the realities of its present and future funding" (The terms of reference are attached as Appendix 1). The OPTIONS II and SOMARC II Projects are pleased to assist the NFPB to develop alternative strategies for sustaining high quality, affordable FP services in Jamaica.

As USAID/Kingston and other foreign donor agencies plan phase-out financial, technical, contraceptive commodity, and programmatic support over the next decade, it is imperative for the FP community in Jamaica to focus its attention on achieving self-sustainability. **This paper is intended to provide guidance to facilitate macro-level policy and program reforms for the national FP program to move toward sustainability, rather than an action plan for implementation.** A more detailed action plan for implementation will have to be developed after an overall strategy is determined. Through the new bilateral agreement between the Government of Jamaica (GOJ) and USAID/Kingston, the OPTIONS II Project is looking forward to working with the NFPB and other Jamaican institutions to assist with implementing policy and programmatic changes over the next three years.

The methodology to conduct this study comprised both qualitative and quantitative analyses. The team took a very broad, comprehensive look at the evolution of the FP situation in Jamaica by interviewing a cross-section of representatives from the FP community as well as reviewing existing studies and reports that have been generated over the last two years, which examine prospects for sustainability of FP in Jamaica. These existing reports offer a data-rich, extensive catalogue of information which are, where appropriate, integrated and referenced in this paper. (See Appendix 2: Contact List and Appendix 3: Bibliography.)

The team also conducted a TARGET model analysis, which is a computer-based analytical model developed by J. Bongaarts of The Population Council and J. Stover of The Futures Group. The TARGET Model estimates the number of contraceptive users and commodity supplies that would be required to serve the projected user population. The TARGET Model analysis will be discussed in more detail in this report; however, it is important to mention that the TARGET analysis herein is meant to provide an illustrative order of magnitude, based on achieving replacement level fertility by the year 2001. For the purposes of this study on sustainability, the TARGET model input assumptions and output estimates form part of the basis for examining future program needs. (See Appendix 4: Target Setting Model.)

III. BACKGROUND

The population of Jamaica is estimated at 2.4 million, with an average growth rate of 1.4% from 1970-89. Migration has been a major component of population change in Jamaica since the early 1970s in terms of serving as a release valve for population growth; however, migration patterns over the last decade indicate a trend toward lower out-migration, which will lead to even more serious pressures on development efforts.¹ The FP program, which has achieved approximately 55% contraceptive prevalence (CP) and contributed to a total fertility rate (TRF) reduction from approximately 6 to 3, has played a valuable role in helping the GOJ align population growth with the pace of overall national economic development. According to a recent cost-benefit analysis of Jamaica's FP program, which was conducted by the NFPB and the RAPID III project, the FP program, historically, has resulted in reduced GOJ expenditures in the health and education sectors.² While the FP initiative has made great strides, the future challenges that lie ahead are of tremendous magnitude.

The current contraceptive use of approximately 55% of women of reproductive age in union, perhaps, can be better thought of in terms of an absolute number of users, which is estimated at approximately 229,000 women. This absolute number, however, will continue to increase in the absence of any change in contraceptive prevalence, simply due to the still young age structure of the population and the consequent in-built momentum of population growth in Jamaica. For example, by the year 2000 the absolute number of women of reproductive age will have increased by approximately 17%.³ In addition to maintaining current CP for this growing population, there is the challenge of reaching national development objectives, which are stated as "to increase prevalence from approximately 55% to 62% and to reduce the total fertility rate to replacement level by the year 2000".⁴ Maintaining and expanding services will also have to evolve in full consideration of improving the quality of care, which is certain to pose difficult challenges, particularly given existing resource constraints and dwindling foreign donor assistance. The current economic climate of Jamaica, which is characterized by a struggling economy and drastic decreases in real purchasing power, is also recognized as an impediment to sustainability. The economic plight that men and women face today, however, may be in and of itself a motivation to lead individuals to taking action to control their own fertility.

¹Economic and Social Survey Jamaica 1990, Planning Institute of Jamaica.

²RAPID III Project Famplan Model Application: A cost-benefit analysis of the Government of Jamaica Family Planning Program.

³Demographic Statistics 1990, Statistical Institute of Jamaica.

⁴Jamaica National Population Policy, Population Institute of Jamaica.

IV. CURRENT FAMILY PLANNING MARKET ANALYSIS

A. Current Contraceptive Market

The information presented in this section on current market analysis is extracted from the 1983 and 1989 Contraceptive Prevalence Surveys (CPS), unless otherwise referenced. According to the 1989 CPS, overall contraceptive prevalence was estimated to be approximately 55 %. Table 1 indicates recent trends in overall contraceptive use, as well shifts in method mix that have occurred over the last fifteen years in Jamaica.

Table 1
Use of Contraception - 1989 CPS

METHOD	Total 1975-76	Total 1983	Total 1989
Pill	11.9	19.3	19.5
Female Sterilization	8.1	10.9	13.6
Condom	6.6	7.6	8.6
Injection	6.2	7.6	7.6
IUD/Vaginais	3.5	3.0	1.6
Withdrawal	1.4	1.9	2.4
Rhythm	0.3	1.1	1.0
Other	0.0	0.0	0.3
Not Using	62.0	48.6	45.4
TOTAL PREVALENCE	38.0	51.4	54.6

Contraceptive prevalence increased substantially from 38% in 1975-76 to 51.4% in 1983; however, the increase from 1983-89 was less dramatic, with CP moving from 51.4% to 54.6%. This slowing down in prevalence growth is expected, as reaching new acceptors becomes increasingly difficult. It also means, however, that the FP program must prepare to face the challenges of both maintaining current high levels of prevalence and accessing a harder-to-reach target market. Examination of current patterns of contraceptive use as well as non-contraceptive use reveal certain challenges that the NFPB must address in order to continue the fertility decline in Jamaica and to reach the GOJ goal of 62% contraceptive prevalence by the year 2000.

Recent trends also indicate a limited shift in the method mix of the program. There was a slight increase in the use of female sterilization and the pill from 1983 to 1989. Generally, as CP increases and people become more accepting of FP, the use of longer-term and permanent methods increases, which is integral to achieving sustainability. This shift, however, has not occurred in Jamaica. Consequently, the NFPB must take efforts to shift users to longer-term methods, which will increase client satisfaction and program cost-effectiveness.

Currently, FP services are provided overwhelmingly by the public sector. Table 2 indicates the sources of FP services for both clinical and supply methods.

Table 2
Source of Contraceptive Supplies - 1989 CPS

METHOD	PUBLIC	PRIVATE	UNKNOWN	TOTAL
Pill	64.2 %	34.5 %	1.3 %	100 %
Injection	92.2 %	7 %	0.8 %	100 %
IUD	54.2 %	42 %	3.8 %	100 %
Condom	41.3 %	54.9 %	3.8 %	100 %
VSC	88.2 %	11.4 %	0.4 %	100 %

Non-users of FP fall into two categories: those who have never used contraception and those who have used a method and have discontinued for some reason. Reaching these two types of non-users requires very different strategies.

The largest group of non-users who have never used a method are women in the 15-19 year age group. Survey data indicate that this group is very much at risk of becoming pregnant. Of the women aged 15-19, 53% stated that they have had sexual intercourse. The highest percentage of women who have had a child (18.8%) reported having had that child between the ages of 15 and 17, and 14.6% of the women aged 15-19 stated that they are currently pregnant. These indicators of risk of pregnancy for 15-19 year old females contrast sharply with the fact that the median age at first use of contraception is 19. In addition, levels of knowledge regarding the specific methods of FP are lower for the 15-19 year age group. This is an important market segment that must be informed of the importance of FP and encouraged to accept a FP method.

Thirty percent of women in union had used contraception but are not currently using a method. The majority of these women, 54.8%, were using the pill and 21.2% were using injection. Of the former pill users, 31.6% cited health problems as their reason for discontinuing and 24.2% cited bad side effects. Of the former users of injection, 43% cited health problems as their reason for discontinuing and 27.5% cited bad side effects. Of the former IUD users, 24.9% cited health problems as their reason for discontinuing and 32.2% cited bad side effects. Anecdotal evidence indicates that pill users may have difficulty obtaining the same formulas of pills and consequently suffer from side effects resulting from the use of different dosages. Women who should be using FP are dropping out because they have difficulty accessing the method they need or are not receiving counseling that enables them to deal with the side effects they may be experiencing.

B. Service Delivery Structure

The structure of the present FP service delivery system is articulated quite succinctly in a report written in January 1991 on privatization and cost recovery options for the Jamaica Family Planning Program.⁵ Extracting directly from and expanding on this analysis, this section provides a brief overview of the Jamaica Family Planning Program system. Also, additional details on specific activities can be found in the NFPB's and other service provider's annual reports. The purpose of

⁵Smith, Janet M. and Ravenholt, Betty B., Privatization and Cost Recovery Options for the Jamaica Family Planning Program: A Background Analysis, January 1991.

writing this section is to take a "snapshot" of the present system, highlighting the most relevant activities and inefficiencies.

The present service delivery system is comprised of several service delivery channels, which together deliver all FP services in Jamaica. To varying degrees, seven types of service facilities participate in the system, including the MOH, NFPB, CDC, JFPA, employers, private physicians, and commercial pharmacies. For this analysis, the FP program is defined as having six elements: 1) commodities and logistics; 2) information, education, and communication (IEC); 3) service delivery; 4) counseling; 5) advocacy; and 6) monitoring and coordination. Also, the FP delivery system serves a variety of consumers, which for this analysis are categorized into three groups: 1) safety net consumers (lowest three deciles); 2) social marketing consumers (fourth through seventh deciles); and 3) "commercial" consumers (top three deciles).

Table 3 summarizes the structure of the present system by program element and the different consumer groups receiving services from the various service channels.

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

	Commodities/ Logistics	Service Delivery	IEC/ Awareness	Counseling	Advocacy	Monitoring/ Coordination
MOH	1,2	1,2	1,2	1,2		1,2
NFPB	1,2	1,2	1,2	1,2		1,2
CDC	1,2					
JFPA	1,2	1,2	1,2	1,2		1,2
Employers	2,3	2,3	2	2		
Priv. MDs		2,3		2,3		
Comm. Pharm.	3					

Key to consumer groups:

- 1) Safety Net - lowest 3 consumption deciles
- 2) CDC (social marketing) - 4 to 7 consumption deciles
- 3) Commercial Consumer - 8 to 10 consumption deciles

Commodities and Logistics - Almost all of the contraceptive commodity supply is currently provided by USAID/Kingston, with the exceptions of a small amount of pills (Ovral) that the MOH procures independently from USAID/Kingston and Depo-provera, which is primarily supplied by UNFPA. Public sector commodity distribution and logistics is handled by the NFPB. The NFPB currently receives commodities from the donors and distributes them directly to public health facilities and to Grace Kennedy Distributors for the social marketing program. Also, the JFPA procures its commodities through IPPF and manages its own distribution. There is much room for improvement in public sector commodity distribution and logistics management, which is identified as problematic, characterized by poor accountability and re-occurring stock-outs. Technical assistance is available to improve this situation through the project grant agreement between the GOJ and USAID/Kingston. Requisite to improving the system is the hiring and/or assignment of a qualified full-time staff person, with proper authority and responsibility for commodity procurement and

logistics management. **As the GOJ has agreed to finance contraceptive commodities for public sector needs on an increasing proportional basis over the next five years, strengthening commodity management is a matter of extreme urgency.**

Service Delivery - Service delivery here is defined as either dispensing/distributing contraceptives or method application, which includes IUD insertions, depo-provera injections, and surgical contraception procedures. FP services are provided through seven channels, including the: 373 MOH health centers; 3 NFPB clinics; 2 JFPA clinics and employment-based outreach; private physicians, both general practitioners and obstetricians-gynecologists; employers; and commercial pharmacies. According to the 1989 CPS, the MOH provides approximately 80% of all services. The NFPB clinics serve an estimated 2000 users; however, the costs associated with serving these users is extremely high, resulting in an inefficient use of resources.⁶ The JFPA clinics and employment-based outreach serve a small number of contraceptive users.⁷ The organization is, however, stifled by understaffing. The social marketing program, Commercial Distribution of Contraceptives (CDC) is responsible for an estimated 58,300 pill and condom users and shows promise for future expansion.⁸ Historically, private medical providers have played a passive and minor role in service delivery. However, tapping into the private medical community is an important avenue for program expansion.

IEC/Awareness - For the most part, the NFPB has taken responsibility for IEC activities through its Communications Unit, with financial support from the World Bank. NFPB's efforts have been hampered by difficulties in accessing funds from the World Bank project, which is a combination of matching grant and loan assistance. Support for IEC from the World Bank is currently under review. IEC activities are focused on providing educational materials for the mass audience and, to some extent, special target groups. With the exception of a small-scale maintenance campaign, which used previously developed advertising messages, no mass media activity has taken place in the last few years, and no method-specific IEC messages have ever been advertised. Also, recently a newsletter series was launched. Aside from the NFPB's IEC activities, little else has occurred. Linkages with the Ministry of Education and other groups that are likely to support IEC are weak.

Counseling - These services are provided on a very limited basis by already over-stretched MOH health personnel, plus 15 NFPB liaison officers, who travel within their respective territories offering FP counseling at public sector facilities. NFPB-provided counseling at public sector sites, however, only amounts to part-time counseling at any given service delivery point. The NFPB also sponsors the "Marge Roper" call-in and walk-in advice program, which has been successful. The JFPA also offers counseling as a routine part of their service delivery, but personnel shortages constrain such activity.

Advocacy - The role of advocacy in promoting FP in terms of garnering policy-maker support has been virtually ignored over the last five years. The NFPB has suffered from GOJ funding cuts and

⁶National Family Planning Board Draft Annual Report for Year Ending 31st March 1991.

⁷Jamaica Family Planning Association Service Delivery Statistics for 1991.

⁸SOMARC II Project, Commodity Management Information System, Reported Sales in Jamaica for 1991.

high attrition of specialist personnel, all of which have resulted in the deterioration of perceived leadership and organizational morale. Day-to-day operations seem to have overshadowed the undertaking of an advocacy role. The PIOJ also addresses advocacy for population; however, the PIOJ treats population in a broad economic development context into which fertility regulation, simply, is included. The situation calls for aggressive actions to increase advocacy measures which are critical for GOJ support.

Monitoring and Coordination - Monitoring and coordination, and responsibilities for FP implementation are assumed by both the MOH and the NFPB, with some assistance from the Statistical Institute; however, there is plenty of room for improvement. The MOH routinely collects service delivery statistics at its facilities, as does the NFPB and JFPA; however, private sector activity is not routinely monitored, and no comprehensive management information system is in place. Data are collected, but are not necessarily driven by policy-making needs or used for program planning and evaluation.

V. FAMILY PLANNING MARKET

A. Future Contraceptive Market

Using the TARGET Model, OPTIONS II conducted analyses of the Jamaica FP program and projected illustrative future resource requirements, based on various assumptions concerning the new program directions. It must be noted carefully that for the purposes of this study the authors conducted an illustrative TARGET setting exercise, which is intended to provide an order of magnitude of required effort. When the NFPB reaches a point of developing action oriented implementation plan, a refinement of the analysis will be required.

As a bit of background, the TARGET Model was developed in 1986 by The Population Council and The Futures Group (J. Bongaarts and J. Stover). The model determines FP requirements to meet specific fertility goals and estimates, by method and service delivery source, the number of contraceptive users, new acceptors, and commodities required to achieve a desired total fertility rate, given estimates of changes in the other proximate determinants of fertility.⁹

Based on John Bongaarts' proximate determinants of fertility framework, TARGET incorporates the following factors into projections of users, acceptors, and commodity requirements for the FP program: 1) the natural increase of the population; 2) assumptions regarding future method mix; and 3) estimates of the future involvement of the private sector in service provision. The assumptions were based upon analysis of the 1989 CPS and estimates of the potential market for FP, which the private sector can serve. The complete results of the analysis are provided in Appendix 3.

The total market for FP services in Jamaica is quite large and growing. Of the 615,200 women of reproductive age in Jamaica, 86.2% have been or are currently sexually active and 67.8% are currently in a consensual union (as defined by the 1989 CPS). Of the women of reproductive age currently in union, over 88% indicated that they do not want to become pregnant. Only one-half of these women, however, are currently using contraception. In addition, of those currently pregnant, over 51% felt that the pregnancy was mistimed and another 18% indicated that the pregnancy was unwanted. Clearly, in addition to the women who are currently using FP, there remains a large potential market for FP services.

The future market for FP in Jamaica requires meeting the needs of four important target market segments:

- 1) Current users;
- 2) People who are not currently using;
- 3) Users who are not using the most efficient and appropriate methods for their needs; and
- 4) People who are obtaining their services from the public sector but should be using the private sector.

⁹Stover, J. et al, Target-Cost, A Model for Projecting Family Planning Service Requirements and Costs to Achieve Demographic Goals, The Futures Group, 1991.

Four assumptions were used in the Target analysis (Table 4):

- 1) Population projections published by STATIN;
- 2) Replacement level total fertility rate by year 2001;
- 3) Shifts in method mix moving users of supply methods to long-term and permanent methods; and
- 4) Shifts in method source moving users from public sector services to private sector services.

Table 4
Assumptions Used in the Target Model Analysis
Method and Source Mix

METHOD	1989 %	2001 %	PUBLIC/PRIVATE 1989	PUBLIC/PRIVATE 2001
Pill	36	28	65.5/34.5	50/50
IUD	3	5	58/42	50/50
Female Ster.	25	30	89/11	75/25
Male Ster.	0	3	20/80	30/70
Injectable	14	15	93/7	60/40
Other	7	2	60/40	45/55
Condom	15	9	45.1/54.9	30/70
Norplant	0	8	20/80	20/80

Note: Although Norplant is not currently available in either the public or private sector, an estimate of source mix for 1989 was included for purposes of the model.

The rationale for shifting the method mix from such a heavy reliance on supply methods to greater use of long-term and permanent methods is based on the fact that women of higher parity continue to use supply methods despite the fact that they are seeking to limit their births rather than space them, as evidenced in the 1988 CPS. The 1989 CPS shows that of women with three children, 18% are using the pill; of women with four children 18.1% are using the pill and 39.6% are not using any method; of women with 5 children 36.5% are not using a method. In addition, of women who desire no more children, 17% are using the pill and 5.7% are using the condom. These women should be counseled to use long-term or permanent methods. This increases both the satisfaction of the FP user method-effectiveness and the cost-effectiveness of the FP program.

Assumptions regarding the shift from public sector to private sector sources of FP methods are based on estimates of the size of the market the private sector can serve in the next several years as well as information regarding the willingness and ability of clients to pay for services. Of current users of public sector health services, 40% also use private sector sources for their health needs. This group is willing and able to pay for services which they perceive to be beneficial to them.

Research also reveals that 59.1% of users of public sector FP services earn over J\$15,000.¹⁰ These FP clients are able to pay for their services. In addition, many of these clients indicated that they would be willing to pay for FP services. Consequently, if regulatory obstacles are eliminated so that the private sector is able to introduce FP services at reasonable prices, the public sector users who have a higher disposable income will switch to the private sector sources to obtain what they perceive to be higher quality care.

The illustrative TARGET Model analysis indicates the levels of resources required to provide FP services in the public sector given the above mentioned assumptions. This breakdown is provided in Table 5.

Table 5
Number of FP Users by Method and Source
Years 1989 and 2001

METHOD	PUBLIC SECTOR USERS - 1989	PUBLIC SECTOR USERS - 2001
Pill	54,100	49,600
IUD	4,000	8,100
Female Sterilization	51,000	72,500
Male Sterilization	0	2,900
Injectable	29,900	38,700
Other	9,600	2,900
Condom	15,500	8,700
Norplant	0	5,200

B. Future Program Needs

With the phased and eventual withdrawal of commodity supplies from USAID and possibly other donors, the national FP system will need to address the important questions regarding sources of supply, cost, cost-recovery, method mix, demand forecasting and logistics management for future program development and sustainability.

Having reviewed the current FP situation as well as looked to the future in terms of estimating demand for contraception and the phasing-out of donor support, this section highlights the major program needs and issues for continued future success.

1) **National Support and Advocacy** - The impact and sheer necessity of an effective and sustained national FP program is unquestioned. The continuation of the FP program at the requisite level of impact will necessitate a meaningful and tangible level of national consensus and support that can only be generated through advocacy and promotion for support of FP. The NFPB

¹⁰Hope Enterprises Ltd., Final Report on Public Sector User Survey for Women 15 - 49 Years, Jamaica, November 1991.

is the organization uniquely qualified to play this role. The demands of the advocacy role, however, will require a single mindedness of purpose and a reorientation of the Board's energies and resources to advocate for support of FP among all sectors of the community, which would include:

- * Political support to demonstrate the understanding by decision-makers of the importance of the issues, and to influence the provision of the resources;
- * Commercial support to demonstrate that the private sector understands and appreciates the linkages between population and productivity, and supports interventions to address these linkages; and
- * Societal support to demonstrate that the community at large, especially the family, the church and the educational system rationally recognizes, accepts, and contributes to the continued development of the FP program.

2) Financial Support - More so than many other development interventions an investment in the management of population growth, through an effective FP program, pays dividends far greater than the sum of the expenditures outlayed. This reality has been demonstrated at the macro-level as it pertains to national development, and at the micro-level as it impacts on individual aspirations and family life styles. The impact of FP will not be realized, however, without meaningful and sustained financial support at all levels - at the budgetary level through the GOJ, at the personal level through a commitment to investing (not spending) on FP, and at the commercial level through private sector participation in FP service delivery.

3) Program Development and Demand Generation - The future program needs to evolve through a process of transition to meet the changing needs of the situation, which includes four key actions:

- * Modify the implementation process to identify and recruit new partners, and to direct and monitor the intervention of all the partners toward the cohesive achievement of desired goals;
- * Improve the management process to re-tool and refine the skills and expertise within the NFPB to play the leadership role and to increase the efficiency of the FP system;
- * Revise strategies and interventions to be more responsive to the needs of the clients - inclusive of new methods (ie. Norplant); increased use of other long-term and permanent methods; new methodologies to access hard-to-reach clients; and creative initiatives to sustain current participation; and,
- * Generate demand for and motivate usage of the FP services. Constant and persuasive influence must be brought to bear on the potential clients. The assumption that an awareness of FP necessarily translates to active acceptance is inaccurate. Efforts need to be directed toward moving persons from a passive acceptance of FP to a proactive participation.

4) Service Delivery Expansion and Sustainability - The present FP system has successfully delivered services, resulting in more than one-half of all women at risk (child bearing age) investing in FP. There remains the important responsibility of sustaining the delivery of FP services to users currently in the system, inclusive of shifting some of these users to more appropriate and cost-effective methods, as well as creating services that will attract new users in order to achieve the target replacement level fertility.

The future program needs to support existing interventions and develop new initiatives to procure commodities and expand activities, all within an environment of reduced donor support. Unfortunately, no panacea for sustainability exists. No single intervention alone can meet all the service delivery needs.

C. Future Service Delivery Structure

There are different service delivery system configurations that can be considered to strengthen and expand the FP program; however, in the context of achieving sustainability one factor is certain: the future FP program will require an expanded team of players if the mandate is to be realized.

At the hub of this expanded team is the NFPB, which will provide critical leadership, direction, coordination, monitoring, and, above all, advocacy. In this role, the NFPB becomes the think tank for the MOH and the catalyst that sparks the progression of ideas and initiatives for the system. Also, the MOH will continue to play a valuable, irreplaceable role within the new system to: 1) establish service delivery protocols and regulatory policy, particularly as it affects program implementation; 2) facilitate the service delivery process by providing the necessary financial resources; and 3) provide FP services through the public health system to the "safety net" (indigent) population.

The private sector is expected to play a greater role in the delivery of services, particularly for the segment of the community that can be weaned away from the public sector and those with a greater ability to contribute wholly or in part to the cost of FP services. In this regard, the commercial sector, health insurance sector, private physicians and employers, to name a few, would have important roles as team players in the FP system.

In view of the required expanded team of players, the future service delivery system needs to be thought of rationally in terms of how best it can be configured to serve current and potential contraceptive users. As is discussed in a previous section herein, consumers can be categorized into three groups: 1) safety net consumers, consumers in the lowest three deciles; 2) social marketing consumers, consumers in the fourth through seventh deciles; and 3) "commercial" consumers, high end consumers in the top three deciles. Table 6 shows the proposed system by program element and delivery channel according to consumer group.

Table 6
Family Planning Consumer Groups
by Program Elements and Delivery Channels - Proposed System

	Safety Net Consumers	Social Market Consumers	Commercial Consumers
Commodities and Logistics	MOH	Comm. Pharm., NGOs, Employers	Comm. Pharm., Private MDs, Employers, NGOs
Service Delivery	MOH	NGOs, Employers	NGOs, Employers
IEC/Awareness	MOH, NFPB	NFPB, NGOs, Employers, Comm. Pharm.	NFPB, Employers, Private MDs, Comm. Pharm.,
Counseling	MOH	NGOs, Employers, Commer. Pharm.	NGOs, Employers, Comm. Pharm.
Advocacy	NFPB	NFPB	NFPB
Monitoring and Coordination	MOH, NFPB	NFPB, NGOs, Comm. Pharm.	NFPB, NGOs, Private MDs, Comm. Pharm.

Key to consumer groups:

- 1) Safety Net - lowest 3 consumption deciles
- 2) Social Marketing - 4 to 7 consumption deciles
- 3) Commercial Consumer - 8 to 10 consumption deciles

Ministry of Health - The MOH will retain full responsibility for the safety net population by continuing to provide contraceptive commodities, service delivery, IEC, and counseling, as well as working closely with the NFPB to monitor and coordinate activities. Regarding contraceptive commodity logistics, the current system of distribution vis-a-vis the NFPB is functional. However, in the proposed system, the MOH/GOJ will either have to assume the sourcing, procurement and logistics function or provide funding directly to the NFPB for commodity procurement, distribution and logistics management.

National Family Planning Board - The NFPB's activities cut across all consumer groups. However, in the proposed system, the NFPB will shift away from service delivery implementation. The NFPB will play the lead role in monitoring and coordination of the FP program at a macro-level and will generate advocacy support among policy-makers. To the extent that the World Bank Project still supports the NFPB's IEC/awareness activities, the Board is envisioned to continue its work in this area and to pursue cost-efficient ways to collaborate with the Ministry of Education and other groups.

Non-Governmental Organizations - The role for NGOs, such as Operation Friendship and the JFPA, is envisioned to expand. These groups should become more involved with serving the social marketing and commercial consumers through implementing all program elements, although advocacy is primarily the responsibility of the NFPB.

Commercial Pharmacies - These distribution outlets are strictly meant to serve the social marketing and commercial consumers through the sale of contraceptives and proper counseling in their use. Commercial pharmacies will also need to take a responsible role for tracking contraceptive sales and will have to cooperate with the NFPB in order to contribute to overall program monitoring and evaluation.

Employers - Employers can and already do, in some instances, provide some elements of FP. It is envisioned, however, that employers can play a greater role either in serving the social marketing and commercial consumers by providing commodities, services, IEC, and counseling directly through company-based clinics or through health insurance coverage, which would include FP. It is important to mention that private health insurance companies still need to be convinced to include FP as a part of their health schemes. As a potential avenue for financing FP, working with health insurance companies shows promise.

Private Physicians - Medical doctors are envisioned to provide full FP service for the social marketing and commercial consumers. Like the commercial pharmacies, the physicians will also need to take a responsible role for tracking contraceptive sales and will have to cooperate with the NFPB in order to contribute to overall program monitoring and evaluation.

D. Commodity Supply and Logistics

Under the new USAID/Kingston Family Planning Initiatives Project, NFPB will be provided commodities, logistics support, training, and technical assistance in the management of the public sector commodity supply system. In addition, commodities for the social marketing project will be provided to the private sector marketing organization for two years, after which time the private sector will assume the costs of commodity supplies.¹¹

Total projected commodity requirements referred to in Table 7 were constructed using the TARGET Model, which as mentioned earlier, is predicated on meeting the national goal of replacement level fertility. The proposed strategy for method mix, which was jointly determined by the NFPB and the authors of this report, has three main objectives:

- 1) emphasize more long-term, cost-effective methods;
- 2) control the rate of growth of the pill and reduce the use of condoms and spermicides for contraception; and
- 3) promote increased use of tubal ligation for women who have completed their families, and introduce male vasectomy.

¹¹USAID/Kingston, Project Grant Agreement Between the Government of Jamaica and the United States of America for the Family Planning Initiatives Project (Project No. 532-0163).

Table 7
Commodity Volume
Total Projected Requirements 1992-98
(US\$000s)

YEAR	PILL	CONDOM	IUD	INJECT.	NORPLANT	SPERM.
1992	1119.8	3420.3	2.2	144.4	2.7	438.0
1993	1131.4	3394.3	2.3	149.7	3.1	417.0
1994	1141.5	3360.0	2.5	155.0	3.5	396.0
1995	1150.3	3318.3	2.6	160.4	3.9	372.0
1996	1157.8	3268.8	2.8	165.8	4.4	348.0
1997	1163.7	3211.0	2.9	171.3	4.9	321.0
1998	1168.2	3145.2	3.1	176.7	5.4	291.0

- Notes: 1) These volumes refer to minimum requirements to achieve prevalence targets for each method and does not make any allowances for spoilage, wastage, or unanticipated increases in method use.
- 2) Projections for spermicides are based on the assumption that approximately three in ten users of all "other" methods (3.9% of CP) will use the foaming tablet.
- 3) Projections for IUDs and Norplant are based on the number of new acceptors per year.

A. Public Sector Supply System

There were approximately 193,000 FP clients served through the public sector in 1990, with 72% of these clients accessing contraceptive methods in clinics and hospitals. The other 28% were served through the social marketing program. Under the proposed structure contraceptive commodities available through the public sector are primarily meant to serve the "safety net" and/or economically indigent, who, based on the STATIN definition would represent clients in the lowest three consumption deciles. A survey of current users of public sector health facilities indicates that approximately 60% of these clients would not be able to or would find it difficult to contribute to the cost (through user fees) of health services. The remaining 40% of the current public sector clients can afford to purchase contraceptives and, in fact, are paying for other health costs through private physicians.¹² The intended strategy is to wean the users who can afford to pay away from the public sector and into the private sector network.

Projections for commodity needs for the public sector referred to in Table 8 are also predicated on influencing the method mix, so that the emphasis on supply methods is replaced by an increase in use of long-term methods, particularly sterilization. In so doing, the start-up costs for transferring the technology (ie: mini-lap training, Norplant implants, IUD insertions) to the public sector would be covered under technical assistance through the Family Planning Initiatives Project, and the benefits would be realized thereafter. In short, by increasing the emphasis on more effective methods, the costs of re-supply methods are reduced, and the reduction in fertility accelerated.

¹²Hope Enterprises Ltd., Final Report on Public Sector User Survey for Women 15 - 49 Years, Jamaica, November 1991.

Finally, it is also assumed that contraceptive commodity costs in the public sector, which to date have been funded primarily by USAID/Kingston, will become and always remain a GOJ responsibility in the same way as the provision of basic drugs. To the extent that user fee systems are ever applied to primary care facilities, then one would expect that some cost-recovery should be instituted for contraceptives. Without this system, a charge should never be made for contraceptives alone. Given that foreign exchange will always be required for commodity purchases, improved efficiencies in commodity management becomes mandatory. A method mix that emphasizes long-term and permanent methods will lead to a reduced fertility rate and a more cost-effective program.

Under the new system, responsibility for contraceptive commodity forecasting, procurement, distribution and logistics management for the public sector could be either assumed by the MOH or retained by the NFPB. It should be noted, however, that the entire commodity management process requires a full-time, dedicated level of effort and a well developed, reliable infrastructure. Regarding private sector commodity needs, transferring the social marketing program to the private sector, which is called for in the FPIP bilateral, will reduce the projected public sector commodity costs by almost one-third.

To reiterate, under the FPIP, the GOJ has agreed to assume the costs of contraceptives that are currently provided by USAID/Kingston for distribution in the public sector, at a cumulative rate of 20% per annum, commencing in 1993. Table 8 indicates the projected replacement costs for commodities (at today's costs) that need to be assumed by the GOJ in order to serve the indigent, safety net population. In 1993, when the GOJ assumes the responsibility for providing 20% of the commodity needs for the public sector, the cost is projected at US\$76.2 thousand. In 1996, the cost for providing 80% of the commodities is estimated to be US\$293 thousand; and by 1997, when the Government assumes full financial responsibility for commodities the cost is projected at US\$360.6 thousand.

Table 8
Estimated Commodity Projections
Public Sector 1992-98
(US\$000s)

YEAR	PILL	CONDOM	IUD	INJECT.	NORPLANT	SPERM.
1992	690.1	1413.4	1.2	122.4	0.5	246.0
1993	682.6	1360.0	1.2	122.8	0.6	231.0
1994	674.0	1304.0	1.3	122.8	0.7	213.0
1995	664.3	1246.0	1.3	122.7	0.8	195.0
1996	653.7	1186.3	1.4	122.3	0.9	177.0
1997	642.0	1124.9	1.5	121.6	1.0	162.0
1998	629.4	1062.3	1.5	120.6	1.1	141.0

Table 9
Estimated Commodity Costs - Public Sector
CIF/Jamaica US\$

Contraceptive @ Us\$ Prices	1993	1994	1995	1996	1997	1998
Pills @.180	19,660	38,820	57,310	75,310	92,450	90,630
@.246	6,720	13,270	19,610	25,730	31,590	30,970
Condoms @.0642	17,470	33,490	48,000	60,930	72,220	68,200
IUDs @ 1.158	280	605	905	1,300	1,740	1,740
Inject. @ .96	23,580	47,155	70,675	93,930	116,740	115,780
Norplant @ 27.74	3,330	7,770	13,315	19,975	27,740	30,515
Foaming Tab. @ .1122	5,185	9,560	13,130	15,890	18,180	15,820
TOTAL COSTS	@20% 76,225	@40% 150,670	@60% 222,945	@80% 293,065	@100% 360,660	@100% 353,655

Notes: All amounts rounded up.

CIF - Cost, Insurance and Freight.

1) Low dose pill @.18(cents).

2) Mini pill @ .246(cents).

There are three reasonable alternatives to be considered in establishing a system of contraceptive supply for the public sector.

Alternative 1: IPPF International

IPPF, through its purchasing company in London called FHMS, acts as a contraceptives broker, with a central buying function that allows the organization to purchase contraceptives on behalf of participating associations and organizations at very competitive prices. The NFPB or GOJ could contract with IPPF to supply all public sector needs for injectables, pills, condoms, IUDs, and spermicides. The advantage of this alternative is that IPPF has the expertise to locate and negotiate the best possible deals, an expertise that the NFPB or GOJ would therefore need not duplicate. Moreover, the NFPB or GOJ would only need to communicate with IPPF and not with the many different suppliers of contraceptives, and would also benefit in reduced shipping costs by consolidating product orders through a single source.

Alternative 2: Direct Orders from Manufacturers

The NFPB or GOJ could, as an alternative, determine through their own initiative the best possible source and price direct from various manufacturers. By dealing with manufacturers, NFPB or GOJ

would possibly have the advantage of being able to negotiate a price net of an importers margin. For example, the Latin America Division of Schering is prepared to offer a special price for oral contraceptives, based on a regional volume as opposed to a smaller market volume. This arrangement would be directly with Schering and not through their local agent. NFPB or GOJ would, however, have to accept the responsibility for all shipping arrangements and provide hard currency to pay for the supplies. The main advantages to this alternative are greater control over the system and good prices. The disadvantage is that the NFPB or GOJ would have all the responsibility for sourcing and supply and obtaining foreign exchange.

Alternative 3: Orders through Manufacturers' Agents

In this instance, instead of dealing directly with manufacturers, the NFPB or GOJ could place orders with the local or regional representative of the manufacturer. This process is currently being practiced with orders of Ovral oral contraceptives as well as medical supplies for the clinics. The advantage is that NFPB or GOJ would deal with a representative who supplies a product in-country without any of the responsibilities of locating a source and arranging for importation. There could also be savings to the NFPB or GOJ in warehouse and handling fees, since the NFPB or GOJ would draw on supplies when required without necessarily having to maintain a central warehouse. Moreover, payments to local agents are made in local currency, thereby negating the foreign currency constraint. The disadvantage is primarily cost. Ordering through manufactures' agents is likely to be the most costly method of sourcing supplies since costs will include the representative's margin, plus the conversion cost of the foreign exchange (marked-up) and a possible agent's service fee.

Table 10 illustrates the differences between the three sources measured on the important variables of price, logistics (including sourcing, shipping, and warehousing), and financing.

Table 10
Public Sector Supply Source Alternatives

	IPPF	MANUFACTURE	AGENT
Price (ie. pills/FOB)	.20c - .25c	.30c - .40c	.50c
Logistics	Full Service	Partial	Full Service
Finance	Forex	Forex	Local

* Price is in US cents. FOB means freight on board.

As indicated, IPPF offers the best price and provides a full service to the NFPB inclusive of multiple product sourcing, consolidated shipping, and insurance in transit. The NFPB or GOJ would be required to warehouse the product locally. Sourcing from the manufacturer would result in higher price than IPPF but a better price than the manufacturer's local agent. Additionally, the manufacturer would handle logistics only for their product.

B. Private Sector

The private sector market is defined as all other segments of the market that are served outside of the public sector. These would include current and potential clients who access contraceptives

through social marketing, NGOs and PVOs involved with FP service delivery, health insurance companies, private physicians, private clinics, and clients paying commercial prices through retail outlets.

The report, "Privatization and Cost Recovery Options for the Jamaica Family Planning Program: A Background Analysis", stated "where the overall national policy is toward increased privatization of services and where there is no price or quality benefit to users for service provision through the public sector, it appears imperative to allow the private/commercial sector to replace public sector activities." This and other reports clearly point the way to having a greater private sector participation in FP.

As stated earlier, one major objective of the new FP system is to transfer some of the burden of service delivery from the public to the private sector. In 1989, approximately 28% of all contraceptive users were served through the private sector. The objective is to increase private sector service delivery to 42% by the year 1998, the last year of scheduled funding from USAID/Kingston. The major strategies for increasing private sector participation include:

- * Improve and increase the private sector's ability to deliver FP services, particularly through retraining, providing access to methods, and address those legal and regulatory issues that would impact negatively on a potential contribution from the private sector;
- * Emphasize the delivery of long-term and permanent methods and associated counseling through private physicians and other private services;
- * Significantly increase the proportion of supply methods provided through the private sector; and
- * Expand the social marketing activity entirely through the private sector, by extending distribution and offering a wider choice of contraceptive products and brands.

Historically, FP training opportunities were provided mostly to public sector service providers, physicians, midwives, and nurses, and relatively little to private sector counterparts. In order to expand the involvement of the private sector, they will also need to be retrained, and future training opportunities particularly for sterilization, implants and intra-uterine devices will be offered through the FPIP.

Additionally, physicians and private clinics will also need access to contraceptive methods at prices that, with the added value of professional services, would be affordable to potential consumers. The strategy would be to supply physicians and clinics through the social marketing program, thereby assuring continuity of supply and sustainability of the service.

The major recurrent cost in the provision of FP, other than salaries, is the cost of consumable contraceptives, particularly: pills, condoms, injectables, and spermicides. As Table 11 illustrates, the new overall strategy for FP will be to transfer significant proportions of the delivery of each method from the public sector to the private sector. For example, the total estimated cost in 1992 to provide the injectable through all sources would be approximately J\$2.8 million, of which the private sector portion would be J\$440 thousand (7%). In 1998, using current prices, injectables would be projected to cost J\$3.5 million, of which the private sector is expected to account for J\$1.1

million (32%). The rate at which the private sector can expand should be viewed conservatively, given the lead time necessary to stimulate interest, build consensus and set-up programs.

Table 11
Family Planning Methods By Source

	1989 PUBLIC %	1989 PRIVATE %	1998 PUBLIC %	1998 PRIVATE %
Pill	65	35	54	46
IUD	58	42	52	48
Fem. Ster.	89	11	79	21
Male Ster.	--	--	27	73
Injectable	93	7	68	32
Condom	45	55	34	66
Norplant	--	--	20	80
Spermicide	60	40	48	52
All Methods	72	28	58	42

Table 12
Commodity Projections
Private Sector 1992-98
(US\$000s)

YEAR	PILL	CONDOM	IUD	INJECT.	NORPLANT	SPERM.
1992	429.7	2006.9	1.0	22.0	2.1	192.0
1993	448.8	2034.3	1.1	26.9	2.5	189.0
1994	467.5	2056.1	1.2	32.2	2.8	183.0
1995	486.0	2072.3	1.3	37.7	3.2	177.0
1996	504.1	2082.5	1.4	43.5	3.5	171.1
1997	521.7	2086.1	1.5	49.7	3.9	162.0
1998	538.8	2082.9	1.6	56.1	4.3	150.0

The purpose of contraceptive social marketing programs (CSM) as intended by USAID, is the provision of contraceptives at a price affordable to lower income groups through existing commercial distribution systems. In doing so, an important segment of the market has consistent and convenient access to products at affordable prices at a very economical cost per user. It is not

the intention that social marketing programs serve the indigent, but rather, as in the case of Jamaica, consumers in the fourth to seventh consumption deciles, as defined by the STATIN.¹³

The issue facing the NFPB now is how best to manage the social marketing program in light of the new strategic direction in FP service delivery, the need to assure growth and sustainability, and the changing role of USAID/Kingston in support of the social marketing activity. The report on privatization and cost recovery options (Smith and Ravenholt, 1991), which was previously referenced, and a separate detailed memo on the subject, discuss at length the pros and cons of the NFPB retaining management of the social marketing activity.¹⁴ An objective analysis of the management of the social marketing program under the NFPB, indicates that as currently structured the program will not be sustainable as it is configured today, primarily because the cost of delivering the service far outstrips the costs recovered. For example, during fiscal 90/91, the total cost to the NFPB for managing the social marketing program was almost one million dollars (J\$975.6 thousand) excluding commodities, which alone are valued at US\$240 thousand, advertising and promotion, and overhead (office space, utilities etc.). The revenue generated by the social marketing program was approximately J\$412.1 thousand or 42% of the lowest possible cost for managing the program.¹⁵

Historically, the prices of the products have been kept very low to be sure of its affordability to the target consumer. Sustainability has not been an objective before now. And though the prices of the products must be in time raised to the level where they at least cover the commodity costs, this alone will not achieve program sustainability. In a private sector marketing organization, marketing costs - staff, transportation, promotion, management, distribution, etc. are amortised over multiple products. By adding contraceptive products to this existing system, there would be very little additional or marginal cost (other than those directly related to the product) to deliver the product to the consumer. Consequently, the private sector would be able to deliver contraceptives to a greater number of acceptors at a lower cost, resulting in cost efficiency and sufficient profitability to justify continued investment. The NFPB will not be able to amortise the cost of the social marketing system to a level where it could be as efficient and profitable as the private sector.

In addition to the skills and infrastructure that the private sector brings to the social marketing program, the marketing support from USAID/Kingston will only be available if the social marketing program is managed by the private sector.¹⁶ These additional resources, estimated at US\$900 thousand, will be used to expand the social marketing initiative, which will require the introduction and marketing of new contraceptive products, additional oral contraceptive formulations and new brand names. By expanding the product line through segmenting the market, more clients will be served. The resources available for social marketing in the commercial sector will be vital, not only

¹³Economic and Social Survey Jamaica 1990, Statistical Institute of Jamaica.

¹⁴Ravenholt, B., Memorandum on Points to Consider in Making Decisions Concerning Management of the Social Marketing Program, 21 March 1991.

¹⁵National Family Planning Board Financial Statements for Year ended March 31, 1991.

¹⁶USAID/Kingston, "Project Grant Agreement Between the Government of Jamaica and the United States of America for the Family Planning Initiatives Project" (Project No. 532-0163).

to expand the initiative and motivate trial and usage of the social marketing brands, but will also reduce the dependency on the public sector for FP service delivery.

The recommendation therefore is for the NFPB to select the appropriate private sector marketing organization which will develop, expand, and sustain the social marketing activities for FP in response to the established objectives and strategies for FP service delivery through the private sector. As part of this study, preliminary discussions were held with Jamaica's leading pharmaceutical and consumer products distribution companies including: Schering and Wyeth; Lasco Distributors; Grace Kennedy Distributors; and Facey Commodity. All of these firms expressed a keen interest in the social marketing of contraceptives.

In order for the social marketing program to thrive, some critical policy and regulatory issues need to be addressed, such as:

- 1) Duties and taxes on contraceptives add to the cost of the product and may be counter productive to the Government's goal of reducing fertility. All such tariffs should be waived for contraceptive products, or at least on those contraceptives sold through the social marketing program.
- 2) Regulations governing the marketing of oral contraceptives should be liberalized to allow for consumer access to low dose pills without prescriptions, and the sale of pills outside of the traditional pharmacy outlets to include selected general stores.
- 3) Policies prohibiting the advertising and promotion of ethical contraceptives in the mass media should be rescinded to allow the use of this important communication vehicle to inform and motivate usage of contraceptives.

As will be discussed in the next section, the NFPB has a critical role to play to facilitate these and other policy and regulatory reforms.

VI. NFPB - THE NEW ROLES AND FUNCTIONS

A. The New Roles

1) Leadership

The NFPB is expected to assume an aggressive leadership position for the national FP system in much the same way as the Jamaica Tourist Board or the Jamaica Coconut Board assumes leadership for their respective sectors. Neither are implementing organizations, in that they do not own or manage hotels or farms. Both lead their sectors by:

- * Setting goals and standards;
- * Influencing and directing policy;
- * Monitoring implementation;
- * Evaluating impact; and
- * Lobbying on behalf of the interests of their constituents.

Like the NFPB, these organizations represent the Government's desire to systematize development. To execute the concept of leadership requires a leader, that is an organization with skills to create focus and attention, build consensus, garner resources and support, direct action, and generate results. The first priority of the NFPB then is to ensure the presence of leadership skills that the institution can execute its leadership role.

2) Management

The NFPB needs to develop an institution with the capabilities of managing change, managing innovation, managing the FP system. The NFPB needs to manage and ensure the efficient use of current resources, particularly in view of the changing nature and quantity of those resources, and, mobilize new and additional resources - human, physical, and fiscal. As a new function, the NFPB needs to manage commodities as an important aspect and asset of the FP system.

3) Resource Allocation

As indicated in Table 11, of the J\$9.5 million spent by the NFPB during fiscal 90/91 to operate the FP system, 58% was consumed by employee compensations compared to 29% by service delivery.¹⁷

¹⁷National Family Planning Board, Financial Statements for 1990-91.

Table 13
National Family Planning Board
* Operating Budget Fiscal Year 1991-92
(J\$000s)

Cost Centers	Salary	Travel	Service Delivery	Rent/ Mortgage	Utilities	Other	Total
Admin.	2,130	58	695	177	89	20	3,169
IEC	1,502	304	245	122	62	20	2,255
Service Delivery	1,407	29	1,016	71	27	26	2,235
CDC	237	---	713	26	---	---	976
Research/ Evaluation	384	17	40	38	23	---	501
Training	225	32	66	10	7	---	339
Total	5,425	440	2,774	443	208	86	9,476
% of Total	58%	5%	29%	5%	2%	1%	100%

* All figures are rounded to the nearest thousand.

Three major factors are likely to reshape the allocation of the Boards' resources. First, is the reduced allocation provided to the implementation of FP by the GOJ and the realization that the inflationary spiral has severely contracted the value of this subvention. A major responsibility of the NFPB in the future is to advocate for appropriate allocations to facilitate the implementation of the Board's mandate. This must be a very proactive stance, and the Administrative Unit with the assistance of the Policy and Advocacy Unit must assume the responsibility to ensure that the NFPB receives priority resources from the GOJ.

Second, the new orientation of the NFPB away from implementation to leadership and management of the FP system will require a review of current skills and a possible change in the staffing pattern. This, coupled with budgetary constraints, may necessitate a significant down sizing of the Board's staff, not only to stay within the constraints of available resources, but also to transfer greater resources to critical areas, such as: policy, advocacy, management information, and communications.

Third, the transfer of the social marketing activity to the private sector will reduce the Board's operating cost by approximately J\$900 thousand per year.

B. Functions of the Board

1) Policy Review and Advocacy Unit

The proposed Policy Review and Advocacy Unit will set the overall direction and guidelines for the FP program. This Unit will focus its attention on developing a research agenda for special policy studies and subprojects and undertaking advocacy activities to aggressively promote policy change. To carry out this role, the unit is envisaged to comprise two complementary functions.

Policy Review Function

The policy review function of the proposed unit will play a valuable role to assess the current policy environment; develop and implement strategies for policy reform; and monitor the changing environment. This is a critical function given the policy constraints to the expansion of FP that exist in Jamaica. These policies can be categorized into two types of constraints:

- * Legal and regulatory barriers to the distribution of contraceptives, such as: import duties; cumbersome administrative procedures for clearing commodities at port; and restrictive drug classifications of contraceptive commodities.
- * Medical barriers, such as prescription requirements that limit who is authorized to provide oral contraceptives, other than Perle.

Advocacy Function

The advocacy role of the NFPB will require dynamic leadership to develop and implement a strategy to improve the policy environment surrounding population activities. The NFPB will need to:

- * Develop new analytical tools to determine the extent to which a policy inhibits FP services;
- * Develop presentations which highlight the negative impact of these policies and the importance of removing them; and
- * Conduct seminars, speak at public engagements and political forums and lobby high-level Government and private sector policy-makers in order to promote policy change.

Target audiences for advocacy activities may include Parliamentarians, Medical Association of Jamaica, pharmaceutical regulatory bodies and key ministry policy-makers, just to name a few. The NFPB's lobbying will be geared to improving public relations and the perception of FP as a fundamental aspect of Jamaican social and economic development.

The Policy Review and Advocacy Unit will: 1) determine specialized information needs; 2) collaborate with the Management Information Unit and the Projects Coordination and Liaison Unit to implement activities to promote FP; 4) guide and assist other organizations to conduct research and subprojects; 5) conduct policy analyses, report writing and information dissemination; and 6) design and implement a strategy to build advocacy support among policy-makers.

2) Management Information Unit

The Management Information Unit will have four discrete functions. The first is the design of a simple information reporting system to be implemented by the Ministry of Health and other service providers in order to obtain timely information about service utilization. The actual data collection will be conducted by other organizations which have the capabilities and infrastructure to routinely collect information from throughout the island. This activity will be funded through subcontracts with the NFPB. The second function of the Management Information Unit will be to monitor the

service statistics and the achievement of quantitative goals in order to provide information and feedback for the planning activities of the Project Coordination Unit. The third is to serve as a clearinghouse for information and literature on family planning through the establishment of a computerized library system. The fourth function is to handle day-to-day internal NFPB information management in direct support to the Administrative Unit. Technical assistance for developing an internal management information system will be supported through the project grant agreement between the GOJ and USAID/Kingston. In sum, the Management Information Unit will be responsible for providing data and information which will be fundamental for the strategic planning activities of the NFPB.

3) Information, Education and Communications Unit

The IEC Unit will undertake a fundamental shift in strategy, from playing a major implementation role to directing the implementation of IEC activities. Moreover the large and varied responsibilities of the unit will be more focused on the process of creating behavior change, and motivating beneficiaries and service providers to adopting desired behaviors. Specific responsibilities of the IEC Unit are envisioned to include:

- 1) Develop the overall goals, objectives and strategies of FP IEC to meet the client targets, method mix, and prevalence levels established;
- 2) Develop the communication concepts necessary to influence behavior change among the various target groups;
- 3) Manage and coordinate the execution of IEC strategies through subcontract arrangements and collaboration with other organizations;
- 4) Develop the primary IEC materials to be used by all participating organizations, i.e., information on specific contraceptive methods, teaching aids, and health information for schools, inclusive of family life education, personal hygiene, and sexually transmitted diseases;
- 5) Coordinate the implementation of IEC activities with public and private organizations in order to ensure cohesiveness, and to eliminate repetition and wasted resources and efforts; and
- 6) Monitor the implementation of IEC activities, with special attention to the achievement of objectives and maintaining high standards of execution.

The IEC Unit will work closely with the Policy and Advocacy Units to develop objectives and strategies, with the MIS Unit to set targets and monitor and evaluate effectiveness, and with the Projects Coordination Unit in the implementation of activities. The Unit, under the World Bank project, is provided with resources to implement a national IEC program, and through the FPIP will have access to technical assistance to help in the development of all aspects of the IEC program.

4) Training Unit

As currently configured, the training portfolio falls within the IEC Unit of the Board. Given the importance of training, particularly in terms of the development of strategies, coordination with relevant training institutions and sector projects, identification of recipients, and the establishment of standards and protocols, it is recommended that the Board establish a separate department to manage the training portfolio. It should be emphasized, however, that with sustainability as a principle, the NFPB's training strategies should be developed to train trainers in order to empower organizations and partners to be able to meet the training needs for their respective FP activities.

The primary role of the Training Unit would be to:

- * Develop training standards for FP service delivery, inclusive of manuals for trainers, and training materials for service providers;
- * Identify training needs of the organizations requesting training and identify appropriate trainers, consultants, or local institutions which have the skills to provide necessary training;
- * Implement training of trainers for FP on an institution by institution basis which would facilitate the institution to conduct the training of its service providers;
- * Review and collaborate with training institutions for specialized training, ie: project management and financial accountability; statistics, research and evaluation, and IEC; and
- * Coordinate FP training with other government and non-government organizations in order to eliminate redundancy and improve training efficiencies.

5) Projects Coordination Unit

The Projects and Research Unit was established to meet the need to develop, appraise and manage FP projects carried out in collaboration with government and non-government organizations, as well as to generate data for program development and program evaluation. The future program will, however, require a new orientation of the unit, so that it assumes the primary role of soliciting, facilitating and coordinating FP interventions in other institutions - public and private.

This Unit is expected to follow up on the interest generated through the advocacy efforts of the Board, to sign on organizations interested in implementing FP activities, to assist those organizations in program development, to create partnerships in the sharing of resources to impact on FP, to monitor these organizations' efforts in order to confirm that they continue to serve in areas of greatest competence and to identify gaps in segments not served or services not provided.

In executing its duties the Projects Coordination Unit would liaise closely with all the other Units so that the full resources of the Board could be made available to organizations in their FP intervention.

6) The Administrative Unit

This unit is responsible for managing the efficient functioning of the Board, and its new role is not envisaged to differ greatly from its current function. The administrative process, however, is expected to become more cost-efficient in light of the constraint on resources and the need to sustain FP services without future donor funding. Greater attention will now need to be placed on the management of fiscal and personnel resources, as well as the management of subcontracts and subprojects. In this regard, the Administrative Unit is expected to involve department heads in the accountability process, so that each department adopts fiscal and technical responsibility.

The Administrative Unit will also have the responsibility for managing the commodity logistics system, inclusive of the ordering, importation, storage, inventory control, and distribution of contraceptive supplies for the public sector. The MIS unit is expected to generate forecasts of supplies on which the Administrative Unit would base its orders. Because of the importance of the logistics system, it is imperative that a staff person be assigned the responsibility for this activity. The Unit will have access to technical assistance resources, which will train staff and transfer technology and skills to the NFPB in logistics management.

VII. RECOMMENDATIONS AND NEXT STEPS

This report sets out to assist the NFPB to determine the most appropriate approaches to achieve the nation's population goals and objectives and to deliver an effective, cost-efficient and sustainable FP system. There are three major issues involved, namely: 1) population targets to be served; 2) the role and function of the NFPB to reach and serve the various targets; and 3) how to sustain beyond the inputs from donors. The following recommendations address each of these issues.

A. Population Targets

Historically, the FP system was service driven. That is, clients had access to services and products that were available, and not necessarily what was most effective or efficient. The achievement of a replacement level fertility by the year 2000 will require not only maintaining current users in an economic climate that may test their consistency and commitment to FP, but also reaching the hardest-to-reach segment of the population, current non-users.

1) The NFPB should prioritize population segments to be served based on the TARGET Model analysis, which estimates the number of contraceptive users, by method, that would be required to achieve fertility targets.

2) Based on the illustrative TARGET Model analysis herein, it is recommended that the following segments be considered for priority emphasis in FP:

- * Females age 15-19 who are not currently using a contraceptive method. Data indicates that more than half of these are sexually active, one-in-six are currently pregnant, and one-in-five of all women who have had a child, had that child between the ages of 15-19.
- * Women in union not currently using a method. Data indicates that one-third of these women were previous users who discontinued because of method dissatisfaction.
- * Current public sector users who can afford to use private sector sources. Data indicates that approximately 40% of current public sector users can afford to pay for contraceptive supplies.

3) The NFPB should adopt a strategy of emphasizing long-term and more cost-effective methods of contraception. This will require converting current users to other methods, particularly sterilization (female and male), IUDs and Norplant, and placing new users on the most appropriate method.

B. The Role and Function of the NFPB

1) Family Planning Advocacy

The continuation and further development of the FP system at the requisite level of impact will necessitate a meaningful and tangible level of national consensus and support that can only be generated through a major advocacy role. The NFPB is the organization uniquely qualified to play this role. The demands of the advocacy role, however, will require a single mindedness of purpose

and a reorientation of the Board's energies and resources to effectively advocate for support for FP from among a wide variety of groups.

Implicit in the advocacy role will be the need for the Board to influence and shape policies that impact on the FP system. Specifically, the Board will need to address the legal, regulatory, and operational barriers to the growth and development of FP, which upon preliminary investigation include:

- * Waiving or reducing duties and taxes on contraceptives;
- * Reclassifying oral contraceptives on the drug list to allow for access to the method without a prescription;
- * Liberalizing the distribution of all contraceptives, to allow for sales to be expanded beyond pharmacies to include selected stores, particularly in rural areas; and
- * Permitting the advertising and promotion of all contraceptive methods in the mass media to provide consumers with the basis for an informed method choice.

2) Program Development and Demand Generation

The NFPB will need to go through a process of transition to meet the changed and changing needs of the system and its users.

- * The Board will need to change its role in the implementation process from being a major participant to being the director of the process by coordinating the roles and functions of other implementors.
- * The Board will need to change the management process to re-tool and refine the skills within the Board to play the leadership role to increase the efficiency of the FP system.
- * The Board will need to modify the interventions to be more responsive to the needs of the FP users.
- * The Board must direct demand generation through a strategy that realizes behavior change, and motivates consistent and correct participation in FP.

3) Resource Management

The Board needs to assume the responsibility for garnering financial support for maintaining the FP system. This includes lobbying the Government for priority consideration at the macro level, harnessing private sector participation in FP, canvassing for additional donor support, and convincing FP clientele with the ability to contribute as to the importance of a personal investment in FP.

The resources available to the NFPB from the Government have never been sufficient to meet the demands of the system and are now currently being reduced. There will also be a phased withdrawal of international donor support for FP in cash, commodities, and technical support. To better manage the resources of the FP system, it is recommended that:

- * **The skills of the current staff should be reviewed to ensure the right mix of expertise to execute the new strategy of the Board. This may require the reclassification of posts, retraining of staff, and recruitment of more appropriate skills.**
- * **The size of the current staff should be reviewed, not only to be able to respond to the ravages of inflation and a reduced subvention, but to transfer a greater proportion of resources to critical areas, such as: policy, advocacy, communications, and management information systems.**
- * **The institutional structure and functions need to be reviewed so that human resources and infrastructure match the leadership role the Board will have to play.**

C. System Sustainability

The issues and recommendation discussed above will undoubtedly contribute to the sustainability of the FP system. The following further recommendations will help to assure the realization of a sustainable system.

- * **Commodity costs need to be shared more equitably between the public sector and the user through private sector access. Public sector commodities should serve only the safety net consumer, thereby reducing the Government's liability for commodity costs to more manageable levels.**
- * **The NFPB should retain responsibility for commodity forecasting, procurement, and logistics management for the public sector only; however, the GOJ will have to pay for the contraceptives in order to serve the indigent population.**
- * **The NFPB should immediately assign and/or hire a qualified full-time staff person to manage commodity logistics for the public sector.**
- * **The NFPB should contract with IPPF/FHMS for contraceptive procurement (for public sector commodities) on the basis of a two-year contract in the first instance, which would be renewed based on NFPB's satisfaction with the service provided.**
- * **The management of the social marketing program should be transferred immediately and entirely to the private sector. During the first two years of managing the social marketing program, the company should be provided with donated commodities (Panther and Perle) and marketing support through the FPIP. After two years of support, the company should assume all costs for implementing the social marketing program.**
- * **The private sector company should be selected not only on the basis of competitive pricing, but also on their demonstrated commitment to FP as a necessary and valuable social service. The NFPB's current partner in the CDC program, Grace Kennedy Distributors, has been a longstanding, effective and loyal partner. Grace Kennedy also has the most extensive distribution network in the business, and is financially solvent and well managed. While the recommendation is to investigate opportunities to work with other companies, Grace Kennedy Distributors is, at this time, the preferred company.**

- * The social marketing program should serve that segment of the population in the consumption deciles 4-7, and those who can afford an economical price for FP services.
- * The transfer of the social marketing program to the private sector should allow the Board to reallocate more than a million Jamaican dollars per year to other priorities.
- * More private sector participation needs to be encouraged so that private physicians and other private service providers should assume a greater role in FP, thereby improving system sustainability through "burden" sharing.

D. Next Steps

The NFPB needs to take swift action to move toward developing a sustainable FP program. Understanding of and consensus for the necessary strategic changes are fundamental to implementation. Once the overall program direction is agreed upon by the relevant players, the next steps include to:

- 1) Conduct a workshop to plan and coordinate technical assistance and program support available through the USAID/Kingston Family Planning Initiatives Project and the World Bank Project;
- 2) Develop a 5-year action plan for implementation;
- 4) Develop a 1-year work plan;
- 5) Review staff configuration to meet new strategy;
- 6) Select and transfer full responsibility for the CDC program to a private sector marketing company;
- 7) Develop staff re-orientation program, retraining plan, and, (if necessary), recruitment schedule;
- 8) Hire/assign a staff person to take immediate responsibility for public sector commodity management; and,
- 9) Develop commodity projections for next twelve months, arrange for GOJ funding, and place an order with IPPF for 20% of public sector commodity needs for 1993.

APPENDIX 1
NATIONAL FAMILY PLANNING BOARD

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

Ref. No.....

November 13,
.....

The Director
Office of Health/Nutrition/Population
USAID Mission
6B Oxford Road
Kingston 5

ATTENTION: Mrs. Grace-Ann Grey

Dear Sir:

I take this opportunity of thanking your Mission for organising the study trip to Haiti and Santo Domingo during the period September 22-28, 1991.

The tour was interesting and informative and assisted in crystallising our thoughts on the financial sustainability of the National Family Planning Board's programmes, now that we are undertaking the last Project to be financed by USAID.

A recommendation arising out of the "Tour" is for a Specialist Team of Consultants to be established to study the implications of "Sustainability" including but not confined to the privatisation of the Social Marketing Programme and to make recommendations as to the best alternative direction for the National Family Planning Board given its mandate and the realities of its present and future funding.

The team would consist of consultants in the disciplines of family planning, marketing, finance and management. The family planning consultant could be the coordinator of the team but alternatively the team could select its own leader.

At present the National Family Planning Board and Blue Cross of Jamaica are having discussions with a view to determining, if and how, family planning can be included within a national health plan and in particular within a health insurance scheme. Moreover, to date the Board has also been having dialogue with two drug firms concerning inter alia the role they can play in the provision of contraceptives in the context of a changing National Family Planning Board. Also to be considered would be the report on "Privatisation" which was researched and presented by Betty Ravenholt and her team.

ATTENTION: Mrs. Grace-Ann Grey

November 13, 1991

Of course the consulting team would not be limited only to previous initiatives undertaken on behalf of the Board.

You will realise that the time scheduling of the study as well as any recommendations made will be crucial in that the new USAID/NFPB Project sets certain time constraints which will have to be coordinated if proper scheduling is to be achieved.

Without pre-judging the situation it would appear that on completion of the study by the consulting team, flexibility and adjustments in the time factoring of the USAID/NFPB Project may be necessary, if the findings of the consulting team are to be successfully dovetailed.

You will recall that in our meetings of the Sustainability Committee at the National Family Planning Board, at which you were represented, the idea of a Consultant to undertake the study referred to in the foregoing was mooted and your representative intimated that funding for the study could be met out of the USAID/NFPB Project. It is considered that the team approach, now recommended, is more realistic and workable, given the different disciplines involved and in the circumstances, we are requesting a decision in principle, for funds to be provided in this regard.

It is appreciated that a proper brief will have to be prepared and it is suggested that we hold a joint meeting to fully discuss the matter prior to the preparation of this brief.

Your kind and early attention in this matter would be greatly appreciated.

Yours sincerely,



Alvin E. Rattray
Chairman

c.c. Mr. Lennox Deane
Acting Executive Director
National Family Planning Board.

APPENDIX 2

**OPTIONS II JAMAICA IN-COUNTRY
CONTACT LIST AS OF MARCH 12, 1992**

AMERICAN AIRLINES (Phone 92-48305)

BLUE CROSS OF JAMAICA (Phone 92-79821; 92-79836)
85 Hope Road
Kingston 6, Jamaica, WI

Dr. Henry I.C. Lowe, President & Chief Executive Officer
Ms. Fey Petgrave
Mr. Stewart Gainer

FACEY COMMODITY CO, LTD. (Phone 92-35441-7)
53 Newport Boulevard
Kingston 13, Jamaica, WI
Telex: 2120
Fax: (809) 92-39469; 34952

Mr. Derryck M. Penso, General Manager, Pharmaceutical Division

GRACE KENNEDY & CO., LTD. (Phone 92-37367; 37406; 36446-7; 37442)
64 Harbour Street, Kingston
P.O. Box 86, Kingston, Jamaica, WI
Cable: GRAKENCO JAMAICA
Telex: 2290 GRAKENCO

Mr. Rupert Gallimore, Manager Pharmaceutical Department

LASCO DISTRIBUTORS LTD. (Phone 92-90436; 97621; 97631; 97633-5; 91058)
27 Red Hills Road
Kingston 10, Jamaica, WI

Mr. Lester L. Woolery, Executive Director

JAMAICA FAMILY PLANNING ASSOCIATION (JFPA) (Phone 92-21857)
32 1/2 Duke Street
Kingston, Jamaica, WI

Mrs. Angela Grey, Director

MCCANN-ERICKSON (Phone 92-61410)
17 Knutsford Boulevard, P.O. Box 168
Kingston 5, Jamaica, WI
Telex: 3655 MACADCO JA
Fax: (809) 92-91942
Mr. Roy Burns, Client Services Director

MINISTRY OF HEALTH

Easton Douglas, M.P., Hon. Minister of Health
Dr. Carmen Bowen-Wright, Director of Primary Health Care
Mrs. McFarquer, Family Planning Coordinator

MINISTRY OF HEALTH, EPIDEMIOLOGY UNIT, NATIONAL HIV/STD PROGRAM
Phone 92-18189; 92-63411; 92-66430
30-34 Halfway Tree Road
Kingston 5, Jamaica, WI

Dr. Peter Figoroli, Director
Ms. Sheila Samiel, IEC Coordinator

MINISTRY OF HEALTH, PHARMACEUTICAL SERVICES DIVISION
12-14 Oxford Terrace
Kingston 5, Jamaica, WI

Grace Allen, Director
Ms. Stone
Mr. Sutherland
Mrs. Miller

MEDICAL ASSOCIATION of JAMAICA (Phone 92-99261; 99227)
3A Paisley Avenue
Kingston 5, Jamaica, WI

Dr. Lucien W. Jones, President
Dr. Margaret O. Green, Vice-President
Dr. Horatio A. Dunn, Hon. Treasurer
Dr. Frederick W. Hickling, Hon. Secretary

NATIONAL FAMILY PLANNING BOARD (NFPB) (Phone 92-64896)

June Rattray Building
5 Sylvan Ave.
Kingston 5, Jamaica, WI
Mrs. Beryl Chevannes, Executive Director
Mr. Lennox Deane, Deputy Executive Director
Mrs. Janet Davis, Director, IEC Unit
Dr. Olivia McDonald, Medical Director/Consultant
Mr. Eric Douglas, Director, Marketing Unit
Mrs. Ellen Radlin, Acting Director, Project & Research Unit
Mr. Easton Josephs, Acting Statistician
Mr. Barrington Gordon, Director of Finance
Mr. Alvin Rattray, Chairman of the Board
Dr. Reverend Webster Edwards, Board Member & Operation Friendship
Dr. Carmen Bowen-Wright, Board Member and MOH Director of Primary Health Care
Mr. Vernon James, Board Member and Statistical Institute
Mr. Stewart Gainer, Board Member and Blue Cross of Jamaica

PLANNING INSTITUTE OF JAMAICA, MIN. PLAN, SOCIAL/MANPOWER PLANNING DIVISION (PIOJ)

Mrs. Pauline Knight, Director, Social/Manpower Planning Division
Mrs. Myrtle Hazle, Dep. Director, Social/Manpower Planning Div.
Mr. Easton Williams, IEC Director
Ms. Carmen Miller, IEC Specialist
Ms. Grace-Ann Taylor, Demographic Liaison Officer
Ms. Norma Uman, Demographic Liaison Officer
Ms. Yula ?, Demographic Liaison Officer
Ms. Jacqueline McGibbons, Librarian

STATISTICAL INSTITUTE OF JAMAICA

(The Towers)

25 Dominika Dr.

Mr. Vernon James, Director General and Census Officer
Mrs. Nam (In-charge of census)
Mrs. Higman, Senior Statistical Officer
Mr. Booth

TREVOR HAMILTON AND ASSOCIATES (Phone 92-91396; 91279; 68596)

10 Kensington Crescent

Kingston 5, Jamaica, WI

Dr. Trevor Hamilton, Consultant

UNIVERSITY OF WEST INDIES (Phone 92-70668)

Dr. Don Robothan, Sociology Department Head
Dr. Derryk Gordon, Senior Research Professor, Sociology Dept.
Dr. Barry Chevannes, Senior Research Professor, Sociology Dept.

UNITED NATIONS POPULATION FUND (UNFPA) (Phone 92-65500; 65507-9)

1-3 Lady Musgrave Road

Kingston 5, Jamaica

P.O. Box 280

Kingston, Jamaica

Cable: UNDEVPRO KINGSTON

Fax: (809) 92-68654

Telex: 2245

K.V.J. Moorthy, Director for the Caribbean

Mrs. Jennifer Knight-Johnson, National Program Officer

US AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) (Phone 92-63645)

Fax: (809)-92-93752

Ms. Betsy Brown, Health, Population & Nutrition Officer

Mrs. Grace-Ann Grey, Project Officer

Ms. Kate Mackay, Project Officer

Ms. Joy Jones, Project Officer

Ms. Brigitte Fong-Yee, Administrative Staff

Ms. Maxine Wedderburn, Research Consultant (Phone 809 92-78436)

Hope Enterprises Ltd.

204 Mountain View Ave.

Kingston 6, Jamaica, WI

Phone and Fax (809) 978-0552

WYNDHAM HOTEL (Phone 92-654530)

P.O. Box 112

77 Knutsford Blvd.

Kingston 5, WI

Telex: 2152 and 2409

Fax: (809) 929-7439

WYETH PHARMACEUTICAL CO. (Phone 92-68784)

Mr. Tony McGregor, Jamaica Sales Representative

Appendix 3
Target Setting Model

Title = Jamaica

First year = 1989

Last year = 2001

	1989	1994	1999	2001
TFR	2.90	2.57	2.23	2.10
Women aged 15-49 (Thousands)	615.3	666.0	709.0	724.8

METHODS

Method	Effectiveness	Discontinuation	Consumption
Pill	0.90	0.20	13.0
IUD	0.95	0.15	
Female Steril.	1.00	0.01	
Male Steril.	1.00	0.01	
Injectables	0.98	0.15	4.0
Other	0.70	0.30	0.0
Condom	0.70	0.30	100.0
Norplant	0.98	0.15	0.0

METHOD MIX

	1989	1994	1999	2001
Pill	36.00	32.67	29.33	28.00
IUD	3.00	3.83	4.67	5.00
Female Sterilization	25.00	27.08	29.17	30.00
Male Sterilization	0.00	1.25	2.50	3.00
Injectables	14.00	14.42	14.83	15.00
Other	7.00	4.92	2.83	2.00
Condom	15.00	12.50	10.00	9.00
Norplant	0.00	3.33	6.67	8.00

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PROXIMATE DETERMINANTS OF FERTILITY

	1989	1994	1999	2001
Prevalence (%)	55.0			
Percent WRA married	67.8	67.8	67.8	67.8
Duration of postpartum infecundability (months)	9.0	9.0	9.0	9.0
Induced abortion rates per 1000 women 15-49	0.00	0.00	0.00	0.00
Pathological sterility rates (% childless at age 49)	3.00	3.00	3.00	3.00

DISTRIBUTION BY SOURCE IN 1989

	Pill	IUD	Female Ster	Male Ster
Public	65.5	58.0	89.0	20.0
Private	34.5	42.0	11.0	80.0
	Injectables	Other	Condom	Norplant
Public	93.0	60.0	45.1	20.0
Private	7.0	40.0	54.9	80.0

DISTRIBUTION BY SOURCE IN 2001

	Pill	IUD	Female Ster	Male Ster
Public	50.0	50.0	75.0	30.0
Private	50.0	50.0	25.0	70.0
	Injectables	Other	Condom	Norplant
Public	60.0	45.0	30.0	20.0
Private	40.0	55.0	70.0	80.0

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Jamaica
Output Table for All Methods from All Sources

Year	Percent MWRA Using	Number Using (Thous.)
1989	55.0	229.4
1990	55.9	237.5
1991	56.8	245.5
1992	57.7	253.4
1993	58.6	261.1
1994	59.5	268.8
1995	60.4	276.5
1996	61.3	284.2
1997	62.2	291.9
1998	63.0	299.5
1999	63.9	307.2
2000	64.8	314.8
2001	65.6	322.4

Output Table for Pill from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Cycles (Thous.)
1989	19.8	82.6		
1990	19.8	83.9	18.8	1091.0
1991	19.7	85.1	18.9	1106.5
1992	19.6	86.1	19.0	1119.8
1993	19.5	87.0	19.0	1131.4
1994	19.4	87.8	19.1	1141.5
1995	19.3	88.5	19.1	1150.3
1996	19.2	89.1	19.1	1157.8
1997	19.1	89.5	19.1	1163.7
1998	18.9	89.9	19.1	1168.2
1999	18.7	90.1	19.0	1171.3
2000	18.6	90.2	18.9	1173.1
2001	18.4	90.3		

Output Table for IUD from All Source

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Insertions (Thous.)
1989	1.6	6.9		
1990	1.8	7.5	1.9	1.9
1991	1.9	8.2	2.0	2.0
1992	2.0	8.9	2.2	2.2
1993	2.1	9.6	2.3	2.3
1994	2.3	10.3	2.5	2.5
1995	2.4	11.1	2.6	2.6
1996	2.6	11.8	2.8	2.8
1997	2.7	12.6	2.9	2.9
1998	2.8	13.5	3.1	3.1
1999	3.0	14.3	3.3	3.3
2000	3.1	15.2	3.4	3.4
2001	3.3	16.1		

Output Table for Female Sterilization from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	13.7	57.4		
1990	14.2	60.4	5.0	5.0
1991	14.7	63.4	5.1	5.1
1992	15.2	66.5	5.2	5.2
1993	15.6	69.6	5.4	5.4
1994	16.1	72.8	5.5	5.5
1995	16.6	76.0	5.7	5.7
1996	17.1	79.4	5.9	5.9
1997	17.6	82.7	6.0	6.0
1998	18.1	86.1	6.2	6.2
1999	18.6	89.6	6.4	6.4
2000	19.2	93.1	6.5	6.5
2001	19.7	96.7		

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Output Table for Male Sterilization from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	0.0	0.0		
1990	0.1	0.6	0.6	0.6
1991	0.3	1.2	0.7	0.7
1992	0.4	1.9	0.7	0.7
1993	0.6	2.6	0.8	0.8
1994	0.7	3.4	0.9	0.9
1995	0.9	4.1	0.9	0.9
1996	1.1	5.0	1.0	1.0
1997	1.2	5.8	1.0	1.0
1998	1.4	6.7	1.1	1.1
1999	1.6	7.7	1.1	1.1
2000	1.8	8.7	1.2	1.2
2001	2.0	9.7		

Output Table for Injectables from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Injections (Thous.)
1989	7.7	32.1		
1990	7.9	33.5	6.6	133.8
1991	8.1	34.8	6.8	139.1
1992	8.2	36.1	7.0	144.4
1993	8.4	37.4	7.2	149.7
1994	8.6	38.8	7.4	155.0
1995	8.8	40.1	7.6	160.4
1996	8.9	41.5	7.9	165.8
1997	9.1	42.8	8.1	171.3
1998	9.3	44.2	8.3	176.7
1999	9.5	45.6	8.5	182.2
2000	9.7	47.0	8.8	187.8
2001	9.8	48.4		

Output Table for Other from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	3.8	16.1		
1990	3.7	15.6	4.4	0.0
1991	3.5	15.1	4.2	0.0
1992	3.3	14.6	3.9	0.0
1993	3.1	13.9	3.7	0.0
1994	2.9	13.2	3.4	0.0
1995	2.7	12.4	3.1	0.0
1996	2.5	11.6	2.7	0.0
1997	2.3	10.7	2.4	0.0
1998	2.0	9.7	2.0	0.0
1999	1.8	8.7	1.6	0.0
2000	1.6	7.6	1.2	0.0
2001	1.3	6.4		

Output Table for Condom from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	8.2	34.4		
1990	8.1	34.4	10.7	3444.1
1991	8.0	34.4	10.6	3437.2
1992	7.8	34.2	10.4	3420.3
1993	7.6	33.9	10.3	3394.3
1994	7.4	33.6	10.1	3360.0
1995	7.2	33.2	9.9	3318.3
1996	7.0	32.7	9.6	3268.8
1997	6.8	32.1	9.4	3211.0
1998	6.6	31.5	9.1	3145.2
1999	6.4	30.7	8.8	3071.6
2000	6.2	29.9	8.4	2990.5
2001	5.9	29.0		

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Output Table for Norplant from All Sources

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	0.0	0.0		
1990	0.4	1.6	1.7	0.0
1991	0.8	3.3	2.3	0.0
1992	1.2	5.1	2.7	0.0
1993	1.6	7.0	3.1	0.0
1994	2.0	9.0	3.5	0.0
1995	2.4	11.1	3.9	0.0
1996	2.9	13.3	4.4	0.0
1997	3.3	15.6	4.9	0.0
1998	3.8	18.0	5.4	0.0
1999	4.3	20.5	5.9	0.0
2000	4.7	23.1	6.4	0.0
2001	5.2	25.8		

Output Table for All Methods from Public

Year	Percent MWRA Using	Number Using (Thous.)
1989	39.4	164.2
1990	39.1	166.1
1991	38.9	167.9
1992	38.6	169.3
1993	38.3	170.5
1994	38.0	171.5
1995	37.7	172.3
1996	37.3	173.1
1997	37.0	173.6
1998	36.6	174.0
1999	36.2	174.3
2000	35.9	174.4
2001	35.5	174.4

Output Table for Pill from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Cycles (Thous.)
1989	13.0	54.1		
1990	12.7	53.9	11.0	700.5
1991	12.4	53.5	10.8	696.1
1992	12.1	53.1	10.6	690.1
1993	11.8	52.5	10.4	682.6
1994	11.5	51.8	10.1	674.0
1995	11.2	51.1	9.9	664.3
1996	10.8	50.3	9.7	653.7
1997	10.5	49.4	9.4	642.0
1998	10.2	48.4	9.1	629.4
1999	9.9	47.4	8.8	615.9
2000	9.5	46.3	8.6	601.7
2001	9.2	45.1		

Output Table for IUD from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Insertions (Thous.)
1989	1.0	4.0		
1990	1.0	4.3	1.0	1.0
1991	1.1	4.6	1.1	1.1
1992	1.1	5.0	1.2	1.2
1993	1.2	5.3	1.2	1.2
1994	1.2	5.6	1.3	1.3
1995	1.3	6.0	1.3	1.3
1996	1.4	6.3	1.4	1.4
1997	1.4	6.7	1.5	1.5
1998	1.5	7.0	1.5	1.5
1999	1.5	7.4	1.6	1.6
2000	1.6	7.7	1.6	1.6
2001	1.6	8.1		

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Output Table for Female Sterilization from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	12.2	51.0		
1990	12.5	53.0	3.7	3.7
1991	12.7	55.0	3.7	3.7
1992	13.0	56.9	3.7	3.7
1993	13.2	58.7	3.7	3.7
1994	13.4	60.5	3.8	3.8
1995	13.6	62.4	3.8	3.8
1996	13.8	64.1	3.8	3.8
1997	14.0	65.9	3.8	3.8
1998	14.2	67.6	3.9	3.9
1999	14.4	69.3	3.9	3.9
2000	14.6	70.9	3.9	3.9
2001	14.8	72.5		

Output Table for Male Sterilization from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	0.0	0.0		
1990	0.0	0.1	0.1	0.1
1991	0.1	0.3	0.2	0.2
1992	0.1	0.4	0.2	0.2
1993	0.1	0.6	0.2	0.2
1994	0.2	0.8	0.2	0.2
1995	0.2	1.0	0.3	0.3
1996	0.3	1.3	0.3	0.3
1997	0.3	1.6	0.3	0.3
1998	0.4	1.9	0.4	0.4
1999	0.5	2.2	0.4	0.4
2000	0.5	2.5	0.4	0.4
2001	0.6	2.9		

Output Table for Injectables from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	7.2	29.9		
1990	7.1	30.2	5.0	120.8
1991	7.0	30.4	5.0	121.7
1992	7.0	30.6	4.9	122.4
1993	6.9	30.7	4.9	122.8
1994	6.8	30.7	4.8	122.8
1995	6.7	30.7	4.7	122.7
1996	6.6	30.6	4.7	122.3
1997	6.5	30.4	4.6	121.6
1998	6.3	30.2	4.5	120.6
1999	6.2	29.8	4.3	119.4
2000	6.1	29.5	4.2	117.9
2001	5.9	29.0		

Output Table for Other from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	2.3	9.6		
1990	2.2	9.2	2.4	0.0
1991	2.0	8.7	2.2	0.0
1992	1.9	8.2	2.0	0.0
1993	1.7	7.7	1.8	0.0
1994	1.6	7.1	1.6	0.0
1995	1.4	6.5	1.5	0.0
1996	1.3	5.9	1.3	0.0
1997	1.1	5.4	1.1	0.0
1998	1.0	4.7	0.9	0.0
1999	0.9	4.1	0.7	0.0
2000	0.7	3.5	0.5	0.0
2001	0.6	2.9		

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Output Table for Condom from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	3.7	15.5		
1990	3.6	15.1	4.3	1509.9
1991	3.4	14.6	4.1	1463.7
1992	3.2	14.1	3.9	1413.4
1993	3.1	13.6	3.7	1360.0
1994	2.9	13.0	3.5	1304.0
1995	2.7	12.5	3.3	1246.0
1996	2.6	11.9	3.1	1186.3
1997	2.4	11.2	2.9	1124.9
1998	2.2	10.6	2.7	1062.3
1999	2.1	10.0	2.5	998.8
2000	1.9	9.3	2.3	934.8
2001	1.8	8.7		

Output Table for Norplant from Public

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	0.0	0.0		
1990	0.1	0.3	0.3	0.0
1991	0.2	0.7	0.5	0.0
1992	0.2	1.0	0.5	0.0
1993	0.3	1.4	0.6	0.0
1994	0.4	1.8	0.7	0.0
1995	0.5	2.2	0.8	0.0
1996	0.6	2.7	0.9	0.0
1997	0.7	3.1	1.0	0.0
1998	0.8	3.6	1.1	0.0
1999	0.9	4.1	1.2	0.0
2000	0.9	4.6	1.3	0.0
2001	1.0	5.2		

Output Table for All Methods from Private

Year	Percent MWRA Using	Number Using (Thous.)
1989	15.6	65.3
1990	16.8	71.4
1991	18.0	77.7
1992	19.2	84.1
1993	20.4	90.6
1994	21.6	97.3
1995	22.8	104.2
1996	24.0	111.2
1997	25.2	118.3
1998	26.4	125.5
1999	27.6	132.9
2000	28.9	140.4
2001	30.1	148.0

Output Table for Pill from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Cycles (Thous.)
1989	6.8	28.5		
1990	7.1	30.0	7.8	390.5
1991	7.3	31.6	8.1	410.3
1992	7.5	33.1	8.4	429.7
1993	7.8	34.5	8.7	448.8
1994	8.0	36.0	8.9	467.5
1995	8.2	37.4	9.2	486.0
1996	8.4	38.8	9.5	504.1
1997	8.5	40.1	9.7	521.7
1998	8.7	41.4	10.0	538.8
1999	8.9	42.7	10.2	555.4
2000	9.0	44.0	10.4	571.4
2001	9.2	45.1		

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Output Table for IUD from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Insertions (Thous.)
1989	0.7	2.9		
1990	0.8	3.2	0.9	0.9
1991	0.8	3.5	0.9	0.9
1992	0.9	3.9	1.0	1.0
1993	1.0	4.3	1.1	1.1
1994	1.0	4.7	1.2	1.2
1995	1.1	5.1	1.3	1.3
1996	1.2	5.5	1.4	1.4
1997	1.3	6.0	1.5	1.5
1998	1.4	6.5	1.6	1.6
1999	1.5	7.0	1.7	1.7
2000	1.5	7.5	1.8	1.8
2001	1.6	8.1		

Output Table for Female Sterilization from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	1.5	6.3		
1990	1.7	7.3	1.3	1.3
1991	2.0	8.5	1.4	1.4
1992	2.2	9.6	1.5	1.5
1993	2.4	10.9	1.7	1.7
1994	2.7	12.3	1.8	1.8
1995	3.0	13.7	1.9	1.9
1996	3.3	15.2	2.1	2.1
1997	3.6	16.8	2.2	2.2
1998	3.9	18.5	2.3	2.3
1999	4.2	20.3	2.5	2.5
2000	4.6	22.2	2.6	2.6
2001	4.9	24.2		

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Output Table for Male Sterilization from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Procedures (Thous.)
1989	0.0	0.0		
1990	0.1	0.5	0.4	0.4
1991	0.2	1.0	0.5	0.5
1992	0.3	1.5	0.6	0.6
1993	0.4	2.0	0.6	0.6
1994	0.6	2.5	0.6	0.6
1995	0.7	3.1	0.6	0.6
1996	0.8	3.7	0.7	0.7
1997	0.9	4.3	0.7	0.7
1998	1.0	4.9	0.7	0.7
1999	1.1	5.5	0.8	0.8
2000	1.3	6.1	0.8	0.8
2001	1.4	6.8		

Output Table for Injectables from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Injections (Thous.)
1989	0.5	2.2		
1990	0.8	3.3	1.6	13.0
1991	1.0	4.3	1.8	17.4
1992	1.3	5.5	2.1	22.0
1993	1.5	6.7	2.3	26.9
1994	1.8	8.0	2.6	32.2
1995	2.1	9.4	2.9	37.7
1996	2.3	10.9	3.2	43.5
1997	2.6	12.4	3.5	49.7
1998	3.0	14.0	3.9	56.1
1999	3.3	15.7	4.2	62.9
2000	3.6	17.5	4.6	70.0
2001	3.9	19.3		

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Output Table for Other from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	1.5	6.4		
1990	1.5	6.5	2.0	0.0
1991	1.5	6.4	2.0	0.0
1992	1.5	6.4	1.9	0.0
1993	1.4	6.3	1.8	0.0
1994	1.4	6.1	1.7	0.0
1995	1.3	5.9	1.6	0.0
1996	1.2	5.7	1.5	0.0
1997	1.1	5.4	1.3	0.0
1998	1.0	5.0	1.2	0.0
1999	1.0	4.6	1.0	0.0
2000	0.8	4.1	0.8	0.0
2001	0.7	3.5		

Output Table for Condom from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	4.5	18.9		
1990	4.6	19.3	6.4	1934.1
1991	4.6	19.7	6.5	1973.5
1992	4.6	20.1	6.5	2006.9
1993	4.6	20.3	6.6	2034.3
1994	4.6	20.6	6.6	2056.1
1995	4.5	20.7	6.6	2072.3
1996	4.5	20.8	6.5	2082.5
1997	4.4	20.9	6.5	2086.1
1998	4.4	20.8	6.4	2082.9
1999	4.3	20.7	6.3	2072.8
2000	4.2	20.6	6.2	2055.7
2001	4.1	20.3		

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Output Table for Norplant from Private

Year	Percent MWRA Using	Number Using (Thous.)	Annual Number of Acceptors (Thous.)	Annual Number of Units (Thous.)
1989	0.0	0.0		
1990	0.3	1.3	1.4	0.0
1991	0.6	2.6	1.9	0.0
1992	0.9	4.1	2.1	0.0
1993	1.3	5.6	2.5	0.0
1994	1.6	7.2	2.8	0.0
1995	1.9	8.8	3.2	0.0
1996	2.3	10.6	3.5	0.0
1997	2.7	12.5	3.9	0.0
1998	3.0	14.4	4.3	0.0
1999	3.4	16.4	4.7	0.0
2000	3.8	18.5	5.1	0.0
2001	4.2	20.6		



APPENDIX 4
BIBLIOGRAPHY

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