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EVALUATION OF THE
JAMAICAN FAMILY PLANNING PROGRAM
1974

A Report Prepared By

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Progress toward Jamaica's stated interim goal must be greatly accelerated if that goal is to be achieved. Until recently the program was confined essentially to a clinic-oriented "family planning" approach. With the advent of the Community Health Aides, the concept of outreach functionaries became established, and family planning became one of the five major tasks of these multipurpose outreach workers. While program success has been limited in terms of continuing acceptors and impact to date on national fertility statistics, the process of institution building by the relevant government, academic, and private agencies involved has been accompanied by the progressive acquisition of the political, administrative, and technical capabilities required in order that self-sufficiency may ultimately be attained. In spite of obstacles, some progress in building national awareness of the program has also been made. More needs to be done, chiefly in assisting people to link family planning goals to their own personal and organizational motivations. The evaluators believe that bilateral, multilateral, and private donor assistance should all continue, but better coordination and communication among the responsible agencies as well as with recipient institutions is required if their potential for effective aid is to be realized. The evaluators made 54 program specific recommendations.

TABLE OF CONTENTS

ABBREVIATIONS i

I. PURPOSE, METHODS, AND LIMITATIONS OF THE EVALUATION 1
   1. Purpose. 1
   2. Composition of the Evaluation Team. 1
   3. Methods of Work 1
   4. Limitations of the Report 3

II. BACKGROUND OF POPULATION/FAMILY PLANNING IN JAMAICA 4

III. JAMAICA'S POPULATION/FAMILY PLANNING OBJECTIVES AND POLICIES. . 6
   1. Objectives and Policies 6
   2. Jamaica's Commitment to Family Planning 7
   3. Factors Affecting Jamaica's Population 8
   4. Extent to Which Population Policies Have Been Achieved . . 8

IV. SUMMARY OF FINDINGS AND RECOMMENDATIONS 13

V. END OF PROJECT CONDITIONS, INDICATORS, AND EVIDENCE OF PROGRESS TO DATE 17
   1. Capability within the NFPB, the MHEC, and the UWI in Developing and Implementing Family Planning Policy 17
      1.1 Policy-making Authority 17
      1.2 Scope and Adequacy of Policy 18
      1.3 Policy Role of the NFPB 19
      1.4 Role of the UWI 21
      1.5 Basis for Policy Decisions 23
      1.6 Mechanisms for Policy Implementation 24
   2. General Administrative and Management Capability within the MHEC, the NFPB, and the UWI 26
      2.1 Integration of Family Planning into the Ministry of Health 26
      2.2 National Family Planning Board 27
      2.3 Administration of Health Services 28
         A. National Organization 28
         B. Local (Parish) Organization for Health Services . 30
         C. The Clinic Manager 31
         D. Coordination within the Parish 31
         E. Coordination within MHEC 32
      2.4 Planning 33
      2.5 Organizing 33
      2.6 Administration of the Family Planning Program 36
      2.7 Leadership in the Family Planning Program 37
         A. Top Level Administrators 37
         B. Intermediate and Local Leadership 37
      2.8 Interministerial Coordination 38

Page

2.9 The U.W.I. 38
 A. Functions of the Family Planning Unit 39
 B. Staffing 40
 C. Facilities 42
 D. Funding for the Unit 43
 E. General Administrative and Management Capabilities 43
 F. Institutionalization of the Family Planning Unit into the University 45
 G. Future of the Family Planning Unit 46
2.10 The Jamaica Family Planning Association 46
 A. Strengths 47
 B. Weaknesses 47

3. Capability within NFPB and MHEC in Planning, Establishing, Implementing and Evaluating Medically Adequate Clinical Services, Postpartum Program, Record System, and Follow-Up Procedures 49
3.1 Background of GOJ Family Planning Services 49
 A. Expansion of Family Planning Clinics 49
 B. Clinic Facilities 50
 C. Clinic Staffing 51
 D. Clinic Organization 51
 E. Clinic Performance 52
 F. Efforts to Improve Clinic Performance 53
3.2 Current Status of Contraceptive Services 56
 A. Clinic Performance 56
 B. Contraceptive Methods 57
3.3 Integration with Health Services 58
3.4 Extension of Post-Partum Family Planning 59
3.5 Commercial Distribution Scheme (Westinghouse) . . . 60
3.6 Sterilization Services 62
3.7 Abortion Services 65
3.8 Cytology 67
3.9 Effectiveness of Record-Keeping System and Use Thereof 68
 A. Effectiveness of Record-Keeping System 69
 B. Use of Service Statistics 72
 C. Family Planning Service Statistics Post-Integration 73
3.10 Private Sector Contribution to Family Planning Services 74
 A. Private Medical Practitioners 74
 B. The JFPA 74
 C. The Department of Obstetrics and Gynecology, UWI 77
 D. The University Health Centre, UWI 77
 E. The Family Counselling Centre 77
 F. The Salvation Army 79
 G. Child Welfare Association 79
 H. Operation Friendship 79
 I. Tivoli Gardens Complex 79
 J. The Sugar Industry Labour Welfare Board 79
 K. Goodwill 79

Page

4. Capability in Procuring, Accounting for, and Distributing Contraceptives and Other Family Planning Equipment and Supplies 80
5. Capability in Planning and Carrying Out IE & C Aspects of the Program 82
   5.1 Organizational Structure and Administration of IE & C Services 82
      A. The NFPB 84
      B. The Bureau of Health Education 87
      C. IE & C Responsibilities Post-Integration 93
   5.2 Planning and Evaluation of IE & C 99
   5.3 Education Integrated into the Delivery of Services. 102
      A. Recruitment of New Acceptors 102
      B. Counselling in the Clinics 104
      C. Follow-up of Drop-Outs. 105
      D. Pre-Natal and Post-Natal Education 106
      E. Other Educational Needs Related to Service Delivery 108
   5.4 Educational Activities Designed to Help Prepare Students and Other Young People for Their Responsibilities as Family Members and Future Parents 109
      A. Background 109
      B. Development of National Policy Supporting Family Life Education in the Schools 111
      C. Development of Curricula for Family Life Education in the Schools 114
      D. Specialized Training in Family Life Education for School and Other Supportive Personnel . . 118
      E. Development of Teaching Materials for Family Life Education 119
      F. Implementation of Family Life Education in the Schools 121
      G. Institutional Responsibilities for Family Life Education in the Schools 122
      H. Coordination of Family Life Education Efforts . 123
      I. Evaluation of Family Life Education 124
      J. Findings and Recommendations 124
   5.5 Community Efforts in Family Life Education 127
      A. The Ministry of Youth and Community Development 127
      B. The Ministry of Agriculture 128
      C. Community Development Agency 128
      D. The Jamaica Youth Council 128
      E. The YWCA 128
      F. The Soroptomist Club 128
      G. The Trade Union Education Institute, UWI . . . 128
   5.6 Coordination of Educational Efforts 129

Page

6.0 Capability within NFPB, MHEC, and UWI in Coordinating Recruitment, Training, and Maintenace of Adequately Trained Clinic, IE & C, and Administrative Staff 130
- 6.1 Training of Physicians 131
- 6.2 Training of Nursing Personnel 133

7.0 Capability in Conducting Operational Research, Providing Useful Results, and Integrating Findings into Program 134
- 7.1 The Role of the University of the West Indies . . . 134
  - A. The Family Planning/Epidemiology Unit, Department of Social and Preventive Medicine . 134
  - B. Census Research Program (Department of Sociology) 135
  - C. The Department of Obstetrics and Gynecology . 135
  - D. The Department of Psychiatry 136
  - E. The Institute of Education 136
  - F. The Department of Pediatrics 136
  - G. The Extra Mural Department 136
- 7.2 The Role of the NFPB in Research and Evaluation . 137
- 7.3 Roles of Other Organizations and Institutions in Research 139
  - A. The Ministry of Health and Environmental Control 139
  - B. The Jamaican Family Planning Association . . . 139
  - C. The Family Counselling Center 139
  - D. Other Institutions and Organizations 140
- 7.4 Institutional Capability of Each of These Units in Research 140
  - A. Recognition of family planning research functions by other units, agencies, and individuals 140
  - B. Financial support for research 141
  - C. Research facilities available 141
  - D. Research personnel available 142
  - E. Specific Research and Evaluation Needs Identified and Progress to Date 143
- 7.5 Identification of Research Needs and Priorities . . 145
- 7.6 Relationship of Research Units to Other Program Components 148
- 7.7 Utilization of Research Findings in the Family Planning Program 149
- 7.8 Research and Evaluation Capabilities: Findings and Recommendations 150

8.0 Capability of the UWI as a Regional Population Center . 152
- 8.1 Identification with the UWI, Jamaica as a Regional Center for the Caribbean 152
- 8.2 Agreement on the Concept of a Regional Family Planning/Population Center 154
- 8.3 Financial Support for the Regional Center 155
- 8.4 Present Resources for a Regional Center 155
- 8.5 Current and Past Regional Activities in Population/Family Planning 156
- 8.6 Findings and Recommendations 157

Page

VI. ROLE OF U.S. AND OTHER DONOR AGENCIES 159

1. Effectiveness of External Assistance 159
2. IBRD (World Bank) 164
   2.1 Construction 164
   2.2 Technical Assistance 166
   2.3 Future IBRD Assistance Possibilities 166
3. Pathfinder Fund 167
4. IPPF 168
5. Ford Foundation 169
6. UNFPA 170
   6.1 A Grant of $659,000 to UWI to Assist in Processing and Publishing the Data Obtained in the 1970 Caribbean Census 170
   6.2 A Workers Population Education Project 170
   6.3 Future Role of UNFPA 170
7. PAHO 171
8. Other Donors 171
9. Conclusions and Recommendations 171

VII. PROJECT INPUTS 175

1. Brief Background 175
2. Summary of GOJ and US/AID Project Inputs, 1968-1974 . . . 175
3. Details of GOJ, US/AID, and Other Donor Inputs 175

APPENDICES

A. List of Persons Contacted 196
B. Partial List of References Consulted 200
C. Proposed Functions of the Department of Social and Preventive Medicine, UWI To Support the National Family Planning Program, March, 1972 209
D. Functions in Which the National Family Planning Board Desired Assistance from the Department of Social and Preventive Medicine, UWI 210
E. Partial List of Workshops, Seminars, and Other Training Activities in Family Life Education 212
F. Partial Listing of Specific Research and Evaluation Needs Identified and Progress to Date 216
   1. Operational Studies Required to Guide Administrative Management and to Improve Service Operations 216
      1.1 Evaluation of Standards for Clinic Facilities, Staffing, and Clinic Operations 216
      1.2 Study of Job Functions in the Family Planning Program 217
      1.3 Study of Utilization of Clinic Facilities and Services 218
      1.4 Evaluation of the Postpartum Program 219
      1.5 Studies of Family Planning Acceptors 219
      1.6 Studies of Continuing Users 220
      1.7 Studies of Clinic Drop-Outs 221
      1.8 Studies of Contraceptive Methods 222
      1.9 Research in Tubal Ligation 223
      1.10 Studies of Abortion 223
      1.11 Evaluation of Educational and Training Components of the Program 224

Page

1.12 Program Demonstration/Action Research Projects 226
1.13 Study of Family Planning Functions Performed by Other Agencies 229
1.14 Study of Maternal and Child Health Needs in the Caribbean 229
2.0 Basic Research into Knowledge, Attitudes, Socio-Cultural Characteristics, and Behavior Patterns . . . 231
2.1 Knowledge, Attitudes, and Practices Relating to Fertility and Family Planning (KAP Study) . . 231
2.2 Teenage and Male KAP 233
2.3 Relationship of Male Peer Group Associations and Mating and Family Attitudes and Behavior in a Select Community 233
2.4 Other Male Studies 233
2.5 Unilateral Contraceptive Decision-Making among JFPA Women Clients 234
2.6 Reproductive Behavior and Fertility Patterns in Jamaica 234
2.7 Research on Women's Roles, Child Health, and Fertility in Jamaica 234
2.8 Fertility, Mating and Conception Study (FMC) . . 235
2.9 Socio-Cultural Factors in Fertility (Research Proposal) 235
2.10 Demographic, KAP, and Other Data Related to the Commercial Distribution of Contraceptives 236
2.11 Attitude toward Family Life Education in the Schools 236
3.0 Vital Demographic Data 236
4.0 Other Research Needs 237
G. Partial List of Consultant Visits 239

ABBREVIATIONS

AFPEO	Assistant Family Planning Education Officer
AID	Agency for International Development (US/AID)
BHE	Bureau of Health Education, a unit of the MHEC
CHA	Community Health Aide
DMO	District Medical Officer of Health
DSPM	Department of Social and Preventive Medicine of the University of the West Indies
EV	Encouragement Visitor
FP	Family Planning
FPEO	Family Planning Education Officer
GOJ	Government of Jamaica
HE	Health Educator
HEO	Health Education Officer
HMO	Hospital Medical Officer
IBRD	International Bank for Reconstruction and Development (World Bank)
IDRC	International Development Research Center of Ottawa, Ca
IE&C	Information, Education, and Communication
ILO	International Labor Organization
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JFPA	Jamaica Family Planning Association
KAP	Knowledge, Attitudes, and Practices
KSAC	The Parishes of Kingston and St. Andrew, also referred to as the Corporate Area
MCH	Maternal and Child Health
MHEC	Ministry of Health and Environmental Control

MOE	Ministry of Education
MOH	Minister of Health
MO(H)	Parish Medical Officer of Health
MYCD	Ministry of Youth and Community Development
NFPB	National Family Planning Board
NTL	National Training Laboratories
OB/GYN	Obstetrics and Gynecology
PAHO	Pan American Health Organization, a division of the World Health Organization
PHN	Public Health Nurse
PIO/T	Project Implementation Order/Technical, terminology of US/AID
PMO	Principal Medical Officer in the MHEC
PNO	Principal Nursing Officer in the MHEC
POP	Population
PRO-AG	Project Agreement, terminology of US/AID
RFPO	Regional Family Planning Officer, the MO(H)
SCM	State Certified Midwife
SHE	Senior Health Educator
SRN	State Registered Nurse
TUEI	Trade Union Education Institute at the University of the West Indies
UNDP	United Nations Development Programs
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Fund for Population Activities
US/AID	United States Agency for International Development
UWI	University of the West Indies
VD	Venereal Disease
VJH	Victoria Jubilee Hospital

I. PURPOSE, METHODS, AND LIMITATIONS OF THE EVALUATION

1. Purpose

This review of the Jamaican family planning program was initiated by the United States Agency for International Development, which under agreement with the Government of Jamaica, has been assisting this program since 1966. The scope of the evaluation includes program developments from that time through the present.

According to US/AID representatives, the primary purpose of the evaluation is to provide a basis for improving program design. Guidelines from the Agency identify three major areas for review:

1.1 To determine the extent to which family planning has been institutionalized within the National Family Planning Board, the Ministry of Health in Jamaica, and the University of the West Indies.

1.2 To determine the extent to which targets to reduce fertility have been achieved.

1.3 To determine the effectiveness of U.S. and other donor contributions in achieving project purposes.

The involvement of Jamaicans and donor agency representatives with key responsibilities in the Jamaican national family planning program was recognized as essential to the review process and to utilization of the results.

2. Composition of the Evaluation Team

2.1 Carol N. D'Onofrio, Dr.P.H., M.P.H., Team Coordinator
Assistant Professor of Public Health
School of Public Health, University of California, Berkeley

2.2 Donald H. Minkler, M.D., M.P.H.
Specialist in OB/GYN, MCH, and Family Planning
University of California Medical School, San Francisco

2.3 Hamlet C. Pulley, M.D., M.P.H.
Assistant Director, California State Department of Public Health, Retired, and APHA Consultant recently assigned to study and report on special organizational problems in the Jamaican family planning program.

3. Methods of Work

The evaluation was conducted in Jamaica from March 19th through April 6th, 1974, and reviewed in Jamaica on June 17th and 18th of that year.

Prior to arrival in Jamaica, the team reviewed reports and studies prepared by previous consultants in order to familiarize itself with the background of the program and the work already done by others. In addition.

the team was privileged to meet with four resource persons for a full day on March 13, 1974 in Oakland, California to discuss aspects of the Jamaican family planning program in detail, to clarify the tasks ahead of the team, and to develop preliminary plans for completing them. This was followed by one and one-half days of briefing in Washington, D.C. by US/AID officials and representatives of other agencies which have contributed to the Jamaican family planning program.

In Jamaica, the team met with officials of the National Family Planning Board, the Ministry of Health, the University of the West Indies, and other organizations and institutions contributing to the national family planning effort. To broaden and deepen understanding of the program and its effects, additional documents were reviewed, a number of field visits were made throughout the island, and opinions were sought at many levels from many individuals--providers, consumers, and interested observers. Persons contacted and documents reviewed are listed in the Appendices.

While the team as a whole shared overall responsibility for the evaluation, wherever possible specific assignments were divided among team members to make maximum productive use of each person's particular expertise, as well as of the time available to the group for its task. Dr. Pulley assumed the primary burden of investigating organizational and administrative matters. Dr. Minkler devoted major attention to the clinical aspects of the program, and Dr. D'Onofrio concentrated on information, education, and communication. Within each of these broad areas, team members took responsibility for examining corresponding needs and efforts in training, research, and evaluation.

Towards the end of the team's two and one-half weeks stay in Jamaica, meetings were arranged with the Minister of Health, members and staff of the National Family Planning Board, faculty at the University of the West Indies, and US/AID representatives in Jamaica to discuss preliminary findings and to augment essential background information.

The team then returned to California to draft the evaluation report. Individual members wrote specific sections after which they were reviewed and revised by the team as a whole. At the request of US/AID, preliminary highlights from the report were sent to Washington in rough draft form on April 23, 1974. Reactions to this early copy were helpful in making further draft revisions.

Before the draft was finalized, the team returned to Jamaica in order to discuss its findings and recommendations with the Minister of Health, the Executive Chairman of the National Family Planning Board, and other key personnel. During the team's two day series of meetings on June 17-18, it was accompanied by Mr. Charles Johnson, Chief of the Latin American/Population Office for US/AID Washington and by Mr. Wilbur Wallace, AID Population Officer in Jamaica. The team appreciated this opportunity to share its observations and conclusions with AID officials, as well as with Jamaican leaders, and feels that doing so has strengthened this report.

Throughout its work, the evaluation team has been most grateful for the cooperation and kindnesses extended by the many people wich whom it came in contact. Each of the persons listed in the Appendix has contributed to the preparation of this report, and working with them has been a pleasure for the evaluation team which it will long remember.

4. Limitations of the Report

The evaluation team began this project with the understanding that its findings would be useful to the institutions primarily responsible for the Jamaican family planning program, as well as to the several external agencies supporting this effort, in reviewing past accomplishments, in determining future directions, and in defining foci for continued and new collaboration. Unfortunately, neither Jamaicans nor outside representatives of donor agencies assigned to Jamaica had an opportunity to participate in preparing the evaluation guidelines. Moreover, a number of key persons in the Jamaican family planning program received little or no advance notice of the team's arrival or of its mission and significance. These handicaps plus the magnitude of the changes occurring on the island generally and in the family planning program particularly further complicated completion of a task already recognized as large and complex for the limited time available to the evaluation team.

In spite of these obstacles, the team hopes that it has succeeded in pointing out areas of program progress, as well as possibilities for increasing program productivity. While the worth and the feasibility of our recommendations must be decided by those who know the Jamaican people and their family planning program best--the Jamaicans themselves--our purpose will have been achieved if this report, both in content and in the process through which that content was developed, serves to stimulate the coordinated planning and mutual cooperation upon which further advances will be based.

The report has been organized, insofar as possible, according to the guidelines provided by US/AID. These, however, were developed to facilitate project evaluations within more limited time frames, and thus they were not always amenable to the more comprehensive evaluation which this report addresses. Moreover, because of the complex interrelationships among the many components of the program, certain subjects had to be treated in more than one section of the report. Efforts have been made to minimize repetition of material by referring the reader to other relevant pages.

II. BACKGROUND OF POPULATION/FAMILY PLANNING IN JAMAICA

While voluntary family planning in Jamaica can be traced as far back as 1939 when the "Jamaica Birth Control League" was founded, the beginnings of interest in rapid population growth are more difficult to establish. Family planning as a program began with small clinics in Kingston and St. Ann's Bay, leading to the founding in 1957 of the Jamaica Family Planning Association as an affiliate of IPPF.

Some government effort began as early as 1963, and by 1966 some 25 family planning clinics were opened by a Family Planning Unit in the Ministry of Health. In 1967 the National Family Planning Board was established with the objective of reducing the birth rate from 39 per 1000 (in 1966) to 25 per 1000 by 1976.

The NFPB became a statutory entity in 1970 by virtue of the National Family Planning Act. Since then it has been responsible for operating an essentially segregated, unipurpose, clinic-oriented program, as well as promulgating national family planning policy and coordinating the activities of official and voluntary agencies in this field. From 1968, when computer records of program performance were begun, through 1973, the NFPB's clinics accounted for 121,000 of the total 149,000 clients registered for family planning services by all Jamaican agencies up to that time. Nevertheless, the drop-out rate was high.

As early as 1970 it was recognized that reaching the goal required:

1. rapid acceleration of educational efforts,
2. extension of clinic hours,
3. new patterns of delivery of family planning services,
4. measures to conform with expectations and convenience of clients, and
5. re-introduction of an effective outreach program to recruit new acceptors and to follow-up on drop-outs.

In 1972 a shift of emphasis for the new Five Year Plan called for:

1. full-time rather than part-time clinics,
2. more training of personnel,
3. assignment of additional education officers,
4. integration of family planning with health and social services, and
5. greater involvement of other agencies.

By 1973 the network of clinics had grown to 161 locations (including two mobile units). Seventeen were full-time clinics, 134 "sessional" or part-time clinics, and 10 satellite outposts. Altogether 9,912 family planning sessions were held. By the end of 1973 active acceptors within NFPB's data system numbered 40,000 with another 4,000 in a few clinics not in the system.

The present government's commitment to family planning as one of Jamaica's highest priorities was re-affirmed by the current Minister of Health and given official recognition with publication of "Ministry Paper

No. 1- Family Planning" on January 22, 1974. This document enunciated a major policy change, calling for integration of family planning into regular health services with the transfer of 143 family planning workers from the NFPB into the MHEC establishment.

The implementation of the integration plan became official as of April 1, 1974, and although the NFPB is retained, its role has been altered under the new plan. While the Board is still responsible for coordination, information, training, and evaluation of family planning activities, the actual delivery of services is to be integrated with those of the Ministry of Health and Environmental Control. In the future all health institutions are expected to provide family planning services at any time the Health Centre or clinic is open. The administrative liaison between the Board and the Ministry is the Principal Medical Officer for MCH, Nutrition, and Family Planning in the MHEC, who is concomitantly the vice-chairman of the NFPB.

It is important to note that the health delivery system itself is undergoing profound change in Jamaica. Plans for a National Comprehensive Health Care Programme ("Medicare") are contained in The Health of the Nation, a document prepared by the MHEC, which is now in its "green paper" stage and destined to be debated in Parliament in July.

This document, based upon an analysis of the present health delivery system and the current health status of the nation, identifies health objectives for the next decade and contains recommendations for improvement over the present management of health. Essentially, it envisages 150 primary care units ("community health centres"), each staffed by a "module" health delivery team, emphasizing decentralization and maximal use of paramedical skills. Secondary levels of care and preventive services are to be modified so as to become complementary to the community health centres. An annual cost of approximately $9,000,000 for staffing these modules is foreseen. Proposed capital expenditure is $4,000,000 for the first year, and $2,000,000 additional annually for each of the next four years. It is proposed that these costs be met by:

a) The consolidation fund
b) Obligatory national health insurance, supplemented by:
c) Charges for certain services and supplies
d) Charitable funds, sweepstakes, etc., and
e) Subrogation of third party insurance.

III. JAMAICA'S POPULATION/FAMILY PLANNING OBJECTIVES AND POLICIES

1.0 Objectives and Policies

"Ministry Paper No. 1 - Family Planning", currently the most authoritative source of Population/Family Planning policy, states "the whole purpose of the family planning programme lies in the benefits to be derived by the individual, his or her family, and the social and economic advancement of the population as a whole." Within this framework, a population policy based upon projections of birth, death, and emigration rates has emerged with a recently extended target of reduction in birth rate to 25 per 1000 now set for 1977-78.

In order to achieve this target, the present number of active family planning clients, now estimated at less than 50,000, should rise to 100,000 by the end of 1977. The operational objective of enrolling 25,000 additional users per year will not suffice to reach this goal unless the current drop-out rate is also considerably reduced.

In pursuit of the rapid expansion of family planning acceptance, the following policies constitute the major thrust of the program:

1. Integration of the family planning services into the health delivery system.

2. An enhanced public information and motivation campaign whose objective is "to promote attitudinal and behavioral change so that at the individual and family level there is an increasing sense of responsibility as regards the welfare of children and quality of life."

3. Involvement of other Ministries, organizations and the commercial and industrial sectors in a multi-faceted approach to family planning education and the provision of services.

4. Initiation of teacher training aimed at eventual island-wide Family Life Education in the schools.

5. Expansion of training and research under a comprehensive five-year training programme.

6. Narrowing of the gap between demand for voluntary sterilisation and delivery service.

7. Distribution of contraceptives through commercial channels.

8. Expansion of the postpartum family planning program.

9. Establishment of ten rural maternity centers where postpartum family planning education will be provided.

10. A study of social legislation with changes, where necessary, in order that such legislation will harmonize with programs designed for the social advancement of the population.

2.0 Jamaica's Commitment to Family Planning

The Government of Jamaica was one of the first in the Western Hemisphere to adopt a policy of slowing down the growth of its population. Thus the GOJ, since its first five-year independence plan (1963-68), has officially encouraged "the spread of information on, and techniques for, the spacing or limitation of families for the benefit of those persons who desire them."[1] The present Government's commitment to family planning as one of Jamaica's highest priorities was personally reaffirmed to the team by the current Minister of Health, Dr. Kenneth McNeill.

Indications of Jamaican commitment to family planning include the following:

1. Increasing budgetary support for family planning in every fiscal year since 1968 (from $304,162 in FY 1968-69 to $1,342,000 in FY 1973-74).

2. Growth in family planning clinics from 25 in 1966 to 161 locations served in 1973.

3. Integration of family planning program into the mainstream of health services on April 1, 1974.

4. Re-affirmation in "Ministry of Health Paper No. 1 - Family Planning" that the Government "considers family planning as a matter of the highest priority and unanimous adoption of this document by Parliament.

5. Assurances by the Minister of Health that family planning services will be administered on a broader geographic and time base ("at any time the Health Centre is open"), that integration was not devised simply to save money, and that the program has been "stripped of politics." [2]

6. General agreement by all persons encountered in the course of this evaluation that the Government's commitment to the program is firm and genuine.

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1. Five Year Independence Plan, 1963-68.
2. Meeting of MOH with nurses and FPEOs of the NFPB, April 2, 1974.

3.0 Factors Affecting Jamaica's Population

The main trends in Jamaica's population are summarized by the following data:

A. Fertility: The crude birth rate declined from 42 per 1000 in 1960 to 34.4 in 1970 where it seemed to reach a plateau until it dropped to 31.3 in 1973.

B. Mortality: The crude death rate decreased from 8.8 per 1000 in 1960 to 7.2 in 1973. Further significant reductions are not expected. While detailed age-specific death rates are not available, it is noteworthy that infant mortality dropped from 51.5 per 1000 live births in 1960 to 32.2 in 1970 and still further to 26.2 in 1973. Thus in 1973 only half as many infants were lost in the first year of life as in 1960.

C. Migration: In the ten year period 1960-70, 284,000 Jamaicans emigrated from the island. Emigration, averaging twice the annual number of deaths, is especially significant insofar as it is markedly age-selective, affecting mostly the 15 to 34 year old age group, within the child-bearing span.

Clearly, emigration has been the dominant influence in restraining the population growth rate within recent years. Professor George Roberts of the UWI notes, "Although emigration is responsible for curbing rates of growth to a remarkable degree, it is patently unrealistic to continue to rely on this as a firm policy for containing rates of growth."[1] Assuming that the crude death rate remains at about the 1973 level, and that emigration at these levels is unlikely to continue, it is obvious that control of fertility must be the major concern of public policy.

4.0 Extent to Which Population Policies Have Been Achieved

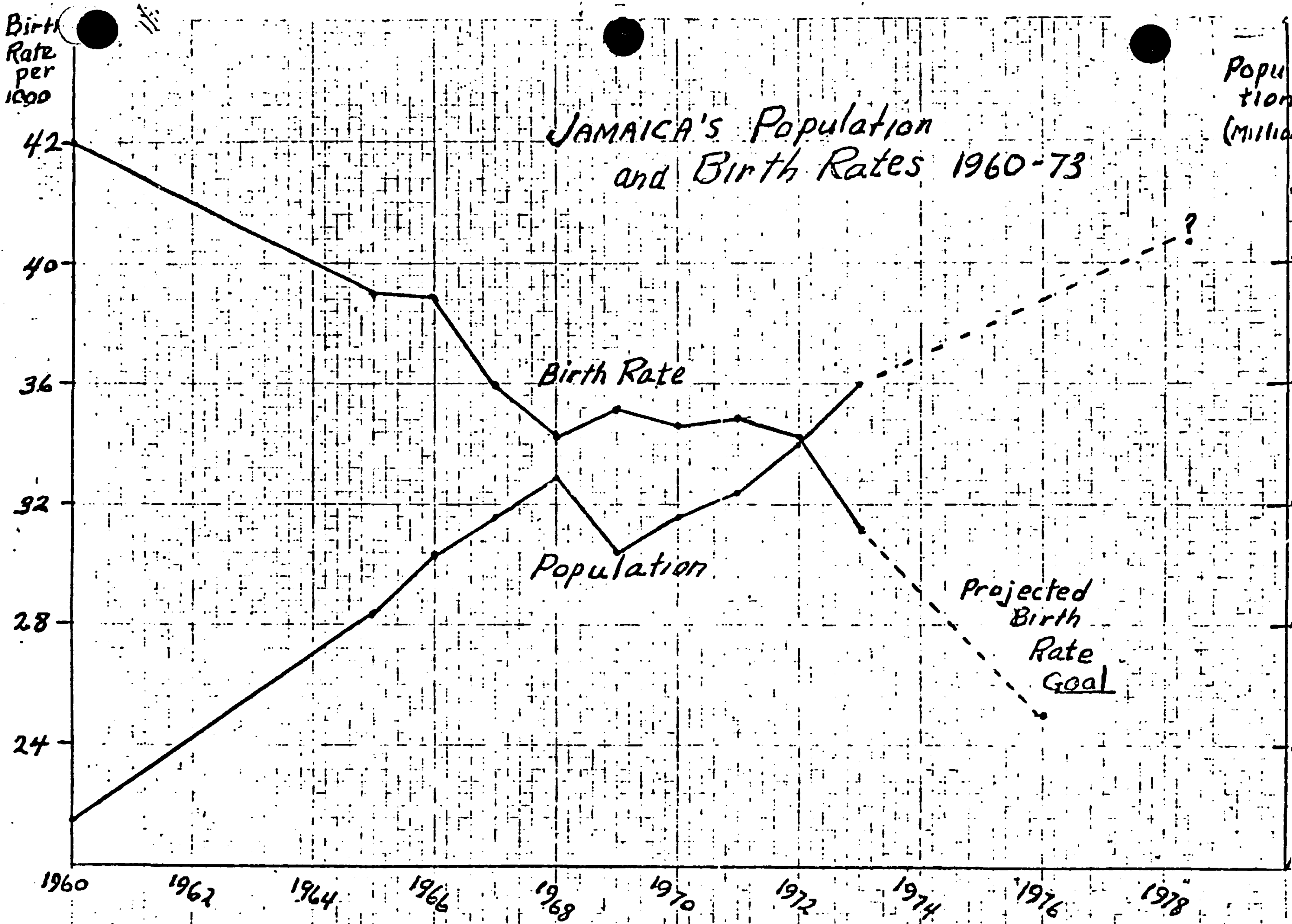
While some degree of impact of family planning activity is generally acknowledged, the demographic changes of the past decade as reported cannot be directly attributed to GOJ public policy or to the family planning program *per se*. More refined indices such as yearly fluctuations in age-specific fertility, the gross reproduction rate, and measures of completed family size will be required to assess the effect of national family planning strategy on recent fertility rates.

1. "The Demographic Position of Jamaica," by Professor George Roberts, 1971.

TABLE I

Population, Birth and Death Rates
1960 through 1973

Year	Population end of December	Birth Rate per 1000	Death Rate per 1000	Rate of Natural Increase	Infant Mortality Rate (per 1000 live births)
1960	1,639,000	42.0	8.8	33.2	51.5
1965	1,811,000	39.0	7.9	31.1	37.4
1966	1,859,000	38.9	7.8	31.1	35.4
1967	1,893,000	35.9	7.1	28.8	30.5
1968	1,923,000	34.3	7.6	26.6	34.4
1969	1,863,700	35.1	7.6	27.4	33.4
1970	1,890,700	34.4	7.7	26.8	32.2
1971	1,911,900	34.9			
1972	1,953,500	34.3	7.2	27.0	30.9
1973	1,997,908	31.3	7.2		36.2



Birth Rate per 1000
Population (Millions)
JAMAICA'S Population and Birth Rates 1960-73
42
40
36
32
28
24
Birth Rate
Population
Projected Birth Rate Goal
?
1960
1962
1964
1966
1968
1970
1972
1974
1976
1978

Lacking these data, performance statistics are generally cited as indirect indicators of progress toward Jamaica's population goal. A summary of recent accomplishment includes the following:

	Registered at Clinics	Continuing Acceptors
NFPB computer data (11/68-73)	121,000	41,000[1]
Two voluntary clinics	9,000	3,000 (estimated)
Sterilizations reported 1972		2,000+
Sterilizations reported 1973		2,379
Total	130,000	48,379

In pursuit of the target of 25 births per 1000 population, an objective of 100,000 female users ages 15-44 years (roughly 30-40 percent of women in the reproductive ages) was established. In the time that the NFPB has had computer services available, 130,000 women have registered, of whom some 44,000 or 30 percent remain as continuing users. In 1973, there were 25,540 new acceptors, and an increase in the numbers of younger acceptors was noted.[2] These figures reflect significant accomplishments in the years since the program began. By simple calculation, however, even these encouraging trends point to achievement of the target no earlier than the late 1980's unless further acceleration in both acceptance and continuation rates is achieved.

The need to improve program performance is highlighted by recent data which show that in Jamaica among women of child-bearing age, there has been a consistent rise in the number of children per woman in the years 1943 to 1970. Data from the years 1943, 1960, and 1970 were used for comparison. The increase is seen in all age groups from 14 to 44, with 1960 showing an increase over 1943, and 1970 showing a still further increase.[3]

The number of births must be reduced by approximately 2,500 each year if the goal of 25 births per 1000 population is to be reached by 1977-78. Unfortunately, currently reported information regarding acceptors does not permit estimation of births averted or couple-years of protection in the absence of data on continuation rates by method and the age, parity, and previous contraceptive experience of acceptors. Recommendations aimed at correcting this shortcoming in program evaluation form a part of this report.

While it is not possible to ascribe direct credit to the national family planning program for the recent decline in Jamaica's birth rate, the evaluation team nevertheless concurs with the opinion that the extension of clinics, establishment of an education and training infrastructure, and actual services provided to date have indeed established the validity of the family planning program as one important element in Jamaica's overall population strategy.

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1. There is some question about the basis for this figure.
2. US/AID Airgram, February 21, 1974.
3. From an unpublished paper by Sonja Sinclair, SRA, MSC, Hygiene, Dept. of Sociology, UWI

The team is convinced, however, that the program's contribution could have been substantially greater with improved planning, management, and coordination at all levels. Strengthening of these essential functions together with integration of family planning into health services and support by a strong information and education effort should lead to marked progress in program performance. The coordination of a family planning program thus improved with social and economic measures "beyond family planning"[1] which involve other public and private sector jurisdictions should render Jamaica's population target within reach.

Whether the goal can be reached within the presently established time frame depends upon the effective implementation of these changes plus the nature and scope of external assistance that is forthcoming in the next few critical years. Finally, it must be noted that even attainment of the goal of 25 births per 1000 population may not suffice to reduce population growth to a level compatible with the economic resources of the island. It is advised that this be regarded as only an interim goal, pending more precise data on demographic trends and economic resources to be derived as the interim target date is approached. Ultimately it should be replaced by a goal expressed as a population growth rate which reflects not only natality, but mortality and migration levels as well. Recognizing this need, Jamaican family planning program administrators have set a tentative target of zero population growth by the end of the century.[2]

1. Berelson, Bernard, "Beyond Family Planning," Science, 163 (Feb. 1969), pp. 533-43.
2. US/AID PROP draft, July 3, 1973.

IV. SUMMARY OF FINDINGS AND RECOMMENDATIONS

It is abundantly clear that progress toward Jamaica's stated interim goal, a reduction in birth rate to 25 per 1000 population by 1977-78, must be greatly accelerated if that goal is to be achieved. The effort to date has been financed by steadily increasing increments of government funds augmented by external assistance from a variety of donors. Until recently the program was confined essentially to a clinic-oriented "family planning" approach. With the advent of the Community Health Aides, the concept of outreach functionaries became established, and family planning became one of the five major tasks of these multipurpose outreach workers.

While program success has been limited in terms of continuing acceptors and impact to date on national fertility statistics, the process of institution-building by the relevant government, academic, and private agencies involved has been accompanied by the progressive acquisition of the political, administrative, and technical capabilities required in order that self-sufficiency may ultimately be attained. The growth of such capabilities is evidenced by:

1. Increasing budgetary support for family planning by the GOJ in every year since 1968.

2. Growth of family planning clinics to 161 locations served in 1973.

3. An annual rate of 25,540 new acceptors reached in 1973, with an estimated 44,000 continuing acceptors.

4. Institutionalization of administrative, training, research, and evaluation functions in the National Family Planning Board, with a recent decision to integrate family planning services and national health services.

The extent to which Jamaica has acquired the specific program capabilities required and the effectiveness of various program inputs, both internally and externally generated, constitute the substance of this evaluation. In brief, however, the team found good progress in formulating family planning policy, although greater interministerial involvement is needed. Ability to provide contraceptive services is good in that an island-wide clinic network has been established. The quality of clinical care is generally high, and contraceptive equipment and supplies are satisfactorily managed. Less strong are abilities to attract contraceptive acceptors and to maintain them as continuing users, as well as to provide sterilization and abortion services.

Inadequate understandings of the roles of information, education, and communication in the program have led to some non-productive and counter-productive efforts, as well as to lack of sufficient long-term administrative support for planned educational approaches. In spite of these obstacles, some progress has been made in building national awareness of the program, in catalyzing the involvement of communities and other national institutions, and in building the base for informed family planning decision-making by Jamaican citizens. Nevertheless much more needs to be done, chiefly in assisting people to link family planning goals to their own personal and organizational

motivations.

Large numbers of Jamaican family planning personnel have participated in training programs, both locally and overseas. Although the quality of training has varied, in general training programs have been good and in a few cases outstanding. Coordination of training priorities with program needs has been less successful.

Where capabilities in the above areas are weak, they tend to be closely related to problems in program planning, organization, administration, management, and coordination. A number of communications difficulties within the program also need to be resolved before communications with other institutions and the general public can be improved. More attention needs to be given to on-going program evaluation and to the use of the results in modifying program design.

Against the background of these strengths and weaknesses, Jamaica must now mount a far more comprehensive attack on the problem of rapid population increase. Its family planning goals must be reconciled programmatically with the broader goals of social and economic development. While family planning, now being integrated with health services and coupled with educational and motivational efforts, is an important element in Jamaica's current population strategy, its wider acceptance depends upon careful orchestration of the family planning effort with the contributions of other ministries, industry, schools, churches, the private medical sector, and the various donor agencies.

Jamaica's increasing committment to the support of its family planning program and its growing capabilities point toward eventual self-sufficiency. Nevertheless, the magnitude of the problem, the present economic crisis, and rapidly changing technology all mitigate against rapid elimination of the need for external assistance. The evaluation team feels that bilateral, multilateral, and private donor assistance should all continue, but require better coordination and communication among the responsible agencies as well as with recipient institutions if their potential for effective aid is to be realized.

The body of this report contains specific recommendations concerning:

* Establishment of an independent interministerial agency dedicated to population planning in relation to total national development . . . . .p. 19

* Planning and decision-making to implement integration of family planning and health services operationally . . . . .p. 26

* Redefinition of the NFPB's coordinating role . . . . .p. 28

* Separation of functions of NFPB Chairman and Executive Director .p. 28

* Review of position of clinic manager . . . . .p. 31

* Filling vacancies in clinic management . . . . p. 31

* Review of functions of the Family Planning/
Epidemiology Unit at the UWI . . . . p. 40

* Funding for the Family Planning/Epidemiology
Unit at the UWI . . . . p. 46

* Importance of the JFPA in the national family
planning program . . . . p. 47

* Redefinition of JFPA role in family planning . . . . p. 47

* JFPA program priorities . . . . p. 48

* JFPA funding . . . . p. 48

* Liaison with MHEC in implementation of commercial
distribution of contraceptives . . . . p. 62

* Controlled experiments in phased non-clinical
distribution of oral contraceptives . . . . p. 62

* Jamaican counterpart for U.S. Field Project
Manager of commercial distribution of contraceptives . p. 62

* Implementation of plans for expansion of training
and provision of equipment to enhance existing
facilities for sterilization . . . . p. 64

* Appointment of ad hoc Committee on Surgical
Procedures Affecting Reproduction . . . . p. 64

* Planning for provision of abortion care in a
comprehensive MCH/FP framework . . . . p. 67

* Training in advanced fertility control techniques . . p. 67

* Study to determine the feasibility of redesigning
the NFPB statistical system . . . . p. 73

* Alternative procurement of injectable contraceptives . p. 81

* Salary levels in reclassification of FPEOs and
AFPEOs . . . . p. 91

* Administrative placement of the Bureau of Health
Education . . . . p. 92

* Annual family planning budget for the Bureau of
Health Education . . . . p. 92

* Provision of qualified health educators to the BHE for assignments of 12-18 months . . . . p. 89

* Consultant services in health education for the BHE . . . p. 92

* Assignment of primary responsibility for IE & C aspects of the family planning program to the BHE . . . . p. 94

* Generally experimental approach to education with systematic evaluation of all educational activities . . . p. 101

* Modification of the NFPB data processing and reporting system according to the Tietze-Potter method of evaluation by continuation rates . . . . p. 101

* Approval of the proposal of Professor Roberts for a study of socio-cultural fertility factors . . . . p. 101

* Completion of the proposed island-wide KAP . . . . p. 101

* Supplementary support to the UWI Census Research Bureau . . p. 101

* Consolidation of available information about attitudes to family planning . . . . p. 101

* Assignment of responsibility and resources for training health workers in education to the BHE . . . . p. 104

* Establishment of a high level position in Family Life Education in the Ministry of Education . . . . p. 125

* Appointment of a consultant in family life education in cooperation with the Ministry of Education . . . . p. 125

* Training of teachers and other supportive personnel in family life education . . . . p. 125

* In-service training in family life education content and methodology . . . . p. 125

* Limited overseas training in family life education . . . . p. 125

* Development of family life curricula . . . . p. 125

* Inclusion of education about the demographic realities and population dynamics in curricula . . . . p. 126

* Expansion of Ministry of Education's committee on family life education . . . . p. 126

* Formation of family life education coordinating committees in each parish . . . . p. 126

* Local development of materials and audio-visual aids for family life education . . . . p. 126

* Allocation of a definite budget for preparation and acquisition of materials supportive of family life education in the schools . . . . p. 126

* Action on request of BHE for specific audio-visual materials . . . . p. 126

* Development of a detailed training plan . . . . p. 131

* Clarification of NFPB responsibilities and relationships in identifying needs and priorities for research and evaluation . . . . p. 147

* Recognition of the Conferences of Ministers of Health (of the Caracom Agreement) as the focal point for initiating activities relating to a regional Family Planning/Population Center . . . . p. 157

* Sponsorship of a regional conference to explore interest in and feasibility of a Regional Family Planning/ Population Center . . . . p. 158

* Continuation of bilateral assistance with latitude for regional direction and a progressive shift to multilateral assistance . . . . p. 158

* Strengthening capabilities within Jamaica for coordinating external donor agency assistance . . . . p. 173

* Origination of requests for donor agency assistance . . . . p. 173

* Donor agency assistance and coordination . . . . p. 173
(Various specific recommendations)

V. END OF PROJECT CONDITIONS, INDICATORS, AND EVIDENCE OF PROGRESS TO DATE[1]

1.0 Capability within the NFPB, the MHEC, and the UWI in Developing and Implementing Family Planning Policy

1.1 Policy-Making Authority

Ministry Paper No. 1 - Family Planning states that the Government of Jamaica accepts responsibility for establishing family planning policy and that the Minister of Health's Office is the focal point for enunciating such policy. Thus clearly defined policy-making mechanisms are established which ensure GOJ support, and a clear authority for articulating policy exists.

Such mechanisms and authority have been inherent since the GOJ's first involvement in family planning and were formalized in the relationship between the Ministry of Health and the NFPB set forth in the 1970 Act creating the Board. Nevertheless, Ministry Paper No. 1 represents more exercise of the Minister's policy-making function than has been true previously.

In the past, primary responsibility for formulating and announcing policy, with the Ministry's advice and consent, rested with the National Family Planning Board. This, however, resulted in some ambiguity and misunderstanding about the extent of the Board's policy-making authority.

Now principal responsibility for policy-making has operationally shifted to higher echelons, and this has helped to clarify responsibilities. As one informant told the evaluation team, "the Government's stand on family planning has been clarified more in the last two years than in the previous decade."

The formal activation of the plan to integrate family planning with MCH and nutrition services which began April 1, 1974, coupled with the personal interest shown by the Minister himself in the successful initiation of this integration, underscores the Minister's Office as the focal point from which GOJ family planning policy emanates.

1. Conditions expected by the end of US/AID Project assistance are designated by the Arabic numerals 1.0, 2.0, etc., through 9.0. Indicators to measure progress to date are specified in sub-headings, e.g., 1.1, 1.2., etc. Findings concerning the extent of progress are discussed in the narrative following these headings and sub-headings.

1.2 Scope and Adequacy of Policy

Ministry Paper No. 1 is a broadly-based statement of the need for family planning in relation to the social and economic development of the country and to the improvement of the quality of individual and family life. Moreover, as previously indicated, it outlines clear program thrusts which, in the opinion of the evaluation team, will be instrumental in accelerating progress toward the achievement of Jamaica's family planning goals.

As discussed throughout this report, achieving these goals will require substantial intensification of program efforts and improvement of program performance. Thus in one sense, current policy may be overly ambitious for present resources and capabilities. In another, however, the targets which have been set may not be sufficient to produce desired progress toward socio-economic development and improvements in the standard of living. Given this dichotomy, the adequacy of policy will need continuing evaluation, which the Minister of Health recognizes.

The scope of the policy contained in Ministry Paper No. 1 represents a considerable advance over previous Governmental policy statements. While the GOJ's first five-year independence plan (1963-68) indicated that the Government was concerned with both national and individual effects of uncontrolled fertility, its approach to the problem at that time was largely limited to the spread of birth control information and services. Voluntary participation was established as an essential program principle, and re-emphasized in a 1966 Ministry of Health policy statement.

Although the objective of the program was—and is—ultimately to improve the quality of life in Jamaica, initially little concern was shown for interpreting the relationships between family planning practice and the achievement of this goal. Rather the underlying rationale for the program was basically economic,[1] with lesser attention to the immediate human aspects. The program stressed the recruitment of new acceptors and program progress was assessed primarily through this measure. The continuation of contraceptive use received less emphasis, as did the impact that this might have on the postponement of first pregnancies, child spacing, or limitation of family size. The significance of these latter factors in bettering family life and in advancing the socio-economic development of the nation were not widely discussed.

As a consequence of this early policy focus, some individuals reportedly came to equate family planning with birth control, but did not really understand the reasons for practicing either. Similarly, some organizations and institutions, failing to recognize the impact of population growth on other national problems, contributed little or nothing to the national family planning effort. Others criticized the NFPB's clinically-oriented approach as too narrow or too economically oriented at the expense of individual and social considerations. The resistance thus generated undoubtedly held the program back.

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1. See a report of an interview with the Hon. Dr. Herbert W. Eldemire, MOH, in "The Minister's View," JFPA News, Vol. 1, No. 5, August, 1971, pp. 7-8. Also see the 1970 IBRD Project Appraisal Report.

Shortly after the present Government came to power in 1972, a greater focus on the social aspects of family planning policy became apparent. In a widely-quoted speech, Dr. Mavis Gilmour, then Parliamentary Secretary of the MHEC, stated that:

> ". . .the emphasis and philosophy behind the interest of this Ministry in family planning is not first and foremost economy, but first and foremost the human being."

Ministry Paper No. 1 translates this notion into specific policy which operationally should do much to help the nation, individually and institutionally, more fully appreciate the relationships between family planning and the quality of individual and family life.

Current policy, however, does not place equal emphasis on the relationships between the demographic situation and total national development. While the Minister of Health avows that the present Government regards family planning as a matter of the highest priority, stating that it is "one of the key factors governing fertility and the rate of population growth," the evaluation team feels that a truly holistic approach with top-level interministerial cooperation to establish policies "beyond family planning" is lacking.

> RECOMMENDATION: That the GOJ establish an independent inter-ministerial agency dedicated to Population Planning in relation to total national development, and charged with coordinating the policies and plans of the various Ministries whose activities relate to the pursuit of national population goals.

In summary, the evaluation team feels that the GOJ has developed sufficient capability in formulating "Family Planning Policy", but has not demonstrated sufficient capability in formulating an overall, broadly-based Population Policy, which is necessary to achieve greater community support for family planning and to bring into focus all of the activities which bear directly and indirectly on human reproduction.

1.3 Policy Role of the NFPB

Although the post-integration status of the National Family Planning Board remains fluid at this time, it would appear that it retains certain functions in suggesting and implementing policy. Its precise role in this regard, however, still is not clear.

The evaluation team sees the Board as a continuing resource to provide the Minister with data, information, and technical advice on which to base policy decisions. Whereas the Board as presently constituted appears to be capable of fulfilling this support role in the integrated family planning program, it does not appear to be equipped for the coordination of activities in health and family planning with those of other Ministries, organizations, and the commercial sector, as is called for in Ministry Paper No. 1.

Although the 1970 Act which established the Board as an independent statutory body included provision for collaboration with other organizations and institutions in the national family planning program, this has been minimal at the policy-making level. Various reasons for this lack have been identified, but four principal ones stand out:

A. First is the problem of the Board's relationship to the Ministry of Health, and specifically, questions about channels of communication between the NFPB and other Ministries. Prior to integration, such contacts as were made with other Ministries seem to have been with middle-management personnel rather than with those persons responsible for Ministerial policies and priorities. Now that Governmental authority for family planning policy is clearly located in the Minister of Health's Office, it is doubtful whether the Board can or should be working at a high interministerial level.

B. Secondly, the Board has not been widely representative of public and private organizations which could contribute to the development and implementation of national family planning policy. This problem was raised in Senate debate prior to approval of the 1970 Bill to establish the NFPB as an independent statutory body.[1] The 1970 IBRD Project Appraisal Report also recognized that inadequate breadth of representation on the Board was hindering program formulation and implementation, and particularly pointed out the need for wider representation of governmental interests in Board membership. Madhok, in his 1973 consultancy report for the IBRD criticized the representativeness of the Board in another respect, pointing out that although the national family planning program was directed primarily to women, at that time only one woman held Board membership. The general problem of inadequate Board representativeness has been addressed in a number of other reports concerning the national family planning program.

The lack of broad representation on the Board has had several consequences. Some organizations have simply remained detached from the national family planning program, unaware of their potential contributions or uncommitted to the need. Others have criticized the "Board's program" because it did not reflect concepts which they felt were important—and because they found no opportunity to introduce them as policy considerations. Still others have undertaken family planning activities quite apart from Board involvement. This has, at best, hindered the development of a truly national coordinated effort, and at worst, has resulted in fragmentation, overlap, and wastage of resources.

Although membership of the Board was reconstituted to become more representative at the time that Ministry Paper No. 1 was released, problems of image still linger, and these are likely to affect the Board's future capabilities in interagency coordination. Statutory limitations on Board size also affect the extent to which widespread organizational representation can be attained.

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1. The Daily Gleaner, Dec. 8, 1970.

C. A third major reason identified for the lack of greater inter-agency involvement in the family planning program relates to the Board's emphasis upon birth control and the heavily clinical orientation of its program. This focus tended to exclude the participation of non-health workers who felt that they had nothing to contribute in this context or that the program was peripheral to the priorities that they saw. For the same reasons, this focus also tended to inhibit the integration of family planning into social and economic programs at the national level and action on related issues.[1]

While the integration of family planning services into general health services represents a substantially expanded program approach, there remains the possibility that some agencies and organizations will still consider "health" narrowly and thus fail to see their role in family planning as a health program. Nevertheless, the MHEC by virtue of its multi-faceted health interests would seem to be more effective than the uni-purpose NFPB in interpreting family planning as an essential component of health considered broadly in the sense of physical, social, and emotional well-being.

D. The NFPB's past efforts to coordinate family planning activities have also, in some respects, inhibited the more widespread involvement of other organizations in national family planning policy development and program implementation. This seems to be because Board staff leadership has not clearly distinguished between the processes of "coordinating" and "directing." As a consequence, the Board, in at least some circles, has developed the image of being arbitrary and demanding, rather than open, facilitating, and cooperative.

1.4 Role of the UWI

The role of the University of the West Indies in formulating family planning program policy is not clear. While Professor George Roberts serves on the National Family Planning Board and several other faculty members have been named to various Board committees, the basis for faculty member participation in Board activities can be variously interpreted, sometimes seeming to rest on an individual's expertise in a discipline and sometimes on his or her membership in a given Department or Unit.

The family planning/population interests within the University as a whole have no organized mechanism for contributing to policy decisions. Thus the University has not made the valuable contributions of which it is capable in the policy-making process. Moreover, some leaders in family planning within the UWI are reluctant to take the initiative in developing a more active role in policy formulation, feeling that unless opportunities are opened for this to occur, they could be perceived as interfering or attempting to "take over." The attitude was also expressed that since questions of jurisdiction are unclear and "everyone is interfering with everyone else," efforts of UWI faculty members to participate more actively in policy formulation would compound an already difficult situation.

Although as later described, certain Departments and Units within the UWI accept major responsibilities in training and research related to the national family planning program, the basis for deciding priorities in relation to overall policy directions is ambiguous. This has resulted in lack of needed financial support for certain projects, program expectations which exceed University resources, much dialogue about the adequacy of University outputs, perceptions of Board interference with the way in which University personnel go about their work, and inadequate integration of University training and research efforts into program operation.

The resulting confusion and breakdown in communications has particularly affected relationships between the NFPB and the Family Planning/ Epidemiology Unit within the University's Department of Social and Preventive Medicine, since this Unit has been developed with US/AID assistance especially to support the national family planning program. Thus in the Unit's report for the latter half of 1973, its Director wrote:

> "There seems to be a lack of meaningful dialogue and decision-making between the Unit and the National Family Planning Board. . . We feel that this problem is due at least in part to a lack of real access of Unit personnel to the decision makers. It seems also, however, that we have been passing through a period of uncertainty over the direction in which the national programme will move, with a consequent lack of clear policy guidelines and implications for programme implementation."

In an attempt to overcome some of these problems, Pro-Ag 72-5 provided for a Policy Coordinating Committee to be established with representation from the NFPB, the MHEC, and the UWI. Specific functions were spelled out for both the NFPB and the UWI to facilitate the work of this Committee, and it appears that both have fullfilled those which can be routinely performed. Only partial progress has been made, however, in discharging those functions which depend upon factors which are not easily controlled. Thus, for example, the UWI's recruitment of personnel has been handicapped in several respects (see pp.40-1), and the NFPB's responsibility to ensure liaison with the DSPM so that the administrative activities of the training office and the statistical officer are in harmony with DSPM activities involves a series of actions by a number of persons.

Over and beyond these matters, other problems have affected the extent to which the Policy Coordinating Committee has been able to carry out the coordination of research and training activities in support of the Jamaican family planning program. These relate to broader issues which are addressed throughout this report and which have affected almost all aspects of program operation.

As the policy roles of the NFPB and the MHEC are changing, the role of the UWI in policy-making remains undefined. Certainly some coordinating mechanism is needed which will enable the University to contribute the full range of its expertise in family planning and population to policy formulation, as well as to integrate its efforts more closely with program implementation and evaluation. While it would be premature to suggest the specific nature of this mechanism until responsibilities and channels of communication within and between the MHEC and the NFPB are stabilized, a beginning point would be a frank discussion of the issues and the options among the leaders of these institutions and those of the UWI who are most concerned with the national family planning program.

1.5 Basis for Policy Decisions

The formulation of effective policy must be based upon a balanced consideration of the problem in all of its many aspects, the resources which are available or can be developed to address it, and the strategies which are most likely to succeed in attaining both short-range and long-range goals.

Conceptualization of the problem--and of possible solutions--depends largely upon the particular viewpoints, vision, and expertise of those who participate in analyzing it. Understanding of the family planning problem in Jamaica has evolved from an early emphasis upon the need for information and services to a recently expanded focus upon family planning as an essential component of comprehensive health care. Concomitantly, responsibility for policy-making has increasingly involved those with expertise in health as it relates to broader human and social problems.

Now the social, demographic, and economic aspects of the population problem need to be more thoroughly analyzed in relation to strengthening family and community life in Jamaica and to advancing the socio-economic development of the nation. This will require increased participation in policy-making by persons with breadth and depth of understanding in the multiple specialty areas involved. Therefore, the expanded involvement of public and private organizations in the family planning program, as called for in Ministry Paper No. 1, is essential to assure an adequate basis for comprehensive policy development.

In addition, those intimately familiar with problems of program delivery and responses to the program in local communities can contribute much to the development of policy which will be workable and effective in the field, for policy must be grounded in a realistic understanding of the possible. This depends not only upon the human and material resources visibly available to the program, but also upon recognition of the potential for generating new resources and creatively utilizing old ones. Moreover, it requires sensitivity to the interests, motivations, skills, and priorities of the people upon which the program depends. Since these factors are dynamic and ever-changing, they cannot be assessed in more than a general way at the national level.

This means that national policy should be sufficiently flexible and provide sufficient freedom for local involvement in planning and decision-making, while at the same time, persons knowledgeable of differing local field situations should have a voice in national policy formulation. Many past weaknesses in family planning policy could have been avoided or corrected through more grass-roots participation in policy discussions and more local feedback on reactions to policy decisions. Some efforts to obtain parish-level involvement in policy determination and program design are now being undertaken.

While policy should be based on the deliberations of a variety of people representing different disciplines, agencies, and levels of program experience, the importance of solid data in policy-making cannot be overlooked. Nevertheless, prior problems in the availability of vital demographic data and service statistics (see pp. 70, 236) have limited the extent to which such information has been used in policy formulation. Action is already underway to remedy some aspects of this problem, and this report contains several suggestions and recommendations designed to improve the data base for planning and evaluation further still. These include better internal monitoring of the program and its various components, increased use of research findings in program planning, and a generally experimental approach to the implementation of new program approaches. The key to the effective utilization of resulting information, however, lies in the analysis of its implications for the program as an integral part of policy development and review.

1.6 Mechanisms for Policy Implementation

While subsequent sections of this report deal with mechanisms for policy implementation in some detail, a few general comments are relevant here.

Family planning policy to date has been concerned with broad program directions, leaving the development of the specific mechanisms through which such policy would be implemented to administrative personnel. Although this pattern appropriately provides needed administrative flexibility, operational planning for policy implementation to date has been delayed and incomplete. Moreover, program personnel have had little or no opportunity to participate in discussing the need for policy changes or in developing plans for policy implementation.

Failure to develop adequate mechanisms for policy implementation in close coordination with policy formation has serious negative consequences, as illustrated most recently by the experience of integration. Since most program personnel first became aware of impending policy changes through the newspaper, the impression was created that program administrators held little concern for their opinions or reactions. In the absence of information about how their jobs would be affected, rumors ran rampant and resistances developed. Energies which could have been channeled constructively into planning instead became dissipated. Thus, as one informant stated:

> "The subject of integration has been like the sword of Damocles hanging over us for months. Concern over 'what will happen to me' has paralyzed both people and the program."

Commitment to the program, no matter how strong, is weakened when those who work within it feel that the program has shown no commitment to them. This occurs with frequency when people have no voice in making the decisions which nevertheless affect them personally and which they are expected to execute.

Another problem arising from insufficient pre-planning for policy implementation is that hasty solutions to complex problems may be adopted simply to answer urgent questions and to bring some order out of chaos. Although such ad hoc decisions may be inadequate, new structures and lines of communication evolve around them which later are difficult to change.

Corollary to this is the tendency to make program decisions without clearly specifying operational objectives and criteria for evaluating progress toward meeting them. This dilutes the possibility of learning from program experience and making needed adjustments accordingly.

Still another consequence is inefficient use of energy and resources. When a problem is complex and there are many ways of approaching it, failure to establish a common frame of reference for dealing with it leads to fragmented and uncoordinated efforts by individuals, groups, and agencies who supposedly are working together. In the absence of a master plan, decisions are made according to varying perceptions of need which may or may not be shared by others. This leads to criticisms of other workers and units, conflicting assumption of responsibilities in some program areas and neglected action in others, and uncertainty about the extent to which efforts contribute to program progress.

At no point in the national family planning program has there been a comprehensive operational plan indicating how all program segments fit together and who has responsibilities for each. Such a framework is now needed so that workers within each unit can see how they relate to others, what channels are available for initiating coordinated action, and how their functions jointly contribute to the achievement of immediate and long-range program goals. This planning framework, however, must not be so detailed or binding that it hinders creativity, initiative, and freedom to respond to changing situations.

In addition, to help avoid problems in the implementation of future policy decisions, primary responsibilties for developing operational plans should be clearly designated at the time that new policy directions are formulated and the persons so designated should be held accountable to those above them in the policy-making chain. Moreover, the process of formulating policy and plans for its implementation, wherever possible, should involve those who will be affected by the decisions which are being made, for this will do much to ensure the mutual acceptability of indicated changes and the necessary commitments to carrying them out.

2.0 General Administration and Management Capability within the MHEC, the NFPB, and the UWI

2.1 Integration of Family Planning into the Ministry of Health

As of April 1, 1974, integration of family planning clinic services officially went into effect. "Ministry Paper No. 1 - Family Planning", which was issued in January, 1974 and introduced on the floor of Parliament by the Minister of Health and Environmental Control on April 3, 1974, is the official document on this subject. In it the basis for integration of services is outlined in detail.

Even though the intent to integrate family planning and other health services was officially announced by the Minister of Health over a year ago, detailed planning for integration remained incomplete as of April 1, 1974 when formal activation of the plan occurred. This action with incomplete planning has produced some inevitable disruptions of service and expressions of protest from personnel whose renumeration and job classification might be affected. The disruptions were generally regarded as temporary and not insurmountable both by GCJ officials and by the evalution team, but some temporary setbacks in program performance should be expected while problems are being resolved.

Although the lack of planning and preparation for integration and the procedures through which it would be implemented reflect serious shortcomings in policy-making and management, there is general consensus with which the team concurs that integration will eventually result in improvement in Jamaica's family planning program. It is still early to assess what precise differences integration will make.

Ministry Paper No. 1 states that "in the future, all health institutions will provide family planning services routinely at any time that the health center or clinic is open to the public." Here it is assumed that "health institutions" refer to the existing primary care units which are destined to be upgraded and staffed by the module health delivery teams outlined in the "Health of the Nation" green paper. The team understands integration to mean the incorporation of family planning into a comprehensive family health format in which most health workers share family planning responsibilities. Thus the family planning clinics will no longer be isolated by separate quarters and staff. As yet, no clear plan is forthcoming for implementing this policy at the point of service delivery.

The team is concerned about how operational decisions will be made to implement the policy of integration. It urges that planning and decision-making include collaboration with knowledgeable field personnel, as well as with all management personnel who have related responsibilities.

RECOMMENDATION: That planning and decision-making to implement integration operationally include collaboration with knowledgeable field personnel, as well as with all management personnel who have related responsibilities.

While such participation has occurred to some extent (as in St. Catherine Parish where the field staff is involved in planning in-service training related to the integration of services), it has not characterized the program sufficiently in the past.

2.2 National Family Planning Board

Although Ministry Paper No. 1 spells out a continued, but altered role for the NFPB under integration, the future of the NFPB is by no means clear. Presently a governmental Committee on Statutory Bodies is conducting an inquiry of such entities with a view toward streamlining the governmental process.[1] The transfer of 143 family planning workers from the NFPB to the Ministry of Health as part of integration leaves the Board with no field staff and a reduced central staff. Several persons in the latter category have resigned and morale among those remaining is generally low. Further, certain appointed members of the Board itself are giving serious thought to the future course of the NFPB and questioning whether its delegated functions are indeed best performed through this body. In the midst of such uncertainty, Board staff are "slowing down" and "grousing about the lack of communication."

Whereas in the past the NFPB had administrative responsibility for the national family planning program, this is now primarily located in the Ministry of Health, leaving the Board largely advisory and coordinating functions. According to Ministry Paper No. 1, "the National Family Planning Board shall concentrate on. . ."

1. Public information and communication in all its various forms;

2. Coordination of activities of the various Ministries, mainly Health, Youth and Community Development, Education, and voluntary organizations, with particular reference to the harmonization of the information and education program with service activities;

3. International matters and assistance;

4. Research:

5. Statistical data and the monitoring and evaluation of the program;

6. Training.

As detailed throughout this report, the evaluation team does not believe that all of these functions are appropriate and realistic for a Board whose responsibility is no longer directly administrative. Furthermore, based upon the Board's past performance, the team has serious doubts about its internal administrative capabilities to carry out these responsibilities. The ability of the Executive Director to exercise continuing leadership has been questioned by a number of persons whom the team interviewed. The lack of checks and balances within the Board is also recognized as a problem.

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1. Personal communication with Professor Michael Smith, member of the Committee.

The contributions of individual Board members and the organizations that they represent are not to be underestimated. Both their efforts and those of the remaining Board staff should be fully utilized to assure that family planning does not become obscured among competing activities as a consequence of integration into the general health program. Although the team acknowledges that detailed attention has been given to post-integration roles of various Board personnel, their capacity to fulfill these roles will be largely dependent upon the quality of Board Executive leadership. Past relationships of the Board with other agencies and organizations may also hinder the development of the strong cooperative ties essential to the level of coordination required.

RECOMMENDATION: The Board's coordinating role as outlined in Ministry Paper No. 1 should be redefined as a responsibility to coordinate family planning activities in the governmental and private sectors as distinct from broader population activities for which a separate interministerial body is recommended.
The office of the Minister of Health would be responsible for this redefinition of duties.

RECOMMENDATION: The functions of the offices of Board Chairman and Executive Director should be separated and assigned to different individuals in order to provide a system of internal checks and balances as well as increased public accountability.

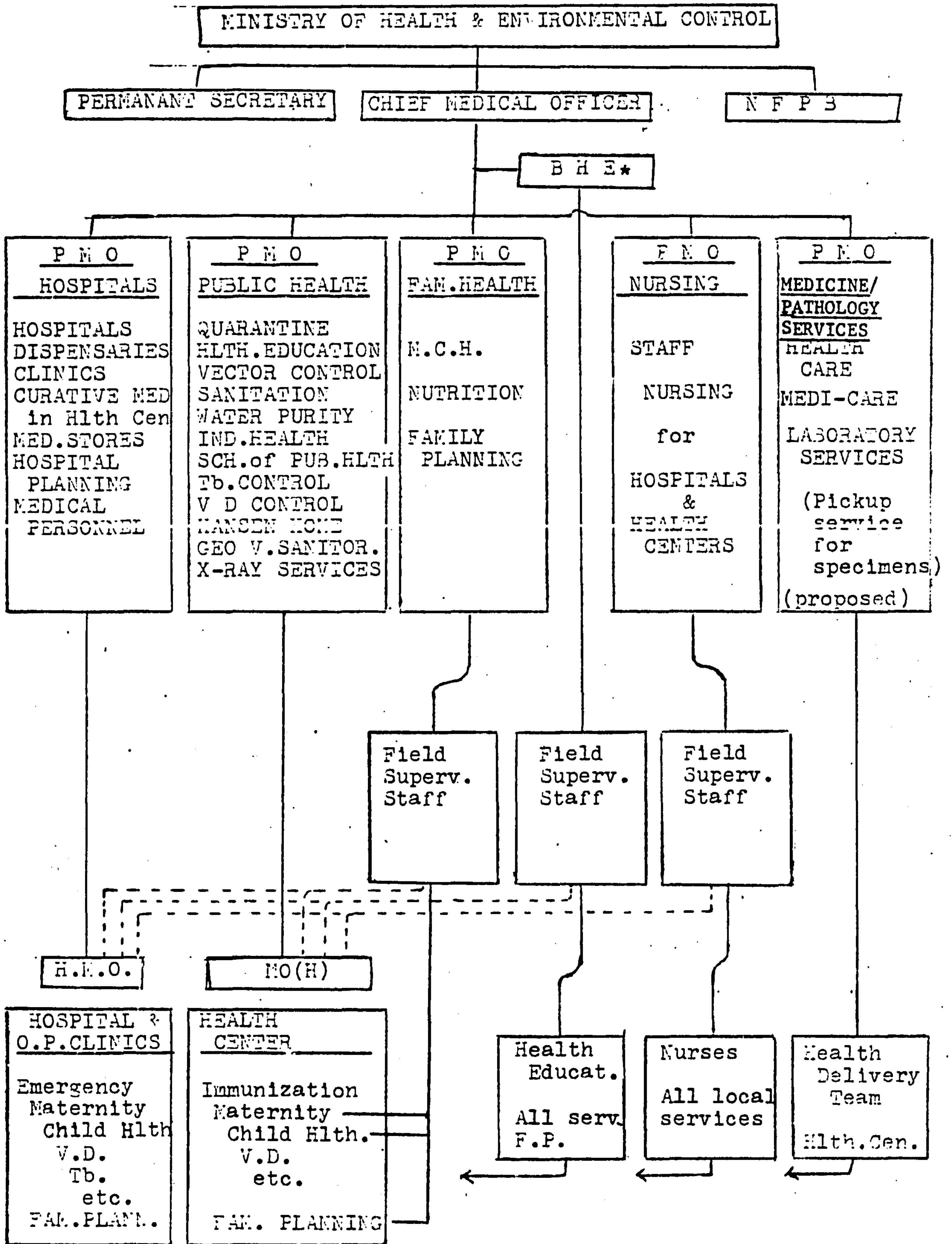
2.3 Administration of Health Services

A. National Organization

In Jamaica, public health and hospital services are administered by a politically appointed Minister of Health and Environmental Control (MOH). He is assisted in fiscal and general management functions by a Permanent Secretary, and in professional aspects by a Chief Medical Officer, four Principal Medical Officers (PMOs), and one Principal Nursing Officer (PNO) with their respective areas of responsibility indicated in the boxes of the accompanying diagram. This diagram shows the BHE in a staff position under the CMO as recommended by the evaluation team at another point in this report, but not as currently located. The National Family Planning Board (NFPB) is in the Ministry of Health, but following integration with reduced staff and functions and without line authority in clinical affairs.

We believe that this is a workable organization with sufficient separation of duties to clarify responsibilities, but nevertheless it requires more than the usual coordination and mutual assistance among all levels of staff, not only internally, but also in relationships with other Ministries and outside organizations.

FIGURE 2



*Placement of BHE is in accord with a recommendation of the evaluation team, and not with its existing location under the PMO: Public Health.

B. Local (Parish) Organization for Health Services

Parish Health Centers and Governmental Hospitals with their out-patient services are essentially local outlets for national health programs. Staffing and administration of these local services is complicated. Both national (Ministry of Health and Environmental Control) and local (Parish) employees are used. The national personnel are from three MHEC units:

1. Public Health Unit: medical personnel, health educators
2. Hospital Unit: medical personnel and aides
3. Nursing Unit: nurses

The Parish personnel are sanitarians and midwives.

Top local health authority is the Medical Officer of Health (MO(H)), employed by the Public Health Unit (MHEC). Within the Parish there may be one or more District Medical Officers (DMOs) in charge of clinics under the general supervision of the MO(H). The Bureau of Health Education (BHE), which employs health education and training personnel, is also in this Unit.[1] The hospital and its outpatient clinics are under a Hospital Medical Officer (HMO), from the Hospital Unit (MHEC). All of the nurses, both at hospitals and health centers, are assigned from the Nursing Unit (MHEC).

With administrative input from these four offices of MHEC and from the Parish Council, it seems almost inevitable that there would be difficulties or inaction, unless:

1. The person in charge of each health center or sub-center is clearly designated, has executive talent, and is respected;
2. The program supervisor has full authority for that specialty; and
3. A good method of coordination and communication has been worked out and followed among top administrators and their staffs in the MHEC.

These points would be recommendations of the evaluation team if they are not already operational.

Two local problems of a general nature surfaced in the short time during our evaluation study:

1. At times there seemed to be undue delay in communications with some of the offices in the MHEC. It might have concerned needed approvals, policy statements, personnel, or supplies.

2. The rigidity with which instructions come from the National Government is sometimes a handicap. The plea is for more flexibility so that local personnel can accommodate to local situations, which may have changed between the time of the initial order, request, or discussion, and the delivery or

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1. See recommendation, p. 92 regarding administrative placement of the BHE.

approval. This is a situation quite comparable to the one we encountered at the national level, in a plea that outside support be granted without the narrow specifications or the limitations of use that might not fit changing circumstances in Jamaica.

It is worth noting that both the MHEC and local government seem receptive to some measure of unification of local health services, and the decision has been made to explore alternatives for achieving this. Further, the Minister of Health has stated that he does not feel any peripheral services should be run centrally, but that management should be regionalized wherever possible with general supervision and monitoring remaining centralized functions.

C. The Clinic Manager

In some instances the present MO(H) is a strong person. We were advised that in some cases he is not. In addition to the MO(H), however, a skilled manager is needed for each health center, for he/she is key to the successful administration of local health services. He/she need not necessarily be a physician, or a nurse, but should be selected for his/her management skill and background of experience. Under the right leadership a team spirit can be developed, in-service training and orientation can be fruitful, clinic services can be made responsive to local needs, priorities can be established and honored, national priorities can be emphasized, and health goals accomplished.

RECOMMENDATION: That the position of clinic manager be reviewed and the job specification rewritten, if necessary

1. to establish authority of that position over the staff assigned from the various units in the Ministry of Health and from the Parish, and
2. to define it as a management position requiring administrative talent and training or experience.

RECOMMENDATION: As vacancies in clinic management occur, they should be filled by candidates having management skills.

D. Coordination within the Parish

Local (Parish) coordination of various medical and health programs is a major responsibility of the MO(H) and his staff. The available health manpower must be assigned to locations and at times that will most completely meet the local service needs, while the utilization of available facilities and other resources must be planned for service and economy.

Coordination requires good communication: policy statements program guides, schedules of clinic times and personnel assignments, and periodic special memos giving non-routine information. Provision should be made for free exchange of information both up and down the administrative ladder. There should also be staff meetings or other means of bringing the parish health team together to develop a strong working relationship.

The coordinating function cannot be done once and then set aside, and it cannot be done by only one person. It is a continuous part of management and it constitutes a portion of the duties of all persons who share in management responsibilities. The desireable end result is a strong team spirit that brings workers together in an attitude of unity and mutual help, so that they help lubricate the gears that otherwise might cause friction in the management machine.

The evaluation team is unable to judge the quality of local coordination of health programs in Jamaica. We do know of two or three well-administered parish health programs. They are under strong leadership.

Now that family planning is a part of the MHEC it must be coordinated with other MHEC program activities. The basis for that coordination has been established by the order of integration.

E. Coordination within MHEC

Since all of the units in MHEC now have a part in the family planning program, coordination is more than ever essential. Family planning program guides, procedures and priorities must be promulgated with uniformity through each of the MHEC administrative units and the clinics, and this requires prior exchange of information and the opportunity for input from each of the Units. We understand that a somewhat formal mechanism--a weekly meeting of top administrators within MHEC--is available for this exchange of information, and clarification of established policy, as needed. Policy changes, program modifications, changes in procedures or methods, review of statistics and priorities, items from the Minister of Health (or other Ministers concerned with the family planning program), and items from the field are appropriate agenda material.

Included in the meetings to be held and on the distribution list for written material are--or should be--the following, at a minimum, or their representatives:

The Minister of Health and Environmental Control, when available
The Chief Medical Officer
PMO: FP/Nutrition/MCH (Family Health)
PMO: Hospitals
PMO: Public Health
PMO: Community Medicine/Pathology Services
Chief, BHE
NFPB Executive Director
Others, by invitation, as needed.

Although the Chief of the Bureau of Health Education is currently under the PMO: Public Health, the integral relationship of education, information, and communication to all programs is such that the BHE should also be regularly represented in staff meetings. A recommendation for different administrative placement of the Bureau in the MHEC is made later in this report (see p. 92).

These points are discussed here because of the fairly complicated official relationships that prevail in Jamaica's Government, and because a change has just been made which, on the one hand tends to simplify local clinic relationships, but which on the other hand establishes new relationships. This therefore is the appropriate time to clarify old and adopt new procedures or policies and working understandings, as they are needed.

2,4 Planning

The planning function requires detailed projections tied in with those persons or groups responsible for accomplishment: the strategy and methods applicable, and the timing, with check points laid out; budgetary data; and the review mechanism and up-dating procedure.

The NFPB and the MHEC did adopt both long-term human reproduction goals (zero population increase as an "ultimate" goal, and two-child average family size by 1985-90), and short-term objectives (25,000 new acceptors per year; 100,000 continuing users by 1977; birth rate 25 per 1000 population by 1977-78).

Assignments within the Board staff were not always clear, however, and involvement of organizations outside the NFPB and beyond the MHEC fell short. Attention was given to the clinical and mechanical aspects of family planning to the exclusion or limitation of essential psychological and sociological approaches. Attendance statistics consistently announced that "something needs to be done to 'sell the program' to the people," but the response of management was only partial, namely, employment of a few more FPEOs and the demonstration project using CHAs. We believe that both of these actions were in the right direction, but not the whole answer.

What will be done now that program responsibility has been transferred from the NFPB to the MHEC remains to be seen. As stated elsewhere in this report, the planning preparatory to the integration step was less than complete. There are significant organizational gaps and planning deficiencies that will have to be worked out belatedly. It is most important to the future of family betterment in Jamaica and to social and economic development, that the planning function involve the many organizations that are influential in peoples' lives, and that planning be comprehensive.

2.5 Organizing

This entails staffing requirements, working out assignments of responsibilities and accountability, staff interrelationships, job descriptions, and the line and staff pattern to be followed.

Although as previously noted, the NFPB did not function without its problems, it did have an established organization and there was a spirit of dedication to the "Cause." However, due largely to the unipurpose organization that was set up, time utilization of family planning personnel was wasteful, especially in the full-time clinics where the patient load was uneven and often skimpy. Now that Board functions have been changed and most of its personnel have been reassigned, job descriptions will need to be reviewed and many of these updated or rewritten.

There is a PMO: Family Health in charge of family planning, nutrition, and MCH, but no staff was transferred to her office. One appointment was made in June, however. How large a staff she will need and what organizational pattern will best serve the program activities for which she is responsible have not been finally determined at this point. There will need to be office help and a field staff. According to the team's latest information, the field staff will have authority over clinic personnel only while they are engaged in activities directly relating to family planning, nutrition, and MCH services in the Health Center. This authority is derived from the MO(H) and the Clinic Manager, and of course, indirectly from the Minister of Health. For the remainder of their time, clinic personnel will work under the technical or professional guidance of others for other specialties.

The organizational pattern we visualize for clinic services is set out in the accompanying diagram (Figure 3). The MO(H) and the Clinic Manager hold key positions with relation to the personnel in the clinic. They manage the operation, which in the integrated plan of clinic services, provides a variety of services as needed in the location and at the time scheduled.

This administrative arrangement is not at all uncommon. Note for example, the manner in which competing airlines are all accommodated at one airport instead of each having its own landing location and facilities. Each has its assigned space and time table, but all make use of many facilities in common.

In an analogous way the local health center provides the setting and facilities for multiple clinical services, each a specialty, and each with its own management staff, but all benefitting by the services of the "resident staff" as assigned by agreement with the clinic manager. Firm ground rules, effective orientation, written guidelines, free intrastaff communication, and good management are essential for the success of a combined operation of this kind.

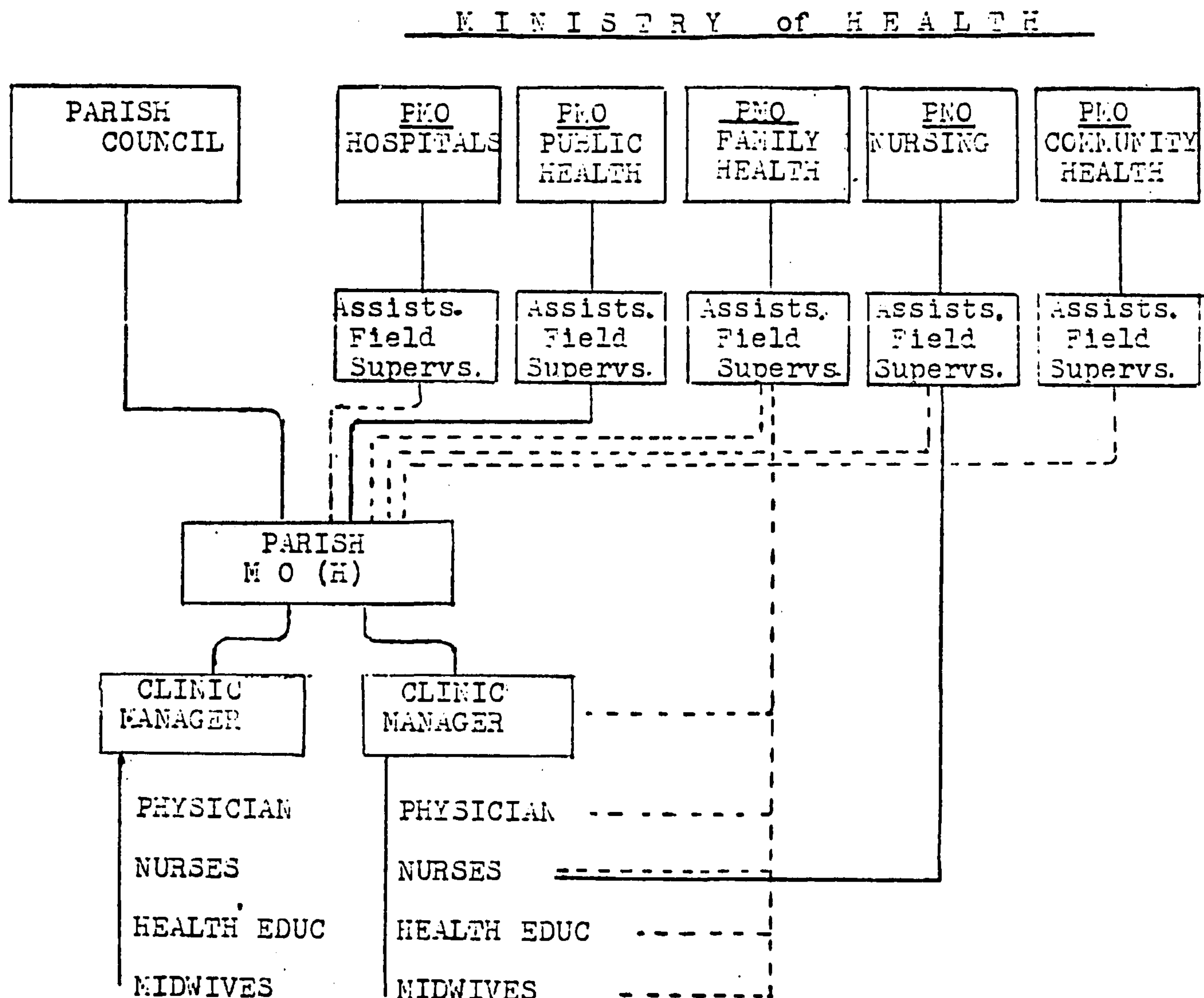
There should be no serious difficulty in managing the family planning program by this general plan that is implied in the "integration" paper. A capable central staff supervises the specialty of family planning in conjunction with MCH and nutrition services nationwide, making use of personnel assigned to local clinical facilities working under the immediate authority of a clinic manager. With the exception of a few parish employees, all are employees of the MHEC. While each unit within the Ministry has its own specific area of responsibility and concern, and its own special techniques, nevertheless all have a common interest--namely the health and well-being of the people they serve.

Within this framework, cooperation should be improved and firm progress toward the broadened objectives of the Jamaican national family planning program can be anticipated.

FIGURE 3

SCHEMATIC REPRESENTATION OF NATIONAL AND PARISH ORGANIZATION for HEALTH SERVICES including FAMILY PLANNING.

(The MEDICAL OFFICER of HEALTH, (MO(H)), has assigned administrative authority for Public Health within the PARISH.)



Key: Line Authority ——————
Technical Supervision ------------

2.6 Administration of the Family Planning Program

Administration includes clarification of job requirements; staff assignments; time accountability; work review; discipline; coordination within MHEC and outside; keeping up with the plan; work reports; statistics and budgetary responsibilities; and the morale factor.

Although there was technical compliance with the above components of administration by the NFPB, it was our impression that administration in general was somewhat lax, e.g., the training office by default was making decisions that should have been made by others, at times there were too many observers at training sessions, the staff was not always punctual. We also felt that coordination was poor. Furthermore, the set-up was not conducive to good coordination with the MHEC at the clinic working level, for pay differentials tended to set the family planning staff apart from others. There seemed to be no strong effort to bring family planning objectives into the consciousness of other units of Government and organizations outside of Government.

While it was the impression of one consultant during a previous visit (September-October, 1973) that the Board staff were adequately trained or being trained, that administrative lines of supervision were being followed in accordance with the organizational structure, and that morale was generally good, there has been considerable deterioration in administrative functioning since that time. Staff shortages have developed, time schedules do not appear to be enforced, incentives to excel seem to be lacking, and the uncertainties of the effects of integration on the future of the respective jobs resulted in work stoppage for a short time.

One consequence of the integration order was to eliminate most of the full-time family planning positions as such, and to utilize the services of many more people (mostly nurses) in family planning as part of their regular assignment. This also eliminated the direct line authority of the family planning Chief over those doing family planning work. As a result, many administrative functions will be performed by other officials, those having line authority over field and clinic personnel (PNO for nurses, PMO: Hospitals and PMO: Public Health for clinicians, and the BHE for health educators.)

Since details of the new administrative arrangement have not as yet been worked out they cannot be given here. It is presumed, however, that Dr. Patterson's office will assist with family planning input into the new job specifications to be written for those whose work now includes family planning; that there will be improved coordination within MHEC; and that stronger efforts will be made to bring other Ministries of the GOJ into the broadened scope of family planning activities. Under Dr. Patterson, the new post of "Supervisor of Field Services in Family Planning" is currently filled by an experienced and capable nurse, Joyce Harris.

Three additional points are offered. First, the substantial increase in the number of people actively participating in family planning services will necessitate augmentation of the training program for nurses, clinicians, midwives, aides, and newly appointed supervisory personnel in the Bureau of Health Education. Secondly, these people, doing other kinds of work, were not selected for their interest in family planning, and so their orientation may need to be especially motivating. Third, because of the increased number of people working in the program there will be greater necessity to work on quality of services continuously. With the changes now taking place, we believe that Jamaica will require externally provided resources in the immediate future to do the required job.

2.7 Leadership in the Family Planning Program

It is our impression that the Ministry of Health and Environmental Control is a strong organization with good leadership. The Minister, a physician, is articulate, energetic, patient, and willing to give consideration to suggestions for program improvement. While he cannot be expected to work out details and personally supervise the program, he does have the position required to see that this is done. He also has the responsibility for negotiating with other Ministries and national voluntary organizations for their support and participation, which is needed.

A. Top Level Administrators

Leadership must extend beyond the Minister's Office and include the whole chain of command in the MHEC. The PMO: Family Health (family planning/nutrition/MCH) is professionally well-qualified and serious about her responsibilities. Her experience in administration, however, is limited. It is our impression that the magnitude and complexity of the tasks assigned to her under integration may overtax her available time and energy. The PNO (Nusring) is articulate, committed to family planning, and eager for the nurses to improve themselves professionally. The Chief Medical Officer, the other PMOs, and the newly appointed Permanent Secretary, all of whom the evaluation team met briefly, seem to be adequately qualified for their respective positions and interested in the family planning program.

B. Intermediate Level and Local Leadership

Intermediate leadership is in part good and in part undetermined due to changes resulting from integration. In general, those individuals who held supervisory positions under the NFPB were well-qualified for their work, however they may need additional training if reassignment requires supervising more than family planning activities. On the other hand, MHEC personnel now engaging in family planning work for the first time or after an interim period may need up-dating of knowledge and skills required to function effectively in the family planning program. Obviously the training program will need to be considerably augmented, but not all specific training needs can be determined until the organizational pattern is more nearly complete and personnel assignments are finalized.

Within the parishes leadership is mixed, some MO(H)s being well-prepared and doing an excellent job, and others falling below standard but needed because of doctor shortages. It would be in the interests of the country to have more parish health services under the direction of persons who hold the DPH from the UWI, and the pool of such persons is scheduled to increase.

Most conspicuously lacking and admittedly most difficult to accomplish are resources, administrative support, and flexibility for community organization work, with the ability to capitalize on the existing citizen and worker organizations to mobilize public opinion in support of family life betterment, including pregnancy planning. Although contraceptive services appear adequate, the necessity to improve public relations and citizen education and participation has been repeatedly emphasized.

2.8 Inter-Ministerial Coordination

Above all, the problems associated with population growth are too complex and too far-reaching to be left to the resources and ingenuity of only one Ministry in the Jamaican Government, and to only one office within that Ministry. There must be strong national leadership in order to enlist commitment at all levels. The total effort must be broadly expanded to include all agencies, both official and voluntary, that have a contribution to make in this undertaking that involves the whole nation, right down to its citizen level in personal participation.

2.9 The U.W.I.

This discussion of administrative and management capabilities within the University of the West Indies focuses on the Department of Social and Preventive Medicine, and particularly upon the Family Planning/Epidemiology Unit within that Department. Information which was obtained through this evaluation about the administrative and management capabilities of other Departments and Units within the UWI is considered in sections of this report concerning University contributions to training and research, and the capability of the UWI as a regional family planning/population center.

Since January, 1971, US/AID has assisted the DSPM in developing local capability in curriculum development, research, and training supportive of the national family planning program with the long-range objective of developing a regional population/family planning center. Initially this assistance was provided through a contract with the University of Pittsburgh which loaned a resident consultant to the Department for one year and through local salary costs for an expanded DSPM population unit. Although the contract with Pittsburgh was intended to extend through December, 1973, it was terminated by mutual agreement in October, 1972, largely because the University of Pittsburgh was unable to supply continuing consultation services to the extent and at the times these were needed.

Pro-Ag 72-5 provided for additional financing over a three year period to support the development of a Family Planning/Epidemiology Unit within the DSPM. Pending recruitment of a Director for the Unit, family planning activities continued under the interim direction of Dr. Karl Smith, who was already a University faculty member. In December, 1972, Dr. Smith was appointed as the Unit's Director.

A. Functions of the Unit

During the period in which the University of Pittsburgh consultant was in residence at the DSPM, a preliminary statement was prepared of functions which the Department might undertake in research and training to support the national family planning program, providing that the necessary funding was received. This statement was revised several times,[1] but was considered tentative, pending the completion of an overall five-year program plan by the National Family Planning Board. Although the NFPB did not complete a long-range plan, early in October, 1972 it did indicate four major areas in which it desired DSPM assistance. These are listed in Appendix D.

In spite of a great deal of effort and external assistance in defining the family planning functions to be performed within the DSPM, these still are the source of misunderstanding between the Family Planning Unit and the NFPB, as well as between the Unit and US/AID personnel in Jamaica. The problem does not seem to lie in the range of functions considered appropriate for the Unit as much as in the priorities and emphases which these are given.

Several reasons for such misunderstanding can be identified, including the tendency of personnel concerned with program operation and performance to judge the Unit's priorities by readily visible activities and easily measurable results when, in fact, much work in developing both training and research is slow, indirect, and long-range in nature. Failure to appreciate this reality also causes program personnel to expect levels of output from the Unit which are not always compatible with the resources it has available and the requirements of particular projects.

Another source of difficulty concerns the development of regional capability and how this should be approached. Program personnel think the Unit ought to devote its efforts entirely to Jamaican needs and thus resent Unit activities which are regional or not directly related to family Planning. Unit personnel, on the other hand, claim that the Jamaican program is their first concern, but that in some cases it can best be served through a regional approach and through activities which consider family planning within a broadened context.

From the Unit's point of view, tailoring priorities to the national family planning program is difficult in the absence of clear communications about program progress and direction. Thus it decries the lack of access to policy deliberations and strongly advocates the need for an overall program plan on which it can base its efforts. The Unit has repeatedly asked for more specific policy guidelines and has prepared suggested lists of priorities

1. Functions proposed as of March, 1972 are listed in Appendix C.

which it considers realistic in view of its knowledge of the program, of the work its potential contributions would require, and of the resources which it has available. Nevertheless, the NFPB has not responded to the Unit's request for further guidance. In view of the Board's inaction in this respect, its criticism of the Unit is hardly well-received.

Dr. Smith affirms that the Unit is committed to supporting the Jamaican national family planning program and strongly states the need for a serious and concerned examination of the Unit's functions in relation to a comprehensive national program plan. The evaluation team concurs that this is needed, especially now that the role of the NFPB is changing and the MHEC is assuming primary responsibility for program direction and implementation.

> RECOMMENDATION: That the PMO: MCH/FP/Nutrition in the MHEC and the Director of the Family Planning Unit in the DSPM, UWI meet including others whom they may designate to review the functions of the Unit in relation to the national family planning program and to explore how these may be better integrated with program policy and operation while at the same time preserving and advancing performance of those functions essential to further institutionalization of the Unit into the University.

B. Staffing

Staffing has been a problem for the Family Planning/Epidemiology Unit since even before its formal organization. Recruitment has been hindered by shortages of qualified personnel, restraints in terms of nationality, difficulties in attracting top-level people to jobs which are guaranteed by project funds for limited time periods and the lack of funds to help with moving expenses. In addition, the recruitment of the Unit's Director was delayed by problems in reconciling salary scales, selection procedures, and questions of tenure with the University, as well as by University processing of late applications.

In order to avoid weakening the government's program, the Unit does not utilize this as a source of personnel recruitment. If it is unable to find qualified personnel elsewhere, it tries to find new people and to develop them to perform required functions. This practice, however, places additional training responsibilities upon senior staff and has resulted in periods of personnel absence for participation in other training programs. As a consequence, the personnel actually available to the Unit at any one time may be less than staff listings would suggest.

During the first year of the contract with the University of Pittsburgh, DSPM staff was augmented by the addition of a health education specialist seconded from the Ministry of Health, a public health tutor, and a research assistant. Nevertheless, inability to recruit a well-qualified social scientist and a public health nurse, as provided for in the project agreement, slowed the Unit's progress. Lack of a well-qualified statistician or research person to act as counterpart to the University of Pittsburgh's resident consultant was also recognized as a problem.

In conjunction with the development of proposed family planning functions for the DSPM during 1971 and 1972, an outline was prepared of the types and number of staff which would be required. A detailed proposal for staff development was prepared during the consultancy visit of Mary Jo Kraft in October and November, 1972.

Pro-Ag 72-2 provided funds for 8 positions, six of which could be filled immediately with the other two being phased in later. Progress in recruiting for these positions is summarized as follows:

Position	Date Funds Available	Date Position Filled
Program Director	Oct., 1972	Dec., 1972
Health Education Specialist	Oct., 1972	Oct., 1972
Administrator	Oct., 1972	Oct., 1972
Research Assistant	Oct., 1972	Oct., 1972
Education Officer	Oct., 1972	Aug., 1973
Senior Research Fellow	July, 1973	________
Statistician	Jan., 1974	________
Secretary	Oct., 1972	Oct., 1972

Presently the Unit has two additional research assistants employed for one year each through savings derived from late appointments of other positions. It also has one Population Intern of five requested through the Frederickson Fellowship program. There are five secretaries, but turnover of secretarial staff has been a problem. Only one has been with the project since its inception, and three have been appointed in recent months.

Recently the Unit lost the services of its Administrative Officer, Mrs. Julie MacFarlane, who is now working with Professor Hugh Wynter in the Department of OB/GYN. Because of Mrs. MacFarlane's thorough knowledge of the Family Planning/Epidemiology Unit, however, this change should be helpful in developing closer communication between the Unit and the Department of OB/GYN. Mrs. Hoo will be the Unit's new Administrative Officer.

Filling existing vacancies now will be extremely difficult since the Unit's funding is not secured beyond September, 1975. The Unit reports that recruiting a statistician of any calibre for a project with a known life of only 18 months is virtually impossible. Due to difficulties in recruiting a Senior Research Fellow, an offer has been made to a candidate for a Junior Research post, but no reply had been received as of the evaluation team's second visit. The assistance of such personnel is critically needed to relieve the Director of some of his heavy work load. In addition, the Unit needs two or three interviewers on a continuing basis to assist with various projects. Employing good interviewers on a part-time basis has been difficult at current salary scales.

With funding running out, current staff may well begin to seek employment elsewhere before the scheduled project termination date. Thus the Unit's staffing problems can be expected to continue and possibly to compound. This obviously will affect the work that it can do.

C. Facilities

As described in previous reports,[1] the activities of the Family Planning Unit have been handicapped by inadequate physical facilities.

DSPM personnel are still housed in two locations several blocks apart. Thus some Unit staff share quarters with University Health Service personnel, but the Unit's Research Assistants and Education Officer are housed in a building on campus which is rented from the United Theological College. Neither ← location provides adequate accomodations for training, and neither is close to the University Hospital complex where the clinical teaching and services of the Medical Faculty are concentrated, to the Departments responsible for pre-clinical medical teaching, or to the Department of Sociology.

Although US/AID provided some funds for remodeling facilities in the University Health Service building, this provided only partial and temporary relief. Therefore in November, 1973 an amendment to that year's Pro-Ag enabled the Unit to construct a floor of a new building on a site near the University Hospital at a cost not exceeding U.S. $99,500. This building was initiated by the UWI's Faculty of Medicine in order to house its Post-Graduate Medical Education Centre.

The new building will initially be two stories, with funding so far shared equally between US/AID and the University. Construction is designed to permit enlargement of the complex in order to house other areas of related activity when additional funds become available. As described elsewhere in this report (see p. 63), Professor Wynter with the support of Dean Ragbeer is currently seeking funds to permit the addition of a two-story Reproductive Biology Unit.

Ground-breaking was scheduled for July, 1974, and completion of construction is anticipated before the end of the year. It is hoped that at that time all of the Unit's staff can move to the new building, enabling it to return the present offices loaned by the University Health Center and to discontinue rental of the United Theological College building.

This move should considerably enhance communications within the Unit and between the Unit and the rest of the campus, especially the Medical Faculty. The new facility will also save many hours of Unit staff time which has necessarily been devoted to finding and renting space for training. Since the new building has been designed with training needs in mind, it will for the first time make adequate space available of the type required for maximally effective training programs in family planning.

1. See consultancy reports by Kraft for March, 1972 and Oct.-Nov., 1972, as well as Trip Report by Nadene Saxton, March, 1973.

D. Funding for the Unit

Development of the Family Planning Unit thus far has relied primarily upon funds from US/AID with contributions of other donors to specific research and training projects and with some supportive contributions, such as space, from the University.

From the standpoint of potentially available funds, it appears quite clear that the Unit cannot be fully supported by Jamaican money in the immediate future. It is unrealistic for donor agencies to expect self-sufficiency during the present period of economic hardship affecting the country. This situation complicates the problem of continuity of operation of the Family Planning Unit, which is aggravated when project funds cannot be continuously assured at least two years in advance. Presently funding for the Unit is not secure beyond September, 1975.

The Dean of the Medical Faculty, while reaffirming that the University cannot assume partial responsibility for support of the Unit within the forthcoming triennium, expressed a determination to seek such a commitment in the triennium which will follow. University priorities for budgeting in the triennium which will extend from August, 1975 through July, 1978 were set four years ago before development of the Family Planning Unit was initiated. A minimum of six years is required to secure funding through the University process.

The Minister of Health and Environmental Control, while indicating that he had not become familiar with the University's contribution to the national family planning effort, stated that he believes that University support to family planning is essential and that he would be willing to help obtain local aid.

E. General Administrative and Management Capabilities

Problems which the Family Planning Unit has experienced in differing definitions of its functions, in the recruitment of enough qualified personnel, and in space have all obviously affected its operations. Nevertheless, the people who are associated with the Unit are highly competent in their areas of specialization, they are committed to the national family planning program, and they have made positive attempts to overcome Unit difficulties.

The Unit has made many contributions to teaching, training, and research in support of the national family planning program. These are discussed in more detail in those sections of this report dealing with these subjects. Such activities are particularly impressive in light of the obstacles which the Unit has faced, and they have identified it as a viable force furthering the family planning effort, both within Jamaica and within the region.

The operation of the Unit is efficiently managed and administered as evidenced by the preparation of a work plan for 1974-75, by busy and motivated staff, and by accurate personnel records, accounts, and inventories of equipment. While the Unit's capabilities in managing training and research projects on schedule have been questioned by NFPB and US/AID staff in Jamaica, the evaluation

team feels that reasonable progress has been made considering the resources available and the problems encountered.

Within the University, communication and coordination is especially strong between the Unit and the Extra Mural Department, which is located across the street. Communication is also good with the Faculty of Medicine, of which the DSPM and the Unit within it form a part. There is need for closer communication and coordination between the Unit and the Department of Sociology, however.

As previously indicated, relationships of the Unit to the National Family Planning Board are troubled in several respects, although personnel from the Unit and the NFPB continue to collaborate successfully in education and training activities. Differing notions of the Board's role in overall direction of the Unit and in determination of its research activities are among the sources of greatest difficulty. In addition, the Unit feels that it should have a stronger voice in program policy formation and decision-making.

The Board's failure to involve the Unit in decision-making creates major communications problems. As of the evaluation team's second visit, the Unit still had not had an opportunity to discuss with the Board the meaning that integration would have for the Unit and the services which it provides. Further, actions by Board staff often imply that the NFPB should control the Unit's day-to-day operations. This is evidenced, for example, by NFPB directions to the Unit to undertake training activities on short notice or to meet with evaluation teams at specified hours, regardless of other commitments which Unit personnel may have. Accordingly, the Dean of the Medical Faculty states that the Board's relationship to the Unit has been more dictatorial than cooperative.

Clearly communications between the Unit and the Board need to be improved. The Unit, with its skills in human relations, should take more initiative in this respect. Two specific suggestions are to inform the Board when Unit personnel will be off the island and to include more discussion of program implications in research reports. Nevertheless, major changes in the Board's manner of dealing with the Unit are indicated.

Educational personnel within the Unit enjoy good working relationships with the Bureau of Health Education in the Ministry of Health. The Unit as a whole, however, currently has no close ties with MHEC leadership. These now need to be developed.

Through its activities in education, training, and research, the Unit has developed excellent relationships with a number of other agencies and organizations at national and parish levels. These provide valuable entry points for further cooperative activities related to the national family planning program.

In sum, the Family Planning Unit has good and continually developing capabilities to contribute to the teaching and research aspects of the national family planning program. These have been handicapped, however, by

difficulties in space and staffing. Although the completion of a new facility will soon resolve space problems and enhance communication with other family planning interests on the campus, the problem of staffing is likely to grow more acute as the date for expiration of current funding nears.

Relationships with the NFPB are a major source of difficulty. Now that the MHEC is assuming greater responsibility for direction and implementation of the national family planning program, these problems may ease, but this will depend upon how coordinating mechanisms are developed. In any event, stronger working relationships between the Unit and MHEC leadership, as well as between the Unit and the NFPB must be developed.

F. Institutionalization of the Family Planning Unit into the University

Although US/AID funds to develop a special family planning unit within the DSPM were available as of October, 1972, the Unit did not begin functioning as an organized entity until January, 1973, shortly after the appointment of its Director. Thus time has been short for the institutionalization of the Unit into the University.

While the Unit's existence as a specialized research and training organization is generally recognized throughout the University, it does not yet have the sanction of official status within the University's structure. In part this may be because Colleges, Schools, and Departments are more typical components of University organization, and in part because the Unit is financed through "soft" project money.

Deeper factors are involved, however, which relate to University autonomy and procedures for protecting academic excellence. Thus the Unit's service relationships to the national family planning program may slow its acceptance by those who feel this violates academic freedom, while the Unit's employment of some personnel who have not passed the test of academic senate review tend to place it on the periphery of the campus community. To some extent these problems affect University personnel everywhere whose activities are based both in academic circles and in the community.

Although the University is unable to help support the Unit in its budget for the next triennium, the Dean of the Medical Faculty is committed to obtaining such support for the triennium which follows. This recognition of the Unit's contributions to the University evidences some progress toward eventual institutionalization. The construction of new quarters for use by the Family Planning Unit jointly with the Centre for Post-Graduate Medical Education can be taken as further evidence of University intent to foster and assist in underwriting the program, even though construction costs are shared by outside funds.

G. Future of the Family Planning Unit

The continuing development of capabilities of all types within the Family Planning Unit relies heavily upon obtaining assurance of funding for at least another three years, and preferably for another five years beyond the expiration of current funding in September, 1975. Unless such assurance can be provided in the very near future, the capabilities now existing in the Unit will begin to weaken, and the Unit as an organized research and training resource will eventually disappear. On the other hand, with additional time to build on the real strengths now present in the Unit, its contributions to the national family planning program and potentially to the region can be expected to grow, both in quantity and in operational importance.

> RECOMMENDATION: That US/AID review the funding needs of the Family Planning Unit for at least a three year period beyond September, 1975 and provide to meet these needs either directly through bilateral assistance or in cooperation with multilateral funding agencies.

Because of the many changes which are occuring in the national family planning program, projecting the Unit's needs beyond the maintenance of a core staff and operating expenses may not be possible until program organization and administrative have stabilized. When this occurs, functions of the Unit in relation to program needs should be reassessed, and the staff development program for the Unit worked out with Kraft's assistance in Fall, 1972 should be reviewed and revised as necessary. Additional funding needed to support the development of the Unit will undoubtedly be identified as a result of these actions.

2.10 The Jamaica Family Planning Association

The JFPA, organized in 1957, has been the most active and well-established of the voluntary family planning organizations in Jamaica. Its primary role has been pioneering new approaches in family planning, as well as in encouraging the Government to assume greater responsibility in the development of a national program.

Now the JFPA clearly is sharing the fate of voluntary family planning organizations in other countries whose pioneering work paved the way for government involvement in the delivery of family planning services. The resultant "identity crisis" in Jamaica, as elsewhere, is not without its frustrations and disappointments. The JFPA, now operating at a reduced budget and with a modified role since the days when it was the sole family planning resource on the island, remains viable and highly respected both within and outside of the national family planning/health establishment. Although interest on the part of individual donors has decreased since the entry of government into the family planning field, and its parish committees are now dormant (except for clinic committees in Kingston and St. Ann's Bay), JFPA leadership remains strong and dedicated and it appears to enjoy the flexibility and freedom that is unique to private organizations of its kind. As noted elsewhere in this evaluation, the Association's clinics still account for a large fraction of the annual total of family planning acceptors in Jamaica (see p. 75).

In a frank and very forthright exchange, Dr. Jacobs and his staff reviewed with the evaluation team the strengths and weaknesses of the JFPA program. These may be summarized as follows:

A. Strengths

1. A Board of Directors that is increasingly (gradually) representative of and responsive to diverse elements of Jamaican society.

2. An ongoing program of action research, including field testing of new contraceptives, innovative outreach efforts, training of health/FP workers, and model clinics.

3. An effective working relationship with the medical community.

4. Recognition by the Minister of Health of the potential contributions of the JFPA to the total national family planning effort.

B. Weaknesses

1. Inadequate funding to support a level of full-time staff commensurate with JFPA field activities.

2. Reduction in geographic coverage of field activities due to cutbacks in funding and staff.

3. Insufficient coordination with the NFPB. For example, JFPA had not yet received at the time of our visit on March 29, 1974, a copy of Ministry Paper No. 1. Without this document, planning for the Association's role in integration could hardly be effected.

4. An apparently insufficient broad base of association membership (which numbers approximately 150 at present), especially representative of diverse elements of the population.

5. Some over-dependence on government subvention and external sources of funding.

RECOMMENDATION: The MHEC and the NFPB should be encouraged to continue to regard the JFPA as an important element in the national family planning program.

RECOMMENDATION: The role of the JFPA in the face of increasing government activity in the health/family planning field should be clearly defined by its own Board in collaboration with representatives of the Ministry of Health and the NFPB. This redefinition of role should emphasize those contributions to the national program that the JFPA is best equipped to provide.

RECOMMENDATION: Program priorities should emphasize the areas of clinical research, demonstration "model" clinics, public education, and investigation of innovative outreach efforts.

RECOMMENDATION: Efforts to secure increased funding to support an adequate core staff should continue and consideration should be given to external support of management functions in addition to specific projects.

3.0 Capability within NFPB and MHEC in Planning, Establishing, Implementing and Evaluating Medically Adequate Clinical Services, Postpartum Program, Record System, and Follow-Up Procedures

In addition to educational and motivational efforts discussed elsewhere in this report, three major new directions in the direct provision of fertility-related services portend important changes in Jamaica's capability in family planning. Ministry of Health Paper No. 1 calls for two new departures in service delivery. First, integration of family planning into health service outlets calls for an end to single purpose sessional family planning clinics and increased availability of family planning service wherever and whenever maternal and child care is delivered. Secondly, the commercial distribution of contraceptives promises relief from dependence on the health delivery system in order to make condoms and oral contraceptives available to a wider range of potential acceptors. Beyond these two programmatic changes, the prospect of an impending change in Jamaica's abortion law provides a potential third important new departure in services affecting reproduction.

Each of these new directions will be discussed separately, following a brief background review of the development of the GOJ's family planning services and a short discussion of their current status.

3.1 Background of GOJ Family Planning Services

Family planning services were first provided by the GOJ in 1964 at Victoria Jubilee Hospital in connection with an IUD research project. In 1966 the Government launched the national family planning program with the establishment of 25 family planning clinics throughout the island.

A. Expansion of Family Planning Clinics

In order to extend the availability of family planning services as quickly as possible, the number of clinics was rapidly expanded, doubling in 1967 and nearly doubling again in 1968. The 1969 Project Proposal indicates a target of 160 clinics by March, 1970, but this evidently was later somewhat reduced. Clinic growth through 1972 is summarized as follows:

Date	Number of Clinics
1966	25
1967	50
1968	98
June, 1969	114
Dec., 1969	135
April 1, 1970	143
May 6, 1971	154
June, 1972	169

According to Pro-Ag 71-5, early targets were met in extension of family planning services to serve urban, rural and remote areas in each of the island's 14 parishes.

Nevertheless, many of these clinics were open on only a part-time basis, thus restricting the availability of services to potential clients. Therefore by 1970 it was recognized that among other program modifications, the frequency of clinic sessions had to be extended. The extent to which this was achieved is indicated by the following date abstracted from prior reports:

Frequency of Clinic Sessions	Year 1970	1971	1972
Daily	4	6	14
2 per week	-)	7)	)
1 per week	43)	54)	)
3 per month	-)131	1)148	)155
2 per month	60)	41)	)
1 per month	28)	45)	)
Total	135	154	169

A particular objective in extending both clinic locations and hours was to increase the availability of family planning services in rural areas. To this end, parish and clinic nurses were trained to enable them to assume expanded clinic responsibilities. Shortly after their training was completed in December, 1971, full-time family planning clinics were provided in all parishes but St. Thomas, and after a suitable facility was obtained, a daily clinic was also established there in April, 1972.

B. Clinic Facilities

The rapid build-up of facilities was achieved partly through the Ministry's construction of new health centers and partly through the rental of space wherever it could be found. The 1969 Project Proposal states that in many cases these facilities did not have adequate space for patient privacy, group or individual instructions, storage of supplies, etc., but that improvement of facilities was beginning to receive greater priority. As of 1970, nearly all service activities were performed in the network of 143 health centers, hospitals, and dispensaries operated by the Ministry of Health throughout the island. . Clinics were reserved exclusively for family planning use by the NFPB on regular schedules of one, two, or four half-days a month.[1]

In 1972, the team which conducted the first external review of the Jamaican national family planning program indicated that the type and quality of health centers varied from modern and comprehensive to one room accommodations. It also noted that the new full-time family planning clinics established by the NFPB were fairly modern and well-equipped. At the same time, however, it observed that the Ministry of Health's networks of health centers were utilized only to a small extent for family planning, principally because of the lack of close liaison and communica-

1. Appraisal of a Population Project: Jamaica, IBRD, June 2, 1970.

tion between the Ministry staff and that of the NFPB.[1] To overcome this problem, the team recommended that the Ministry of Health appoint a Principal Medical Officer for Maternal and Child Health and Family Planning, who would also be Medical Director of the NFPB. Dr. Wynante Patterson was subsequently appointed to this post.

C. Clinic Staffing

Early documents concerning the Jamaican National family planning program indicate that the primary problem in covering the island with a network of services was the shortage of doctors and trained nurses.

The 1969 AID Project Proposal estimated that some 100 doctors, 125 nurses, 125 midwives, and 130 clerks participated in the provision of family planning clinic services. Through 1971, the typical half-day clinic session was conducted by a four-person team consisting of a doctor, a trained nurse, a midwife and a records' clerk. Most of thephysicians and nurses who provided clinic services were either full-time or part-time employees of the Ministry of Health, although some private physicians, contracted by the NFPB on a sessional basis, augmented government doctors. Midwives were usually employed by the local parish councils. These personnel were paid sessional fees by the Board, and this constituted extra income for them.

In 1970, the IBRD Project Appraisal Report recommended a study of the service delivery system in KSAC, as well as a study of job functions to look for the best ways of utilizing highly trained doctors and trained nurses.[2] Subsequently the NFPB provided specialty training in family planning for a number of nurses, who thereafter assumed greater clinical responsibilities.

Beginning in early 1972, full-time clinics were typically staffed by a parish nurse, a resident clinic nurse, a midwife, and a clerk, who were full-time employees of the NFPB. The family planning nurses conducted routine physical examinations, including pelvic examinations, took Pap smears, and selected the method of contraception best suited to the client. Physician services were used only on a referral basis. Part-time clinics were served by public health nurses and midwives employed by the Ministry of Health and supervised by the Board's parish clinic nurse. Non-NFPB clinic workers continued to receive honoraria from the Board for family planning sessions.[3] In addition, the NFPB paid sessional fees to physicians, nurses, and other staff who provided family planning services in clinics operated by other organizations.

D. Clinic Organization

Prior to integration, GOJ family planning clinics were under the

1. Sodhy, et al. Report of First External Review: Jamaica National Family Planning Program, IBRD, July, 1972.
2. Appraisal of a Population Project: Jamaica, IBRD, June 2, 1970.
3. Madhok, "Jamaica: Report of a Mission to Review the Family Planning Program, IBRD, May 30-June 11, 1973.

jurisdiction of the National Family Planning Board. At the national level, the clinical program was administered by the Board's Medical Director, a Clinic Supervisor, and two Assistant Clinic Supervisors. In the parishes, the RFPO (Parish Medical Officer of Health) was administratively responsible for the clinics, which after 1971 were supervised by the NFPB's parish clinic nurse.

Depending upon the frequency with which they offered sessions, clinics were categorized as full-time (8 hours on weekdays and 4 hours on Saturdays), sessional, and satellite. Full-time clinics operated on separate premises, and part-time ones in Ministry of Health facilities. Although some of the newer clinics offered family planning in conjunction with MCH and other services, most clinics provided just family planning services and cervical cytology screening. At VJH, separate sessions were held according to the method being offered, e.g., depo-provera, orals, or IUDs. VJH also held special clinic sessions for teenagers and new acceptors.

According to the 1970 IBRD Project Appraisal report, the tradition of interspersing family planning sessions in the schedules of multipurpose clinics, plus the difficulty of recruiting staff for full-time single-purpose family planning clinics, largely determined the pattern of service offered.

E. Clinic Performance

Although the NFPB averaged slightly more than 2,000 new acceptors each month from November, 1968 through January, 1970, clinic performance was uneven. Thus clinic statistics for 1970 showed that the 23 best performing clinics accounted for 66.8% of new acceptors, another 25 clinics had an intake of 16.9% of total new acceptors, and the remaining 103 clinics together accounted for only 15.3% of new acceptors.[1]

The 1970 IBRD Project Appraisal Report pointed out that the NFPB must soon begin to examine the cost-effectiveness of individual clinics and alternative ways of providing service to target populations being covered at high cost. At that time, the Board was establishing individual cost accounts for each clinic. Shortly thereafter, Dr. Karl Smith of the UWI did a survey of the family planning delivery system in KSAC and identified some weaknesses in services. Since then, as summarized shortly, a number of efforts have been made to improve the quality of service provided.

Still, serious under-utilization of some clinics has been noted by a number of subsequent reports on the Jamaican national family planning program. In 1973, for example, Pulley indicated that a substantially larger caseload could be handled by the existing staff and facilities if they were being fully and more evenly utilized. He further reported that:

1. Pro-Ag 71-5

"The 36 least active family planning clinics saw from 4-9 patients per clinic session during the quarter ending in June, 1973. Five saw no new patients, and 8 saw only one new acceptor."

The 1973 annual statistical report of the NFPB indicates that clinic performance continued to lag in certain parishes.

A number of suggestions have been made about the reasons for under-utilization, some of which relate to the clinics themselves and some to their potential client populations. That clinic hours are related to clinic performance is indicated by a report in October, 1973, which showed that the 17 daily clinics accounted for more than half of the program's total clients.[1] On the other hand, sessional or part-time clinics have been disappointing in performance. According to the NFPB's Executive Chairman, when clients must be turned down and requested to return at another time, they likely will not come back and the clinic's reputation will suffer.[2] The Director also speaks about difficulties in delivering services in human and organizational terms. Among client factors inhibiting clinic utilization, problems of transportation in rural areas and reluctance to be seen entering family planning clinics have particularly been identified as barriers.

F. Efforts to Improve Clinic Performance

According to the 1969 Project Proposal, US/AID would assist the GOJ, through the NFPB, to review and evaluate clinic operations. Specifically this review was expected to result in a number of administrative decisions leading to improved clinic performance. In addition to extending clinic hours, these included appropriate changes or redirection or relocation of clinics to better serve the population, better assignment and training of clinic personnel, changes in the educational approach to clients, better coordination with "outreach" personnel to attract women to come to the clinic, and better follow-up of drop-outs.

Continuing review of clinic performance with the objective of improving clinic efficiency was also a target of Pro-Ags 71-5 and 73-2, and in addition was recommended by the 1972 IBRD-Sponsored evaluation team and by Pulley's consultancy report in late 1973. Nevertheless, aside from a few operational studies of clinic services (see Appendix pp. 216), little has been accomplished in this regard. In part this may be due to problems with service statistics, as well as to the lack of clearly defined responsibilities for analyzing them and making action recommendations. In addition, the development of review criteria is not a simple task, for factors such as the size of the potential client population, frequency of clinic operations, and other family planning resources available must be taken into consideration. Still, the unmistakable conclusion is that the importance of evaluating clinic performance as a major tool for improving clinic services has been largely overlooked.

1. "Jamaica," Oct. 29, 1973.
2. Per Pulley's 1973 report.

Another attempt to improve clinic services is reflected in Pro-Ag 71-5 which called for review and redefinition of criteria for locating clinic services to best serve the population. The Project Appraisal Report for the period December, 1969 through June, 1971 further recommended the consolidation, rescheduling, relocation, and closing of part-time clinics with poor performance, while according to Pro-Ag 72-3, a shift of emphasis in the new 5-year plan also called for part-time services to be converted to full-time services. The 1972 IBRD-sponsored evaluation team noted a trend in this direction, but questioned its advisability in that it represented a disintegration from health facilities. By 1973 the process of consolidation, relocation, and closing of part-time clinics with poor performance was not notably advanced. In that year, a total of 9,912 family planning sessions were held in 17 full-time clinics, 134 "sessional" or part-time clinics and 10 satellite operations.

The integration of family planning and health services has long been recognized in Jamaica as another option for improving clinic performance. This was recommended in the AID Project Appraisal Report for the period December, 1969 through June, 1971, while Pro-Ag 70-5 calls for the introduction of integration in pilot areas in a way that could be evaluated as to feasibility and effectiveness. While services apparently were integrated in some locations, systematic evaluation of this experience was not evident. Now that the integration of family planning into health service clinics has been ordered throughout the island, further consolidation of clinics will be accomplished. The details of this integration are found in the policy statement "Ministry Paper No. 1 - Family Planning' and are discussed elsewhere in this report.

The development of model clinics was another concept intended to increase the efficiency and effectiveness of family planning services, but no clearly recognized model facility was existent by the time of the evaluation team's visit. While some indicated that the Acacia Avenue clinic had been designated as a model, others claimed that it was poorly located to serve this function. Another clinic on Windward Road in East Kingston was reportedly set up as a model, although its operation apparently has not led the way for new patterns of service delivery. The Family Planning/Epidemiology Unit at the UWI has also discussed the development of a model family planning clinic in which innovative approaches in service, education, and evaluation could be tested and which could also serve as a field experience center for family planning trainees. In addition, the new family planning clinic facility being completed at Victoria Jubilee Hospital is currently being proposed by some as a model clinic site.

Experimentation with mobile clinics to serve outlying areas has also been recommended and this is currently being tried in the parishes of St. James and Hanover where a mobile unit on loan from the JFPA is being used in conjunction with outreach by Community Health Aides (see pp. 103). The unit is staffed by a nurse and an education officer from the NFPB daily clinic and by midwives from the areas visited. The Unit's program is integrated into the Maternal and Child Health Clinics, in addition to which night sessions are held to accommodate people who are unable to attend during the days. The unit normally operates Mondays through Thursdays, but is also used two Fridays each month solely for

motivation and education purposes.[1]

A study of the percentage of acceptors from the mobile clinic who make return visits has just been completed by two UWI students, and initial figures suggest that attendance figures doubled over 1972. The St. James MO(H) states, however, that the unit is still not serving the numbers anticipated and that more groundwork is needed.

Efforts to improve family planning services through education of the public and training of clinic personnel are discussed in sections of this report dealing specifically with those program components.

1. "Mobile Clinic Operations," Family Planning News, NFPB and JFPA, December, 1973, p. 12.

3.2 Current Status of Contraceptive Services

Just prior to integration, the NFPB had 161 clinics, including two mobile clinics. Five full-time clinics were operating in the Kingston-St. Andrew Corporate Area, in addition to which the major town in each of the 12 rural parishes had a full-time clinic, open from 8:30 to 4:30 on weekdays and from 8:30 to 12:30 on Saturdays. Other clinics were sessional, including a few night clinics.

A. Clinic Performance

The fact that "new acceptors" increased by 3,538 in 1973 (after a levelling off of new acceptors at about 22,000 per year for the previous three years) is more indicative of concentrated effort in a few locations than of wider dissemination of contraceptive practice throughout the island. Nevertheless, this progress is to be lauded, and demonstrates the latent "readiness" to limit fertility which may be expected island-wide when services are readily available and suitably provided.

The evaluation team believes that the current transition to fully integrated FP/MCH services will provide a greatly improved context for family planning acceptance in rural areas, and that once the immediate logistic and staffing problems of integration are resolved, further improvement in acceptance rates will ensue. Not only does the MCH setting offer better access (daily vs. weekly availability, etc.) and a more logical entry-point in relation to maternity and child care, but also the anonymity and privacy that the multipurpose clinic lends to the acceptor is enhanced. The importance of these latter considerations was stressed in all of our rural contacts.

It is especially noteworthy that 47 percent of all new acceptors in 1973 were in the Kingston-St. Andrew area with another 23 percent reported from only three rural parishes (St. James, Manchester, and St. Catherine). While a detailed analysis of this disproportionate achievement in these dissimilar locations is beyond the scope of this evaluation, it is nevertheless important to point out at least those features of their relative success which may be fruitfully replicated elsewhere.

Aside from the known relationship between urbanization and fertility patterns, the potential inherent in "maternity centered" family planning for increasing family planning acceptance is emphasized by the fact that the sessional clinics at Victoria Jubilee Hospital, averaging 131 patients per session, yielded the largest number of new acceptors of any clinic, daily or sessional, on the island. The completion of the ten rural maternity centers and the expansion of VJH itself should have a positive impact on family planning acceptance. This needs to be augmented by closing any remaining gaps in family planning services to postpartum patients in other Jamaican hospitals, and further, by enlisting the practicing midwives into more active promotion of contraceptive acceptance, either through clinic referrals or through dispensing of non-prescription methods.

In regard to the high-performance rural clinics, it is probable that their achqevement is at least in part attributable to the leadership of MO(H)s whose appreciation of and dedication to family planning is

reflected in their parish activities. Two of these (as well as, significantly, the MO(H) of KSAC) are diplomates of the DPH course at UWI. The filling of more rural posts by physicians with special public health training in family planning and the extrapolation to all parishes of successful experiments in motivational outreach, such as that of CHAs, will further improve rural clinic performance. It should be noted that three of the current DPH enrollees at UWI are Jamaicans.

B. Contraceptive Methods

GOJ clinics offer all contraceptive methods, including orals, IUDs, injectables, spermicides (foams, jellies, etc.), diaphragms, suppositories, condoms, and voluntary sterilization. Contraceptive services and supplies are free, except that patients selecting orals pay a token 10 cents per cycle if they are able. Contraceptive preferences of NFPB clients over the years are summarized as follows:

Method	Percent of New Acceptors by Year			
	1970	1971	1972	1973
Orals (pills)	53%	58%	47%	44%
IUD	11	11	8	7
Condom	5	9	15	16
Depo-provera*	--	--	15	23
Spermicides	15	13	9	6
Other	16	9	6	4

The "mix" of contraceptive preferences among new acceptors deserves mention. In particular, acceptance of the long-acting injectable "depo-provera" is rapidly increasing, with over 500 new acceptors per month currently reported. The popularity of this method is attributed by Jamaican officials to a culturally deep-rooted conviction that medicine injected is somehow better than medicine ingested, as well as to the simplicity of a method which requires attention once every three months rather than daily. The anonymity with which contraception by means of injection is possible may also be a factor.

At Victoria Jubilee Hospital, injections were by far the most commonly selected method among both new acceptors and continuing users during 1972. Teenagers especially chose depo-provera in large proportion, although this method is not provided to those who are nulliparous.

The clinical problems attendant upon this method (menstrual disturbances, delayed return of ovulation upon cessation) that have deterred its popularity in other countries do not seem to concern the clinicians with whom we conferred in Jamaica, and should be studied in carefully controlled clinical experiments. Nevertheless, further extension of the availability of injectable contraception appears warranted on the basis of experience to date, and should be supported by whatever agency is best equipped to assure continuing supplies.

Oral contraceptives (at least 44 percent of new acceptors) and condoms(16 percent) account for the bulk of the remainder of acceptors. With the adoption of the commercial distribution scheme, the network of

*Included as "other" until 1972.

available sources of each of these modalities will be greatly extended, but it remains to be seen whether the necessary concomitant motivational/ educational program necessary to ensure the success of non-clinical distribution will be effective.

The Jamaican national family planning program has relied mainly on oral contraceptives, and the pill remains the most popular method, although recently there has been some annual decline in the percentage of new acceptors selecting this modality. Nevertheless, the importance of the pill in the program is reflected not only by NFPB statistics, but also by the data collected in the 1973 Westinghouse survey to assess the potential for commercial distribution of contraceptives. In anticipation of this move, steroids were removed from the medical list late last year.

The distribution of condoms has steadily increased, quadrupling in 1973 over the preceding year. Colored condoms are especially popular, reportedly because they are stronger and don't puncture. Current distribution is estimated at 123,000 condoms (all types) per month, however no accurate record of the number of condom users is available.

The IUD at present is not the method of choice by many Jamaican acceptors. The declining popularity of the IUD during the life of the program may be due, in part, to the fact that initially some untrained people performed insertions with subsequent complications. Side effects are also claimed to be a deterrent, including those which are rumored to occur, such as "it fly up in her neck and drop out her ear."

The dearth of information on continuation rates by method is symptomatic of the emphasis on reaching new acceptors, with insufficient attention to high dropout rates. The attempt by the UWI staff and other researchers to re-establish IUD acceptance and to introduce newer IUDs, such as the copper-T, are exceptions (see pp. 222).

3.3 Integration with Health Services

It is generally agreed that Family Planning offered through the NFPB clinics alone has suffered from underutilization, high cost per acceptor, and duplication of effort. Integration into health service outlets should result in better use of clinic time and personnel, with resulting improvements in clinic cost-effectiveness. Nevertheless, integration can enhance family planning acceptance only if it is accompanied by the training of health workers in their family planning responsibilities and by providing health care services which include the appropriate entry points for family planning intervention in the MCH cycle.

Since physicians are largely concentrated in the cities and engaged chiefly in curative medical care, the provision of nursing and paranursing personnel is critical to the delivery of family planning services island-wide. Of the total of approximately 7,000 employees in the MHEC, some 2,839 are identified as the Health and Hospital Nursing Service resources. Expansion of the cadre to over 3,200 including all levels of nurses, PHNs, midwives, and nurse-practitioners is projected. Integration of Hospital and Public Health nursing functions has already begun with the opening of the new Montego Bay Hospital. Mrs. Hunter-Scott, PNO, outlined for the evaluation team the new organization of the nursing

and paranursing services. Basic nursing education, in-service training, and career development through advanced nursing education are provided for, and all nursing personnel will be expected to teach family planning as an integral part of health care.

Likewise, the Government's plan for expansion of rural health service calls for community health centers in which primary care is provided, preventive and curative services are blended, and locally available paramedical skills are extensively utilized. The extension of Community Health Aides to all parishes is one step in this direction, and is endorsed by Jamaican health authorities generally, although some warn against a too-rapid expansion at the expense of careful selection and training to insure effective performance of CHAs in the field.

The Bureau of Health Education, in addition to strengthening its field staff by adding a Deputy Director for special programs and increasing its Senior Health Educators with regional responsibilities to three, also plans to expand its training service. This will be discussed in more detail later.

In summary, the evaluation team believes that the directions taken by the MHEC to improve and expand health services in addition to integrating family planning into these services indicate a growing capability in the provision of family planning services which will result in improved cost-effectiveness, as well as enhanced utilization.

3.4 Extension of Post-Partum Family Planning

The postpartum approach to family planning, which has been a major component of the national family planning program, was an early portender of the integration of services. Now as part of integration, family planning advice and services will be extended to postpartum and postabortal patients in all hospitals and rural maternity centers throughout Jamaica.

The maternity centered "Post-Partum Programme" began at Victoria Jubilee Hospital, which accounts for 20-25 percent of all births on the island. The substantial contribution of the program to the total family planning effort[1] has already prompted its extension to five additional hospitals in rural areas. The completion of the new wing of VJH and the ten rural maternity centers provided by the IBRD loan will undoubtedly enhance the potential for pre- and post-natal motivation for family planning. Numerically, the effect of these expanded facilities on numbers of potential acceptors remains unknown, however, until the degree of utilization and average length of stay in these facilities are established.

Whereas contraceptive services and family planning education stand to be improved by this expansion of institutional obstetrical services, the demand for facilities for sterilization (and legal abortion, assuming

1. Detailed most recently in the 1972 Report for Victoria Jubilee Hospital by June C. Rattray, FPEO.

clarification of the present law) remain largely unmet. These will be discussed under separate headings.

3.5 Commercial Distribution Scheme (Westinghouse)[1]

The commercial distribution of contraceptives is announced in Ministry Paper No. 1 as a strategy for making family planning more accessible to Jamaicans. Consideration of commercial distribution was previously recommended by the IBRD-sponsored external review team in 1972.[2] The JFPA has also been interested in making contraceptives more available, and initiated the distribution of condoms by encouragement visitors and male motivators.

The evaluation team agrees in principle with both the need for and the decision to approve the inclusion of Jamaica among countries in which non-clinical distribution of pills and condoms is planned. We did, however, encounter important reservations in the course of the evaluation which prompt certain recommendations regarding execution of the project.

It must be noted at the outset that the GOJ contribution to the project specified in the preliminary agreement had not yet been committed at the time of our visit, nor had the PIO/T been completed. Accordingly, our evaluation of the project is of necessity confined to the August, 1973 report of the Westinghouse Population Center, the references to the scheme in Ministry Paper No. 1, and conferences with the AID Population Officer and various Jamaican professionals conversant with this subject. Although import duties were not yet eliminated, we are informed that this is a technical formality that will be accomplished shortly and without difficulty. Oral contraceptives were removed from the list of prescription drugs in late 1973.

The Westinghouse report established the rationale for extending distribution and use of pills and condoms. Extensive survey data are provided regarding current users, potential users, and suppliers. However, no information is included regarding the current and projected roles in contraceptive distribution by non-physician personnel within the present family planning or health infrastructure. It is admitted that the elimination of dependence on health service outlets is the very essense of the project. Nevertheless, there are sufficient doubts in the minds of a number of our Jamaican informants to prompt consideration of some intermediate alternatives to the progression first to pharmacies, then to general stores and supermarkets as distribution outlets for oral contraceptives. No objections were raised to the rapid proliferation of outlets for condoms.

Surprisingly, the doubts encountered by the team do not reflect medical conservatism regarding the occurrence of complications without screening. Jamaican health professionals appear to accept generally the

1. Ref. AID Contract # CDS/3319
2. Sodhy, et al., Report of First External Review: Jamaica National Family Planning Program, IBRD, July, 1972, pp. 33-35.

risks-versus-benefits rationale for non-clinical distribution and the relatively higher risk of pregnancy itself. Their reservations, however, stem from the observation that inconsistent or otherwise erroneous use of oral contraceptives is common even among users whose pills are accompanied by careful instruction and monitoring in the existing family planning clinics. Accordingly, they question whether point of purchase brochures, advance messages through the media, or whatever other means are employed will suffice to forestall mis-use and whether the consequences of wide-spread mis-use may discredit this most important contraceptive modality.

The evaluation team feels strongly that the generally favorable disposition toward the commercial distribution concept among Jamaican physicians, unique among health professionals elsewhere, is an important factor not to be overlooked. Their cooperation is essential to the success of this venture, and it would be regrettable if their carefully considered reservations and suggestions are ignored in the effort to establish the role of the commercial sector.

The Westinghouse studies establish the feasibility of a commercial distribution system capable of reaching persons who do not reside within a reasonable distance from a pharmacy or clinic. While the resulting relief from dependence on a limited health care delivery system is acknowledged, several of the team's informants questioned the assumption that "equipped with accurate information regarding safety, effectiveness, availability and usage, fertile-age couples in Jamaica will be able to make intelligent decisions concerning contraception."[1] Arguing against reliance on this assumption is the experience of high dropout rates and contraceptive failures due to improper use (of orals particularly), in spite of accurate information provided by family planning professionals. Moreover, the disenchantment engendered by mis-use spawns negative rumors and thus risks discrediting this most valuable modality. These problems are reported to be most pronounced in rural areas--precisely those geographic sectors of Jamaica that commercial distribution is designed to serve more adequately.

While acknowledging the ultimate benefits of truly commercial distribution among a population properly prepared, the evaluation team shares the opinion of many Jamaican professionals that an important intermediate step toward this goal has been overlooked. The freer distribution of contraceptives by a number of non-physician categories of health workers who, nonetheless, are trained to counsel in proper contraceptive use represents logical progression toward wider distribution, which at the same time offers greater protection against consumer mis-use. The Westinghouse study confirms the inadequate knowledge even of pharmacists about contraception, yet stresses advertising and promotion rather than training of pharmacists in contraceptive counselling.

The generally favorable disposition of Jamaican health professionals toward elimination of "medical" prerequisites to oral contraceptive use

1. Westinghouse Population Center, "Distribution of Contraceptives in the Commercial Sector of Jamaica," p. 4.

(prescription requirement, periodic examination, etc.) and the integration of family planning clinics into health centers with expansion of outreach functionaries (CHAs, male motivators, encouragement visitors, etc.) offer a unique opportunity for an orderly progression from clinical to commercial distribution. The intermediate step of utilizing health auxiliaries freely for distribution of subsidized contraceptives can give way to commercial distribution as evidence of public acceptance and consumer knowledge of proper contraceptive use are demonstrated. The success of the commercial distribution scheme, as well as the continuing cooperation of health professionals, could be enhanced by this approach.

Although questions have been raised within the U.S. Mission about the necessity for a Jamaican based field project manager, the evaluation team feels that the careful monitoring of this important new departure in contraceptive delivery requires that this post be filled. Moreover, the field project manager must be thoroughly conversant with and coordinate closely with the existing MCH/FP distribution system in order that alternative distribution mechanisms may complement one another. To this end, a Jamaican counterpart to the field project manager should be designated early and trained with a view toward Jamaican self-sufficiency in management of alternatives to clinical distribution by the end of the project:

> RECOMMENDATION: That implementation of the commercial distribution project include liaison between the project staff and the staff of the PMO:FP/Nutrition/MCH in order that full cooperation between existing medical and contemplated non-medical outlets for contraceptives is assured.

> RECOMMENDATION: That a phased non-clinical distribution include controlled experiments in distribution of oral contraceptives by various levels of non-physician health personnel (including nurses, CHAs, male motivators, etc.) in addition to pharmacists prior to full implementation of the distribution plan in various retail outlets.

> RECOMMENDATION: That the U.S. Field Project Manager based in Jamaica be responsible for training a Jamaican counterpart over the life of the project, in order to assure continuity and that the responsibilities of such counterpart include coordination of the commercial distribution scheme with established GOJ family planning/MCH programs.

3.6 Sterilization Services

The NFPB initiated sterilization services as part of its program in 1972, and during that year 1,081 tubal ligations were reported in KSAC and six parishes. In 1973 government hospitals reported 2,379 female sterilizations. Reports are not routinely received from other hospitals.

There is no question that the provision of resources to respond to a large pool of ready acceptors requesting sterilization is one of the greatest immediate needs of the GOJ program. Dr. Leslie Williams' disclosures of the VJH survey indicating that approximately 70 percent of women delivering at VJH would welcome sterilization was echoed by other hospital officials elsewhere on the island, all of whom cited long waiting

lists for interval sterilizations and inadequate surgical facilities for puerperal tubal ligations. The NFPB statistical review for 1973 reveals that nearly 60 percent of all acceptors had at least three previous pregnancies and one-third had five or more previous pregnancies. Data from Westmoreland, which has consistently led among rural parishes in incidence of sterilization, indicates a recent increase in requests among the 25-29 year old age group. Unquestionably ready accessibility of terminal methods would not only contribute measurably to total births averted, but in addition would free up scarce resources to concentrate on providing reversible contraceptive service to younger acceptors of low parity, and to spacers.

The case for puerperal sterilization is strengthened over its demonstrated cost-effectiveness and simplicity, by the fact that the sterilization procedure is obscured from public view by childbirth as the reason for hospitalization. This feature of "privacy" in family planning acceptance was stressed everywhere, and cited also as a "plus" for integration of family planning into MCH health clinics. For this reason, even though interest among physicians in laparoscopic and other "interval" techniques runs high, training in these modalities should not be allowed to overshadow the first priority in sterilization, which is the expansion of facilities and training for immediate puerperal tubal ligations. The expansion of VJH, the opening of the new Montego Bay hospital, and the 40 bed hospital at Maypen (Clarendon parish) for gynecological cases including sterilization, should ease the bottleneck in these locations somewhat, particularly if planning includes provision of special areas where "ambulatory" surgery can be performed.

Dr. Patterson has understandable reservations about the role of laparoscopic sterilization in Jamaica. She is fully aware of the need to expand facilities for sterilization rapidly and very supportive of the plans to utilize alternative locations in the Kingston area for minor surgical procedures. Nevertheless, she cautions against too heavy reliance on any one method, and questions whether the transition to a totally outpatient procedure should not be gradual, until Jamaican physicians become thoroughly experienced and proficient in this procedure. We believe that her counsel should be heeded, and that Jamaica should not be hurried into a stereotyped or Americanized version of sterilization care. Moreover, we believe that the research in culdoscopic sterilization conducted by Dr. Hugh Wynter at UWI represents an important Jamaican contribution to the world's experience with alternative procedures and should be continued for comparison with the laparascopic and other modalities.

Dr. Hall is currently performing laparascopic sterilizations at UWI, supplementing Professor Wynter's culdoscopic program, but he is in need of an additional laparoscope. It has been suggested that the new building, to house the Family Planning/Epidemiology Unit and UWI postgraduate Unit on the ground floors, include two additional stories comprising a Reproductive Biology Unit and sterilization clinic. These activities will form the basis of an international training center, and since several current and potential donors are involved (US/AID, UN, Ford, Pathfinder), careful coordination of inputs will be required if the potential to expand upon the valuable UWI experience in advanced fertility control technology is to be realized.

Personal communication with Dr. Winfield of AID/w and Dr. Lubell of AVS International Project indicates that sufficient inputs which are outside of the bilateral agreement are now assured to provide training and equipment for six laparoscopic sterilization centers throughout Jamaica. The evaluation team agrees that this approach addresses itself to a serious unmet need. Nevertheless, the team feels that the potential of surgical sterilization in Jamaica is unlikely to be fully realized by an "advanced technology" approach alone, especially if this neglects the human factors which determine the advice that the first patients to experience this technology pass on to their friends and neighbors.

RECOMMENDATION: Current plans for expansion of training and provision of equipment to enhance existing facilities for sterilization should be implemented without delay.

RECOMMENDATION: An ad hoc "Committee on Surgical Procedures Affecting Reproduction", chaired by Dr. Patterson, should be appointed, to develop a master plan for development of resources throughout Jamaica. US/AID assistance and technical backstopping should be at the disposal of this committee as requested, and the content of the master plan should comprise:

A. An overall MHEC policy regarding voluntary sterilization, including consideration of subsidies to meet overhead and equipment costs incurred by institutions providing sterilization procedures, and provision of free sterilization service to all voluntary acceptors.

   A review of current priorities and unmet needs in existing hospitals where opportunities for puerperal sterilization are currently thwarted by overriding demands on available facilities for emergency and curative operations.

   1. Cost-benefit analysis of curative vs. preventive (elective) surgical care.

   2. Alternatives to large hospital surgical suites and/or general anesthesia for puerperal sterilizations, including

      a. Smaller and simpler "ambulatory care" surgery units within or adjacent to large hospitals for provision of minor gynecological procedures including sterilization.

      b. Satellite clinics in urban and peri-urban locations where out-patient sterilization (both puerperal and interval) is provided, following sufficient experience with such procedures on an in-patient basis.

      c. Mobile teams trained and equipped to provide out-patient sterilization in rural locations throughout the island, once experience has demonstrated the feasibility of this approach.

C. A detailed plan for training of personnel, including:

1. Sterilization counselling and case-finding by outreach workers (public health educators, CHAs, etc.), MCH/FP clinic staffs (midwives, nurses, physicians), and hospital personnel.

2. Training of physicians in techniques of sterilization.

a. Participant training in short courses at U.S. institutions (Advanced Technology Fertility Control Program).

b. Post-graduate training in Jamaican teaching hospitals.

c. In-service training by traveling U.S. teams (Johns Hopkins, etc.), and other consultants.

D. An inventory of required equipment and facilities needed to erase current backlog and to provide service for projected sterilization caseloads.

E. Careful multidisciplinary review and appraisal of studies, both completed and contemplated, leading to plans, policies, and educational programs designed to increase acceptance of male sterilization in Jamaica.

In view of the rapidly changing status of and growing experience with sterilization in other jurisdictions, technical assistance to Jamaica in the implementation of these recommendations may be advantageous.

NOTE: The changing legal status of abortion in Jamaica is discussed elsewhere in this report. Nevertheless, in anticipation of clarification of the abortion law in the near future, the above charges to the Committee on Surgical Procedures Affecting Reproduction may be applied as well to the preparation for expansion of facilities and training that will then be required. Since both abortion and sterilization may be provided in comparable "minor" gynecological surgery facilities and the requisite training and skills are related, such a Committee represents a logical focal point for building abortion care into a comprehensive MCH/FP framework.

3.7 Abortion Services

The difficulties of achieving needed clarification of the abortion law in the face of potent religious and political opposition are well appreciated by the GOJ. Nevertheless, the MHEC is committed to achievement of clarification at the earliest possible moment, and has accordingly taken the necessary steps to structure the modification of the existing law so as to assure passage. The JFPA has for a number of years spoken out on the need for clarification, and in late 1972 with the UWI, IPPF, and the NFPB co-sponsored a major conference to explore the issues.[1] In the

1. "The Implications of the Curative and Preventive Aspects of Family Planning in the English-speaking Caribbean," UJIN Conference sponsored by the University of the West Indies, Jamaica Family Planning Association Ltd., International Planned Parenthood Federation, and National Family Planning Board at the Medical Lecture Theatre, December 15-16, 1972.

private sector, Dr. James Burrowes has been a leader in articulating the need for legal clarification, while the press has helped to advance debate.[1]

The original call for a law providing abortion "on demand" has given way to a more moderate amendment to the present law permitting abortion in the face of a threat to the mother's "health" as well as "life," a change making possible a substantial increase in the availability of legal abortions on medical grounds.

The legal steps toward enactment are already well along, and the proposed bill has been approved by the Prime Minister's office and discussed by the Minister with the Council of Churches--an important step. Further clearance by a parliamentary body which reviews the language of proposed legislation remains before the measure is submitted to Parliament, but the Minister is confident that the bill in its present form is assured of passage within the next few months. Dr. Patterson shares this view, and is concerning herself with planning for the added facilities and training that the clarified abortion law will necessitate.

Although illicit abortion is considered to be exceedingly widespread and a leading factor in maternal morbidity and mortality in Jamaica, the evaluation team was unable to obtain data on the number of hospital beds occupied by patients suffering from complications of non-legally induced abortions. It is estimated, however, that at least 3,000 women are admitted yearly into Jamaican hospitals with various stages of incomplete abortion, and Victoria Jubilee Hospital alone treats approximately 1,500 women annually for the effects of illegal abortion.[2] The team's visit to the septic abortion ward at VJH confirmed the widely held view that the costs, both economic and in human suffering, of abortion inducted in dangerous non-medical circumstances are very high.[3]

The extent to which substitution of legal for clandestine abortions will relieve this burden is impossible to assess with accuracy. Already a considerable number of therapeutic abortions are being done by private physicians, as well as in government hospitals, and the superintendent of one rural hospital informed us that the number of requests for abortion among pregnant teenagers has significantly increased in recent months. While there are no hard data from which to estimate the need for bed space and surgical facilities, it is clear that the demand will greatly exceed the available resources following legislative clarification. Carefully planned external support will be needed if this demand is to be met.

1. For example, Thompson, Leslie, "We Need Enlightened Abortion Laws," The Jamaica Daily News, November 15, 1973.
2. Russell, Aubrey, "Family Planning at Johns Hopkins Hospital," Family Planning News, NFPB and JFPA, Jamaica, June, 1973.
3. For a description of some of the techniques used in illegal Jamaican abortions, see "The Quacks," Family Planning News, NFPB and JFPA, Jamaica, November, 1972, pp. 6-7.

Dr. Patterson estimates, on the basis of available medical personnel trained or trainable in abortion techniques, that about twenty uterine aspirators will be needed in the immediate future. She notes that a number of private practitioners already have such equipment, and aspirators are in use at the VJH and UWI hospitals. In addition, she is in possession of twenty demonstration kits for field trials of the Menstrual Regulation procedure, and a member of her staff attended the conference on Menstrual Regulation in Hawaii in December, 1973. We were unable to learn in the course of this visit of the extent to which second-trimester abortion is provided. However, on the basis of an imminent change in the abortion law, and evidence of demand for, and professional interest in providing modern and safe abortion care, we strongly recommend the following:

> RECOMMENDATION: That planning for provision of abortion care in a comprehensive MCH/FP framework be undertaken by the same Committee on Surgical Procedures Affecting Reproduction referred to in the foregoing recommendations under 3.6 (Sterilization Services).

> RECOMMENDATION: That training in advanced fertility control techniques including the management and public health aspects of pregnancy counselling, pregnancy testing, and out-patient and free-standing clinic abortion care, be made available as a high priority item in external assistance to the GOJ program.

3.8 Cytology

Tests for early detection of cervical cancer were incorporated into the national family planning program in 1966-67, and during this same period a cytology laboratory was developed in the Ministry of Health Department of Laboratories. US/AID provided technical and commodity support for the cytological laboratory service through 1969 on the understanding that future commodity needs would be financed by the GOJ (Pro-Ag 69-1).

The NFPB goal for this aspect of the program was to take Pap smears on all new acceptors, upon the assumptions that this test would serve to attract women to family planning clinics, that it would identify patients for whom neither the pill nor the IUD should be recommended, and that it is a sound health measure independent of family planning considerations.

Pro-Ags 70-5 and 71-5 both indicate that efforts would be undertaken to motivate clinic staff to take Pap smears, as well as to keep accurate records on those patients who had this service performed. According to the 1969 Project Proposal, the NFPB coordinated follow-up of patients and treatment of cases with the MO(H)s in the parishes, where FPEOs contacted patients with abnormal results. While the Board encouraged treatment of positive cases, this was the responsibility of the Ministry of Health. Later the Board employed a part-time gynecologist to follow-up positive cases and to arrange for treatment. In addition, the Board charged its Scientific and Drug Committee with reviewing the cytological aspects of the program and making recommendations regarding it.

The 1972 IBRD evaluation team reported that a total of 42,626 smears had been examined since 1969 at an average cost per smear of J$1.63, excluding the costs of consultants. A total of 368 positive cases was detected during this time, of which 135 cases received treatment. This team also reported delays of 6 months to one year from the time the smear was taken and the time the patient received treatment.

While the current evaluation team was unable to obtain any more recent statistical data on the number of smears actually taken or the follow-up on cytological smear reports, the indirect evidence indicates that these laboratory services are not yet effective in the early detection of cervical cancer among family planning clinic patients. The Catholic Multiservice Center, for example, reports delays of up to six months in recovering reports of routine cytological smears obtained in its facility.

In the process of integration, the decision has been taken that cytology services should be reviewed and should properly fall under the gynecological and pathological services now being operated by the MHEC. The Minister of Health has set up a special committee to assist the transfer and to plan for improved services. In addition, the Minister intends to decentralize laboratory services in order to facilitate processing of samples. It is understood that Project Hope will send a laboratory specialist to Montego Bay, which means that the refrigerated van now transporting samples to that part of the island will be able to cover a more restricted area more intensively.

3.9 Effectiveness of Record-Keeping System and Use Thereof

A system of recording and reporting clinic data was set up within the NFPB with assistance from the Ford Foundation in 1968 and operationalized in November, 1969. Key features of this system include:

Registration of New Acceptors: A registrant at any GOJ family planning clinic who is placed on a contraceptive method is an "acceptor" and is counted as a "new acceptor" only once.

An admission card is made out in duplicate for each new acceptor at the clinics and one copy is sent to the Board. An acceptor is identified by name, date of birth, marital status and parity, and by a clinic number issued to her when she first registers.

More detailed data are collected at the clinics on one of every ten acceptors.

Recording Revisits: The clinics make out in duplicate a record on each acceptor on revisit and send a copy to the Board. If a patient loses the green card bearing her number, search is made using the identifying data on her original registration card, and the number is usually found, even if she is changing clinics.

Identification of Dropouts: An acceptor becomes a "dropout" only when she fails to return to the family planning clinic

for three consecutive months following the date given for her return visit. When a dropout eventually does return, at the same clinic or at a different one, she is reinstated as an acceptor, using her old clinic number.

Statistical Reports: From the above records, IBM cards are compiled and computer tabulations are obtained from the central statistical processing service of the GOJ. Monthly and quarterly reports are prepared which provide information on:

1) number of new acceptors by clinic, by parish, by method of contraception accepted, by age, and by parity.
2) number of revisits by clinic, by parish, and by method of contraception.
3) number of acceptors missing visits by clinic and by parish.

Statistical reports are fed back to the clinics, and FPEOs and AFPEOs follow-up acceptors who have missed clinic visits.

Types of complaints are also fed into the Board by the field officers and fed back through quarterly statistical reports.

A. Effectiveness of Record-Keeping System

The capabilities of the NFPB's statistical staff are generally highly regarded. Nevertheless, a number of problems have been identified with the statistical system.

In connection with a request for documentation for the NFPB master file update and tabulation programs made to the International Statistical Programs Center of the Bureau of the Census, Washington, D.C., the ISPC in April, 1974 provided a brief evaluation of the computer programs used by the Board. This stated that:

1. "The system works. That is, it does what it is 'supposed' to do.

2. "The best method to produce tables is to use CENTS. This means that the Fortran programs currently being used to produce tables should be entirely replaced by (1) a new extractor program to collect and format data to be used by (2) the CENTS package, which would produce all tables that are printed currently, as well as any new tables that may be desired.

3. "The system should, if possible, be redesigned. This may require some policy decisions and relatively minor program changes, or may require extensive work. Perhaps a feasibility study--systems analysis should be done to determine this. In other words, the range of effort of this task could be anything from start over (client-record forms and all), to minor revisions to the existing system, or no change.

"There are several good reasons for redesigning this system:

a. The massive, heterogeneous master file must be processed every month, even though most of the records in the file are unaffected and most of the data fields in the affected records are unchanged.

b. It appears that the system is designed so that this file is ever-expanding, because no records are ever dropped from it.

c. Perhaps updates could, or should, be done quarterly, instead of monthly.

d. The client record number has no positive control built in to prevent transpositions. For example, a "check digit" or the first two alphabetic characters of the name could add a significant level of control.

e. The edit phase of the update is extremely simple. A number of additional edit features could be added to a new update-edit program that would improve that phase of the current system."[1]

Other problems with service statistics identified by the evaluation team and by previous consultant reports include:

1. Registration Form: Some feel that the registration form ("yellow card") is too long and complicated. Also, it lacks information needed for effective follow-up of dropouts, e.g., the patient's "pet name" by which she is usually known, and names and addresses of others who generally know where she can be located.

2. Data Collection Problems: Many of these relate to clerical errors and omissions. Training of clerks has been undertaken in an effort to overcome these and other difficulties (see p.).

3. Infrequent and Incomplete Statistical Reports: Computer breakdowns have resulted in delays in providing regular statistical reports. Breakdowns have also sometimes resulted in elimination of certain tables, e.g., numbers of new acceptors and revisits by parish, by age, and by parity.

4. Omission of Needed Data: Certain types of data needed for program evaluation are not provided by present service statistics. Principal omissions include:

    a. Data on new acceptors from all sources. Although the JFPA and the Catholic Family Counselling Center

1. Memorandum to Mr. Norman Lawrence from Mr. Carl Gray, Bureau of the Census, Washington, D.C., April 15, 1974.

use NFPB patient record forms, figures from their clinics are not included in statistical reports. No data are available on acceptors through other voluntary clinics, private medical practitioners, or commercial distribution.

b. Adequate information on continuation rates, including continuation rates by method, age, parity, and age of last child.

c. Adequate information on dropouts. Reasons for dropping-out particularly are needed.

d. Relation of clinic performance to other variables, including the number and frequency of clinic sessions, the relative size of the operation, and targets assigned or expected. In the absence of such data, ordering of clinics by numbers of acceptors and revisits can be misleading in assessing clinic performance.

Data on clinic costs as related to clinic performance are also needed. A previous evaluation team observed that "this relationship between cost and performance statistics needs to be brought together on a continuous basis (e.g., monthly or quarterly) Although it is sometimes hard to estimate costs, it serves as a reminder to possible deficiencies and as a guide for adequate planning. Cost data by clinic and parish could be computerized as well using a similar system to that of performance statistics."[1]

In sum, more data to help improve clinic operations are needed.

e. Some estimate of births prevented/couple years of protection. The 1972 IBRD-sponsored evaluation team pointed out that while such estimates from service statistics have their limitations, they "serve as a reminder of the 'gap' between acceptor statistics and the 'program goals' of reducing the birth rate."

5. Lack of Statistical Interpretation. More interpretation is needed, especially of the relationships between new acceptors, their drop-out rates, and their post-use performance, all age-parity-method specific by parish and possibly by clinic.

1. Sodhy, et al., Report of First External Review: Jamaica National Family Planning Program, IBRD, July, 1972, p. 35-36.

6. Reliability and Validity of Clinic Statistics. Professor Roberts and Mr. Wallace question the authenticity of NFPB statistics, in that 123,000 new acceptors were reported between November, 1968 and the end of 1973, and yet only 41,000 continuing users are on the active role nationally. This means that presumably some 80,000 women have been family planning drop-outs, an inordinately high figure, especially considering the recent drop in birth rate.

   The 1972 IBRD-sponsored evaluation team implied the need for validity and reliability checks on the quality of service statistics in that they recommended that this should be done.

   In 1971 Kraft also questioned the validity of the statistical system, observing that:

   a. The number of new acceptors reported is probably inflated, for women visiting clinics are recorded as new acceptors, even though no contraceptive method is given. This is done on the basis that failure to identify the method is due to clerical error.

   b. The number of actual dropouts is probably less than reported, for many women who are successfully using an IUD or a diaphragm do not return to the clinic for check-ups, statistics on the numbers of former users who have been sterilized are not available, and other women may be using contraceptives obtained commercially.

B. Use of Service Statistics

Pro-Ag 70-5 stated that in 1970 the NFPB would give priority to the feedback of clinic service statistics and other information regarding such matters as individual clinic performance, review and exchange of ideas on problems, and program trends. Although the NFPB subsequently began to develop comparative figures for clinics in relationship to specific targets, this effort reportedly has now been discontinued.

Problems in the NFPB's statistical system, as described in the preceding section, obviously affect the uses to which the resulting data can be put. Quite apart from system difficulties, however, the evaluation team did not obtain evidence that available statistics are being regularly used to monitor and improve program performance. Detailed analysis of acceptance and continuation rates and of clinic performance over time were not found, nor were possible reasons for changes identified in depth. Reallocation of NFPB resources to assist clinics and parishes with poor performance was not apparent. Changes in clinic hours or locations and clinic consolidation were not justified in terms of program data, nor were the results of these changes formally evaluated. The effects of program innovations, with few exceptions, have not been analyzed via the statistical system. Moreover, responsibilities for these functions seem to be vaguely defined in terms of the staff members who should carry them out.

These deficiencies seriously limit the extent to which the program can learn and benefit from its own experience. At the same time, however, it should be pointed out that these problems are not unique to the national family planning program. Thus the 1970 Kingston Social Agency Survey revealed throughout the social welfare community "total inability to produce statistics on what and how much it did, whom it served, and what it accomplished for the community through these services."[1]

C. Family Planning Service Statistics Post-Integration

Ministry Paper No. 1 - Family Planning indicates that under integration the NFPB will continue to be responsible for statistical data and for monitoring and evaluating the national family planning program. Specifically the Board is charged with:

a) The design and updating of data collection systems so as to obtain all data which is useful for the purpose of providing the Board and the main executive agencies with information on which to plan programs and facilitate evaluation.

b) Having monthly, quarterly, and annual reports prepared and circulated with dispatch.

c) Having such reports along with other available information appraised by the Evaluation Committee.

d) Taking appropriate action in relation to program planning and execution, following (c) above.

e) Administrative responsibility for seeing that proper arrangements are made for data processing, i.e., systems relevant to data collection and print-out designs.

f) Liaising with the UWI and the Registrar General's Department with particular reference to vital statistics and research.

These tasks are essential to achieving maximum efficiency and effectiveness in the program. Nevertheless, performing them involves overcoming a number of complex problems. Whether or not the Board is equal to this challenge remains to be seen.

The evaluation team believes that a logical beginning point would be to follow the suggestion of the International Statistical Programs Center of the U.S. Bureau of the Census, and therefore recommends:

RECOMMENDATION: That a study be conducted to determine the feasibility of redesigning the NFPB statistical system to better meet current program needs.

In addition, the post-integration relationships and operational responsibilities of the NFPB, the MHEC, and the parish (MO(H)s for reviewing service statistics and making indicated changes in program operation need to be clarified, and accountability for the performance of these functions should be established.

1. Proposal for Family Counselling and Multi-Services Center.

3.10 Private Sector Contribution to Family Planning Services

The degree of private sector participation in the total Jamaican family planning effort is not reflected in the statistical reports of the NFPB. Some indication of private sector support is provided by the estimate of public and private sector distribution of contraceptives in Jamaica for 1971 reported in the Westinghouse Commercial Distribution Study.[1] The potential of commercial distribution channels for expanding availability of contraceptives is discussed on pp. of this report. This section briefly describes other contributions from the private sector.

Although the following listing may well be incomplete, it does indicate widespread support for family planning among non-governmental resources. These resources should now be further developed and coordinated into a comprehensive national effort.

A. Private Medical Practitioners

The role of private medical practitioners is limited by their concentration in the urban centers and by a doctor/population ratio which makes heavy demands on curative services. Nevertheless, those physicians whose practice is confined to reproductive medicine are reported as "willing and anxious to help," and fully cognizant of the importance of family planning to the nation's development. Dr. James Burrowes estimates that private physicians currently perform approximately 5 percent of the surgical procedures affecting reproduction, but could do considerably more with closer collaboration between the government and private sectors. The common meeting ground of government and private physicians is the OB/GYN society, and its leadership has been particularly influential in calling for legislative clarification of the abortion law.

B. The J.F.P.A.

The JFPA operates two full-time family planning clinics,[2] and also contributes directly to the delivery of family planning services through the field distribution of contraceptives by a mobile unit and outreach workers. NFPB forms are used to record data on all new and continuing acceptors. In addition, as detailed elsewhere in this report, JFPA educational activities, especially in relation to abortion, contribute indirectly to the development and improvement of family planning services.

1. "Distribution of Contraceptives in the Commercial Sector of Jamaica," Westinghouse Population Center, 1973, p. 22.
2. These two clinics were the first in Jamaica. A study of the growth and development of their clientele through 1964 has recently been prepared in cooperation with the International Demographic Statistics Center of the U.S. Bureau of the Census. Entitled The Evolution of a Family Planning Movement in Jamaica, the study is authored by Shirley Smith in cooperation with Dr. Carl Stratmann and Mr. Basic Morgan. It was published circa 1972.

The Association's East Street Clinic in Kingston is the busiest on the island, with the following service statistics for 1972 and 1973:

Year	New	Revisits	Men	Total
1972	1,318	12,569	2,563	16,450
1973	1,191	12,550	4,278	18,019

The pill is the most popular method at this clinic, but efforts are being made to increase acceptance of the IUD, and there were 185 insertions in 1973. The clinic is participating in the NFPB project to test the acceptance and effectiveness of the Dalkon Shield and the Copper T as compared to the Lippes Loop. The Board provides the clinic with all contraceptive supplies and a financial grant equal to 50 percent of operating costs. Dr. Jacobs, JFPA's President, hopes that eventually the GOJ will assume full responsibility for this clinic.

The Beth Jacobs Clinic in St. Ann's Bay, through arrangement with the NFPB, provides daily family planning services for the parish. Although this clinic registered a cumulative total of 11,929 acceptors through 1972, there has been a steady decline in clinic attendance for a number of years. Discussions with IPPF representatives in late 1973 resulted in selecting this clinic as the site for a Model Family Planning Program, which was launched in March of this year. IPPF has provided the JFPA with $50,000 for this project.

Funded for one year, but planned for three years, the Model Program has three components:

1) <u>Improved fertility control requiring medical services</u>
Increasing stress will be placed on IUDs; male and female sterilization (vasectomy and laparoscopy) will be initiated during 1974; and diagnosis and treatment or referral of complications related to reproduction or contraceptive use will be increased.

2) <u>Increased supply of contraceptives not requiring medical attention</u>
This will be accomplished through establishing a non-medical section at the Beth Jacobs clinic and by field distribution of orals, condoms, and spermicides.

3) <u>Postpartum and postabortal program at St. Ann's Maternity Hospital</u>
In addition to family planning counselling, methods will be provided to postpartum and postabortal patients who desire. Depo-provera and condoms are the preferred methods for the postpartum period.

No evaluation of the model program is possible at this early stage of the project.

The JFPA has also been operating a mobile clinic/male motivators project in St. Ann's parish since August, 1973. This project is funded by Pathfinder for one year, and approved by the National Family Planning

Board. It is anticipated that the action phase of the project will last up to three years, with additional funding contingent upon reasonable progress during the first year.

The project utilizes a Volkswagen mini-bus, one of two given to the JFPA by IPPF in 1973. The unit has been modified to permit consultations to be held within, and is also equipped with a loudspeaker and projector for motivational presentations. Staffed by a midwife who is in charge, another midwife who acts as clerk, and a driver/technician, the unit visits villages and communities five days per week on a pre-arranged monthly schedule. Five male motivators (see pp. 103) provide advance publicity by conducting house-to-house visits, contacting men in typical gathering places, and organizing group discussions. Reportedly the mobile program is generally well received, although strong resistance has been encountered in a few villages.

A major objective of the mobile clinic project is to bring family planning motivation and services to rural areas of the parish where existing facilities are sparse or non-existent. Particular emphasis is on motivating males to use contraception, but the project also encourages men to have their women use birth control. Both condoms and pills are distributed, as well as spermicidal methods. In addition to recruiting new acceptors, the project aims to provide a continuous supply of contraceptives to clients who are unable to attend clinics regularly, and thus to aid in lowering parish clinic dropout rates. It is hoped that this new mobile outreach approach can serve as a model for future expansion into other areas of Jamaica where access to family planning services and facilities is difficult.

The mobile clinic idea is not new to the JFPA, however, for the old Jamaica Family Planning League once operated a unit which it passed on to the Association when the League ceased to provide services in 1962. The JFPA operated the unit for a time in St. Ann's parish, but it did not prove successful in those days, primarily because family planning was then discussed only in whispers and the unit was too visible a means of dispersing contraceptives.

The JFPA re-introduced a mobile unit to Jamaica in June, 1970 when the Rotary Club of Montego Bay presented a modified Ford minibus to the St. James Family Planning Association, one of the JFPA's parish committees. This unit was attached to the Montego Bay Clinic and staffed by its personnel, but since no special staff were employed to man the unit, it could operate only on a very limited basis and sometimes irregularly. In 1971 the Clarendon Family Planning Committee raised local funds to provide for a two-week visit of the mobile clinic to that parish, for which the JFPA arranged advance publicity. In 1972 the St. James mobile unit operated in Clarendon for a period totalling six weeks. Although the Clarendon Committee wanted to continue and expand this work, funds were not available to do so.[1]

1. The mobile unit belonging to the St. James Family Planning Association was formally donated to the JFPA when the parish committee wound up its activities concurrent with the establishment of a full-time family planning clinic in Montego Bay by the NFPB at the end of 1971. As a result of negotiations between the NFPB, the JFPA, and the St. James MO(H), this unit was loaned to the Board program in St. James beginning in December, 1972. for use with its Community Health Aide project there (see pp.)

Reports of the JFPA mobile clinic operations in Clarendon indicate impressive numbers of men, as well as women, were reached and large quantities of condoms and other contraceptives were distributed. Early reports of the current mobile unit project in St. Ann's show similar results. Nevertheless, a cursory review of sample quarterly reports from both parishes reveals disappointing turnout at second (follow-up) visit. Here it should be noted that evaluation and reporting criteria for mobile clinic operations in the two parishes are not uniform.

Progress evaluation of the current mobile unit/male motivators project in St. Ann's was conducted by Pathfinder in January, 1974, and data are being collected to permit a more detailed evaluation at the end of the first project year. In general, however, Madhok's conclusion from the 1973 IBRD evaluation of the Jamaican national family planning program still seems valid, i.e., "Mobile services are expensive but they meet a need which is not otherwise met."[1]

In addition to its mobile clinic project and the field aspects of its Model Clinic Program, the JFPA is interested in promoting field distribution of contraceptives in other ways. The Association, in fact, conducted a small survey on the private sales of contraceptives by such commercial enterprises as drug stores and barber shops in 1968-69, and initiated the non-clinical distribution of condoms by its field workers in 1972 as a corollary to the development of its male motivators program. Currently it sees the need to encourage condom distribution in factories through management, with the hotel industry on the North coast as a major target. Due to the NFPB's plans to expand the commercial distribution of contraceptives, the JFPA now does not place major emphasis upon this activity, but rather plans a complementary and supportive role.

C. The Department of Obstetrics and Gynecology, UWI

The Department of OB/GYN, UWI holds five general family planning clinic sessions weekly, as well as two special clinics which concentrate on IUD insertions. In addition, as discussed elsewhere in this report, the Department of OB/GYN is a leader in sterilization services and research (see p. 63), and contributes to the delivery of family planning services through its teaching and other activities.

D. The University Health Centre, UWI

The Department of Social and Preventive Medicine has a link with the University Health Centre, but information about the type of family planning services provided by the Health Centre was not obtained by the evaluation team.

E. The Family Counselling Centre

The Family Counselling Centre, operated since March, 1967 by the Roman Catholic Archdiocese of Kingston in a low-income urban area, is

1. Madhok, R.N., Jamaica: Report of a Mission to Review the Family Planning Program, IBRD, May 30 - June 11, 1973, p. 12.

dedicated to promoting more stable and responsible family life. Counselling, education, community development, and birth regulation services are provided in an effort to meet individual and family needs comprehensively.

Initially the Centre offered one clinic session per week and instruction in the rhythm method. In February, 1968, however, it began to dispense oral contraceptives, and the pill has been the Centre's primary method ever since. The number of clinic visits for family planning supplies, counselling, and information has grown steadily, increasing from 566 in the third quarter of 1968 to 1,562 visits in the second quarter of 1973. Cumulative clinic visits now number over 10,000, half of these for oral contraceptives. Currently the Centre serves 800 active pill users. NFPB patient record forms are used, and monthly statistical reports are sent to the Board.

As with other family planning clinics, dropouts pose a problem, however the Director of the Centre, Father Kane, feels that if a woman can be maintained on the orals for three months, her chances of becoming a continuing user are greater than with any other method. Only two cycles of pills are provided per patient at a time in order to build in regular opportunities for supportive counselling when new contraceptive supplies are obtained.

The Centre also provides screening for cervical cytology and has done many Pap tests, including for women who were not interested in birth regulation. The Director reports some resentment from the NFPB about the levels of costs resulting from the quantity of tests performed, and further says that delays in receiving laboratory reports have been a problem. Centre staff personally follows-up cases with suspicious test results.

Based upon its past experience and the results of several surveys in which it has participated, the Centre is particularly interested in experimenting with better urban systems for the delivery of comprehensive family services. Currently it proposes to expand existing services into a Multi-Service Centre in Cockburn Pen in order to link various social services without having to refer clients from agency to agency. This concept was pre-tested in existing facilities during the last three months of 1973, and evaluated in early 1974. It has the support of the NFPB, as expressed by Dr. Patterson, as well as backing from a number of public and private social agencies. Several Ministries of the GOJ, as well as representative voluntary organizations have been invited to participate, and commitments thus far obtained ensure that the Multi-Service Centre will indeed be able to provide multiple services including, at a minimum, help with emergency housing, care for the elderly and the handicapped, and poor relief. Each participating agency will have an office in the Centre and will be asked to contribute an annual subsidy to cover costs of operation.

US/AID has assisted the Centre since 1967, and now is being asked to help with construction costs in the amount of US$16,500 for a new building across the street from existing facilities. The Director feels certain that this would be catalytic in obtaining local funding to complete construction. Since the Multi-Service Centre concept represents

an important experiment "beyond family planning," and since it should result in a significant increase in capability for reaching out to potential new acceptors and for raising continuation rates, the evaluation team recommends:

> RECOMMENDATION: That US/AID assist the Family Counselling Centre with construction costs for a new building to house the proposed Multi-Service Centre.

F. The Salvation Army

A medical and family planning clinic was opened by the Salvation Army in early 1971, which AID assisted in constructing and equipping. The clinic is open on Thursday afternoons for pre-natal care and on Monday evenings for family planning services. Women receive information on responsible parenthood and contraceptive methods at the time of their clinic visits.

G. Child Welfare Association

The Child Welfare Association, which is the largest and oldest of the Jamaican voluntary services for children, established family planning as part of its program in 1961. The Association operates a family planning clinic once weekly as a part of its work in teaching family responsibility. Average annual attendance, as reported in 1972, was 1,196 patients.[1]

H. Operation Friendship

Operation Friendship is an urban welfare project situated in a slum area of western Kingston. It is operated as a joint project of the Churches, the United Congregation of Israelites, and a number of service clubs. Its multi-faceted program includes offering family planning as part of health services.

I. Tivoli Gardens Complex

Tivoli Gardens Complex provides a broad array of educational, cultural, recreational, social and health services operated by a voluntary body, the West Kingston Trust. A family planning clinic is held twice weekly.

J. The Sugar Industry Labour Welfare Board

The Sugar Industry Labour Welfare Board began distributing contraceptives in sugar estate health clinics in 1962 and now conducts family planning clinics for sugar workers on these estates.

K. Goodwill

Goodwill also reportedly provides some family planning services, however the evaluation team did not obtain further information about this.

1. The Role of Social Welfare in Family Planning: Jamaica

4.0 Capability in Procuring, Accounting for, and Distributing Contraceptives and other Family Planning Equipment and Supplies

The Administrative Officer under the NFPB is the administrator of the National Family Planning Store. Among his designated list of duties are:

(1) Liaison between the Medical Director, the US/AID Family Planning Officer, the Chief Technical Officer (Pharmacy) of MHEC, Supervisor of Clinics, and other agencies.

(2) To see that stocks are adequately maintained.

(3) To see that drugs and medical supplies are delivered to clinics throughout the island.

The Administrative Officer also heads the section which includes the Senior Administrative Assistant, the Executive Officer (Stores and Supplies), the Office Superintendent, the Storekeeper and his staff, and the Registry. Coordination of ordering, receiving, storing, issuing and transporting of drugs, furniture, and medical equipment, office equipment, et cetera, is the responsibility of the Executive Officer (Stores and Supplies). How these offices will be affected by the transfer of some NFPB staff to the MHEC is not yet clear.

Previous documents concerning the Jamaican national family planning program indicate some problems relating to supplies. Thus Pulley in late 1973 recommended that "efforts should be strengthened to avoid drug shortages that necessitate 'non-medical' alteration of the prescription for an acceptor." More broadly, the AID Project Appraisal Report for the period July, 1971 through December, 1973 states that "problems of management of commodity distribution, inventory, and stock records are still bothersome."

That these functions were being satisfactorily discharged at the time of the evaluation team's visit is evidenced by the following indicators:

1. The US/AID Population Officer is in possession of complete and up-to-date inventories which are reported in detailed monthly statements.

2. Supplies are requisitioned far enough in advance to allow sufficient time for procurement and delivery. The memo accompanying the list of commodities and supplies needed from January 1 to December 31, 1974, was dated 19 November 1973. While the evaluation team encountered no specific evidence of depleted stocks in the various clinics, Mr. Lester Woolery (Procurement Officer MHEC) strongly recommended allowing for a lead time of six months in requisitioning either from US/AID or GOJ stores.

3. Adequate liaison is maintained among the relevant offices. Mr. Woolery characterized the US/AID Population Officer as "very cooperative and accessible." Likewise, Mr. Wallace

appeared satisfied with the data furnished him by the NFPB Administrative Officer. The possibility was discussed that moving the office of the Population Officer from NFPB headquarters to the U.S. Embassy could hamper this ready accessibility, and neither Mr. Wallace nor the evaluation team felt that liaison would be materially affected by such a move.

Mr. Woolery called our attention to certain problems inherent in US/AID procurement procedures. In particular he appealed for more flexibility in adapting certain items procured in the USA to the requirements of Jamaican field conditions. While his observations were concerned chiefly with such items as sizes of instruments, reaction of equipment to sterilization by boiling, et cetera, the Administrative Officer echoed the same plea in regard to drugs, noting that Ovral tablets are strongly preferred over the recently standardized Norinyl formulations distributed under US/AID's new procurement policy.

Jamaica is unique in the degree of acceptance of depo-provera among contraceptive alternatives. Approximately 15,000 acceptors were using the injectable method by the end of 1973, and Dr. Patterson feels that this number may well be doubled in 1974. At this rate of increase there is no assurance that supplies can be obtained with continued dependence on US manufacturers. Shortages last year resulted in additional units being supplied by IPPF through the JFPA (10,000 units) and by the British High Commission (60,000 units) on a one-time only basis. Some discussions have been held with UNFPA regarding alternative future procurement of depo-provera, but the issue has not yet been resolved.

RECOMMENDATION: The GOJ should actively seek alternative procurement (such as through UNFPA) of injectable contraceptives in order to assure uninterrupted supplies in the face of increasing acceptance of this method.

Finally, the way appears virtually cleared for execution of the commercial distribution scheme for condoms and oral contraceptives. According to legislation enacted late in 1973, the steroids were removed from the "medical list." The elimination of import duties on these contraceptives, which was recommended in the IBRD 1972 evaluation, does not require legislative action, and Mr. Woolery indicated that this would be accomplished shortly by an administrative order from the Minister of Finance.

5.0 Capability in Planning and Carrying Out IE & C Aspects of the Program

In initiating cooperative efforts in the Jamaican family planning program, the GOJ and the U.S. Government recognized the importance of education in the successful delivery of family planning services and therefore in the attainment of overall program objectives. Accordingly, during the life of the program, a great deal of effort, time, and money have been devoted to information, education, and communication. Although IE & C aspects of the program have been handicapped by a number of organizational, administrative, and conceptual problems, as of 1974 most Jamaicans seem to be aware that family planning is possible, that a national family planning program exists, and that contraceptive services are available. Groundwork has also been laid in many areas for further development of an educational program which will encourage more widespread and long-term acceptance of family planning--clearly a major program need.

The Draft Guide for the Review and Appraisal of the Educational Component of Family Planning, published by the Pan American Health Organization in 1973, provides detailed indicators for assessing capabilities in the information, educational, and communication aspects of family planning programs. While the scope of work assigned to the evaluation team did not make it possible within the limits of time available to apply all of these indicators to the Jamaican program, in somewhat modified order and form these guidelines provide a framework for the following discussion.

5.1 Organizational Structure and Administration of IE & C Services

When the national family planning program was launched in 1966 under the family planning unit of the Ministry of Health, the responsibility for the educational aspects of the program naturally fell to the Bureau of Health Education. In the early years of the program, the BHE developed a comprehensive educational plan,[1] and initiated a number of activities which were consistent with it. During this time, the NFPB also began a publicity campaign related to the program.

When the National Family Planning Board was established as an independent statutory body in 1970, primary responsibility for IE & C shifted from the Bureau of Health Education to the Board. The BHE, however, retained responsibilities for technical advice and consultation, as well as for media production and assistance with training. In addition, when the FP/Epidemiology Unit was formed at the UWI, the responsibilities with which it was charged included training, research, and evaluation related to the educational aspects of the program. A Training and Education Committee was formed by the Board to coordinate the efforts of these groups and of the JFPA, all of whom have remained active in IE & C throughout the life of the program. A number of other public and private agencies have been involved in family planning and family life education activities, although not always directly through the auspices of the Board.

1. National Family Planning Programme of Jamaica: Family Planning Education Plan, 1968-1971.

Although the rationale for shifting major educational responsibility from the BHE to the NFPB was not made clear, it may well have rested in recognition of the need to integrate education closely with all other components of the program. Nevertheless, the net result of this action was to remove the direction of the educational aspects of the program from those with most professional training and experience in this field.

The change in educational program responsibility apparently took place with a minimum of planning and discussion among the people involved. Because of its commitment to the family planning program, the BHE in its own right as the educational arm of the MHEC continued to promote and conduct programs and training in family planning and family life education. In addition, it endeavored to cooperate with the NFPB and repeatedly questioned how needed educational functions were to be provided.[1] Specifically, the BHE sought clarification of the services which the Board expected from it, as well as of the arrangements under which resources would be made available to support these services. Answers apparently came as specific questions arose, and delineation of responsibilities and channels of communication were never entirely clear to all educational workers or to those with whom they were expected to relate.

Since the Bureau of Health Education seems largely to have been left out of major program decision-making, its careful educational plan was largely replaced by a series of ad hoc efforts. Moreover, because of its isolation from program planning, the Bureau lacked an adequate context in which to plan even the reduced responsibilities which it was delegated by the Board. As late as March, 1973, the Bureau was still attempting to obtain clarification, and thus it submitted to the NFPB a document suggesting areas of BHE responsibility in the national family planning program.[2] Although this outlined a number of ways in which the Bureau could support and collaborate with the Board, as well as certain activities it could undertake independently to advance the program, a response from the NFPB was not forthcoming. As noted elsewhere in this report (see p. 40), the FP/Epidemiology Unit of the UWI has experienced similar problems, as have other agencies.

It is to the credit of the educators of the NFPB, the BHE, the UWI, and other institutions that they developed informal relationships and communications channels for working through consequent problems as well as possible, and this undoubtedly contributed considerably to progress in the educational aspects of the program. At the same time, however, lack of access to developing program plans and to current field data coupled with the lack of clearly designated responsibilities and lack of clear lines of accountability for their discharge inevitably led to fragmented efforts, missed opportunities, incompleted activities, and wasted resources. These problems urgently need to be remedied if education is to realize its full potential for advancing the national family planning program.

1. Educational Services in Family Planning, BHE
2. Suggested Areas of Responsibility of Bureau of Health Education in the Education Programme of the National Family Planning Board, BHE, 8/3/73.

A. The NFPB

Within the National Family Planning Board, allocations for IE & C have been ranked among the largest budget items. Most of this money has gone to a mass media campaign, for which the Board contracted with a Jamaican advertising company, and for the employment of a limited number of field workers. NFPB support for the development of a family life education program under the Ministry of Education, has been channeled through the MHEC's Bureau of Health Education.

Responsibility for IE & C within the Board is assigned to an Information, Education, and Training Section, the Director of which reports to the Executive Director. Because of the personnel changes occurring at the time of the team's visit, it is not possible to reconstruct the exact composition of this unit prior to integration, but it apparently grew over the years, accompanied by some shifts in position titles and descriptions, as well as by recurrent questions about the roles, functions, and relationships of staff.

As of July, 1972, the unit included in addition to the Director, two Assistant Director positions (one of which was vacant, and the other of which was occupied by a Communications Officer), a Training Officer, and a Public Relations Officer. An evaluation team reporting at that time felt that the functions of this latter officer implied dual responsibility and supervision, and further strongly recommended that a separate Training Office be established within the Board.[1] Subsequently the unit was reorganized as the "Information and Education Section," and although the Public Relations Officer remained within it, the Training Officer was reassigned to head an independent training unit. By 1974, the I and E Section included a third Assistant Director.[2] Other personnel attached to this unit at one time or another according to previous reports included a Statistician and staff, and a Librarian.[3]

The Board's I and E Section has been charged with primary responsibility for developing, implementing, and evaluating the educational aspects of the national family planning program, for coordinating its activities with the BHE and the FP/Epidemiology Unit of the DSPM, UWI, as well as with the JFPA. A Committee was formed for this latter purpose, which, according to most persons interviewed by the team, functioned fairly well in spite of some operational difficulties. The JFPA, however, was rarely represented at Committee meetings, and coordination with other groups and institutions involved in family planning education was only minimally achieved through this mechanism. In addition, follow-through on

1. Sodhy, Sirageldin, and Cernada, Jamaica National Family Planning Program, Report of First External Review, July, 1972, IBRD.
2. East-West Communications Institute, "Inventory-Analysis of International Support for Education and Communication (IEC) in Population/Family Planning: Report on Jamaica," January, 1974.
3. Tulloch-Reid, Jean, Background Paper for Asian Regional Seminar on Family Planning, to be held at the University of Singapore, Nov. 5-15, 1972, p. 7.

ideas generated was a problem--most probably because of the enormous gap between the scope of needs and opportunities identified and the available personnel to act on them. Unpredictable administrative and budgetary support heightened these difficulties.

In addition to the Board's staff Committee, the Board itself had an Education and Training Committee, with the following terms of reference:

1) Examine national program goals in light of existing demographic, economic, sociological, educational, health, and welfare trends to determine the scope and nature of education and training needs.

2) Make recommendations regarding the target groups to be reached and orders of priority and channels for reaching.

3) Review and evaluate the individual education and training programs and make recommendations accordingly.

4) Pay special attention to coordinating the training/education programs of the Board and those being undertaken by other governmental and voluntary agencies.

Since this Committee first met just prior to the release of Ministry Paper No. 1 setting forth the policy of integration, it has had limited time for impact on the program.

Until recently, the Board also had a Publicity, Public Relations, and Training Committee. Mrs. Carmen Stewart of the BHE, Mrs. Ivy McGhie of the FP/Epidemiology Unit, UWI, and Mrs. Sybil Frances of the UWI's Extra-mural Department served on both Committees. In addition, Mrs. Stewart and Mrs. McGhie are members of the staff committee to coordinate educational efforts of the NFPB, BHE, and the UWI, as well as the Board's sub-committee on training, while Mrs. McGhie and Mrs. Frances also serve on the Board's Policy Coordinating Committee, which is concerned with relationships between the NFPB and the University. Although these overlapping memberships may have been designed to facilitate coordination, if the Committees had met with any frequency, they would have placed an undue burden on the individuals involved, each of whom carries major operational responsibilities for the national family planning program. As it was, this multiple committee structure seems to have fragmented planning and action, rather than to have facilitated it.

As of April, 1974, the Board's Committee on Education and Training and its Committee on Publicity, Public Relations, and Training were merged to form a new Publicity, Public Relations, and Training Committee. Although the name of this new Committee does not reflect a concern with education, at its first meeting, Committee members decided to prepare a paper for the Board which identifies fundamental concepts which must be taken into account in setting education program policy. This will address, _inter alia_, the educationally naive notion that program performance can be substantially improved through continuing major emphasis on public information campaigns.

The Committee, which now includes representatives from the NFPB, the BHE, and the UWI, also decided to enlarge its membership to include repre-

sentation from the Ministry of Education, the Ministry of Youth and Community Development, the Trade Unions, the Jamaica Council of Churches, and the Council of Voluntary Social Services. This decision is consistent with program needs and the Board's recently announced intent to work with and through other organizations and to be influenced by them. Whether or not the Board will be successful in obtaining expanded organizational coordination remains to be seen, and will depend in large measure on the quality of staffing provided, sufficient administrative flexibility for true joint planning to take place, and Committee representation in policy-making and program planning deliberations.

To implement the educational field arm of the program, the NFPB, with the assistance of the BHE, recruited and trained some 14 Family Planning Education Officers (FPEOs). Later, in 1971, approximately 35 Assistant Family Planning Officers (AFPEOs) were recruited in two groups by the Board with no participation by the BHE in the selection process. Personnel standards set by the Bureau in its original plan were not utilized, and thus the BHE's carefully laid-out strategy for long-term development of health education capabilities in Jamaica was not supported.

Administratively, the FPEOs and AFPEOs were assigned as follows: 1 FPEO and 2 AFPEOs to each of the 12 rural parishes; 3 FPEOs and 4 AFPEOs to KSAC; 1 FPEO with 5 AFPEOs to the postpartum program at Victoria Jubilee Hospital. In addition, 11 educational officers were assigned to the Bureau of Health Education for national family planning educational activities.

These personnel were paid by the Board and expected to carry out a program which it planned. In so doing, they were to receive technical advice, guidance, and supervision from the BHE, which nevertheless was not consulted by the NFPB regarding such personnel matters as promotion or transfer. At the parish level, the FPEOs and AFPEOs worked under the administrative direction of the RFPO (the parish Medical Officer of Health), and at VJH, under the Hospital's Chief Medical Officer. This complex administrative arrangement, combined with unresolved philosophical differences between the NFPB and the BHE concerning the nature of the educational program that was needed, as well as the problems of coordination which have plagued the program as a whole, tended to dilute the work of the health education field staff. Moreover, salaries were set so low that attrition has been something of a problem. Nevertheless, many FPEOs and AFPEOs are dedicated to their work and good at it, and thus they have remained with the program in spite of these difficulties.

At the parish level, FPEOs were charged with overall responsibilities for developing, planning, executing, and evaluating the educational aspects of the family planning program in accordance with NFPB and MHEC policies. They also were responsible for training programs in the parishes, for coordinating the family planning activities of voluntary agencies working in collaboration with the RFPO (the parish MO(H)), and for various other educational functions supportive of the family planning program.[1] AFPEOs assisted with these functions, augmented by family planning clinic staff and parish personnel who, among their other duties, were charged with educational responsibilities.

1. Duties of the Family Planning Education Officer, NFPB.

As part of integration, all FPEOs and AFPEOs have been assigned to the Bureau of Health Education. This includes the Board's former Assistant Director of the Information and Education Section who has been responsible for the postpartum program, as well as its former Communications Officer (who was originally recruited by the BHE, which also arranged for her training.) Several other senior staff working in IE & C have either been transferred from the Board or have resigned. This leaves the NFPB with a substantially reduced IE & C staff.

B. The Bureau of Health Education

The Bureau of Health Education has contributed to the national family planning program since its inception through the development of the original comprehensive educational plan, through participation in training efforts, through promotion of family life education, through community organization activities, through collaboration on a variety of inter-agency committees, through materials production, and by conducting one national survey and several smaller ones. While the Bureau's ability to provide field services has been limited by staff shortages, each AFPEO assigned to the Bureau had responsibility for working with two or three parishes on training, guidance of IE & C activities, and supervision of educational field staff. Specific projects in which the BHE has been involved are detailed throughout this report.

Although the Bureau has long been responsible for the educational aspects of the health programs conducted by the Ministry of Health, its staff remained constant from 1963 through the early years of the national family planning program. In accord with the recommendations of one of the program's first consultants[1], 11 education officers were assigned to the Bureau to enable it to assume a more vital role in family planning education. Just prior to integration, the Bureau had a staff of 37, which included a professionally trained health education specialist as Director, the 11 education officers assigned from the NFPB, and a variety of artists, printers, and clerical personnel. Vacancies among the health education officers were common, however, due to secondment and leave.[2] In this regard, it should be noted that the Bureau has supplied a number of key personnel to other agencies which are making major contributions to the national family planning effort. These include Mrs. Ivy McGhie, who was seconded to the FP/Epidemiology Unit at the UWI; Miss Jean Tulloch-Reid, now seconded to the Social Welfare Unit of the Extra-Mural Department of the University; and Mrs. Daphne Kelley, formerly NFPB Communications Officer.

As already indicated, the Bureau's contributions to the program, while substantial, have been considerably handicapped by the level of its relationships with the NFPB and its relative isolation from overall program direction. In addition, the NFPB has never allocated the Bureau an annual budget within which to plan and work. Thus although the Board assigned the BHE responsibility for certain types of media production,

1. Grout consultant reports, June-August, 1969 and November-December, 1970.
2. Bureau of Health Education, Annual Report, 1972.

the Bureau had to go "hat in hand" to the NFPB for each separate project. The basis on which funds for these projects were approved, reduced, or denied was never clear, but it does seem certain that these decisions were not founded upon professional judgments of the role that such projects could play in a comprehensive educational program. As just one consequence, the demand for family planning materials produced by the Bureau has often exceeded the supply.

Nevertheless, it should be pointed out here that in FY 1973-74, approximately 10 percent of the NFPB's budget (or about U.S. $150,000) was devoted to IE & C. In contrast, during FY 1972-73, the MHEC allocated only 4 percent of its total operating costs to the Bureau of Health Education for its work in all program areas. During this period, approximately 60 percent of the BHE's staff time was spent on family planning.

With integration and the transfer of all FPEOs and AFPEOs to the Bureau, the BHE will, for the first time, have field staff. No major changes in field location assignments are anticipated, and FPEOs and AFPEOs will continue to be travelling officers. Their functions, however, will be officially expanded to encompass education for total health, and accordingly, they will be renamed Senior Health Educators (SHEs) and Health Educators (HEs) respectively. In many instances, these personnel have already been working "beyond family planning" as an essential strategy to gain community support for the family planning program. This approach indeed was inherent in their training and encouraged through the professional supervision supplied by the Bureau, although skills and accomplishments in community organization were apparently not considered by the NFPB in evaluating the work of its educational staff.

Planning for re-organization of the BHE under integration has been rushed, for its Director, Mrs. Carmen Stewart, had been told informally that family planning education personnel and primary educational functions were to remain with the NFPB. On January 24th, however, she was advised that NFPB education personnel were to be integrated into the Bureau. A working party to plan for reorganization began the next day, and since that date, a major portion of Mrs. Stewart's time has been devoted to developing the best possible structure for the Bureau, which now will be responsible for 110 employees.

By the time of the evaluation team's visit, a detailed organizational plan had been developed and tentative job descriptions for various classifications of personnel were drafted. The organizational scheme had not yet been submitted to the Minister of Health, however, and Mrs. Stewart recognized the need for field testing of the job descriptions. In addition, she had identified a number of organizational problems which had been the subject of several discussions with the Working Party and others, but which as yet, had not been completely resolved. Among these were the need to develop effective mechanisms for continuing identification of areas of program need, for providing adequate support and supervision to field staff, for refining job descriptions and organizational arrangements, for upgrading staff skills, and for a field reporting system which can serve as a tool in continuing education and program evaluation.

Although the team concurs with Mrs. Stewart's recognition that the BHE organizational plan will require further refinement and testing, it

feels that her draft proposals are basically sound. If these are accepted, community organization activity supportive of the family planning program should measurably increase.

In each rural parish, two HEs will each be assigned responsibility for community organization in a specific geographic sector and the community itself will be their unit of concentration. The SHE will have similar responsibility for a somewhat smaller geographic section, in addition to which he/she will provide supervision and consultation for the two HEs, will coordinate parish health education activities, and will have responsibility for efforts related to the smaller national level health programs, e.g., venereal disease and communicable disease control, and dental health All education personnel will emphasize activities related to family planning, since this is a priority national program. The health educators working in the parishes will be directly responsible to their respective parish MO(H)s for their day-to-day activities, while the BHE will provide technical supervision and supportive services. The BHE will also be responsible for the recruitment and placement of health education personnel, for making recommendations for promotion, for discipline if necessary, and for assuring that these workers carry out their educational functions. To facilitate coordination, the BHE will serve as advisor to parish MO(H)s regarding the educational staff assigned to them.

The scope of the supervisory and support services needed from the BHE will require strengthening it considerably at executive, administrative, and clerical levels. Mrs. Stewart therefore proposes adding two Deputy Directors. One Deputy would work through four centrally-assigned senior health education officers (SHEOs): one responsible for training, two for field services, and one for priority national level programs, including family planning. The other Deputy Director would oversee three other major units: general administration, communications media and research, and library services. The Director would remain responsible for overall direction and administration of the Bureau, and for coordinating its planning and activities with the programs of the Ministry, as well as with other institutions and agencies involved in education. A tentative organization chart for the Bureau is outlined on the following page.

Finding sufficient qualified personnel to fill these new assignments may pose a problem, and the Bureau could use some assistance in this regard during the next 12 to 18 months. While some senior personnel transferred from the NFPB to the BHE will assume high administrative posts, there are not sufficient people to fill all supervisory positions and one of those who is qualified will be leaving shortly for Master of Public Health Training at the University of Minnesota.

> RECOMMENDATION: That US/AID make available to the BHE four qualified health educators for assignments of 12 to 18 months each to assist with the Bureau's post-integration responsibilities, including regional supervision of the health education staff.

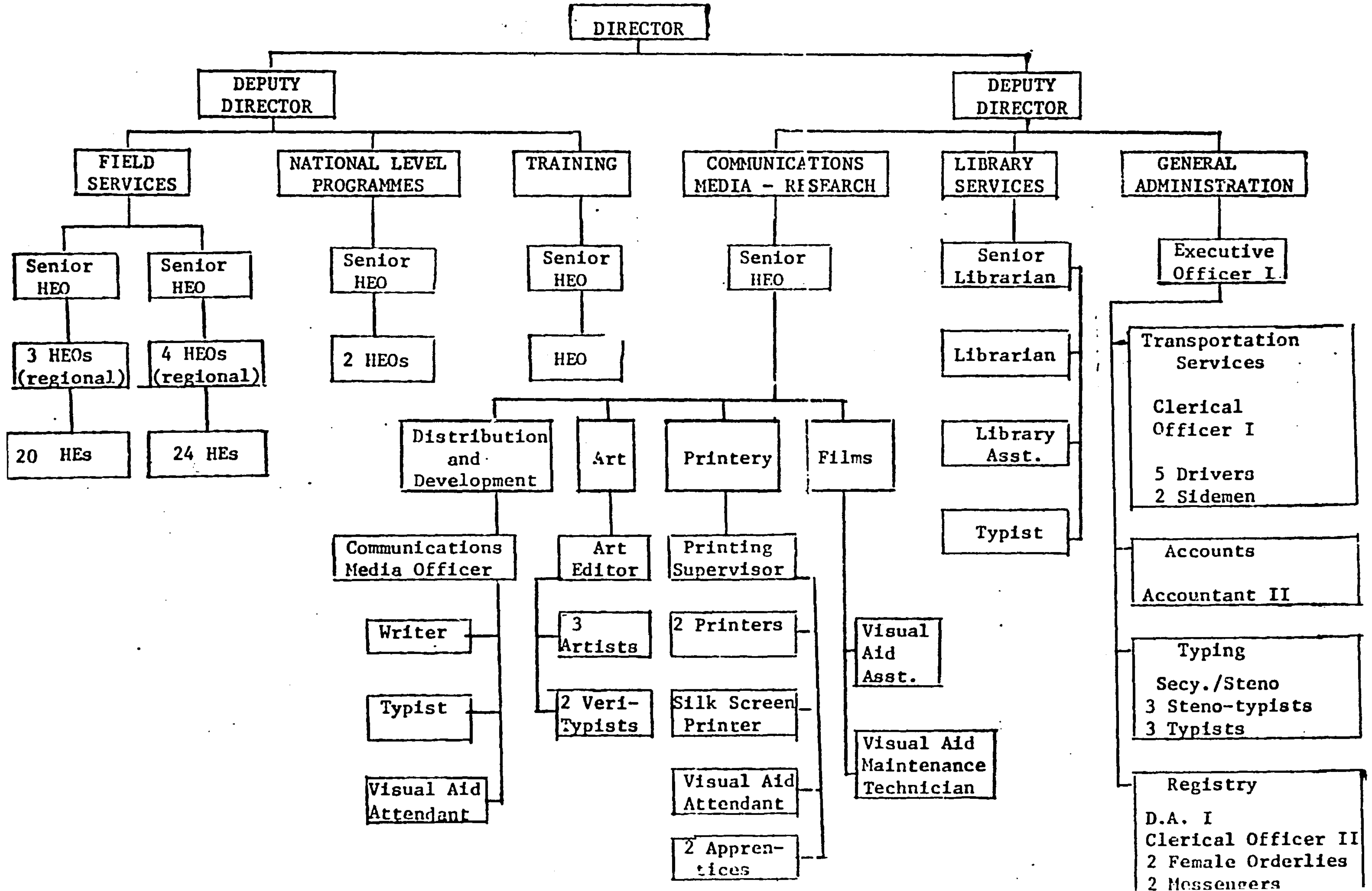
In addition, while all FPEOs and AFPEOs who desire will continue to be employed by the Bureau, their understandings and skills will need to be broadened and upgraded. Although the plan originally developed for the family planning education program specified that all education officers

FIGURE 4

PROPOSED ORGANIZATION CHART

BUREAU OF HEALTH EDUCATION - MINISTRY OF HEALTH AND ENVIRONMENTAL CONTROL

June, 1974



would, at a minimum, demonstrate the understandings and skills required of health educators with Baccalaureate degrees, this criterion was not adhered to by the NFPB in employing personnel--partly because the pool of such people is very limited. Since family planning education staff come from a variety of backgrounds, and since their training was relatively short-term and not broadly focused, more training will obviously be needed, as discussed elsewhere in this report (See p.). In addition, since all future vacancies will be filled with persons who meet these educational requirements, efforts must be launched to train workers who can meet these criteria.

Undoubtedly one problem in recruiting--and keeping--qualified educational personnel has been the level of salaries paid. Efforts have been made to upgrade health education positions within the Ministry since 1956, but these as yet have not been successful. The FPEOs and AFPEOs received salaries only a little better. Since the transfer of these personnel to the Bureau of Health Education will require reclassification under the Jamaican Civil Service, this is an ideal time to rectify the salary scale.

> RECOMMENDATION: In reclassifying FPEOs and AFPEOs as SHEs and HEs, and in reclassifying other IE & C personnel, every effort should be made to upgrade these positions to salary scales which will attract and keep qualified health education personnel and which will develop increasing professional health education strength in Jamaica. These salary scales should become effective as soon as individuals incumbent meet the existing qualification standards required of new recruits for health education positions.

The present organizational placement of the BHE under the PMO: Public Health in the MHEC is likely to pose a number of problems in planning and implementing educational aspects of the family planning program for three major reasons:

1) Since the Director of the BHE is not at a high administrative level, she would not be expected, organizationally, to participate in top-level program planning and evaluation efforts within the Ministry, nor with major program planners and directors in other agencies. Nevertheless, this is essential in order to integrate the educational aspects of the program closely with the overall program thrust. The current weekly meetings of the BHE's Director with the CMO, while useful, cannot provide the needed level of educational input into overall planning and decision-making.

2) Ministry Paper No. 1 - Family Planning indicates that family planning education will be carried out by nurses, midwives, public health inspectors, community health aides, and many others in addition to the public health education staff. Nevertheless, the present organizational placement of the BHE does not provide clear formal communication channels to and from these workers for purposes of supporting and coordinating their educational efforts.

3) Health education personnel will be working in hospitals as well as in public health facilities, yet present administrative placement of the Bureau of Health Education does not lend itself to the provision of technical and support services to hospital staff.

Because education should be integrated into all aspects of the program, and because all health workers share responsibility for family planning education, the evaluation team strongly recommends that the BHE be administratively placed in a staff rather than a line position within the MHEC. This is a pattern commonly followed in many major health agencies throughout the world, and the team believes that Jamaica would find it beneficial. Therefore it recommends that:

RECOMMENDATION: That the Bureau of Health Education be administratively placed in a staff, rather than a line position in the MHEC, preferably directly under the CMO, so that professional education services may be readily available to all units and workers in the Ministry to assist them in recognizing and discharging their educational functions.

As discussed later in this report, implementation of this recommendation would also help to strengthen training in the Ministry.

The Bureau of Health Education also needs a clearly specified annual budget for family planning education so that it may plan on a comprehensive and long-range basis rather than having to rely on item by item approval. This will be critical in overcoming the problems of coordination which have characterized the majority of past IE & C efforts.

RECOMMENDATION: That the Bureau of Health Education be requested to submit an annual budget for family planning, which after any needed modifications and administrative approval, the Bureau would be responsible for managing.

While the evaluation team believes that the Bureau of Health Education has a sound grasp of the problems and challenges which it is now facing, it recognizes that it confronts an enormous task. Therefore some external assistance to the BHE would be helpful, and in fact, has been requested by its Director.

RECOMMENDATION: That short-term and/or long-term consultant services in public health education be made available to the Director of the Bureau of Health Education, as requested, to:

1) assist with the development of an up-dated comprehensive program plan for the educational aspects of the family planning program;
2) assist with the integration of FPEOs and AFPEOs into the Bureau's functioning;
3) assist with the development of a strong central organization and staff capable of providing effective and timely support and supervision to field staff;
4) assist the BHE and the UWI in the reassessment of health education training needs and the development of an up-dated training plan;

5) assist with the development of more effective mechanisms for coordinating the planning, implementation, and evaluation of the educational aspects of the national family planning program.

C. IE & C Functions and Responsibilities Post-Integration

According to Ministry Paper No. 1, under integration the NFPB is to retain major responsibilities in information, communication, and education (see p. 27). Who exactly is responsible, however, is not specified, but a statement prepared by the Executive Chairman clearly indicates that this is to be Board staff.[1] The Bureau of Health Education was not consulted in this decision, and indeed the BHE's Director first became aware of it through the work of the evaluation team.

When queried by the team, the Board's Executive Chairman stated that the direction of the information, public relations, and mass media aspects of the program will remain with the NFPB, and that these would be coordinated with local IE & C activities through the parish Medical Officer of Health. The Board's Director of Information and Education also stated that the NFPB would retain responsibility for information services, but additionally said that the Board would have a major role in coordination of educational activities conducted by such agencies as the Ministries of Education, Youth and Community Development, and Agriculture. She indicated that some responsibilities would be jointly shared with the BHE, but that these, as yet, were not too clearly defined. Post-integration roles of the Board in IE & C thus are rather hazy, while plans for the coordination of NFPB efforts with those of the BHE had not been yet jointly discussed by the time of the evaluation team's visit.

The evaluation team seriously questions the proposed NFPB responsibilities in information, education, and communications for many reasons:

1. Separation of educational field staff and BHE administrative and support staff from responsibility for major components of the IE & C program is very likely to lead to a piecemeal approach to the individuals, groups, communities, and institutions that educational efforts as a whole should be targeted to reach.

2. The Board no longer will be directly administrative, and thus its capability to develop, implement, and evaluate educational aspects of the program in tandem with the program as a whole will be limited. This is true in the operational as well as policy-making aspects, which should be based upon on-going evaluation of field experience and considerable field input.

3. The Board now has a greatly reduced staff in IE & C, for most educational and communications personnel have been transferred to the BHE. The evaluation team thinks it is very unrealistic to expect remaining staff, no matter how quali-

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1. Detailed Functions--National Family Planning Board Staff, Annexure II.

fied, to perform the numerous functions outlined by the Board's Executive Chairman in his statement of post-integration staff functions.

4. Past IE & C performance of the Board staff has not demonstrated the strong capabilities in this area which the national family planning program urgently demands.

On the other hand, the Bureau of Health Education has professional expertise, a large staff; demonstrated capabilities in planning, implementing, and evaluating educational programs; experience in integrating family planning education into other health programs; and administrative placement in the institution now primarily responsible for the national family planning program. The evaluation team therefore recommends:

> RECOMMENDATION: That the Bureau of Health Education be assigned primary responsibility for planning, implementing, and evaluating all educational aspects of the national family planning program, with consultation and assistance from the FP/Epidemiology Unit at the UWI, and with advice from the Publicity, Public Relations, and Training Committee of the National Family Planning Board. IE & C staff remaining with the Board should be reassigned to the BHE.

Similar recommendations were made by the Board's Education and Training Committee at a meeting on January 14th, 1974, i.e.

1. "That the I.E.C. Section of the Family Planning Programme should not be divided but should be transferred in toto to the Bureau of Health Education,

2. "...that the three assistant directors now attached to the I.E.C. Section be transferred to the Bureau of Health Education."

This Committee also recommended that the Board should have on its staff a senior officer having a strong coordinating function with the Bureau in relation to the I.E.C. program and the various agencies participating in family life education, and that this officer be advised and assisted by either a communications strategy officer or a sub-committee of the Board.[1]

A chart summarizing changing responsibilities in IE & C during the life of the national family planning program follows. Responsibilities noted in the right-hand column are those suggested in the statement by the Executive Chairman of the Board,[2] but not recommended by the evaluation team except where the BHE is designated as the responsible unit. It is

1. Report of the Second Meeting of the National Family Planning Board Committee for Education and Training, held at the Board's Office, 5 Sylvan Avenue, Kingston 5 on Monday the 14th February, 1974, commencing at 2:30 p.m.
2. Detailed Functions--National Family Planning Board Staff, Annexure II.

hoped that this chart can be useful to Jamaican program administrators and policy-makers in reviewing needs and capabilities for developing, implementing, and evaluating a strong educational component within the family planning program. This will require making optimal use of the educational expertise existing in Jamaica.

CHANGING RESPONSIBILITIES IN IE & C
1968 - 1974

Function	Original Plan 1968 - 1970	PRIMARY RESPONSIBILITY After NFPB Became Statutory Body to Integration 1970 - March 31, 1974	Post-Integration as Proposed by NFPB Staff, April 1, 1974
Preparing an annual plan for the educational aspects of the FP Program--the plan to include identification of problems, groups to be reached and methods to be employed, and requirements for doing the job.	BHE	BHE to provide professional expertise to NFPB, which delegated primary responsibility to Education and Training Committee FPEOs responsible at parish level.	Public Information and Communication Section of NFPB Staff
Obtaining the active participation of government agencies, religious groups, service clubs, and voluntary agencies in support of the FP Program	BHE	NFPB	Public Information and Communication Section of NFPB Staff
Coordinating the activities of all agencies and organizations involved in family planning education	BHE	NFPB	Public Information and Communication Section of NFPB Staff
Providing guidance in educational methods to be used in the training program of the NFPB	BHE	NFPB BHE to assist with design of training programs FP/Epidemiology Unit of UWI to consult	Public Information and Communication Section of NFPB Staff to design Training programs and make arrangement for conducting and/c participating in the
Providing training in educational methods and techniques to family planning clinic and other health personnel, personnel of other agencies and organizations participating in the family planning program, and staff of the NFPB	BHE	NFPB BHE to assist with design of training program and conduct those related to IE & C program component. FP/Epidemiology Unit, UWI to consult.	BHE within MHEC FP/Epidemiology Unit at UWI NFPB staff to retain major responsibility for training.

Function	Original Plan 1968 - 1970	PRIMARY RESPONSIBILITY After NFPB Became Statutory Body to Integration 1970 - March 31, 1974	Post-Integration as Proposed by NFPB Staff, April 1, 1974
Preparing, producing, and distributing materials for use in the FP educational program.	BHE	BHE to produce or arrange for production of audio visual materials. NFPB prepared some materials.	Public Information and Communication Section of NFPB Staff to prepare materials (posters, booklets, films, slogans), participate in design of mass communications programs, provide resource materials. BHE to continue with materials production.
Selecting, purchasing, and distributing educational materials and equipment for use in the FP program.	BHE	NFPB staff BHE to participate in selection of a-v equipment and supervise maintenance.	BHE
Carrying out public information activities needed in the educational program through press, radio, TV, printed materials and other media.	BHE	NFPB Public Relations Officer	NFPB Public Relations Officer to have major responsibility for mass media programs.
Collaborating in planning the advertising and publicity campaigns of the NFPB.	BHE	Publicity Agency Committee representatives of various agencies asked to react.	

Function	Original Plan 1968 - 1970	PRIMARY RESPONSIBILITY After NFPB Became Statutory Body to Integration 1970 - March 31, 1974	Post-Integration as Proposed by NFPB Staff, April 1, 1974
Accelerate development of a comprehensive family life education program by working with the Ministry of Education and other groups on the development of sex education curricula, the training of teachers and youth leaders to carry out sex education in the schools and with youth organizations and involving parent groups in support of these programs.	BHE	NFPB BHE FP/Epidemiology Unit, UWI	NFPB to provide advisory and resource service. BHE and FP/Epidemiology Unit at UWI to continue activities in this regard.
Carrying out investigations and fact finding studies related to the education program.	BHE	NFPB staff to identify areas for research, determine priorities, see that arrangements are made for carrying out research, study findings, and see that these are implemented. FP/Epidemiology Unit of UWI to continue research activities in education.	NFPB staff to identify areas for research, determine priorities, see that arrangements are made for carrying out research, study findings, and see that these are implemented.
Training, and technical supervision of the NFPB's Family Planning Education Officers (FPEOs) and Assistant Family Planning Education Officers (AFPEOs), and consultation to these personnel on request.		BHE Director and Assistant Directors of NFPB	BHE (all these personnel now assigned to BHE)

5.2 Planning and Evaluation of IE & C

Planning and evaluation of education cannot take place apart from the specific objectives that education aims to achieve. Therefore the lack of sufficiently defined operational targets in the national family planning program has handicapped both planning and evaluation of IE & C efforts.

Although a detailed educational strategy was developed for the period 1968-71, the implementation of this strategy became diverted in the transfer of responsibility for IE & C from the BHE to the National Family Planning Board. The NFPB was committed to a mass advertising campaign and thus gave little emphasis to the individual, group, and community approaches which, according to existing experience, research, and theory, afford more promise for effecting lasting changes in knowledge, attitudes, and behavior than does the simple spread of information.

Within the NFPB there seems to exist some confusion about the concepts of information, education, and communication respectively, as well as about the distinctions and relationships among them. As a result, activities which should be closely coordinated have been undesirably fragmented under Board direction. The importance of tailoring messages, methods, and timing of IE & C activities to have maximum sustained impact upon specific target populations seems not to have been understood by the Board. Similarly, its IE & C activities as a whole suggest inadequate appreciation of the fundamental principle that education is a process of discovery and development, occurring over time at a pace and in a way differing for every individual.

In addition, the Board has provided much more administrative support for and encouragement of "birth control education" than for comprehensive family life education, of which family planning is an integral part. Nevertheless, there are clear indications that this latter approach is better received by the community and more effective in motivating the adoption of family planning practice because it addresses the "whys" of this behavior. In contrast, some NFPB messages, such as "you don't have to be pregnant" or "the less the merrier" are seen by some Jamaicans as negating basic values supportive of quality family life.

Another fundamental principle which has not been applied by the NFPB is that involvement in planning can in itself be a powerful educational experience. Thus rather than creating a variety of opportunities at both national and local levels for people to participate in thinking through the need for family planning from their own particular perspectives and to identify actions they should take accordingly, the Board has tended to tell people what to do. As a result, resistance has been generated, if not to family palnning itself, then to the Board's manner of promoting it.

Since the effectiveness of education depends greatly upon sensitivity to the relevant dynamics of each situation, most educational efforts are, of necessity, experimental in nature. Therefore feedback on reactions to various educational approaches is of critical importance in gradually developing methods which can be more generally applied. Nevertheless, the Board has not encouraged such feedback from its field personnel, nor has it utilized research data about Jamaica and Jamaicans which might provide

valuable clues for educational planning.

It is unfortunate that the island-wide KAP study proposed in the 1969 PROP and supported under the terms of various Pro-Ags has not yet been conducted (see pp. 231-32). Even lacking the data such a study could provide, however, the existence of a vast awareness-practice gap among Jamaicans is evidenced by a number of smaller studies, surveys, and data from the statistical reports of the NFPB. The widely held opinion that significant numbers of Jamaican women are favorably inclined toward family planning is indirectly supported by the apparently high prevalence of induced abortion, interest in sterilization (see p. 62), and the relative success of the maternity-centered approach of the post-partum program. Nevertheless, the apparent under-utilization of uni-purpose family planning clinics island-wide, as reflected in the NFPB statistical report, indicates that the informational effort is yet to reach the vast majority of potential acceptors in such a way as to transform their presumed readiness to curtail fertility into meaningful action.

The educational component of the national family planning program also suffers from the lack of a solid data base from which verifiable indicators of achievement could be drawn. Without detailed knowledge of continuation rates by method among family planning acceptors, the output of family planning motivational efforts cannot be accurately assessed. By the same token, lacking intercensal data regarding the age structure of the population and age specific fertility, it is impossible to assert that the reduction in crude birth rate from 1972 to 1973 is attributable to an increase in contraceptive practice. GOJ capability in planning and carrying out IE & C programs will be greatly enhanced if and when these critical indices for which data sources already exist in Jamaica are made available to those responsible for policy and program planning.

There are competent educational specialists in Jamaica who have expertise in applying essential principles in the design of comprehensive educational programs which are integrated with overall program efforts. In the face of inadequate administrative support and leadership for the exercise of such expertise, they have worked wherever they were able, coordinating efforts as possible, to develop expanding community and organizational support for family planning and sound educational activities encouraging family planning practice. The progress which has been made in education can largely be attributed to these endeavors.

Now that the Minister of Health has advanced the policies of integrating family planning with general health services, of expanding the involvement of other organizations and agencies in the national family planning program, and of supporting the introduction of family life education into the schools and the community, the need for skilled and truly comprehensive educational program planning is paramount.

While facilitating such planning should be the primary responsibility of those personnel with training and experience in education and the principles upon which education is based, development of the multi-faceted educational program which is needed will also require administrative and policy support. This means that sufficient resources must be allocated to do the job which is needed, that training in education must be provided for all health workers who have contact with the public, and that the program must provide ample opportunity for meaningful citizen participation in developing, implementing, and evaluating those aspects of the program which are most relevant to their own needs and interests.

Several recommendations have already been made which promise to improve the planning, implementation, and evaluation of the educational component of the national family planning program. Several more are contained in the pages which follow. In addition, the data base for program planning, and specifically for educational program planning, should be strengthened. Therefore the evaluation team recommends:

RECOMMENDATION: That a generally experimental approach to education be adopted with systematic evaluation of all educational activities, even though available resources may limit such evaluation in many cases to no more than a subjective discussion of the results obtained.

RECOMMENDATION: That the NFPB data processing and reporting system be modified according to the Tietze-Potter method of evaluation by continuation rates.

RECOMMENDATION: That US/AID approve the proposal of Professor G.W. Roberts for a study of socio-cultural fertility factors in 400 women and 100 men (extension of the 1971 study of Fertility, Mating, and Conception, see pp. 235)

RECOMMENDATION: That the proposed island-wide KAP study be completed (see pp. 231-32)

RECOMMENDATION: That supplementary support be provided as needed (from either U.S. or other donors) to the UWI Census Research Bureau, to assure processing and publication of intercensal data regarding vital events, age-specific fertility, and age-structure of the population.

RECOMMENDATION: That available information about the degree of support, apathy, or objections to family planning and the factors associated with these attitudes be consolidated from research studies, observations of field personnel, and discussions with grassroots opinion leaders in order to improve the design of educational approaches tailored to the particular needs and interests of target groups for education.

There is also need to develop up-dated educational plans to guide both national and parish level work. The 1968-71 plan for education provides a useful outline of topics which should be considered, as does the 1973 set of guidelines prepared by PAHO for evaluating the educational components of national family planning programs. Since the need for such planning is already recognized by educational leadership in the BHE and the UWI, the evaluation team makes no specific recommendation in this regard.

5.3 Education Integrated into the Delivery of Services

Education as an integral part of family planning service delivery is critical to program success, for it is through education that new acceptors are recruited, that their decision to adopt contraceptive use is crystallized and reinforced, and that information basic to continued effective utilization is imparted. In such education, however, it is important to remember that the practice of family planning is not necessarily synonymous with the practice of birth control, for in its broadest sense, family planning encompasses wanted pregnancies.

This concept has not always been adequately communicated in the Jamaican national family planning program, where, for example, women who discontinue contraceptive use for whatever reason are automatically considered "dropouts." The attitude this reflects may, in fact, encourage dropping out. Misunderstanding about the goals and the meaning of family planning have in many ways influenced the extent to which family planning education has been integrated into the delivery of services, as well as the way in which this has been done.

A. Recruitment of New Acceptors

Because readiness to accept family planning varies, the recruitment of new contraceptive acceptors involves both long and short-range goals. For persons who are resistant or indifferent to family planning practice, for reasons such as ignorance, fear, fatalism, distrust, or perhaps simply perceived lack of immediate need, long-term educational efforts are needed to create awareness that family planning is possible, to arouse interest in trying it, to answer the specific questions related to contraceptive use, and to build social support for continued practice.

In this regard the total spectrum of community health education activities designed to reach people through their existing interests and to assist them to discover for themselves the value of family planning is aimed at eventually increasing family planning acceptance. Family life education in the schools is a complementary long-term educational thrust designed to build knowledge, attitudes, and practices supportive of improved individual and family well-being, of which family planning in its broadest sense is an essential part. These aspects of the Jamaican national family planning program are discussed elsewhere in this report, while this section concerns the more short-term goals related to the recruitment of new acceptors.

For persons who are already motivated to practice family planning, the educational problem in initiating a new program may be one of merely providing information that services are available, as well as when, where, and how they may be obtained. Short-term educational program goals, however, must also include reaching persons without such high levels of readiness for family planning practice, including especially those for whom unplanned pregnancies would pose particular risks, i.e., teenagers, women whose multiple and closely spaced pregnancies endanger their health, those whose precarious economic and social condition may be jeopardized by additional pregnancies, and those who, while indifferent or resistant to family planning, still do not want to bear children in the immediate future. These problems are best approached through individual contact on a one-to-one or small group basis, supported by community organization activities and media which provide social support for action by those in need. In recognition of these principles, Ministry Paper No. 1 states that IE & C aspects of the program should place emphasis on efforts to reach high-risk groups, and person-to-person counselling in and out of clinics.

Thus far FPEOs and AFPEOs in the parishes have carried out a wide range of educational activities which directly and indirectly are aimed at the recruitment of new acceptors. The recruitment and training of some 300 community health aides has intensified outreach to potential acceptors in KSAC and the parishes of St. James and Hanover since late 1972. Evaluation of CHA effectiveness, especially in improving nutritional status of young children, but also in promoting family planning clinic attendance by women in the child-bearing years is being carried out through a Cornell University Project (see p. 217) Ministry Paper No. 1 calls for extending CHAs throughout the island.

Other health workers, including nurses, midwives, and sanitarians have been charged with the recruitment of new acceptors through their field activities. The evaluation team obtained no information on the extent to which this has actually been attempted by such workers or the methods which have been used.

The JFPA has pioneered the development of person-to-person approaches for recruiting new acceptors, first through its Encouragement Visitor program and currently through its work with male motivators (some of whom are females). Evaluation of EV efforts found no significant differences in clinic attendance in areas where Evs had and had not worked. Since other variables are involved, however, this does not necessarily mean that the EVs had no impact on either immediate or delayed acceptance. Nevertheless, it is unfortunate that this evaluation did not examine the processes and methods of education rather than simple input-output measures, for this could have provided insight into how the work of EVs and similar workers might be made more effective. The team therefore suggests that evaluation of the JFPA's current male motivators project should place more emphasis on analyzing educational variables.

Other than the JFPA's male-oriented educational activities, recruitment of new acceptors to the national family planning program has primarily focused on females. Nevertheless, men should also be included in educational efforts, not only because they, too, can use contraceptives, but also because of the important roles they may play in female utilization. In spite of much discussion about male opposition to family planning, the steadily increasing distribution of condoms suggests the existence of considerable male interest. Therefore it is now time to develop and field test educational approaches to men, as well as to fertile couples regardless of whether these are legal and stable unions.

Except for the work of the AFEOs and the AFPEOs, outreach to potential new acceptors in Jamaica seems to have been based upon the general assumption that merely getting more workers into the field will increase acceptance rates. Accordingly, little attention has been given to the initial and continuing training and supervision needed in communications, personal relations, and educational methodology upon which effective outreach must be based. This lack should now be corrected. The evaluation team therefore recommends:

> RECOMMENDATION: That the BHE be assigned responsibility and resources for assessing and meeting training needs in education of MHEC personnel who work with the public, and that the supervision and coordination of such educational contacts in the parishes be the responsibility of senior health education parish staff.

In addition, more systematic attention needs to be given to the mobilization of workers in other agencies and disciplines for family planning motivational work. This was provided for in Pro-Ag 71-5, and the family planning education officers in at least some parishes have been working in this direction. In the relatively brief period of the evaluation team's visit, however, no information was obtained on the extent to which this has occurred and what results have been achieved. Progress should now be assessed in each parish in order to develop plans for more intensified community involvement in advancing the family planning program.

Finally, the potential role of current contraceptive users in recruiting new acceptors should be fully recognized and efforts made to tap into informal networks of communication among friends and neighbors via satisfied family planning clients. This, however, necessitates ensuring that clients are satisfied--a need fully consistent with the types of communication required to prevent and overcome the presently high drop-out rate.

B. Counselling in the Clinics

High drop-out rates evidence the need for improvements in patient counselling at the time of contraceptive acceptance and return visits. The study currently in progress by the Family Planning/Epidemiology Unit at the UWI on the degree to which new acceptors have the knowledge essential for the effective use of the contraceptive method they have chosen promises to yield useful insights for the improved training of nurses and others in family planning counselling techniques (see p.)

The team was told that much drop-out may be due to incorrect use of the pill, e.g., that women share pills with different types of friends and that pills are skipped. When pregnancy results, the impression is left that oral contraceptives do not work. Similarly, failure to provide adequate education in conjunction with IUD insertions may well have contributed to the present low acceptance rates associated with this method and to the rumors which surround it.

Clinic education of family planning patients requires more than simply telling them about birth control methods, however. People must be treated with respect and provided an opportunity to discuss their questions, doubts, and problems. The team was told by informants not directly associated with the national family planning program that the unsympathetic way people are treated in family planning clinics is a major problem, and specifically that middle-class health workers are poorly equipped to help the poor and illiterate resolve their fears and anxieties about the whole reproductive process. Thus some have come to see clinic personnel as "pill-pushers" rather than as public servants capable of initiating and maintaining truly helping relationships. To the degree that family planning clinic clients are left with such impressions, clinic attendance will be negatively affected, not only because many of these clients will fail to return, but also because they will discourage their friends and relatives from going.

Effective clinic education also requires time and privacy. While inadequate and crowded facilities may limit the degree of privacy achieved, clinic personnel should do all that they can to provide it, both by the place they select for education and by the voice levels they use in counselling. Similarly, every effort should be make to take time with patients for adequate communication. This need not only be provided in situations devoted primarily to education, for with adequate training of staff, much education can be accomplished in conjunction with the delivery of services. Such opportunities can be expected to increase as the result of the integration of family planning services with general health care.

C. Follow-Up of Drop-Outs

Because of the high family planning drop-out rates in Jamaica, there is wide recognition of the need for adequate follow-up. Several approaches to overcoming this problem have been identified, including in Pro-Ag 69-1 the development of a statistical system for the rapid feedback of information needed for continuous follow-up of patients. Although the evaluation team did not have the opportunity to assess the extent to which such a system has been developed and is being utilized, problems with statistical data discovered suggest that this probably has been minimal. Other approaches include home visiting, but again this seems to have been sporadic and dependent upon available resources rather than an integral part of planned educational work.

Systematic plans for the follow-up of drop-outs now need to be developed, fully utilizing the restructured services of health education officers in the parishes, the expanded numbers of CHAs soon to become available, and the spectrum of other health field workers. In addition, the resources of other agencies and citizens in local communities should be enlisted to minimize the drop-out problem.

The best approach to overcoming high drop-out rates is, of course, prevention through adequate clinic counselling. In addition, the availability of health workers to answer questions as these arise is important. Particular attention should be paid to identifying reasons for dropping-out in order to develop specific educational plans for resolving these problems.

D. Pre-Natal and Post-Natal Education

The Jamaican postpartum family planning program began as an educational effort at Victoria Jubilee Hospital, which was one of the original 25 hospitals participating in the Population Council's International Demonstration Project, initiated in 1966. According to Pro-Ag 69-1 (Revision 2), the program included educational talks, distribution of pamphlets and other materials in the hospital, establishment of a system to refer new mothers to nearby family planning clinics, and a follow-up program for women who failed to appear at these clinics.

While this same Pro-Ag indicates that the NFPB was implementing postpartum family planning education not only at VJH but in rural hospitals throughout the island as well, Victoria Jubilee was the only hospital with full-time Family Planning Education Officers assigned to it. There Mrs. June Rattray worked with five AFPEOs, whereas other hospitals were served on a part-time basis by the education officers assigned to the parishes. Accordingly, VJH was the only institution with intensified postpartum educational activities, and it is the only one which at that time was making any kind of readily visible effort.

Against this background, Pro-Ag 69-1 (Revision 2) provided for an evaluation of the postpartum program in order to refine methods of postpartum education and service activities that could be extended island-wide. Specific questions to be answered in the evaluation included:

1. How many hospital patients visit family planning clinics?

2. What motivates them to do so, i.e., which educational technique used in the program is the most effective?

3. What objections do patients who fail to visit clinics have to family planning?

Although the latter two questions reflect rather naive assumptions,[1] some efforts to evaluate the program as agreed were undertaken by the FP/

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1. Question 2 implies that motivation is external rather than internal, that a single educational technique can change complex motivational patterns, and that the same educational approach will work with all women. Question 3 assumes that the barriers to clinic attendance rest in patient objections to family planning, thus neglecting the possibility that other barriers may exist

Epidemiology Unit at UWI (see p.). Although Dr. Leslie L. Williams of VJH said that he never saw the final report, he believes that it indicated that clinic utilization could be improved if there were better physical facilities which would permit privacy in patient counselling and if there were more training of staff in counselling skills.

Mrs. Rattray's 1972 Report for Victoria Jubilee Hospital provides detailed information on the educational activities undertaken, the results achieved, and the problems encountered. Particularly noteworthy is the innovative effort to involve fathers in the program and the successful response which was obtained. Although this was discontinued because staff had to return in the evenings, its renewal at VJH deserves serious consideration, as does its extension to other maternity care settings.

Problems of educational staff hours have limited the percentages of postpartum women reached, for educational officers do not work on Saturday afternoons, Sundays, or holidays. Since babies nevertheless are born at these times and since post-delivery stays are usually brief, this means that some women have not had the opportunity for postpartum family planning education. Recently it has been decided that clinical and educational services will be provided by nursing staff, and this should do much to extend the availability of education to all postpartum patients. Some educational officers should continue to work with the postpartum program, however, in order to provide the planning, coordination, development of new program approaches, and supportive materials which are needed for it to be maximally effective.

In addition, possibilities for education which have not yet been explored need to be investigated. During a recent visit to Jamaica, Martha Stuart noticed the television sets in the wards at VJH and suggested the use of closed-circuit TV to reach postpartum patients. According to the Matron at Victoria Jubilee, however, most of the existing sets are non-functional and many are out for repair so that not every ward has one. While it is possible that new equipment could be purchased and that educational videotapes could be developed specifically for postpartum patients, the costs versus the benefits of this scheme should be carefully evaluated prior to full-scale initiation of such a project. If this is done, provision should be made for personnel to care for the equipment, since at present VJH has no one who can do this.

While the construction of ten rural maternity centers is designed to extend postpartum family planning education, these centers will be served by education officers on only a part-time basis. Therefore training of the resident midwives in education should be a priority. Unfortunately, the centers do not provide adequate facilities for group education of antenatal patients or for the scope of education consistent with the integration of services.

With integration, education in the pre- and post-natal periods should be expanded to a concern with total maternal and child health. In particular, emphasis should be placed on the encouragement of breast-feeding, which has been identified as a practice which would help to overcome many nutritional problems experienced by Jamaican infants.

E. Other Educational Needs Related to Service Delivery

The integration of family planning and health services, as well as the predicted clarification of the abortion law and the extension of sterilization services open up a number of new educational needs and opportunities. These need to be analyzed in order to incorporate appropriate plans into overall educational program development.

Some needs which should now be approached through education integrated into service delivery include extension of family planning education to patients who represent pregnancy risks because of cardiac problems, diabetes, or other medical conditions. The possibility of discussing family planning, and particularly the use of the condom, in venereal disease clinics should also be explored. Assessment of interest in male sterilization and education about this procedure should be undertaken, as should education to assure that females being sterilized fully understand and consent to the operation. If the abortion law is revised and abortion services accordingly extended, education will also be needed to encourage women to seek first trimester pregnancy termination rather than the more difficult second trimester procedure.

5.4 Educational Activities Designed to Help Prepare Students and Other Young People for Their Responsibilities as Family Members and Future Parents

In Jamaica, as in many countries, family life education is needed on two broad, but complementary levels. The first is in the schools, which provide the best opportunity for reaching the next generation of parents, and which therefore are a focal point for educating youth about the fundamentals of their bodies and human reproduction--concepts all too many parents are ill-equipped to teach because of their own lack of education in this area. Optimally, however, family life education in the schools extends far beyond mere information about anatomy and physiology, and also encompasses the formation of healthy attitudes toward human sexuality and responsible parenthood, which in turn are critical to the development of individual and family life styles compatible with social and economic development. Thus if the family planning movement is to become durable and self-sustaining, family life education has to become an integral part of the school curriculum.

According to the Minister of Health, Dr. Kenneth McNeill, the present need for adequate family life education in all schools and colleges in the island

> "...is all the more pressing because so many families are unable to cope with the task of rearing their children in a manner which stresses this and other aspects of personality development.... Among the results of ignorance and undesirable social attitudes, not the least is the frustration and unhappiness of school girls who, through premature pregnancies, drop out of school to give birth to unwanted babies. This sets up a cycle of inadequate parenthood, neglected children, poverty, illiteracy, lack of training skills, unemployment, poor housing, unstable families, delinquency, and sometimes crime."
>
> Ministry Paper No. 1 - Family Planning

Family life education in the schools must be complemented by family life education in the community. Indeed, since schools are an integral part of the community, the implementation of school curricula is difficult, if not impossible, without community support. At the same time, the community should be a focus of education in its own right in order to reach those persons--young and old--who are not touched directly by the school system. In this regard, the school becomes an important community resource. School and community programs thus reinforce each other, and progress in one area facilitates progress in the other.

While this intrinsic relationship is recognized, for purposes of organization, this section of the report concerns family life education in the schools and the following section discusses community programs.

A. Background

The following summary background statement is drawn from a number

of previous reports[1] which provide detailed information about Jamaican developments in education for family living.

Prior to the formation of the National Family Planning Board in 1967, some teachers in Jamaica, assisted by Public Health Officers, endeavored over a period of years to teach family life education in the schools and to experiment with effective methodologies for doing so. Nevertheless, these efforts were primarily in the form of counselling, and they lacked coordination and continuity except, perhaps in the Roman Catholic Schools where a "Workshop on Sex Education" produced by the Catholic Education Association had been held for several years.

The Ministry of Education first indicated some general concern for family life education in 1954 when the Education Authority appointed a sub-committee to make recommendations for the introduction of sex education in the schools. While recognizing that the responsibilities of instructing children rested with their parents, this sub-committee thought that, due to existing economic conditions and the lack of knowledge of some parents, the schools should play a leading role in the sex education of children, [illegible] of parents and teachers. The sub-committee's report was accepted by the Education Authority and submitted to all School Boards and the Principals of schools in 1955 with the request that its recommendations be put into effect. No systematic island-wide approach resulted, however, and there is no evidence that many schools made an effort to get any programs going.

In 1963 the Guidance Officer of the Ministry of Education attempted to discover whether the time was yet ripe for the introduction of sex education into the schools and found that the churches assumed a cautious attitude, while the Ministry of Education adopted a permissive approach, encouraging schools to develop their own programmes of sex instruction provided that they did not run counter to community wishes. In response to the need for sex education for young people, several programmes indeed were organized at the parish level between 1962 and 1967.

A detailed description of activities since 1967 follows. In general, these reflect steady efforts by committed individuals in the Ministry of Education, the BHE, and the University of West Indies. Their endeavors have been accompanied by--and quite probably have stimulated--growing interest and concern for family life education among parents, teachers, church leaders, community agencies, and various other groups. Although strong governmental support for family life education in the schools has developed more slowly, enormous progress has been made within the last eight months.

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1. For example, McGhie, Ivy, "Developments in Education for Family Living," Draft, xerox, circa 1971; "The National Family Planning Education Program Plan for 1968-71;" "Social Welfare Aspects of Family Planning: Jamaica, West Indies," circa 1972; East-West Communication Institute, "Inventory-Analysis of International Support for Information, Education, and Communication in Pop/Family Planning: Report on Jamaica," Jan., 1974; Nicol, Margorie, "Institutional Development Programs: Report on Site Visit to Jamaica," Dec. 5-12, 1973, Population Council.

B. Development of National Policy Supporting Family Life Education in the Schools

In 1967 the Ministry of Health and the newly formed National Family Planning Board agreed that the Bureau of Health Education should undertake, on behalf of the Board, to accelerate "the development of a comprehensive family life education programme, including sex education in the schools, by assisting the Ministry of Education in the development of sex education curricula, in the involvement of parent groups for the acceptance of the new curricula, and in the training of teachers to carry out the programme in the schools.[1] This concept was further legitimized when the National Family Planning Board was legally established as a statutory body of the Government of Jamaica in October, 1970. The enabling legislation thus states that the Board "may provide for sex education and encourage the development thereof; and collaborate with other bodies and persons in the preparation and carrying out of family life programmes."[2]

To assist with the operational development of this policy, the Bureau of Health Education requested through US/AID the services of a short-term consultant in family life education on an intermittent basis over a period of two years (June, 1969 through August, 1971). One of the first recommendations of this consultant, Dr. Ruth E. Grout, was that priority be given by the Ministry of Health through the NFPB and the BHE, in cooperation with the Ministries of Education and of Youth and Community Development, to the formulation of plans and the expansion of programmes in family life education for youth.[3] Representatives of these organizations did come together to work out a coordinated approach to the problem of providing education for family living in Jamaica and jointly prepared a position paper[4] which was the basis for a policy statement issued by the Ministry of Education in January, 1970.[5]

This 1970 statement recognized the need for adequate sex education in all schools and colleges on the island. Since, however, the proposed program encompassed many other broader objectives than the mere provision of information about the anatomy and physiology of sex, the Ministry of Education paper recommended calling the course "Education for Family Living" rather than "Sex Education." In addition, so that the program would not run counter to community feeling, the Ministry of Education specified that the approval of parents must be sought before initiating a course in any school. This, then, provided the policy foundation for a community-wide approach.

Although the Ministry of Education's Guidance Officer, and representatives from the BHE, the UWI, and the NFPB have worked together and

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1. Organization of Educational Services Family Planning Programme, Jamaica, April 29, 1968, pp. 10-15.
2. An Act to Provide for a Board to be known as the National Family Planning Board, No. 22-1970, August 13, 1970.
3. Assignment Report of Ruth E. Grout, June 26-August 22, 1969, p. 12
4. A Position Statement on Education for Family Living
5. Ministry of Education Position Statement on Sex Education in the Schools.

with a number of other groups towards implementing the policy outlined in the 1970 statement, several problems slowed progress until recently. Chief among these was some disagreement among governmental institutions, as well as in the community, on the meaning and scope of family life education. Thus while the Ministry of Education and the BHE were interested in a comprehensive program, the NFPB (but not necessarily the individuals who represented it) was seen to consider family life education as little more than an euphanism for sex education. This latter impression may have been fostered by the NFPB's emphasis on birth control and its related lack of stress on the broader meanings of family planning. In any event, differences in interpretation of policy apparently delayed joint efforts and the advancement of institutional and community support for expanding family life education in the schools.

Within the last eight months, however, there has been a remarkable change in the degree of support for family life education in the educational sy. Although this undoubtedly represents the cumulative effects of efforts over a number of years, two recent developments seem to have been particularly instrumental in accelerating change. One is a general and pragmatic thrust in curriculum development, for the identification of knowledge, attitudes, and skills which young people should have at the end of their schooling led to new recognition of the central importance of family life education in the curriculum. The other major impetus was the public declaration of governmental policy support for family life education in the schools by both Dr. Kenneth McNeill, the Minister of Health, and Mr. Eli Matalon, the Minister of Education, at the opening session of the Caribbean Health Education Workshop, held in November, 1973.[1] This was supported by the joint announcement that family life education is to be added to the school curriculum in Jamaica, and that proposals and plans for introduction of the subject are under examination in the Ministries of Health and Education. Mr. Matalon additionally announced that the Guidance Office of his Ministry was currently helping to promote health education in primary schools, and that in the near future budgeting would be provided for the program as a whole. Governmental support for family life education in the schools was again confirmed by Ministry of Health Paper No. 1, dated January 22, 1974.

Although the Minister of Education, Mr. Matalon, accepted another Ministerial post in March, 1974 and the Ministry's permanent secretary also recently changed, persons interviewed expected the new Minister of Education, Mr. Cooke, to be supportive of the programme and were encouraged by the fact that the new permanent secretary for the first time is an educator, Dr. Erron Miller. Another positive sign is that in early April, the planning unit of the Ministry of Education was collecting data on what would be needed to put the program forward. This information was to be submitted to the Minister of Finance for review and action on a budget.

In light of the above, it can be concluded that there is now strong governmental support for incorporating family life education in the schools. In addition, the consensus of persons interviewed was that the program now has enough momentum for rapid progress to continue.

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1. The Daily Gleaner, Monday, Nov. 26, 1974 and The Jamaica Daily News, Wednesday, November 21, 1974.

It is indeed unfortunate that US/AID missed an opportunity to further these positive developments through the work of the Educational Sector Analysis Team it sent to Jamaica in March, 1974. Apparently, however, investigation of needs and opportunities for family life education in Jamaica was not included as part of this Team's assignment, and thus was of only peripheral concern. (See pp. 161)

C. Development of Curricula for Family Life Education in the Schools

As indicated in the previous section, efforts to develop curricula for family life education in the schools were underway well before the establishment of the Jamaican family planning program and the formation of the NFPB. These latter events, however, notably strengthened this thrust by stimulating increased awareness of the importance of curriculum development and by making additional resources available for this purpose. Thus the NFPB's plan for the educational aspects of the family planning program 1968-71 included as a recommendation the development of sex education curricula and their introduction to teacher training colleges, as well as to public and private elementary and secondary schools.[1] Similarly, the Bureau of Health Education set as targets for 1968 holding discussions with key persons in the Ministries of Education, Youth and Community Development, the Institute of Education, the UWI, and the Jamaican Teachers' Association toward the establishment of an interagency curriculum committee, and completing a study then in progress on current sex education programmes in schools and youth groups.[2] The Bureau also planned to work with the Ministry of Education's curriculum committee on sex instruction, established in November, 1968 as an offshoot of the Ministry's 1954 sub-committee, in developing the content of curricula suitable for the various types of schools and age groups to be reached.

An interagency Working Committee (or perhaps more accurately, subcommittee) on Education for Family Living was appointed by the Ministry of Education's Committee on Sex Education in late 1968. This group included representatives from the Ministry of Education, the Bureau of Health Education of the MHEC, the Jamaican Family Planning Association, religious groups, and community organizations. Although the scope of its task has expanded and its membership has been somewhat modified over the years, the Committee has worked on curriculum development ever since.

Among many contributions to curriculum development, a significant early one was the Bureau of Health Education's thorough survey of sex education in the schools, which was completed, approximately, in 1969.[3] The resulting report provides a wealth of information, useful then as a basis for curriculum planning, and useful now as a basis for measuring change. One of the more important findings was that only 29.3 percent of the responding schools actually gave some sort of formal sex education as part

1. National Family Planning Education Programme, p. 7
2. National Family Planning Programme of Jamaica: Family Planning Education Plan
3. Sex Education Survey, compiled by the Bureau of Health Education, Ministry of Health, Kingston, Jamaica, W.I., circa 1969.

of their educational activities, although of the schools not providing such instruction who were asked whether it should be given 96.3 percent said that it should.

During 1968-69, the Bureau of Health Education also worked with the interagency Committee on Education for Family Living to prepare a tentative syllabus for teacher training institutions and draft curricula for various age levels. These materials were submitted to the National Curriculum Committee of the Ministry of Education with the recommendations that:

> (1) The programme should be initiated in September, 1969, in at least all Junior Secondary Schools and in Secondary High and Technical Schools in the Corporate Area and that certain primary schools be selected in various geographic areas of the island to participate in a pilot scheme.
>
> (2) A prescribed programme of sex education be implemented with the least possible delay in all in-service training programs for teachers through seminars under joint auspices of the MOE, the BHE, and the NFPB.

These objectives are reflected as targets in the 1969 Project Agreement between the GOJ and US/AID, but the Ministry of Education did little to support their implementation.

Most progress in curriculum development therefore has resulted from seminars and workshops organized with and for persons who actually would be involved in instruction, both in teacher training institutions and in Junior and Senior Secondary Schools. These endeavors served to build commitment for the program even as it was being developed. At the same time, they produced tangible materials which provided a basis for further work.

Thus, for example, the Bureau of Health Education working closely with the Ministry of Education arranged and conducted a conference for Secondary School teachers in KSAC on July 31, 1969. Of the 17 schools invited, representatives from eight Corporate Area High Schools attended. The objective of this conference was to discuss the problems and programs of Education for Family Living as they existed in the schools and to plan for the future development of that aspect of education in KSAC Secondary Schools. At that conference, it was agreed that there would be several follow-up seminars with staff of schools represented. Another outcome was that a panel of three persons representing the Ministry of Education, the Bureau of Health Education, and a Secondary School Principal, visited eight secondary schools for the purpose of helping the teachers understand and explore ways of initiating family life education programs. Later a symposium on the structure of the Jamaican family was held at St. Hugh's High School. About 20 teachers from three Corporate Area Schools attended.

Another conference conducted jointly by the Ministry of Education and the Bureau of Health Education was held on February 20, 1970. Six of the seven teacher training colleges invited were represented. Among other work undertaken, the tentative _Syllabus for Family Life Education for Junior Secondary and High School_ levels, prepared by the Ministry of Education's Working Committee was reviewed and discussed. As a result, the need for a

teachers' manual to accompany the syllabus outline was expressed. Subsequently teachers developed complementary lesson plans which clearly state objectives for each unit, build on the natural interests and questions of students, and suggest participation techniques and suitable activities for fostering healthy attitudes toward human sexuality, human relations, and personal hygiene. Mico Teachers' College also began to develop its own syllabus in sex education.

In July, 1971, participants in another workshop prepared resource guidelines in Education in Human Sexuality and Education for Responsible Parenthood. These were used on an experimental basis in a number of schools, colleges, and community programmes, and provided a point of departure for two follow-up workshops in 1972. These latter workshops, planned to run simultaneously and to share resource material and personnel, were designed primarily for training participants in the preparation of teaching units and aides to be used respectively in schools and with adults of low level reading ability.

In spite of these accomplishments, varying interpretations of family life education again seem to have delayed progress in curriculum development for the schools. Those dedicated to this task therefore also endeavored to define the concept for a wider audience,[1] as well as to build family life education programs in the community.

Another major delay was occasioned by a small request in 1970 to the United Nations Development Program for funds for materials and curriculum, as well as for three scholarships.[2] According to Jamaican informants, the donor agency representative was so enthusiastic about developing plans that he felt the program should be greatly expanded and therefore recommended a substantially increased budget.[3] Not only did this negate Jamaican interests in conducting a small pilot project, it exceeded national capabilities at the time to implement the more ambitious program. Furthermore, the size of the revised budget forced Cabinet review of the proposal, which created additional delay. Although the Cabinet eventually approved the proposal, UNDP action on it was still pending at the time of this team's visit.

Currently there is policy agreement on the meaning and scope of the family life education curriculum to be developed. Thus both the 1970 Ministry of Education Position Statement and the 1974 Ministry of Health Paper No. 1 indicate that the program in family life education goes far beyond mere information about the anatomy and physiology of sex, to include objectives stressing the development of healthy attitudes, good interpersonal

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1. See, for example, Trixie Grant-Somerville, The Family and Family Life Education, mimeo, as well as an article by the same title in Mental Health, the Journal of the Jamaica Association for Mental Health Ltd., 1973, pp. 9-11, 19, 24.
2. Exact information about the size of the initial request was not available, but it was estimated to be about $5,000.
3. Again, precise information about the amount of the revised budget is not available, but apparently while in Jamaica the UNDP representative suggested an increase to about $100,000, which later was revised upward to $500,000 - $700,000.

relationships in the family and between the sexes, an adequate personality, and sound moral principles. Moreover, the latter document indicates that instruction will be integrated with the on-going health and social studies subjects already being taught in the schools and will cover the span of a child's school career from the primary to the senior high stage. This is consistent with Grout's 1970 recommendation that development of programs and materials in family life education give stress to the health aspects of family living. In addition, instruction on the relationship of Jamaica's demographic situation to the social and economic development of the nation should be included in social studies curricula at all levels.

Ministry of Health Paper No. 1 also stresses that "the programme will be designed and carried out in such a manner as to reassure the public of the benefits to be derived and to counter any adverse criticisms that are not based on facts." In this regard, there have already been consultations with the Jamaica Council of Churches and the Jamaica Teachers' Association, and both organizations have pledged their support.

With this policy agreement, there is now a more concentrated effort on curriculum development in family life education, supported by the overall curriculum thrust. While because of unclear governmental approval, family life education was not emphasized in the comprehensive new curricula being developed for grades one and six during 1973, the Director of the BHE reported after a curriculum meeting in April, 1974 that family planning will be a part of the sixth grade curriculum guide. Moreover, indications are that the curriculum guides being developed for grades two and seven during 1974 will definitely incorporate instruction in this area. In the meantime, the family life education curriculum resources already prepared are still available and being used by teachers and schools committed to providing such instruction as soon as possible. Although the Syllabus for Family Life Education is not differentiated by grade level and may be overly technical in parts, with training of the personnel who are to use it, it has proved a useful guide.

Another major advance in curriculum development occurred on March 21, 1974 when resource people from the Ministry of Education, the Bureau of Health Education, the UWI, the NFPB, and social development agencies met in St. Mary's Parish with community teams of school personnel, family planning staff, and representatives from the Youth Corps for a workshop aimed at local curriculum development. This pilot project, initiated with the assistance of the National Training Laboratories, applies behavioral dynamics to the development and application of family life education in a three stage model. Phase One stresses team-building, in which community groups identify the data needed on which to base family life education for a particular school. In addition, resource people are identified and plans are outlined for resource coordination. After a six to eight week period during which the community teams collect indicated data and involve people in their own institutions, Phase II convenes a second workshop (tentatively scheduled for July), at which actual programmes will be designed. During Phase III, these programmes will be tested in the schools, followed by another workshop to evaluate the results. Although it was originally hoped to complete all three stages of the model by Summer, 1974, a delay in beginning the project means that Phase III cannot be initiated until September of this year.

Other current work in curriculum development is incorporated with teacher training projects. Miss Robin Whittlsey, Fredrickson Foundation Fellow assigned to the Family Planning Unit, DSPM, UWI, is assisting with these efforts. In addition, one full day of the PAHO-sponsored Caribbean Workshop in Health Education, held in November, 1973, was devoted to examining and developing feasible ways and means to incorporate and/or extend school health education, including family life education as part of the school curriculum in the 17 countries represented.

D. Specialized Training in Family Life Education for School and Other Supportive Personnel

The training of teachers and other personnel, such as principals, education officers, executives of the Jamaica Teachers' Association, and heads of teacher training institutions, first in sex education and then in family life education has long been recognized as a need and a priority in Jamaica. This is reflected in specific targets set by the Bureau of Health Education for 1969 and 1970,[1] in the NFPB's plan for the educational aspects of the Family Planning Programme 1968-71,[2] and in the Ministry of Education Position Statement in 1970. Accordingly, many seminars and workshops have been held to create interest among teachers and other school personnel in family life education, and to develop their capabilities in this regard. As previously pointed out, such meetings frequently have been combined with specific objectives in curriculum development and/or materials preparation. They also have often involved personnel from community agencies working with youth, and some conferences have been arranged specifically for these latter groups.

A partial listing of activities to promote training in family life education (Appendix E) indicates the extensiveness of efforts in this regard. In addition, family planning education officers and health officers in the parishes have for a number of years been discussing with groups of people, including internship teachers, the introduction of family life education into the schools. Perhaps the most outstanding example is in Portland Parish where for three years the MO(H), Dr. Moody, worked with the family planning education officer and the BHE to develop a training programme for teachers. The course, which was held during October and November, 1970, was repeated again with teachers and community leaders at a later date. Currently several schools in this parish are interested in introducing family life education into the schools, and a teacher from this area would like further training in this specialty.

Several Jamaicans working in key spots in the development of family life education programmes have already participated in short-term training courses abroad. Thus, for example, the Senior Education Officer in charge of the Family Life Education programme in the Ministry of Education attended a three week seminar at Stockholm, Sweden on Family Planning and Sex Education. More recently this officer and a represen-

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1. National Family Planning Programme of Jamaica: Family Planning Education Plan.
2. National Family Planning Education Programme.

tative of the NFPB went to a CSIDA-sponsored conference on family life education held in Trinidad during April, 1974.

Although the foregoing efforts have all been important in awakening interest and initiating activity in family life education in the schools, the need for teacher training is still great. While most teacher training colleges in Jamaica have some sort of a programme now only two have actually included the subject in the curriculum, but none has yet made it a required subject. During the two years that there has been an elective in family life education at Michael Training College in Kingston, only 16 students have taken this course, out of a student body of 400. Bethelehem Training College also offers an elective, and Church Teachers' College at Mandeville has indicated interest in doing so for a period of two years, provided that the government will support it thereafter.

Both the Ministry of Education 1970 Position Statement and Ministry of Health Paper No. 1, 1974 recognize that the shortage of personnel prepared to teach family life education makes it unfeasible to initiate an immediate island-wide programme in the schools. Therefore, priority is given to teacher-training both in the teachers' colleges and in pilot projects in certain geographic areas, as well as through in-service courses. In addition, recognition is given to the importance of efforts to improve the attitudes of all teachers towards sex so that their influence on students will be wholesome.

E. Development of Teaching Materials for Family Life Education

The need for teaching and reference materials in family life education was also recognized at the inception of program development efforts, as is indicated in BHE targets for 1968 and 1969. These targets included:

1. Develop a reference library of sex education texts, materials, and media to be added to as new texts,materials and media become available.

2. Develop a kit of teaching materials on sex education for use by leaders of youth groups.

3. Complete preparation of a script for a film directed to teenage audiences and begin production.

4. To the extent possible, provide speakers and materials requested by church groups, marriage officers, and registrars.

5. Continue work with teenagers in the development, pretesting, and evaluation of educational materials and approaches.

6. Discuss with the Jamaica Library Service the provision of materials on sex education in all branch libraries throughout the island and on school mobiles.

Within the limitations of time available to the evaluation team, it was not possible to ascertain the extent to which these and later targets have been met. As discussed elsewhere in this report, however, the

BHE has produced and distributed many teaching materials supportive of family life education. In addition, sets of books on family life education, including sex education, have been presented to the libraries of the Ministry of Education and of Teacher Training colleges. A reference library is also available at NFPB Headquarters, and another at the University of the West Indies where materials from the Family Planning/ Epidemiology Unit, the Social Welfare Center, and other programs are pooled as a common resource. This latter library includes a number of locally produced materials, as well as supplies for producing more. Some films and materials are also available at the parish level through the FPEOs.

In addition, a workshop in the preparation of family life education materials was held at the United Theological College of the West Indies from July 19-31, 1971. Recognizing the need for materials written by Jamaicans or West Indians which deal directly with local situations and problems, the workshop aimed to develop such materials for use in family life education programmes with parents, schools, churches, teacher training colleges, and youth and community groups. Existing materials, local and foreign, were also reviewed and those which were suitable or adaptable for Jamaican (or other Caribbean) use were specified. Participants at this US/AID and UNDP supported workshop included representatives of basic, primary, junior secondary and secondary schools; teacher training colleges; the Institute of Education, UWI; the Jamaican Teachers' Association; the Jamaica Council of Churches; the Council of Voluntary Scoial Services; the Sugar Industry Labour Welfare Commission; and personnel from the NFPB and Ministry of Health.

One year later, in July, 1972, two more workshops, run simultaneously, were devoted to the preparation of family life education materials for use in the schools,[1] and with low level adult readers.[2] Participants worked in small groups to prepare and field test materials, after which they were revised and displayed. The NFPB, the Ministry of Education, the BHE, and the DSPM, UWI collaborated in these efforts which were funded by UNESCO through UNFPA and World Education.

Currently the Bureau of Health Education, in conjunction with the Youth Development Agency of the Ministry of Youth and Community Development, is responsible for the films, posters, pamphlets, charts, and flash cards all produced locally. In response to increasing demand, the BHE has made filmstrips, films, exhibits, models, and charts available on request, and has distributed booklets, leaflets, and other locally produced materials, as well as some from overseas. It has also arranged exhibits of materials available through the Bureau, to which agency personnel, community leaders, and the public have been invited. Actual ability to supply materials, however, has been limited by the lack of a definite budget allocation to the Bureau for this purpose.

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1. Report on Workshop in Education for Family Living, held at the Trade Union Education Institute, UWI, Mona, Jamaica, July 17-29, 1972.
2. Workshop in the Preparation of Family Life Education Materials for Low Level Adult Readers, Held at the Social Welfare Training Centre, UWI, Mona, Jamaica, July 17th-31st, 1972.

The Family Life Education Unit of the Social Welfare Training Centre at the UWI has also produced a number of teaching materials.[1] As of the team's visit, the Ministry of Education had no budget for such materials, although this well may change with the new policy support for family life education curriculum development.

While the material already produced is very good, much more can be done,[2] and the need for teaching materials in family life education remains great. The primary barrier remaining seems to be one of financial support.

The team concurs with Grout (1970) that priority should be given to the development of Jamaican materials, including films, booklets, and other audio-visual aids. A good start has been made in this regard, and considerable capability exists in Jamaica for materials production. Moreover, the education which takes place through involving teachers, community leaders, and others in the process of materials development is an important benefit which should not be overlooked.

The documentation of successful projects and programs in family life education is another important type of material which can assist with the development and strengthening of the national effort. At Grout's (1969) recommendation, the BHE documented and publicized some projects and programs with health personnel, teacher training colleges, and the Jamaica Youth Council. As indicated by footnoted references throughout this section of the report, many additional materials describing program experiences have been prepared. In addition, a student teacher-intern recently wrote about his experiences in implementing family life education for the Ministry of Education's Guidance Newsletter.

F. Implementation of Family Life Education in the Schools

Problems in the development of supportive policy, curricula, teacher training, and materials have all affected the extent to which actual family life education programs could be instituted in schools. Nevertheless, a number of schools now have some instruction in this area, although a listing of these schools and the type of instruction provided was not available to the evaluation team. Reportedly, however, eight parishes (including Kingston, St. Andrew, Clarendon, Hanover, Manchester, Portland, St. Ann, and Westmoreland) have on-going programs.

Work in these parishes is chiefly with Teachers' Colleges, and Junior and Secondary Schools, as well as with youth clubs. Generally, it is supervised by the Family Planning Education Officers, assisted by

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1. For example, Establishing Personal Guidelines for Sexual Behavior, Some Concepts on Human Sexuality, and Growing as an Individual, all published by the Social Welfare/Family Planning/Family Life Education Unit, Social Welfare Training Centre, Extra Mural Dept., UWI, Mona, Kingston, 1973.
2. A similar observation was made by Nicol, "Institutional Development Programs: Report on Site Visit to Jamaica," Dec. 5-12, 1973, Population Council.

the Bureau of Health Education. Teaching is done by FPEOs, school nurses, Medical Officers of Health, public health inspectors, and some teachers, as well as by 16 Peace Corps volunteers working with the Guidance Officer in the Ministry of Education and assigned primarily to rural areas. Of particular interest in this regard is a project in Clarendon Parish where Peace Corps volunteers and health officials cooperatively plan to saturate the schools in each of four areas with a coordinated guidance, family life, and health education program. Another resource is provided by the Family Counselling Center in Kinston, which under the leadership of Father Kane, offers speakers in family life education to interested schools.

These efforts are still far from providing systematic, islandwide teaching in family life education, however the Ministry of Education is scheduled to re-integrate this subject into the schools in September, 1974. The extent to which this will result in reaching more young people in the immediate future remains to be seen, but given the present handicaps, it is doubtful whether all students will receive instruction in this important area through the schools in the coming year. At the same time, recent developments indicate that major progress can be expected.

G. Institutional Responsibilities for Family Life Education in the Schools

The primary responsibility for planning, implementing, and evaluating family life education in the schools, of course, rests with the Ministry of Education. Nevertheless until recently only the Ministry's Guidance Officer, Mrs. Trixie Grant-Sommerville, worked on this task--largely through her own initiative and in addition to her other duties. Although Grout reported in August, 1971 that the Ministry of Education was then taking steps to find funds for a post in family life education within the Ministry, the MOE still has no other professional staff in family life education or health education.

Although Mrs. Grant-Sommerville is due to retire at the end of this year, she has offered her continuing services to the Ministry of Education if it establishes a post in Family Life Education. Such a post clearly will be essential in order to operationalize the Ministry's announced policy to integrate family life education in schools throughout the island. Mrs. Grant-Sommerville, as a dedicated, skilled, and knowledgeable specialist in family life education, would be an invaluable asset in planning and implementing the national program. The size of the task, however, is too great for any one person, and thus additional professional and support staff will be required.

The Bureau of Health Education, through agreement between the Ministry of Health and the NFPB, has had responsibility, on behalf of the Board, for accelerating the development of a comprehensive family life program in the schools, as well as in the community. In spite of staff and budgetary limitations, the Bureau has made significant contributions in this regard, and should continue its support and assistance.

The role of the FPEOs in promoting family life education was formally recognized in August, 1969, when Dr. Lenworth Jacobs, then

Director of the NFPB, specifically charged these workers to assume their share of responsibility in promoting family life education. Shortly thereafter, as an expansion of the BHE's services, a health education officer within the Bureau was assigned principal responsibility for the development of school and youth programs in cooperation with the Ministry of Education and the Ministry of Youth and Community Development. In addition, each of the health education officers employed by the BHE provides assistance in health education, including family life education, to the specific parishes to which they are assigned. These personnel have stimulated and supported many programs at the local level, which now provide a valuable base for a systematic national effort. Their role will become even more important in the expanded program.

The Family Planning/Epidemiology Unit at the UWI has also been integrally involved with the planning and development of workshops, seminars, and other training activities, supportive of family life education in the schools. Although the Unit's work plan for 1974-75 does not clearly spell out its continuing role in this regard, assistance with such training activities, and especially teacher training, should receive high priority. In addition, the Unit should continue its present efforts to evaluate past activities as the basis for planning future training sessions (See pp. 225-26.)

The Social Welfare Unit in the Extra-Mural Department of the UWI is another valuable resource for the development of family life curricula, teaching materials, and training programs. Its contributions should continue to be recognized and utilized as an integral part of program development, as should those of many other organizations and groups actually or potentially contributing to family life education in the schools.

H. <u>Coordination of Family Life Education Efforts</u>

The interagency Working Committee on Family Life Education appointed through the Ministry of Education provides an effective mechanism for coordinating efforts in family life education of the agencies represented: The Ministry of Education, the Bureau of Health Education, the NFPB, and the Family Planning Unit, UWI. The close geographic proximity and frequent exchange among personnel of the latter organization and the Social Welfare Centre of the UWI also lead to informal coordination of the activities each carries out.

Nevertheless, more planning and coordination of effort from the top seems indicated and has been previously recommended.[1] Personnel from the Ministry of Education and the Family Planning Unit at UWI are particularly conscious of this need, both nationally and at the parish level. While many individuals, representing a variety of disciplines and agencies, already have a strong record of productive collaboration, this needs to be strengthened through top-level administrative commitment which recognizes the need for such effort and facilitates it through adequate allocations of personnel, time, money, and other supports.

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1. Nicol, 1973.

I. Evaluation of Family Life Education

Both the Child Guidance Officer of the Ministry of Education and the Health Education Specialist with the Family Planning Unit, UWI point out the need to evaluate existing programs and resources in family life education. As one said, "We have done a lot of experimentation, but we haven't clinched our results yet in terms of evaluation." This is generally recognized as a major weakness.

Mrs. Ivy McGhie at the UWI identifies two specific operational needs in evaluation:

1) To determine the responses of teachers who participated in the early workshops in order to establish a baseline of what has been accomplished.

2) To determine how additional teachers to be involved in workshops view family life education.

To meet these needs, Mrs. McGhie is working to develop two questionnaires, the analysis of which will provide the basis for designing additional training programs. At the time of the team's visit, the first questionnaire was in the process of preparation with the assistance of Miss Robin Whittlesey, and was to be utilized with former family life education trainees at Bethelehem Teachers College.

J. Findings and Recommendations

In spite of general recognition of the need to incorporate family life education in ths schools, clear governmental policy to this effect has been lacking until recently. Resulting handicaps, including shortages of trained family life education personnel, have delayed the development of a strong and systematic national program in the schools.

Nevertheless, through the coordinated efforts of a small group of individuals representing at the national level the Ministry of Education, the Bureau of Health Education, the NFPB, and the Family Planning Unit, UWI, considerable progress has been made in introducing family life education into school curricula, as well as in fostering community-based programs. Similar efforts at the parish level have occurred and are occurring in many places.

While these efforts have not always had a direct effect, they do seem to have had a cumulative impact in creating greater awareness of the need for family life education, in encouraging other organizations and groups to initiate programs, and in building a solid base for further progress. The development of the program to date in many respects bears out the prediction made by Dr. Ruth Grout in her final consultancy report (August, 1971):

> "As with any dynamic programme, growth in family life education in Jamaica cannot be expected to occur in an orderly fashion...A particular event must often be seen in perspective and in its relationship to other events in the continuum of joint efforts in order to recognize its special contribution to an ongoing programme."

The joint announcement of a policy endorsing family life educa-

tion in the schools by the Ministry of Health and the Ministry of Education represents a major advance. Support should now be given to implementing this policy as soon as possible. Specifically:

RECOMMENDATION: The Ministry of Education should establish a high level position in Family Life Education, with adequate professional and clerical staff and sufficient budgeting, to develop and implement a comprehensive plan for integrating family life education into the schools of Jamaica and to conduct periodic evaluations supportive of program progress and improvement.

RECOMMENDATION: A consultant in family life education should be appointed in cooperation with the Ministry of Education to assist with the planning, implementation, and evaluation of training in family life education content and methodology in all teacher training colleges, as well as its extension to all schools.

RECOMMENDATION: Training of teachers and other supportive personnel in family life education is a high priority. Instruction in family life education by other than regular classroom teachers should be phased out as soon as possible so that students may develop relationships with their regular teachers which will encourage discussion throughout the school year and not just when special units are given. Since bringing in outside resource people to teach family life education sets it apart from other instruction, this is to be discouraged except when school staff are so unprepared or so uncomfortable with the subject matter that they cannot function effectively. Insofar as possible, outside resource persons should be used primarily for demonstration and teacher training purposes, and then only until sufficient numbers of teachers can be prepared to carry out such instruction themselves.

RECOMMENDATION: In-service training in family life education content and methodology should be provided for all teachers with interests and personal characteristics which make them suited to teach this subject in the schools. Efforts should be made to recruit at least one such teacher from every school in Jamaica

RECOMMENDATION: limited Overseas training in family life education should be made available for teacher training faculty and Ministry of Education personnel carefully selected by these institutions in accord with a plan for extending family life education in teacher training institutions and other schools.

RECOMMENDATION: Efforts to develop curricula both at the national and parish levels should be encouraged. Depending upon the experience with the model 3-stage curriculum project in St. Mary's parish and upon the request of Jamaicans, National Training Laboratory assistance should be made available for other such projects which involve community people in designing curriculum guides tailored to local needs. External curriculum guides are unlikely to meet Jamaica's interests and they do not have the same potential for training as does the local development of

curricula through workshops, committees, and other mechanisms. Therefore no foreign curriculum materials should be supplied except at Jamaican request.

RECOMMENDATION: Curricula in family life education and related curricula, in addition to focusing broadly on the development of sound individual and family attitudes and practices, and the relationship of family size and spacing to individual and family health, should also include education about the demographic realities and population dynamics in Jamaica as these have implications for social and economic development.

RECOMMENDATION: The Ministry of Education's present committee on family life education should be expanded to include representatives from all agencies and groups working in family life education programmes. The functions of this committee should be to coordinate these programmes at the policy and operational levels so that they may complement and reinforce each other.

RECOMMENDATION: Family life education coordinating committees should be formed in each parish to ensure that efforts of the schools, the Ministry of Health, the Trade Unions, the Youth Camps, and other groups are complementary.[1]

RECOMMENDATION: Insofar as possible, family life education materials and audio-visual aids should be developed locally and not imported except at Jamaican request.

RECOMMENDATION: The Ministry of Education allocate a definite budget for preparation and acquisition of materials supportive of family life education in the schools.

RECOMMENDATION: The request of the Bureau of Health Education for specific projection equipment, films, filmstrips, and books should be filled as soon as possible.

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1. See discussion about general need for coordination at the parish level, p. ____

5.5 Community Efforts in Family Life Education

The many efforts to promote family life education in the schools have been parallelled by equal efforts to promote it in the community. In conjunction with the development of the educational plan for 1968-71, a comprehensive list was prepared of agencies, organizations, and community groups whose participation in the national family planning program should be sought. By the Spring of 1974, all but a handful of these were somehow involved in activities relating to family planning and family life education.

While the efforts of the Bureau of Health Education, the Ministry of Education, the Family Planning Unit at the UWI, and the NFPB cannot be credited with directly stimulating the multiple community programs now in progress, it seems certain that they have had an indirect effect as indeed has had the national family planning program as a whole. Nevertheless, it is difficult to pinpoint where an idea originated or how it grew into visible accomplishment. In the long run, this should not be as important as the fact that both public and private agencies are now assuming responsibilities for extending family life education through their own resources and auspices. Some of the major contributors and their undertakings are summarized as follows:

A. The Ministry of Youth and Community Development

This Ministry now has family life officers. Mrs. Aileen Fraser is the family life education advisor in the planning unit.

In the past, the Youth development Agency traditionally conducted on-going family life education programs in its youth camps. Family planning is a new component which has been woven into these programs in recent years. For example, at Chestervale Residential Youth Camp for boys, during the past years two weekend training courses for leaders have been conducted by the camp doctor and district nurse. The leaders were expected to pass on the information to other boys in their groups. In addition, regular evening programs are conducted in small and in large groups on various matters relating to sex education and family life.[1]

Now in the reorganized program of the Youth Development Agency, family life education is a compulsory program for both boys and girls in all youth centers. Programs in family life education are also given for young people associated with child care institutions; and the Child Care and Protection Division, as well as as the Probation Department are considering the inclusion of counselling on sex education and family planning methods in their educational programs.[2]

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1. Tulloch-Reid, Jean, Background Paper for Asian Regional Seminar on Family Planning, to be held at the University of Singapore, Nov. 5-15, 1973.

2. East-West Communications Institute, January, 1974.

The Ministry of Youth and Community Development, under the Minister, Mr. Douglas Manley, brother of the Prime Minister, and the Social Welfare Unit of the Extra-Mural Department at UWI also hold joint teaching seminars and workshops as often as possible.[1]

B. The Ministry of Agriculture

Some training for home economics officers, wives of farmers, and agricultural officers in family life education has already been accomplished. A seminar for the home economists was held in Spring, 1973.

C. Community Development Agency

This agency, a branch of the Social Development Commission (formerly Jamaican Social Welfare Commission) in liaison with the Youth Development Agency effects a multiple approach to village life by providing a wide range of community services in districts throughout the island. Training in family life education includes the responsibilities of parenthood, nutrition, and family planning.

D. The Jamaica Youth Council

This organization showed some early interests in family life education and sponsored some seminars around the island in cooperation with the Bureau of Health Education, funded through the World Assembly of Youth. The man in charge went into politics, however, and activity has since waned.

E. The YWCA

The YWCA has integrated family planning into its on-going programs of family life education.

F. The Soroptomist Club

Family planning and responsible parenthood is one of the four major project areas of the Soroptomist Club. In 1970 the club produced a booklet on Responsible Parenthood which has had wide circulation.[2]

G. The Trade Union Education Institute, UWI

In cooperation with the three trade unions in Jamaica (National Workers Union, Bustamanate Industrial Trade Union, and the Trade Union Congress), the Trade Union Education Institute at the UWI has recently been funded by UNFPA for a three year program in workers' population education.[3] This project has the long-range objectives of creating increased awareness of population problems in relation to general social and economic development in Jamaica; of the impact present demographic trends in the nation will have on employment, working conditions, wages, and family income; of providing information and learning experiences which will enhance the acceptance of family planning as a way of life in Jamaica; and of providing information and learning experiences which will help families to cope more skillfully with the problems and responsibilities of every-day family life.

1. Nicol, 1973
2. East-West Communications Institute, Jan., 1974
3. Project Request to UNFPA from the Trade Union Education Institute, June 15,1[illegible]

Immediate objectives are to conduct 100 "Parish seminars" for the more influential Union leaders and delegates with an aim of reaching one percent of the membership of the three Unions with population and family life education (2,500 men); to train 100 "voluntary out-reach workers" for a field program; and to provide population and family life education to rank and file workers, with emphasis on family planning.

5.6 Coordination of Educational Efforts

Because of the problems which have characterized the national family planning program in general and because of the lack of strong administrative support for family planning educational activities, coordination of these multiple educational efforts remains a problem.

In early April, the NFPB reconstituted its Education and Training Committee with a new name, and at its first post-integration meeting, this group initiated efforts to bring together representatives of many of the organizations now active in family planning/family life education to reassess needs and reaffirm or reassign responsibilities. This type of joint planning is certainly to be encouraged, for it will substantially affect the consistency of the messages reaching the people from these various sources and will permit mutually supportive actions by the agencies concerned.

The ability of the NFPB to coordinate educational work in family planning, however, remains to be demonstrated. In addition to resolving previously identified problems in administration, such capability will also require a broad conceptualization of family planning and an operational appreciation of the differences between "coordination" and "control."

6.0 Capability within NFPB, MHEC, and UWI in Coordinating Recruitment, Training, and Maintenance of Adequately Trained Clinic, IE & C, and Administrative Staff

During the life of the Jamaican family planning program, much effort has been devoted to training of personnel. Still, much more is needed. Ministry Paper No. 1 estimates that approximately 4,000 persons need to be trained at various levels in family planning techniques and counselling.

An adequate supply of capable personnel is, of course, basic to the planning, implementation, and evaluation of any program. This has been recognized as central to the success of the Jamaican family planning program since at least 1968, as reflected especially by the priority which has been assigned to training, budget allocations for this purpose, training functions specified for NFPB, MHEC, and UWI staff and committees, the scope of past training efforts, and recommendations contained in a series of previous consultant and evaluation report.

Recruitment obviously depends upon manpower available, while training of necessity must be tailored to the skills of those who are recruited and the functions they are expected to perform. Maintenance of personnel is related not only to these factors, but also to salary scales, job satisfaction, and competing opportunities. Analysis of Jamaican capabilities in these respects therefore is most complex and requires resources beyond those available to this evaluation team.

Although many of the training programs designed to date have been good and some outstanding, their quality is difficult to assess by criteria other than reports of participants. Data are not available on differences such training made in performance of workers, and how this may be associated with program response.

In general, training should be based upon an assessment of the functions to be performed, the numbers of people presently available to do these jobs, the levels of their current knowledge and skills, and the resultant gaps which training should address. Building upon this type of analysis, the content, methodology, length and setting for specific training activities can be determined, and the outcomes can be evaluated. There is little evidence, however, that this pattern has been followed consistently.

Consequently, many people with responsibilities, actual or potential, in the Jamaican family planning program have somewhat mixed feelings about training. At times, it is seen as an imposition, as irrelevant, as a lark, or as a waste. Some feel that there has been too much training, with key personnel arbitrarily removed from critical functions at inappropriate times to attend training courses. Nevertheless, there is a recognition that training is important provided that it is coordinated with individual and program needs.

Efforts to achieve this coordination have met with less than success. Partly this is due to different interpretations of "coordination." Partly it is due to lack of understanding about the planning and educational processes that underpin effective training programs. Partly it is due to ambiguity about the responsibilities and functions of various units for training. Certainly frequent by-passing of field personnel in the development of plans for training has also contributed to the accumulated problem.

> RECOMMENDATION: That a detailed training plan be developed based upon an assessment of training needs related to integration, considering the phasing of training with service needs, and involving all concerned parties who are expected to participate in training whether by releasing personnel for training, by assisting with the provision of content and methodology, and/or by enrolling in training courses.

6.1 Training of Physicians

The indifference or "let George do it" attitude of many physicians not directly employed in family planning work--an inevitable price of the uni-purpose family planning program now being integrated--is recognized as a major item of unfinished business to be resolved if the integration of family planning into health services is to succeed. This attitude not only reflects the "curative" emphasis in medical education in Jamaica as elsewhere, but also is compounded by the incentive payments (sessional fees, honoraria, fees for sterilization procedures) which have characterized physician participation in the program to date.

Although the Minister of Health stated emphatically and publically on April 2nd, 1974 that no health personnel would suffer any personal financial loss with cessation of incentive payments upon integration, the necessary adjustments in classification, etc. to assure this are not yet forthcoming, and even when these questions of renumeration are resolved, the notion that fmaily planning is somehow something extraneous to mainstream health care still lingers. While the Medical Faculty of the UWI and the Nursing and Midwifery schools already have some family planning content in their current curricula to prepare present undergraduates for integrated family planning/health care roles, most of our informants agreed that the task of in-service trianing of physicians in the field is sizeable, and that some setbacks in program performance can be anticipated until the problem of roles and responsibilities of professionals in the newly integrated clinics is sorted out.

During 1973 some of the Medical Officers of Health at the Parish level (St. Catherine, Pt. Antonio, Duncans, Trelawn) participated in Parish Team Building Workshops conducted by trainers from UWI, with the assistance of NTL trainers supported by US/AID. An additional eight MO(H)s attended an NTL conducted conference at Oracabessa. It is regrettable that these exercises could not have reached the medical officers of all parishes well in advance of the deadline for integration, and an examination of the NFPB's projections for training of staff suggests that the Training Unit of

the Board cannot be expected to provide the in-service training at the physician level that integration of services requires.

Clearly, the various departments of UWI, augmented by whatever participant training overseas and visiting teams of technical assistance specialists in advanced fertility control procedures, must continue to be the major resource for physician training in support of the GOJ program. While the research output of the US/AID supported Family Planning/Epidemiology Unit has been the subject of some criticism, the record of training activities of the DSPM is impressive. In addition to technical family planning/sterilization methodology taught by the Department of OB/GYN and some family planning content in Pediatrics which is just beginning, the curriculum in family planning provided by the DSPM has reached 100 doctors graduated in 1973 (39 of whom are Jamaican) and 71 in 1972 (25 of whom were Jamaica). The post-graduate Diploma in Public Health Course was completed by four physicians in 1972 and four in 1973 with another four (three of whom are Jamaican) currently enrolled in this course. In our interview with Dr. D'Souza (MO(H) of St. James/Hanover), he paid particular tribute to the preparation in this DPH course of one of these graduates (Dr. Pamela Lewin), who has become a bulwark of the family planning work of these two parishes. Indeed, it is apparently no coincidence that the parishes in which the graduates of the DPH courses at UWI now serve as MO(H)s are those in which significant improvement in family planning clinic performance has occurred (as indicated by decrease in births per 1000 population from 1972 to 1973).

Participant training in various U.S. sites has enhanced Jamaican expertise in current family planning technology, but will need to be expanded as facilities for performance of tubal ligations become more available, and particularly with the anticipated clarification of the law regulating abortion. During 1973 two physicians received training in Washington, D.C. (postpartum program, family planning services), two at Downstate Medical Center (tubal ligation), and one at Carolina Population Center (family planning program administration.) In addition, Dr. Dean attended the conference on Menstrual Regulation in Honolulu in December, 1973, and Dr. Hall has had training in the U.K. in laprascopic sterilization.

U.S. training consultants in Jamaica have included Dr. Stubblefield (uterine aspiration) and the travelling teams of Johns Hopkins Advanced Fertility Technology program (laparascopic sterilization). Dr. Wynter, Professor of OB/GYN at UWI, has been trained in culdoscopic sterilization by Professor Gutierrez-Najar of Mexico, and has now trained another UWI obstetrician/gynecologist in this technique. With these trained physicians as a nucleus, and with laparascopic sterilization now being done in at least two centers and culdoscopic sterilization in one, some capability now exists for training in these modalities in-country. However, the facilities in question are currently badly overtaxed (with waiting lists for sterilizations of 3-6 months!) and with the completion of the addition to Victoria Jubilee Hopsital and the Montego Bay Hospital plus the ten rural Maternity Centers expected this year, it is obvious that both participant training abroad and in-country training by visiting consultants must continue if even the backlog in sterilization alone is to

be served. Moreover, the anticipated clarification of the abortion law, which now appears imminent, will require for its implementation, both training and equipment. (Dr. Patterson estimates approximately 20 aspirators in addition to those already in use in Jamaica will be needed.)

While the rural maternity centers are to be staffed largely by midwives, there is interest in the concept of traveling sterilization "teams" visiting a number of rural locations in rotation in order to provide ambulatory surgery to meet the growing demand for sterilizations. The rural maternity centers offer suitable locations for such services hitherto unavailable outside the urban communities.

6.2 Training of Nursing Personnel

According to the Minister of Health, the "brain drain" of skilled persons, particularly nurses, of recent years has now been reversed, and an adequate supply of nurses appears assured even if some defections should occur in the course of integration. Indeed, the MHEC seems confident enough in the supply of trained nurses and midwives for the foreseeable future to contemplate a National Health Service program emphasizing combined preventive and curative services locally available with widespread use of paramedical skills. Our interview with Mrs. Hunter-Scott, PNO, MHEC, confirmed the Minister's optimism regarding manpower. She noted that some 250 nurses have returned from the U.K. following training and that the bonding of nurses emigrating for professional training has become an effective instrument for assuring their return for service in Jamaica.

In addition to those trained abroad, the UWI now trains approximately 100 nurses per year, and island-wide, approximately 200 nurses are trained annually. The total complement of nursing staff employed by the MHEC now numbers 2,839, and an extensive reorganization of the nursing and para-nursing service is underway. Under this program in-service increments of training, heretofore admittedly lacking, are provided, with opportunities for advancement based on educational requirements met plus evaluation of proficiency.

The PNO feels strongly that integration of family planning into mainstream health services will enhance the acceptance of family planning, and she intends that in-service training shall equip all categories of nursing personnel to teach fmaily planning.

Increments in the next year's budget include provision for expansion of the nursing establishment (to a projected 3,206), expansion of midwifery training with schools projected for Mandeville and Spanish Town, and recruitment and training sufficient to staff the ten rural maternity centers now under construction, the new Montego Bay Hospital, and the expansion of VJH. With Nursing and Midwifery the key roles in the delivery of family planning services, the evaluation team feels that the present move toward integration is timely and that the nursing establishment in the MHEC is under capable leadership.

Note: See Appendix 3, Dr. Pulley's Report on Training and Manpower as of October, 1973, Appendix 4, Training Activities Completed in 1973 and MHEC Chart of Organization of Nursing and Para-nursing Service.

7.0 Capability in Conducting Operational Research, Providing Useful Results, and Integrating Findings into Program

A variety of consultant and evaluation reports have stressed the need for operational and basic research to guide program efforts since the inception of the Jamaican national family planning program. Faculty at the UWI have also frequently voiced the need for research and evaluation upon which to base program planning, training, and service delivery. Personnel responsible for the operational aspects of the program, however, have generally shown less appreciation for the contributions of research and evaluation in improving program effectiveness and have sometimes been impatient with the time such efforts require, as well as with the problems they encounter. This has affected both the development of research capabilities for the program and the utilization of research results.

7.1 The Role of the University of the West Indies

The 1969 AID Project Proposal identifies as a major element of the national family planning program "evaluation and action research, with leadership to be provided by the appropriate departments of the UWI, preferably through a UWI Population Center serving the territories of the Caribbean."

Jamaica thus looks primarily to the University of the West Indies for research and evaluation in family planning. Reliance to date has been particularly heavy upon the Family Planning/Epidemiology Unit within the DSPM, the Census Research Program in the Department of Sociology, and the Department of Obstetrics and Gynecology, each of which has specialized contributions to make. Several additional UWI Departments are actual or potential resources for research relating to the national family planning program. The UWI therefore has a broadly based interdisciplinary infrastructure for undertaking research which has relevance to the family planning goals of Jamaica, as well as potentially to the Caribbean.

A. The Family Planning/Epidemiology Unit, Department of Social and Preventive Medicine

The DSPM has been a service and consultation resource in training, research, and evaluation to the national family planning program since at least 1969. In order to strengthen its capabilities in these regards, US/AID provided a resident consultant from the University of Pittsburgh during 1971-72. Among his other functions, this consultant completed postpartum and abortion studies at Victoria Jubilee Hospital, arranged for short-term consultants on research methods, and worked out an agreement with the NFPB and the US/AID Population Officer about the research role of the DSPM. The contract with the University of Pittsburgh was terminated in October, 1972, however, largely because resident personnel requested under the renewal proposal could not be recruited.[1]

As of Kraft's consultation visit in March, 1972, the DSPM has prepared a preliminary statement of the functions it might assume in research

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1. PAR, July, 1971 - Dec., 1973.

and training if funding were available, with the intent to make these plans more specific as the five-year plan of the NFPB evolved. Tentative research functions included carrying out research according to priority needs identified jointly with the NFPB, identifying program areas requiring research on an on-going basis, providing consultation to other groups engaged in research on behalf of the NFPB, helping NFPB establish procedures for evaluating the family planning program, keeping an up-to-date record on all studies that have been conducted or are being planned which are relevant to the family planning program in Jamaica, and developing a model family planning clinic within the DSPM in which innovative approaches in service, education, and evaluation could be tested.

By Project Agreement in mid-1972, the formal establishment of a Family Planning/Epidemiology Unit was authorized for October, 1972, but the Unit was not formally created until January, 1973, when Dr. Karl A. Smith was appointed as its Director. This Unit was charged, inter alia, with conducting operational studies of family planning activities to improve client motivation, efficiency of program operations, and effectiveness of method utilization. In anticipation of integration of family planning and health services, the AID Project Paper dated 10-3-72 expands the scope of research expected from the unit to "family planning/health."

The AID draft Project Proposal submitted in July, 1973 states as a goal that operational research capability will be well established and in operation in the Unit by the end of the next project period. This is based upon the assumption, however, that adequate budget for operational research can be maintained from a combination of government and donor sources. Since the Unit's current funding is due to expire in September, 1975, its continued development as a research resource clearly depends upon obtaining renewed funding commitments in the very near future.

B. Census Research Program (Department of Sociology)

The Census Research Program in the Department of Sociology, under the Direction of Professor George Roberts, conducts demographic research concerning population status and trends throughout the Caribbean. The Program recently received a UNFPA grant of $569,000 for the analysis and publication of 1970 census data collected from 15 Caribbean nations. In addition, the Department of Sociology conducts other research with family planning implications.

According to Nicol (December, 1973), the Census Research Program may eventually be separated from the Department of Sociology to enable both to grow.

C. The Department of Obstetrics and Gynecology

The Department of OB/GYN conducts clinical research on fertility control measures, including contraceptive methodology, abortion, and sterilization. The recent appointment of Dr. Hugh Wynter as Head of the Department is expected to result in intensification of family planning activity in this Department.

D. The Department of Psychiatry

Professor Beaubrun and two of his associates in the Department of Psychiatry are currently assisting Dr. Eugene Brody in a study of female clients of the JFPA.

In addition, Professor Beaubrun, who is also President of the World Federation for Mental Health, in a letter dated February 8, 1974 to the US/AID Population Officer in Jamaica, expressed his interest in collaborating with the AID-sponsored family planning program.

E. The Institute of Education

Dr. Phyllis MacPherson of the Institute of Education is currently directing a small study with social welfare students on attitudes of 15-19 year-olds toward the introduction of sex education into the schools. In addition, Dr. MacPherson has participated in many training activities related to the national family planning program.

F. The Department of Pediatrics

The involvement of this Department in family planning research is just beginning. Recently, however, the Chief of the Department joined an interdisciplinary Committee from the UWI which is guiding the work of a Child Development Research and Training Centre which is being established on the Mona campus as part of a Caribbean-wide action/research project funded by UNICEF.

G. The Extra Mural Department

The aforementioned interdisciplinary Child Development Research and Training Centre is being developed through the Social Welfare Unit of the Extra Mural Department of the UWI. This Unit has spearheaded efforts to define the role of social welfare in family planning through conferences, a survey of family planning functions being performed by social workers in Jamaica, and a study for the U.N. on the subject. The Unit also has action/research interests in training, in community development programs, and in projects conducted by students.

The Trade Union Education Institute is another unit within the Extra Mural Department which will have an increasing role in action/research related to the national family planning program. The TUEI recently received a UNFPA grant of $237,000 for collaborating with the three major trade unions in Jamaica to provide workers with a broadly-based program of family life education.

In addition, Professor Rex Nettleford, who heads both the Extra Mural Department and the TUEI within it, is an expert on Jamaican folklore, including male attitudes and practices. Thus he represents an important resource for improving insight into public reactions to the national family planning program.

7.2 The Role of the NFPB in Research and Evaluation

The Act which established the National Family Planning Board provided that it could undertake and promote research in relation to family and population planning. The NFPB has not, itself, conducted any special surveys of either its clients or the general population, but rather makes arrangements with appropriate researchers to do so. Reliance has been particularly heavy upon the UWI in this regard.

Currently the NFPB has two Committees concerned with research. One is the Planning and Evaluation Committee, a sub-committee of the Board itself with the addition of two co-opted members. The other is the Policy Coordinating Committee which was established in accord with Program Agreement 72-5. The membership and functions of these two Committees are outlined on the following page. In addition, the Board's scientific and Drug Committee is charged with making recommendations as to what scientific research should be undertaken. The Board as a whole has responsibility for clearing research projects related to its program.

Operationally, the Board has another research and evaluation function, which is the collection and analysis of program statistics. Although the quality of the Board's statistical resources seem to be widely acknowledged, many of the persons contacted by the team felt that the NFPB's statistical outputs to date have been disappointing in terms of quantity, frequency, validity, and types of information analyzed (see pp.69-73).

Ministry Paper No. 1 - Family Planning, states that under integration the NFPB will have continuing responsibilities in research, including:

A. Identifying areas for major and minor research.

B. Determining priorities in this field and having consulted with the Policy Co-ordinating Committee, in the light of finances available, seeing that arrangements are made to have research projects carried out.

C. Studying the findings and seeing that these are implemented where appropriate.

In addition, this document indicates that the Board will continue to be responsible for statistical data, monitoring, and evaluation of programs. This includes, specifically, liaising with the UWI and the Registrar General's Department with particular reference to vital statistics and research.

NFPB Committees Concerned with Research and Evaluation

	Planning and Evaluation Committee	Policy Coordinating Committee
Membership:	*Professor G. W. Roberts, Chairman *Dr. A. W. Patterson, NFPB and MHEC *Mrs. C. McFarlane, NFPB Dr. Karl Smith, UWI JFPA Representative	*Mr. Conroy Allison, Chairman *Dr. A. W. Patterson, NFPB & MHEC *Professor G. W. Roberts, UWI Dr. Karl Smith, UWI Mrs. Ivy McGhie, UWI Mrs. Sybil Frances, UWI Dr. Hugh Wynter, UWI Dean M. Ragbeer, UWI Ms. Thelma Thomas, NFPB Mr. Eric Owen, NFPB *Mr. R. A. Ramcharan, MHEC Mr. Wilbur Wallace, US/AID
Functions:	1. Interpret findings on program evaluation to the rest of the Board members. 2. Review evaluative material and translate it into terms that are meaningful to the Board in connection with its policy-making and program planning responsibilities. 3. From time to time determine priorities, review progress, analyze findings and utilize where necessary, these findings toward the planning of on-going and new programs. 4. Coordinate the work in evaluation and research areas of the program and make recommendations. 5. Make recommendations on policies for achieving program objectives. 6. Review and analyze materials on evaluation and research contained in the quarterly report submitted by the On-going Evaluation Committee. 7. Examine and review the goals of the program in the light of demographic, economic and other trends in order to determine effect on the national family planning program.	1. To carry out coordination of research and training activities in support of the Jamaican national family planning program.

*Member of the NFPB

7.3 Roles of other Organizations and Institutions in Research

A. The Ministry of Health and Environmental Control

The potential role of the MHEC, as well as of other Ministries, in research and evaluation does not seem to be widely acknowledged. Nevertheless, the role of these institutions in supporting field research and the need for a generally experimental approach in the program as a whole should be recognized in order to assure the administrative support essential for operational research and program evaluation to take place.

B. The Jamaican Family Planning Association

The JFPA has carried out several action research projects, and has participated jointly in others. Nevertheless, the Association's facilities for evaluating its own projects are limited, and efforts in this direction have been rather superficial so far. The potential of the JFPA as a resource for action research thus is yet to be realized.

The Association is currently evolving from its original service and education role into an agency which is complementary to the Government's family planning program with new opportunities to undertake innovative projects. As part of this change, it has established a newly restructured research and evaluation section, headquartered at the East Street Clinic in Kingston. The JFPA's experiment with male motivation, and its mobile unit and model clinic projects are examples of action research for which the capability of the JFPA has not yet been adequately demonstrated or recognized.

C. The Family Counselling Center

Although the primary focus of the Family Counselling Center has always been on service, it has participated in surveys of social agencies and has conducted small studies of its client population. At present, the Center recognizes the need to develop within its staff a strong commitment and a capability to engage in research focused upon issues relating to reasons for under or non-utilization of family planning services, with particular emphasis upon the exploration of motivational and attitudinal factors. To this end, it is working with Dr. Geraldine Conner and Dr. Nancy Veeder of the Boston College Graduate School of Social Work, in cooperation with members of the social work staff of the UWI.

The Center's proposed Multi-Service Center is to include a research unit, whose primary responsibility will be statistical accounting and research directed toward on-going program evaluation for planning. Secondarily, it will provide opportunities for field experience in research for social work students from the UWI and Boston College. The unit will also provide opportunities for Family Counselling Center staff, Boston College faculty, and other interested faculty to carry out research related to issues in family planning utilization.

Currently the Center is seeking funds to develop the research component of its program.

D. Other Institutions and Organizations

Although other public and private agencies are not now visibly involved in research and evaluation related to the national family planning program, their potential in this regard should be recognized and its development should be encouraged. The Ministries of Education and of Youth and Community Development particularly are becoming increasingly active in family planning programs which should be evaluated as they progress and which afford good opportunities for action research.

Since the Conference on Family Planning in Social Welfare in Jamaica (Nov. 25-26, 1970) recommended that social workers should become more involved in various aspects of family planning research and that on-going studies of the implications of family planning should be undertaken by the Jamaica Association of Social Workers, these interests should also be encouraged.

7.4 Institutional Capability of Each of These Units for Research

Institutional capability for research, of course, depends upon overall institutional strength. The following discussion therefore should be read in the context of earlier remarks concerning the general institutional capabilities of the UWI (including the FP/Epidemiology Unit in the DSPM), the NFPB, the MHEC, and other organizations. Within this framework, institutional capability specifically for research can be further assessed by several indicators.

A. Recognition of family planning research functions by other units, agencies and individuals

All persons contacted by the evaluation team recognized the research roles of the FP/Epidemiology Unit, the Department of Sociology, and the Department of OB/GYN at the UWI. Tangible evidence of such recognition is provided by the fact that representatives of all three research resources serve as members of the NFPB's Policy Coordinating Committee, while representatives of the first two also serve on the Board's Planning and Evaluation Committee.

The real and potential contributions of other UWI Departments to family planning research do not seem to be so widely acknowledged, although Mrs. Sybil Frances of the Social Welfare Unit in the Extra Mural Department was named to the Policy Coordinating Committee shortly after its formation.

The NFPB seems to be recognized by most, if not all, individuals engaged in research relating to family planning as the central body for coordinating research and evaluation efforts and for integrating these with program needs and operations. The FP/Epidemiology Unit of the DSPM is most closely related to the NFPB in this regard, although not in an entirely satisfactory manner as will be discussed shortly. The Department of Sociology and the Department of OB/GYN seem to maintain much more autonomy from the NFPB. Although the Board is kept informed of the research activities of both of these Departments, it seems to have relatively little influence on the research they undertake. Other UWI Departments involved in research do not, insofar as the team was able to ascertain,

work with or through the NFPB, and so the extent to which they accept the Board's coordinating role in family planning research must be questioned. The JFPA sends copies of research proposals and reports to the Board, but other public and private organizations apparently do not do this routinely.

Most persons interviewed by the evaluation team were aware of the JFPA's several field experiments, but their contribution in terms of action research was not generally acknowledged. Much of the problem seems to lie in the research methodologies being employed.

There also seems to be general awareness of the research interests of the Family Counselling Center, although this is not seen as primarily a research organization. Other agencies and institutions are not yet recognized as having family planning or related research involvements, although some have realized that these organizations, too, represent potential research resources.

B. Financial Support for Research

With a few exceptions, research and evaluation efforts to date have been supported by US/AID assistance and grants from other donors Although various Departments and Units within the UWI have demonstrated their abilities to secure outside funding for research proposals, major reliance upon such grants to support research units is precarious, especially in these days of tightening foundation pursestrings. Moreover, core research staff and facilities may be lost if a grant request is delayed or not approved. UWI informants report that it is extremely difficult and time-consuming to get funds, and currently a researcher is considered lucky to have project monies available within two years after submitting a research proposal. Such delay is particularly risky for the FP/Epidemiology Unit of the DSPM, for other University personnel are better protected through institutional integration.

Given the financial situation of the UWI (see p.135), as well as the general economic difficulties Jamaica is now facing, prospects for local funding of research and evaluation are not bright at this time. The GOJ, however, has promised some financial assistance for computer facilities to assist Professor Roberts with the analysis of census data. It would be in the interests of the national family planning program to have a small budget earmarked for operational research on priority problems, as well as for facilitating progress on major research projects which are delayed by funding tangles. The conduct of family planning and related research will, however, continue to depend heavily upon external donor agency support for the foreseeable future.

C. Research Facilities Available

Physical facilities for research (as well as for other activities) in both the FP/Epidemiology Unit of the DSPM and the Department of OB/GYN at the UWI are severely limited, as described in previous reports.[1] The

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1. See Kraft, March, 1972; Memorandum from Nadene Saxon dated April 27, 1973, and Report by M. Nicol for the Population Council, December, 1973.

construction of new facilities to house these units as part of the University Hospital Complex will relieve these problems and therefore increase this aspect of research capability as soon as they are completed. The present target date for completion is the end of 1974.

Computer facilities in Jamaica also pose certain problems, although these are generally recognized as the best in the Caribbean. Most available programs are written for more powerful computers than those now available on the island, which are no longer being manufactured. Long line-ups waiting for computer time have also delayed data analysis on several projects. In addition, the current energy shortage has sometimes resulted in power failures, but Professor Roberts reported in June that these are being overcome. Nevertheless, equipment is something of a bottleneck. Mr. Brackett and Mr. Lorens from US/AID were in Jamaica in January, 1974 to investigate these difficulties,but the results of their visit are not known to the evaluation team.

Looking beyond questions of research space and equipment, the island itself can be considered a research resource. Professor Roberts' recent research proposal points out several factors identified by Dr. Vera Rubin as facilitating social science research in Jamaica:

> "...with a high population density, the country is comparatively small in terms of geographical scales; this both facilitates island-wide mobility for a research team (except for a few areas of difficult accessibility), and makes it possible to transcend the conventional 'community study' approach and to conceptualize research problems on a multidimensional and multidisciplinary scale."

D. Research Personnel Available

Although the evaluation team did not have the opportunity to examine specific research reports by Dr. Karl Smith of the FP/Epidemiology Unit in the DSPM, UWI, his research competency generally seems to be highly regarded, as do the capabilities of other research personnel on his staff. Nevertheless, problems in recruiting and keeping research staff (see pp. 70-71) have limited the Unit's capabilities in this regard. Until the funding problems of the Unit are resolved, these difficulties can be expected to continue. Although the recruitment of qualified consultants has been suggested to bridge the resulting gaps, this assumes that suitable consultants would be available for the research in question, which may well not be the case.

Professor George W. Roberts of the Department of Sociology at the UWI is widely recognized and respected as an outstanding demographer, while Dr. Hugh Wynter in the Department of OB/GYN at the University is also well regarded for his research abilities. The quality of the research personnel now available at the University therefore is not in question, but the UWI's capacity to recruit and keep supportive research staff is likely to continue as a factor limiting overall research and evaluation capabilities.

E. <u>Specific Research and Evaluation Needs Identified and Progress to Date</u>

A variety of research and evaluation needs have been identified during the life of the Jamaican national family planning program. In broad terms, these include three categories:

1. Operational studies required to guide administrative management and to improve service operations.

2. Basic research into socio-cultural characteristics and behavioral patterns of various groups, such as teenagers adult males, high risk women, and support groups, e.g., the political and business sectors.

3. Analysis of vital demographic data.

The US/AID Project Appraisal Report for the period December, 1969 through June, 1971 specifically recommended studies in the first two broad areas, while the third is generally recognized as fundamental to evaluation of the national family planning program and its relationship to the changing population situation.

Appendix F details research needs identified to date and progress in meeting them. Comments here therefore concern quantity and quality of research conducted as an indicator of research capability. Emphasis is upon the FP/Epidemiology Unit of the DSPM, UWI, since its research functions are most closely tied to the Jamaican national family planning program.

Research projects have been actively designed and carried out by the FP/Epidemiology Unit even before it was formally established, but there have been problems. These principal criticisms of the Unit's research activities have been offered by NFPB personnel and US/AID representatives in Jamaica:

1. That the regional interests of the UWI and the services the Unit provides to other Caribbean islands dilute the services available to Jamaica.

2. That NFPB priorities are not accepted by the Unit.

3. That research is lagging.

Concerning the first criticism, we believe that it is necessary for the Unit, as part of the UWI , to serve the Caribbean group of islands, and that in doing so it does not necessarily reduce the service to Jamaica. While population and family planning problems among the islands of the Caribbean may differ in some respects, they nevertheless have many features in common. Information yielded by research in connection with problems of one island often has application to others. Furthermore, it is incumbent on the University, as a regional institution, to serve the broader interests of the region as a whole. There seems to be no reason to think that this will deprive Jamaica of research services, even though the cost of the UWI unit is borne by a project written, essentially, for Jamaica.

The second criticism relates directly to the adequacy of the mechanisms for identifying and communicating NFPB research priorities, a subject which is considered in the following section. In addition, however, it should be understood that a University must, for valid reasons, plan its work for one to five years in advance, and adjust its research program to both budget considerations and the availability, skills, and interest of research personnel. It is most difficult and wasteful under most circumstances to change the research pattern once it has been adopted and is underway. To have a research proposal considered in competition with others, it should be submitted early and if possible allowed to gravitate to its logical place in the general plan. It is also understood that University and non-University personnel may evaluate research projects from rather different perspectives.

We do believe, however, that the FP/Epidemiology Unit, and the University as a whole, should be as generous as possible in the appraisal of field projects for research attention. So called "Developmental Research," closely related to practical problems in the field of family planning, deserves most careful consideration. Both Dr. Smith of the FP/Epidemiology Unit and Dr. Standard of the DSPH assured the evaluation team that research relevant to the Jamaican family planning program is the Unit's highest priority.

The third criticism has to do with limited or lagging production. Dr. Smith knows that the constraints under which he is operating result in delay in obtaining the results in which he, too, is interested. There are a number of valid reasons to explain delays, primarily in getting research projects launched. Most of these have to do with finding an available researcher with the right training, background, and interests. Conflicting personnel requirements between the UWI and the funding agencies often hamper or delay recruitment. Having found the right person there is then the problem of competition with other institutions for his/her services, salary, fringe benefits, living conditions, moving expenses, laboratory associations, other faculty members who might have an influence on the research, etc.

It might also deserve comment that good research is time-consuming. Research design must be done with meticulous precision to make the results trustworthy. Furthermore all research involves some unforeseen operational difficulties and some inevitable dead-ends. Apparently these problems are not fully appreciated by certain Jamaican and US/AID personnel who themselves have never been intimately involved in the research process. The continual pressures these individuals bring to bear on the FP/Epidemiology Unit do not serve to advance research, but rather drain time and energy away from research tasks.

One other handicap should be mentioned, namely the difficulty of operating with short-term funding. Fluctuations in U. S. and Jamaican dollar amounts of research allocations between the time research is funded and the project actually gets underway create numerous problems in budget readjustment. Moreover, the usual difficulties of recruiting and perhaps training the right person become almost impossible when the project cannot [illegible] end at a time that is interim and transfer opportunities for the researcher are not good.

Given these problems, it is the impression of the evaluation team that the FP/Epidemiology Unit has produced well within the time that it has been operative. This period, however, has been relatively brief, and thus the real test of the capability of the Unit lies ahead.

Although the quantity and quality of research produced by other Departments within the UWI was not investigated as thoroughly by the evaluation team, evidence that was obtained suggests that rather similar patterns apply. That is, taking into account the length of time each of these Departments has been in operation and the particular problems which each has had to face, research accomplishments in general tend to be outstanding. The fact that laparoscopic sterilization appears to be superceding the culdoscopic approach does not detract from the value of Professor Wynter's research into the latter modality.

The productivity of the NFPB in meeting its program evaluation and research coordination responsibilities is less impressive. Performance in these critical areas needs to be substantially improved if the program as a whole is to benefit from its own operational experience, as well as to take advantage of research findings from other Jamaican institutions concerned with fertility and family planning.

Although the MHEC has not assumed a major role in research, the few experimental studies in which the Bureau of Health Education has participated have been of good action/research quality. Such participation should be encouraged. In addition, program evaluation within the various MHEC units which now have increased family planning responsibilities as a result of integration should be more frequent and systematic.

The JFPA to date has played only a peripheral role in family planning program research. The data which it shared with the evaluation team on the male motivators project were basically concerned with the number of contacts made. Hopefully, the design will address more critical questions such as the number of new and continuing male users influenced by this project, and the strengths and weaknesses of the educational methodology being employed. Moreover, it is to be hoped that the JFPA will assume a strong role in developing and testing new approaches to family planning which will lead the way for strengthening the Government's island-wide program.

7.5 Identification of Research Needs and Priorities

Project Agreement 70-5 establishes as a target setting up a special advisory committee to review research proposals and to recommend priorities in order to assure better definition of program research needs. This apparently reflected the existence of a problem in this area, which in the opinion of the evaluation team has not yet been completely resolved.

Although overlapping membership among the NFPB's Research and Evaluation Committee and its Policy Coordinating Committee, as well as staff participation on these Committees encourage sharing of research concerns, it is not clear who has primary responsibility for gathering information about the totality of research needs as these are expressed within various facets of the program, as well as for examining the array of research possibilities and determining research priorities as they relate

to changing program status. The evaluation team therefore was unable to obtain a precise statement of current research priorities. Moreover, it is doubtful whether such a statement exists, except perhaps in the minds of certain individuals. Nevertheless, it seems that some generally agreed-to statement of research concerns would be an essential tool in facilitating decision-making about specific research projects and proposals, both within the NFPB and its Committees, as well as within the various research units allied to the program. In the absence of such guidelines there are real risks that research in peripheral areas may be approved and/or that important research questions will be overlooked. Undue delay in responding to requests for clearance of research proposals is another consequence which upon occasion may endanger funding opportunities.

According to the minutes of the Policy Coordinating Committee, Dr. Karl Smith of the FP/Epidemiology Unit, DSPM, UWI asked for research policy guidelines in June, 1973. Dr. Smith further reports that although he presented the Policy Coordinating Committee with a rough draft of various research possibilities, he has never received a clear indication of the priorities which these should be given. The Dean of the Medical Faculty confirms that the Family Planning/Epidemiology Unit submitted to the NFPB in December. 1973 a draft of priorities. available funding. recruitment problems, etc., but has received no reply to date.

Members of the Policy Coordinating Committee have expressed somewhat diverse opinions about the desirability of research guidelines. Thus Professor Roberts cautions about the dangers of documenting research policy too far in advance, although he feels that flexible guidelines would be helpful, and that the sharing of information and ideas can be productive. He does not believe, however, that any external body can or should dictate the specific activities of a research unit, which should formulate its own research policy. Dean Ragbeer thinks that the concept of a Policy Coordinating Committee is all right, but that the way in which it has worked is not. He suggests reviewing general lines of authority and breaking them down into service components related to the objectives of the program. Mr. Ramcharan has stated that the documentation of research guidelines would follow the implementation of integration, and suggested that the Committee put in writing the questions which its members wish explained or clarified.[1] This, in fact, has been done, with the delineation of alternative solutions to each issue.[2] Discussion of these questions and decisions about the course of action to follow, however, have apparently not yet taken place.

Among the important questions yet to be resolved are:

1. Who is responsible for determining:
    a. kinds of information to be acquired in order to evaluate the program

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1. Minutes of the Policy Coordinating Committee, June 20, 1973.
2. Possible Questions for Discussion, Concerning Responsibilities for Clinical Evaluation, Statistical and Research Aspects--National Family Planning Programme.

b. how it will be obtained--by whom and through which channels
c. the mechanism for analyzing data obtained
d. who has authority to program changes as indicated by the data.

2. Who is responsible for collecting, analyzing, and reporting clinic data?

3. Where are clinic records to be kept and compiled, at Parish and National levels?

4. What is the system for compiling, publishing and disseminating data to:
   a. Ministries, Departments and Divisions of government involved in the program
   b. Volunteer and private agencies involved in the family planning program?

5. Who is responsible for setting up the plan of evaluation, and for determining:
   a. kinds of information required
   b. how it will be obtained
   c. by whom it will be obtained
   d. through what channels
   e. the mechanism for analyzing the data
   f. staffing requirements, or contracts needed for analysis.

6. Who is responsible for the coordination and implementation of the various aspects of the evaluation plan?

7. Who is responsible for formulation of program changes as indicated through the evaluation and research data?

All of these matters obviously have implications for the identification of research needs and priorities. Therefore the evaluation team recommends:

> RECOMMENDATION: That the NFPB as soon as possible clarify the responsibilities and relationships of its Committees and staff in identifying needs and priorities for research and evaluation as these relate to the national family planning program, that the individuals and units designated as responsible be held accountable for producing flexible research and evaluation guidelines within a delimited time period, and that they be given the necessary administrative support to complete this task.

In implementing the above recommendation, efforts should be made to secure the ideas and suggestions of all program components and to tailor research and evaluation plans to the realistic workload that existing research and evaluation resources can be expected to carry.

7.6 Relationship of Research Units to Other Program Components

Because of the many unresolved questions relating to the identification of research needs and priorities, as well as to the assignment of responsibilities for undertaking needed research and evaluation, coordination of the various research resources available to the national family planning program is weak. Nevertheless, there is a certain variable degree of informal research coordination among many of the key individuals involved. In addition, Dean Ragbeer of the Faculty of Medicine at the UWI is making strong efforts to improve coordination among the various medical Departments by holding regular meetings for this purpose. The appointment of Dr. Karl Smith as Vice Dean of the Medical Faculties on March 21, 1974, and the recent confirmation of Prof. Wynter as head of the OB/GYN Department should enhance coordination and cooperation among the several family planning interests involved.

This, however, does not adequately provide for coordination among the various Departments within the Faculty of Medicine and other Departments of the University engaged in family planning research. The need for such coordination has been expressed in a number of ways. The first external review of the Jamaican family planning program (Sodhy et al, July, 1972), for example, noted the need for coordination between the research units headed by Dr. Karl Smith and Professor George Roberts. More recently, the research proposal submitted at the suggestion of Dr. Vera Rubin states:

> "We do not have at this time (nor does Dr. Roberts) a comprehensive understanding of the program under the direction of Dr. Karl Smith, who is in the Department of DSPM."

The same proposal indicates that the Department of Sociology had not yet received a copy of the research proposal by Dr. Eugene Brody, which involves the UWI Department of Psychiatry.

Professor Roberts agrees that a case can be made for greater exchange of information within the University, for "although those interested in population/family planning get together, they do not do so enough." Interest in greater coordination and research collaboration at the UWI generally seems high. According to Professor Roberts, Professor Standard of the DSPM has actively tried to bring this about, while Dean Ragbeer's contributions in this regard are also widely acknowledged. A report for the Pathfinder Fund (Morehead, December, 1972) also states that both Dr. Wynter and Dr. Burkette from the Department of OB/GYN are "most enthusiastic about establishing a family planning unit which is University-wide and interdisciplinary." Dr. Beaubrun of the Department of Psychiatry recently wrote to the US/AID Population Officer in Jamaica expressing interest in collaboration with the national family planning program. Mrs. Sybil Frances of the Social Welfare Unit in the Extra Mural Department strongly affirmed commitment to interdisciplinary research efforts.

Currently a project now in progress is already providing a tangible base for increased interdisciplinary research collaboration among UWI faculty. Concerned with the needs of the young child in the Caribbean, this project is advised by a Committee which includes the Chief of the ^ Department of Psychiatry, the DSPM, the Department of Sociology, the Social Welfare Unit of the Extra Mural Department, and the Caribbean Food and Nutrition Program.

Department of Pediatrics and representatives from the

When the new family planning complex at the UWI is completed at the end of this year, it should also enhance interdisciplinary communication and collaboration among faculty of the Department of OB/GYN and the FP/Epidemiology Unit. Fortunately, this building is designed so as to facilitate enlargement of the complex to house other areas of activities when additional funds become available. (Minutes of the Policy Coordinating Committee, September 19, 1973).

Coordination between the WUI research units and action elements of the family planning program apparently will be more difficult to attain In the opinion of the evaluation team, this will depend upon resolution of problems within the NFPB already detailed, as well as clarification of program and coordination responsibilities in the MHEC now that integration has occurred. In addition, the inherent difficulties created by the regional focus of the UWI and the essentially Jamaican focus of the NFPB and the MHEC will need to be thoroughly discussed and mutually agreeable compromises reached.

7.7 Utilization of Research Findings in the Family Planning Program

Results from certain types of completed family planning research and evaluation projects have been utilized to modify and improve program operations. Thus clinical services have benefited from research findings relating to the improvement of contraceptive delivery, abortion techniques and sterilization procedures. Demographic studies conducted in the Department of Sociology are continually fed into the program, and Professor Roberts of the Department contributes to the planning and evaluation component of the Board's program through its committees. The educational and training components of the program also seem to have made good use of the limited research data relevant to their functions.

Aside from these areas, however, the evaluation team was unable to find substantial evidence that the results of family planning research and evaluation now completed have been utilized to modify and improve program operation. In general, the problems of communication and coordination which permeate the program account for failure to make better operational use of research results. Thus researchers are unsure of channels through which research reports should be sent to reach those program units for which they have implications. Furthermore, they seem to be unsure of the mechanisms through which research findings get translated into program changes, and if this does happen, they rarely receive feedback about how their work has been applied. Here it should be pointed out that these problems are not unique either to family planning research or to Jamaica. Rather they seem to characterize the utilization of research findings somewhat generally.

Since the need for research and evaluation is recognized by most of those responsible for the Jamaican national family planning program, both program administrators and researchers should make particular efforts to improve the utilization of study results in program design. Researchers can encourage this by including discussion of action implications in research reports, by keeping program units most likely to be interested informed of research in progress, by circulating research and evaluation reports widely (or at least by making it known that such reports are

available),[1] and by accompanying research reports with program data which highlight the seriousness of the problem which the research has investigated. On the other hand, program administrators can take the initiative in keeping researchers informed about unanswered operational questions which might be amenable to research, in providing research access to program activities, and in letting researchers know which research findings have proved useful and which have not.

7.8 Research and Evaluation Capabilities: Findings and Recommendations

From the indicators which the evaluation team used and the evidence that it obtained, it concludes that the UWI provides a valuable research resource to the national family planning program. At the same time, UWI capabilities for research are presently limited by problems of insecure funding, inadequate physical and computer facilities, staff recruitment, and lack of close coordination with the action arms of the program. Members and staff of the NFPB, the MHEC, and other public and private organizations, including donor agencies, are advised to recognize both the strengths and the weaknesses of present UWI research capabilities, and to protect and nurture this developing resource for the program and the nation. This is particularly important given the expanding need for operational research in program problems and for testing experimental new approaches.

NFPB capabilities for program evaluation remain to be demonstrated. Although certain resources are available, their effective and efficient utilization will depend upon resolving a number of questions which have already been identified.

Although "Ministry Paper No. 1 - Family Planning" indicates that the NFPB is to have a continued role in research, it is not clear how the Board's research responsibilities will be discharged and by whom. This needs to be specified in cooperation with the MHEC and the UWI, as well as with other organizations engaged in family planning research efforts. The capacity of the Board itself to conduct or oversee research is questionable, for its staff has had little training in this area. The NFPB's ability to identify research needs and priorities, and to gain the cooperation of viable research units in meeting these priorities will depend both upon closer contact with the operating program and upon improved relationships with research personnel.

The MHEC, as yet, has not assumed responsibility for research and evaluation in family planning, except for isolated clinical and educational studies. With integration, the Ministry and its multiple operating units face new opportunities and challenges for integrating evaluation into all facets of program operation.

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1. At the September, 1973 m[illegible] [illegible]e Policy Coordinating Committee, Professor Roberts suggested [illegible] on the more recent studies undertaken should be compiled into a single, coherent document and circulated to the NFPB Training and Education Committee. This suggestion is one which the evaluation team supports.

The JFPA is currently engaged in small research efforts, but has not begun to realize its full potential for demonstrating and testing program approaches which could lead the way for program improvements in the public sector. The background and experience of the JFPA, as well as its established links with international family planning organizations, render it a valuable asset which should be encouraged and supported as a resource for field research.

8.0 Capability of the UWI as a Regional Population Center

Interest in the development of a Regional Population Center for the Caribbean at the Mona, Jamaica campus of the UWI has been expressed by certain Jamaicans, citizens of other islands, and representatives of external donor agencies for several years. Thus, for example, the US/AID Project Proposal for 1969 states:

> "By 1973 it is expected that a national or regional population center will be functioning to meet training and operational research needs of the Jamaican P-FP program and will be developing a capability to extend a similar function to serve the entire Caribbean by 1975 or 1976."

The Project Appraisal Report for the period December, 1969 through June, 1971 also recommended "the development of a viable national or regional Population/Family Planning Center to provide training, research, and consultation for operating programs." The interim Project Proposal submitted in July of 1973 again refers to this concept, foreseeing an interdisciplinary population/family planning center "first for Jamaica, later for the English-speaking Caribbean as a whole, under the aegis of the regional UWI."

At present, and perhaps appropriately, whatever progress occurs toward a regional center is gradual, ad hoc, and pragmatic, reflecting the diversity of family planning policies and activities among the 15 countries involved. The desirability of establishing such a center is by no means commonly accepted. Some question the viability of a regional concept in general, while others are concerned about the feasibility of the proposal as it relates to the future of the UWI, the resources available to the various islands of the Caribbean, and priorities for development. Still other reservations arise from varying perceptions of what the proposed center would do, as well as how it would be staffed and administered, and mechanisms through which it would function.

While the evaluation team cannot attempt to resolve these issues, it can perhaps assist in defining them by commenting on several indicators of regional capability.

8.1 Identification with the UWI, Jamaica as a Regional Center for the Caribbean

By its very name, the University of the West Indies embodies a regional concept. This is reflected in its structure, financing, staffing, and student body, for the UWI now has three campuses (located in Jamaica, Trinidad, and Barbados) and an extra-mural department in each of 14 territories. The UWI is financed from contributions by the island governments of the English-speaking Caribbean, and attracts students as well as staff from this entire area.

Nevertheless, the UWI is not the only University in the Caribbean, for Guyana established its own University a few years ago at which time it ceased to contribute to the UWI according to the old formula. Some feel that this trend will continue as the various islands try to strengthen their own institutions in the process of social and economic development.

In December, 1973, Nicol reported that another Center for Demographic research will probably soon materialize under Dr. Jack Henwood of Trinidad.[1] The team was also told by certain persons that Barbados would never accept Jamaica as a regional population center, and that the Eastern Caribbean in general would not recognize Jamaica as a regional resource.

Interest in developing national as opposed to regional centers is evident in Jamaica itself. Many persons from the NFPB, the MHEC, and other Jamaican institutions, as well as from the US/AID mission in Jamaica, repeatedly indicated that they saw the UWI's primary responsibilities resting at home. Although regional conferences held at the Mona Campus are well-covered in the press, the legitimacy of sponsoring these has been questioned in some circles and consultant trips of faculty members to other Caribbean islands are even less well understood.

A natural sub-division of the region is created by language, and thus the University of Puerto Rico serves much of the Spanish-speaking Caribbean. Faculty members from the University of Puerto Rico School of Public Health have, however, expressed interest in closer collaboration and exchange with the FP/Epidemiology Unit in the DSPM at the UWI. The University of Cuba also presumably is an important resource to the Spanish-speaking islands, although the team did not obtain much information about this. In addition, many Spanish-speaking islanders quite naturally look to the University resources of Mexico, Central America, and South America.

The extent to which Jamaica would be accepted as a regional family planning/population center therefore is uncertain. There is some indication that the English-speaking islands do now draw on UWI resources from the Mona Campus, but at the same time, the larger of these islands are trying to develop their own resources. Perhaps each of these governments could develop complementary institutions which would serve specialized regional needs, with Jamaica assuming responsibility for family planning/population. To some extent this is already happening in the training of health professionals and the provision of health back-up services through the encouragement and support of PAHO. Another alternative would be to establish the UWI campus in Jamaica as a regional nucleus for training, research, and service in family planning and population with coordinated and complementary activities on each of the other interested islands. A third approach would be to continue strengthening the family planning/population capabilities now in Jamaica with an increased response to requests for assistance from other islands. These alternatives, of course, are not mutually exclusive.

The possibilities of serving Spanish-speaking as well as English-speaking islands are more tenuous, but perhaps exchange between a strong English-speaking University Center and a strong Spanish-speaking one might be established to the benefit of both.

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1. Nicol, Marjorie, "Institutional Development Programs: Report on Site Visit to Jamaica," Population Council, Dec. 5-12, 1973.

8.2 Agreement on the Concept of a Regional Family Planning/ Population Center

Since formal proposals for the establishment of a regional family planning/population center have not yet been discussed by the various governments concerned or even by the various teaching and research personnel who potentially would be involved, there are rather different concepts about what the Center would be. Generally it seems to be understood that the concept would include training, research and evaluation, data processing, teaching, and consultation resources available to all islands in the region. Some individuals, however, envision a more limited scope, e.g., just data processing services or training.

The administrative base for the Center may also be variously conceptualized. Certain documents from US/AID suggest that the FP/ Epidemiology Unit could become the nucleus of a regional population center. More recently, the importance of a broader base has been recognized, including at a minimum the involvement of the Department of Social and Preventive Medicine, the Department of OB/GYN, and the Department of Sociology.

The scope of the proposed Center's expertise, however, is probably the most significant issue in defining the concept more precisely. Some support a family planning program thrust, others seem to picture primarily a demographic resource, and some advocate an expanded combination of both Nevertheless, the deepest split is between those who want to build a visible family planning/population resource and those who see this as only one component of a more comprehensive focus on social and economic development. The latter point of view can be sub-divided according to individual and organizational expertise for assisting development, e.g., those who see family planning as part of comprehensive health care and therefore a part of health services, and those who see it as part of strengthening the family unit and thus integral to social services and community development While these perspectives need not be incompatible, they heavily influence conceptions of which University resources should be involved in a regional center, as well as the functions such a center should have.

It is the opinion of the evaluation team that the extent of agreement on the regional concept cannot be determined until specific proposals are developed. While many people may generally support the development of a regional center, concrete support is not likely to be forthcoming until the nature of this center is more thoroughly explored. Conversely, a specific proposal may generate new sources of support from individuals and groups which to date have not been visibly interested in the center concept.

Reportedly, Mr. D. Roen Repp, Program Officer for UNICEF has developed some tentative guidelines for a Regional Caribbean Center at the UWI, and these guidelines are now ready for discussion. Although the evaluation team attempted to meet with Mr. Repp during the Jamaican segment of its work, scheduling conflicts did not make this possible. In addition, the US/AID Project Proposal dated December 15, 1969 outlines a plan for phased development of a national or regional population center, and many of the ideas contained therein still merit consideration.

8.3 Financial Support for the Regional Center

The financial feasibility of a Regional Population Center, of course, cannot be considered without taking into account the financial stability of the institution in which the Center would be located. As indicated earlier, (see p. 43) the UWI will not be able to assume even partial support for the FP/Epidemiology Unit during the coming triennium, and therefore its capability to support a regional population center must be questioned.

More seriously, a number of persons consulted by the evaluation team were pessimistic about the financial future of the UWI in general. Because of the economic hardships affecting all the Caribbean, as well as the desire of many of these islands to develop their own institutions, contributions to the UWI have decreased, and no further expansion is planned for the next three years. Reportedly some of the smaller islands have difficulty in paying their quotas, and even the GOJ faces severe limitations in providing financial support to the University as a regional institution. Efforts to convene the heads of contributing governments to discuss the future of the University have not, as yet, been successful.

Mr. Hemmerick, UNFPA representative in Kingston, indicates that the U.N. regards the UWI's potential as a population research center in regional terms and that increased regionalization of the University generally would enhance the prospect of further U.N. support. PAHO has already supported a number of regional projects with family planning implications, as has UNESCO. The IPPF sponsored a regional conference on the Mona campus in 1972, and as previously noted, US/AID has encouraged the development of regional capabilities within the UWI for a number of years. Ford and Pathfinder have both expressed interest in the possibility for regional training being developed in the Department of OB/GYN.

While a combination of assistance from international donor agencies might succeed in establishing a regional population center at the UWI, this is likely to depend upon the compatibility of the center's proposed functions as these relate to donor agency philosophies. Moreover, since institution-building is a long-range process, investments would need to be committed over a period of years, with gradual phasing-out coordinated with the UWI's changing capabilities for Caribbean support. This, of course, assumes commitment of the various regional governments to undertake increasing financial responsibility for the UWI, as well as the immunity of such commitment from political changes.

8.4 Present Resources for a Regional Center

The strengths and the limitations of the UWI in training and research related to family planning have been discussed in earlier sections of this report (see sections 1-7). In general, current limitations now affecting capabilities for contribution to the Jamaican family planning program would most likely be accentuated at the regional level, while present strengths can be interpreted as potential regional resources, although in so doing it must be recognized that certain current activities might suffer. The fate of the national training activities now provided by the FP/Epidemiology Unit is particularly of concern to Jamaican family planning program personnel and to US/AID representatives in Jamaica.

More specifically, faculty now associated with the UWI are recognized as highly capable. The capabilities of the Department of Sociology and the Bureau of Census Research in demographic and statistical analysis especially deserve mention. The evaluation team was told that no other Caribbean country has the interest or the expertise represented by Professor G. W. Roberts and his staff. The sophistication of studies and data analysis undertaken with Professor Roberts' direction have not only regional, but international respect, as evidenced recently by the remarks of Dr. Vera Rubin (Roberts research proposal). Although not as widely renowned, many other faculty, including those engaged in population/family planning teaching, research, and community service have earned and deserve academic praise.

Prior reports have made reference to the well-equipped and well staffed data computing center at the UWI, but further investigation is needed to determine whether these would be adequate for regional needs. Problems of long waits for computer time and recent power failures affecting data-processing capabilities would need to be overcome. If this can be done, the Mona campus could become an important computer service center, not only for the Caribbean, but possibly also for Central America

Physical facilities presently are not adequate to accommodate existing UWI teaching and research in family planning. Nevertheless, the new complex which is scheduled for completion in late 1974 could provide a home base for the proposed regional center, and with this possibility in mind, the new facility is designed for easy expansion.[2]

8.5 Current and Past Regional Activities in Population/Family Planning

The viability of the regional center concept is enhanced by the range of regional family planning/population activities already completed or in progress by UWI faculty. Professor Roberts, for example, is currently engaged in analysis of census data for the entire Caribbean. An inter-faculty committee of the University is, with assistance from UNICEF, the GOJ, and other sources, establishing a Regional Child Development Centre on the Mona campus. Three regional PAHO-sponsored conferences on health education, health administration, and health planning, each with family planning implications, were held at the UWI in Jamaica during the last year, and many of the resulting recommendations reflected a desire for closer regional ties. Dr. Karl Smith also consulted on behalf of the Canadian International Development Research Centre in September and November of 1973 for the purpose of mounting assessment and evaluation studies of the family planning programs in St. Lucia, St. Vincent, and Grenada. The Family Planning/Epidemiology Unit is currently proposing a Caribbean Seminar on Problems and Issues in Family Planning for Easter, 1975, and work toward that end is now in progress.

The evaluation team's strong impression from these activities, as well as from specific conversations with UWI faculty members, is that the

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1. See Report by Jean Morehead for the Pathfinder Fund, Dec., 1972.
2. For more details on this facility, see pp. 42.

teaching and research staff at the University now hold a regional view and feel a regional responsibility, as is indeed consistent with the underlying concept of the UWI.

In addition, personnel from the NFPB, the MHEC, the JFPA, and other Jamaican institutions as well as from the UWI, have participated in a variety of regional workshops and seminars directly or indirectly related to family planning. Examples of these include a Seminar on Population Policy jointly sponsored by the Association of Caribbean Universities and Research Institutes (UNICA) and the U.S. National Academy of Sciences in Montego Bay on August 19-25, 1973; two ILO-assisted seminars in Barbados for trade union members from at least 9 Caribbean islands, and an IDRC-supported Caribbean conference in which local personnel attempted to define the needs for research in the areas of demographic and population dynamics at the regional level. Many of the people who have participated in such conferences and workshops express the view that the development of a regional perspective is important and that Jamaica can learn from other islands, just as these islands may also be able to benefit from Jamaica's experiences.

8.6 Findings and Recommendations

Although the UWI has many strengths which potentially could contribute to a regional population center, a number of current limitations would have to be overcome in order to make such a center operational. These include principally problems of staff recruitment and computer facilities.

Beyond these practical matters, however, the extent to which the concept of a regional population/family planning center in Jamaica would be accepted by other Caribbean governments needs to be determined. This will require discussion of specific proposals, as well as their assessment in view of the total range of Caribbean developmental needs.

In addition, the future of the UWI as an institution must be better understood before a major regional center is located within it. Possibly regionalization is the best avenue for developing the strength of the University as a whole. On the other hand, growing nationalism, economic problems, and governmental difficulties in contributing to regional institutions may eventually result in the development of several national Universities.

In view of these considerations, the evaluation team recommends:

RECOMMENDATION: That the various donor agencies interested in the concept of a regional Family Planning Population Center recognize the Conference of Ministers of Health (of the Caracom Agreement) as the focal point for initiating activities leading toward this goal.

RECOMMENDATION: That the donor agencies interested in the concept of a regional family planning/population center sponsor in cooperation with representatives of the FP/Epidemiology Unit, the Department of Sociology, and the Department of OB/GYN a regional conference at the Mona campus, UWI, to explore further

with academic officials and faculty, heads of national family planning/population programs, and high-level government officials, interest in and the feasibility of such a center.

> The team further advises that the potential functions of a regional center be clearly defined and accepted by those who would be involved before questions of organization and structure are examined.

RECOMMENDATION: While exploration of a regional family planning/population center is in progress, external assistance to individual national population activities should continue. Projects funded through bilateral agreement should, insofar as possible, be given latitude to move in a regional direction. At the same time, a progressive shift from bilateral to multilateral assistance by international donors should be encouraged, with careful evaluation of projects with regional scope as indicators of the feasibility of regional cooperation.

VI. ROLE OF U.S. AND OTHER DONOR AGENCIES

Through agreement with the Government of Jamaica and/or other Jamaican institutions, the United States Agency for International Development and other donors have contributed to the Jamaican family planning program in many ways. US/AID has been the principal international contributor, averaging more than half a million dollars annually since assistance began in 1966. Since 1967, bilateral support has been channeled primarily through the National Family Planning Board, with increasing institutional support to the UWI since 1971.

AID's contributions have included equipment and supplies, technical advisory assistance, education and training, local support costs (including payment of salaries for limited periods of time), some construction, and "targets of opportunity." The Agency has also made grants to assist certain non-governmental groups representing local, private initiative in the development and demonstration of health and family planning services that have strengthened the overall national effort. In addition, since 1969, AID has made available the services of a Population Officer, who has worked closely with the NFPB and other Jamaican institutions, and who is currently housed at NFPB headquarters in Kingston.

During the early years of the program, other international donors were not prepared to offer substantial assistance, and the GOJ stated a preference to continue with its bilateral arrangement. In 1970, however, Jamaica accepted a $2,000,000 loan from the World Bank for the construction of a new wing of the Victoria Jubilee Hospital in Kingston, as well as for ten rural maternity centers to be built throughout the island. The Pathfinder Fund, the Ford Foundation, UNFPA, and other donor agencies have also provided project support, and the IPPF has contributed to the Jamaican Family Planning Association since it became an affiliate. The role of multilateral assistance is expected to assume increasing importance in advancing the national family planning program during the years ahead.

While the evaluation team concentrated on the content of the various bilateral agreements which have been the basis of U.S. assistance to Jamaica in the family planning field, it examined wherever possible the contributions of other donors as well. For a partial list of other donor inputs, see pp. 190-195.

1.0 Effectiveness of External Assistance

Although it is possible that the Government of Jamaica, without external assistance, might eventually have reached the present volume of program input, this would have entailed costly delay. Lost time due to such delay would be, in effect, irretrievable, for in the meantime the population base would increase and the problem would become more complex, requiring still greater program effort. Thus we believe that external contributions have unquestionably accelerated program progress and that Jamaica, alone, would not have achieved the present status of accomplishments.

At the same time, however, certain specific aspects of external assistance have not always realized their full potential, while certain others seem to have impeded rather than facilitated the achievement of program goals. In this regard, it should be noted that the commendable development of clinical resources outran sociological and psychological preparation of Jamaicans for family planning and that clinics have not been fully utilized. Perhaps this is because external assistance with equipment, commodities, and facilities is easier to agree upon and to justify than is assistance with the more complex and dynamic problems of human motivation and behavior. Stronger input by Jamaicans themselves, especially from representatives of lower economic classes would have made the program more one of local demand and would have further contributed to its growth and acceptance. This aspect should now be emphasized.

Parenthetically, the evaluation team wishes to acknowledge with praise the work of the AID Population Officer, Mr. Wilbur Wallace. Mr. Wallace and his predecessor, Mr. Alton Wilson, have been both diligent and sensitive in establishing an effective relationship with their Jamaican colleagues. They are both held in high regard among Jamaican officials, and the team, in its observations of Mr. Wallace in his day-to-day activities, feels that he reflects the highest tradition of U.S. foreign assistance.

In general, past assistance from external donors seems to have resulted in most satisfaction, both within Jamaica and within the funding agencies when:

1. There was general agreement, both within the host country and within the donor agency that a need existed and that it was a priority need.

2. Personnel within both the host country and the donor agency at both policy and operational levels utilized the same criteria or guidelines for determining how this need should be met. This apparently happened most frequently when:

   a. Expert technical advice or given commodities were needed rather than assistance with problem-analysis or problem-solving.

   b. There were few available alternatives for meeting the need (e.g., only a few techniques for tubal ligation existed or only a few brands of film projectors were available.)

   c. Accepted professional standards have been established (e.g., basic principles of good obstetrical care).

3. A single unit within the host country, with a clearly designated director, had responsibility for identifying and meeting the need and this director arranged for assistance with a single donor-agency representative who was entrusted with decision-making authority.

4. The results of assistance were readily and quickly visible (e.g., equipment was in place.)

Unfortunately, relatively few of the complicated problems associated with a national family planning program, as well as with the role of that program in social and economic development, meet the above criteria. Consequently, these problems have sometimes been neglected, or where they were not, they often have been analyzed and treated in a piecemeal fashion. Thus, ironically, the more complex and ill-defined the need, the more confusion and counter-productivity seem to have been associated with assistance efforts.

The division of responsibilities for assistance to the GOJ within US/AID, Washington, and between Washington and the U.S. Mission in Kingston, can lead to fragmented views of Jamaica's problems and priorities, resulting in scattered efforts and lost opportunities for furthering the Agency's overall assistance goals. For example, just before this evaluation team's arrival, an Educational Sector Analysis team was in Jamaica contacting various public and private institutions about their educational programs. Although this seemingly would have been an ideal opportunity for an in-depth analysis of current efforts and future potential for family planning and population education within the country, the efforts of the two teams were uncoordinated. In fact, only a chance remark led to this team's awareness of the other team's work. Questions subsequently raised by this team both in Washington and in Jamaica gave the impression that the Educational Sector Analysis Team had not been adequately briefed about the Jamaican family planning program, including its educational component, and that if it investigated this area at all, it did so only peripherally.

Inadequate coordination of assistance within US/AID is compounded by fragmented coordination among the various donor agencies contributing to the Jamaican family planning program. Coordination at present depends on periodic meetings of a "donors group" arranged by UNDP, the initiative of the US/AID Population Officer, the Executive Director of the NFPB, and a somewhat incomplete sharing of copies of projects and other relevant documents. There remains, nonetheless, heavy reliance upon informal contact between individual donor representatives. That these mechanisms are not always effective is illustrated, for example, by the fact that as of March, 1973, the Ford Foundation and the Pathfinder Fund did not have details of the programs each was supporting in female sterilization at the Department of OB/GYN at the UWI.[1]

The need for greater coordination among donor agencies has been recognized in previous reports concerning the Jamaican national family planning program. Thus in 1972, an IBRD evaluation team wrote that "considering the input of outside funding and the variety of international agencies concerned, it would be well if these agencies could get together as a group on some regular basis with the NFPB and the UWI."[2] Similarly, a study of the social welfare aspects of family planning in Jamaica for the UN states:

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1. Saxton, Nadene, Report of Visit to Jamaica, March 13-19, 1973.
2. Sodhy, Sirageldin, and Cernada, Jamaica National Family Planning Program: Report of First External Review, IBRD, July, 1972, p. 29.

"In order to maximize the value of external assistance, it would seem desirable for the various international agencies to collaborate among themselves, and together with local persons responsible for the various facets of the program, to examine the totality of program needs and the contribution that can most conveniently be made by each agency."[1]

The presence of many donor agency representatives on the scene--and even more behind the scenes--coupled with the inadequacy of coordination results in numerous problems. When these representatives, acting from their own individual assessment of the situation and their own views of what is needed next, all press for movement in different directions at the same time, frustration of host country personnel and fragmentation of both Jamaican and donor agency efforts inevitably occur. Moreover, the particular interests, policies, and restrictions of the funding agencies themselves sometimes seem to have greater influence upon the direction of assistance than do the needs and priorities existing in Jamaica.[2] As one informant noted, "This week we're expected to devote all our energies to research, but the following week we're told to concentrate on training." Because the importance of donor agency contributions is well appreciated, advice may be politely heeded and priorities dutifully shifted, but this impedes program progress as a whole and undermines the exercise of Jamaican leadership.

Changes in personnel within funding agencies further complicate this problem, as do the multitude of consultations commissioned by various donor agencies (See Appendix G for a partial list of consultants to the Jamaican family planning program in late 1973 and early 1974). Since these individuals tend to come from developed countries, they sometimes are unfamiliar with the dynamics of development and unprepared to function in the fluidity of situations in developing societies. When this occurs, they may endeavor to initiate and stabilize a change within the term of assignment, even though this time frame is too brief to accommodate the processes of lasting change. The study for the UN on the Social Welfare Aspects of Family Planning in Jamaica put it this way:

"The understandable anxiety of donor and lending agencies for quick results also influences the methods of approach used in programming. In programs such as family planning, which have a strong social component and are concerned with rural peasant communities, approaches adopted through an anxiety to produce quick results are often, in the long run, unproductive, and could be detrimental to the eventual success of the program." (p. 94)

Many other operational problems arise from the sheer numbers of donor agency personnel visiting Jamaica. The fact that Jamaica is a

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1. Social Welfare Aspects of Family Planning, Jamaica, West Indies.
2. Sodhy, Sirageldin, and Cernada, Jamaica National Family Planning Program: Report of First External Review, IBRD, July, 1972, p. 29. Social Welfare Aspects of Family Planning, Jamaica, West Indies.

delightful tourist mecca is perhaps not entirely coincidental. Since most donor representatives and consultants want to see Jamaican personnel with major program responsibilities, these key people must devote a large proportion of their time to such meetings, even though they are already spread too thin and there is a lack of sufficient back-up staff to continue work on projects needed to move the program ahead. Moreover, representatives and consultants from different donor agencies, sometimes arriving one right after the other, often seek very similar information. This happened in the Fall of 1973, for example, when an IBRD consultant on training was followed within a few days by a US/AID consultant on the same subject. Thus the Jamaicans concerned with training had to answer identical questions for different people within a very short time. This is not only a serious waste of scarce host-country manpower, but it also can be interpreted as excessive checking-up and lack of trust.

Many host country personnel said that they typically had no part in deciding what types of consultants would come or the areas that they would investigate. As a result, consultation is not always appropriate in terms of priority needs at the moment. Alternatively, the consultant's skills might be needed, but the timing at which they are made available is out of phase with the Jamaican situation. Thus host country personnel must stop concentrated work on one project to deal with another problem area. On exasperated Jamaican put it this way, "Why do we have to take vitamins when what we really need is a dose of castor oil?" Additional problems arise from the fact that Jamaicans whom external consultants are advised to see frequently receive little or no advance notice of the consultant's arrival or even of the purpose of his visit.

Still another consequence of failure to involve Jamaicans in planning for consultation visits is that the information sought by the consultant may not be readily available. Efforts to provide this information can--and have--diverted personnel from other tasks for days and sometimes weeks. Although the inaccessibility of requested data may be interpreted by the consultant as lack of management ability, sometimes this simply reflects the low priority of such data to accomplishing the job at hand. For example, a health educator would rarely keep track of the number of persons who had viewed a film any more than an obstetrician would count the number of patients on which he had used a speculum. The critical question in both cases is whether the tool, coupled with other activities, accomplished the desired results. Occasionally, some donor agency consultants, whether themselves untrained in a given specialty or whether attempting to follow guidelines prepared by someone else, have sought peripheral data from Jamaican personnel to the neglect of the more central issues. Another source of difficulty has been the demand for relevant information, but of such a sophisticated nature and in such formidable quantities, that the capacities of a developing country for data collection and analysis were insensitively overlooked.

The fate of consultant recommendations is another problem area. Frequently consultant reports are not circulated to the Jamaicans who provided the information on which they were based and who ultimately have the responsibility for shaping and implementing the program. As far as the team could ascertain, Dr. Palley's 1973 report, for example, had been seen by only three members of the NFPB and by no one in the Ministry of Health or at the University of the West Indies.

If consultant reports are seen by Jamaicans, there usually has been no provision for host country personnel to discuss them with the consultants who wrote them, and thus opportunities have been missed for clarifying recommendations, for verifying the observations on which they were based, or for jointly considering strategies for implementation. Sometimes this has led to misunderstanding and misinterpretation, as for example when statements were made without access to all of the facts or when donor agency jargon is not readily understood. The latter point is illustrated by the use of "IE & C", which implies that information, education, and communication can be easily separated. Regretably this erroneous assumption has been translated into less than efficient administrative structures and program approaches which might never have resulted if different terminology had been employed.

Follow-up of recommendations by donor agency representatives has also been less than systematic. Moreover, the recommendations contained in reports prepared by different consultants working for different agencies may actually conflict or work at cross purposes, e.g., in recommended priorities for action. As a consequence of these difficulties, some host country individuals may act on those recommendations with which they agree and ignore those with which they do not. There apparently is enough variety for almost everyone to continue "doing his own thing" with the blessing of at least one foreign consultant or donor agency representative. Whether or not this is actually true could not be verified by the evaluation team in the time available, for follow-up reports of actions taken on past recommendations were scarce, and the recommendations made by the wealth of prior consultants have never been consolidated into a single document.[1]

Needless to say, all of the foregoing problems dilute the reception each new consultant receives and reduce his effectiveness and potential contributions, as well as those of the agency which commissioned him.

2.0 IBRD (World Bank)

The IBRD makes long-term loans at low interest provides some technical assistance. Its current project designated "Loan # 690-JM", was conceived in 1969 and includes both construction and technical assistance elements. These will be evaluated separately.

2.1 Construction

The new wing of Victoria Jubilee Hospital, designed to double the hospital's bed capacity, was planned for occupancy by about September, 1973, but it is not yet completed. When finished, the new unit will provide additional facilities for normal births and lying-in, as well as additional beds for surgical patients requiring sterilization or abortion. Recent technical problems involving the building contractor have further delayed the construction of this sorely needed facility, for which the estimated completion date is now late 1974.

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1. A beginning attempt to remedy this latter problem is made in this repor

The basic premises of the original concept of this needed addition to the hospital are still valid, namely that VJH accounts for a large fraction of the total births in Jamaica and that postpartum family planning education and service enhances acceptance. Nevertheless, it is regretable that the building plans did not provide either for the out-patient clinics or for the operating-room facilities that are required if a maternity-based family planning program is to be comprehensive. Fortunately, the administration of the hospital has the ingenuity to adapt to these limitations, and the remodeling of operating-room space in the existing building is planned following completion of the new wing. In addition, a grant from US/AID has made possible remodeling of a building adjacent to the hospital to provide an out-patient family planning clinic. completion of which is anticipated before the end of this year.

Even with these additions, the advent of new techniques for out-patient sterilization and the expected classification of the abortion law will undoubtedly tax these facilities to their capacity very soon. Anticipating this need, Dr. Patterson, with the cooperation of Dr. Williams of VJH, is planning for several satellite centers in the Kingston area, where such surgical procedures can be provided.

Of the ten rural maternity centers under construction, three are now completed and two are in operation. As mentioned in connection with the VJH expansion, these are designed exclusively for maternity and family planning purposes. The team visited one of the new centers, located at Hopeton, accompanied by Mr. Cleveland Miller, FPEO of St. James Parish. The facility is attractive in appearance and well designed for the stated purpose. Unfortunately, however, in its present form it is limited to a relatively narrow band of the total MCH spectrum, namely better utilization of midwives for antepartum and delivery care and the opportunity for in-patient postpartum family planning education.

In the era of integrated services now dawning, it is strongly recommended that imaginative use of these centers well beyond their original purpose be considered. Each center should become the focal point for a strong preventive health care component, including well-child care and immunizations, education of out-patients and the neighboring population in mothercraft, nutrition and family planning, and community projects in environmental sanitation. Problem pregnancy counseling with referral for terminations where needed, recruitment of candidates for sterilization during periodic visits to the center by mobile sterilization "teams", and agriculture extension education utilizing adjacent empty land to augment nutrition work are among the numerous uses to which the centers may be put. Moreover, their immediate environs can become the models for a systematic approach to obstetrical "triage" in which local "nanas"[1] are enlisted for (a) training in simple hygienic techniques for home delivery of normal cases, and (b) screening and referral of high-risk mothers to the maternity center or nearest hospital for supervised or operative deliveries.

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1. See pp. for discussion of possibilities for working with the nanas.

It is recognized that these suggestions exceed the level of staffing or funding of the maternity centers as currently budgeted. Nevertheless, it is the opinion of the evaluation team that given the current commitment of the MHEC to expanded services in rural areas, the training of parish-level personnel at the auxiliary levels, and the integration of family planning into overall health services, the aforementioned suggestions are not unrealistic.

2.2 Technical Assistance

While the technical assistance inputs provided in the IBRD loan have been overshadowed by the more visible construction projects, their importance is nevertheless recognized. Specific training and operational research provisions have augmented those of the UWI's Family Planning Unit and the NFPB.[1] Several major decisions affecting the national family planning program have arisen out of recommendations made in the course of the annual independent IBRD evaluations provided under the terms of the loan, particularly those pertaining to training, integration of family planning into health services, and the role of the PMO: MCH/FP/Nutrition therein.

The current US/AID evaluation team notes, parenthetically, that many evaluation and consultation visits have been made to Jamaica, and while their value and importance are fully acknowledged by their Jamaican hosts, they inevitably involve some inconvenience and considerable expenditure of time and energy on the part of the visited. Accordingly, it is suggested that such evaluations be planned with Jamaican participation, more widely spaced than was ours and the current IBRD evaluation visit, and wherever possible consolidated for maximum efficiency.

2.3 Future IBRD Assistance Possibilities

According to World Bank representative, Mr. Peter Hall, the IBRD is interested in supporting projects "beyond family planning." In this regard, the Bank is currently exploring with Jamaica the possibility of assisting with a nutrition program. The evaluation team recognizes that this could be an important complement to the MHEC's intensified focus on comprehensive family health care, however, it will be critical to integrate planning for this project with overall Ministry planning in order to avoid fragmenting efforts and overtaxing available human resources.

The team also notes that the project proposal which led to the IBRD's current Jamaican investments outlined a number of benefits, both to the national family planning program and to general social-economic betterment, which should result from the expansion of maternal care facilities.[2] Evaluation of the extent to which the project actually

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1. A similar observation was made by Nadene Saxton of US/AID in her report of a visit to Jamaica, March 13-19, 1973
2. Appraisal of a Population Project: Jamaica, Report No. PP, 2a, International Bank for Reconstruction and Development: International Development Association, June, 1970.

contributes to these objectives would seem a logical extension of the Bank's assistance, and one which would help Jamaica in planning future strategies.

3.0 Pathfinder Fund

In keeping with the philosophy of the Pathfinder Fund, its activities in Jamaica have consisted of support for innovative approaches to family planning services and to small scale projects aimed at "targets of opportunity." Pathfinder's assistance has been directed to the NFPB, to the JFPA, and to the Department of OB/GYN of the UWI.

The culdoscopy sterilization project begun in September, 1972 has also been assisted by the Ford Foundation. Professor Wynter's published experience[1] with the technique has established the safety and feasibility of culdoscopic sterilization as an out-patient procedure. Technical assistance by the Pathfinder staff was especially important in the documentation of this study. Despite the addition of the culdoscopic approach, and the laparoscopic sterilizations performed by Dr. Hall, the UWI hospital continues to have a long waiting list. Additional equipment, the training of additional operators in both techniques, and the expansion of physical facilities for out-patient gynecological procedures are needed in order to meet this need. A new out-patient unit is now contemplated, in conjunction with a reproductive physiology unit, to be housed in the building soon to be constructed for the UWI Family Planning/Epidemiology and Post-Graduate Education units. At the time of this writing, the sources of funding for the two upper floors of the structure remain uncertain. The team agrees with UWI authorities that this planned construction will greatly enhance the capability of the UWI Hospital both in sterilization service and training functions.

The provision by Pathfinder of oral contraceptives and IUDs were ad hoc projects of a stop-gap nature. Aside from assuring supplies to continue needed field operations, they are difficult to evaluate. The introduction of the Dalkon Shield was consistent with the effort to revive flagging interest in intrauterine contraception. Dr. Patterson has been kept informed of subsequent disclosures of potential risks to Dalkon Shield wearers, and is prepared to act upon this information.

The provision by Pathfinder of vacuum aspirators and training consultants in uterine aspiration cannot be adequately evaluated until the abortion law is clarified. The equipment is in use and the physicians trained in out-patient abortion care will form the nucleus for the expansion of services expected following legislative action.

As important as these contributions have been, the evaluation team feels that the greatest potential for assistance by the Pathfinder Fund lies in the search for new motivational and educational approaches to family planning in Jamaica. The fact that the mobile unit (male motivators project of the JFPA) has not yielded significant increases in con-

1. W.I. Medical Journal, 1973, Vol. XXII, p. 107

tinuing contraceptive users does not negate the importance of testing untried new approaches to motivation under Jamaican field conditions. The evaluation team's criticism of these projects lies less with the measured output than with the incomplete evaluation of these experiments. We agree with the suggestion of J. Morehead of Pathfinder that technical assistance in the early stages of such projects should be provided in order to assure adequate evaluation.

The rural paramedical training project for which application was made to the Pathfinder Fund in early 1974 is another example o the type of activity uniquely suited to Pathfinder's style of assistance. Insofar as there is no firm assurance that indigenous midwives will respond to the proposed training by changes in practice favorable to family planning goals, such a project is unlikely to be supported by institutions unable or unwilling to take the risks inherent in untried approaches. Yet these "nanas" are everywhere acknowledged to be a critical influence on fertility behavior, and the experiment is in keeping with Pathfinder's traditional readiness to explore such untapped resources as these. Again, careful evaluation of the one-parish pilot project will be essential in order to assess the desirability of extending nana training islandwide.

Pathfinder has also expressed some interest in working with the Jamaican Federation of Women to help motivate family planning practice through broadly-based action on women's concerns. The Federation has a membership of some 6,000 women and local branches throughout the island. The organization is currently placing emphasis on economic betterment, i.e., teaching women to plant kitchen gardens and helping them to develop and market saleable items. Pathfinder has supported the involvement of women's leadership in other countries in family planning programs as these relate to general socio-economic development, and the potential for this would seem to be great in Jamaica. A beginning point would be a workshop with women's leaders to identify common interests, feasible activities, and ways in which these could be implemented. While the Jamaican Federation of Women should be centrally involved in such discussions, it will be important to include women leaders from other groups as well. Pathfinder's experience with the Asociación para el Estudio de Población in Colombia could be helpful in this regard.

4.0 IPPF

The International Planned Parenthood Federation has contributed to the Jamaican national family planning program primarily through assistance to its affiliate, the JFPA. Nevertheless, IPPF support to the JFPA was greatly reduced in 1974 (from $82,800 to $50,000). Since this amount constitutes nearly 40 percent of the total JFPA budget, the reduction resulted in a significant cutback in JFPA's planned program for the current year.

The team had only limited contact with IPPF before its evaluation visit. Therefore it is not possible to indicate the basis for the reduced level of support or the role of IPPF in JFPA's future funding picture. Clearly this affiliate is in a transitional position with the Jamaican government assuming increasing responsibility for provision of family planning services. Since this thrust makes it more difficult for the JFPA to raise funds through private Jamaican contributions, IPPF support

assumes greater importance. With a substantially reduced budget, keeping a core staff becomes a problem, and this in turn affects JFPA's capacity to carry forth on-going programs, to develop new plans, and even to prepare the uniform reports IPPF requires from all affiliates.

While the JFPA continues to perform a significant service function in its two clinics operated in conjunction with the NFPB, its most valuable future directions seem likely to be predominantly in the fields of training, education, and action research related to new motivational approaches. The team feels that a strong voluntary family planning association is needed to exercise leadership in these areas, and that this can complement government efforts.

In its transitional status, the JFPA can benefit greatly by access to IPPF's world-wide experience and resources in planning its future course. Assistance will be important both in reshaping the JFPA's general program directions as these relate to GOJ inputs and in developing such new pilot projects as male sterilization and expanded roles for women.

5.0 <u>Ford Foundation</u>

The Ford Foundation assisted the Jamaican family planning program with a research grant of $138,000 in 1964[1] and in the development of its statistical reporting system in 1968.

A study of fertility of women of childbearing age and women with completed fertility was carried out in 1971 with support from the Ford Foundation. The Department of Sociology of the UWI conducted the study and analysis, in conjunction with the NFPB and the JFPA. The project addressed issues raised by sociological interpretations of census and other demographic data. The resulting information (especially on the characteristics of fertile unions and knowledge and practice of contra ception) forms the basis for a follow-up study of biomedical and atti tudinal factors in fertility recently proposed to US/AID and provides valuable interim data for program planning.

The other major contribution by Ford Foundation has been the support in conjunction with the Pathfinder Fund of Professor Wynter's research in famale sterilization techniques. The results of his research in culdoscopic sterilization and the published papers emanating from his studies are referred to elsewhere in this report (see pp. 223). Of current importance is the fact that Professor Wynter has recently been confirmed as head of the OB/GYN Department of UWI, and that the prospect of an international training project in female sterilization is now under consideration in connection with completion of the new facility for the Family Planning/Epidemiology and Post-Graduate Education units on the Mona campus.

The extent to which Ford Foundation participation in the UWI program will continue is unknown at this time. It is reported, however

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1. US/AID Project Proposal, Jamaica, 1969.

that Ford enthusiastically supports the new building proposal, although it is not its policy to provide construction funds.[1] Nevertheless, Ford's interests in professional education and institution development could contribute significantly to this program. The evaluation team feels that continuity of the program is important, not only to the Jamaican family planning effort, but also to the eventual regional capability of the UWI as a research and training center for population related activities.

6.0 UNFPA

With the emergence of UNFPA as a major multinational resource in the population field, two new projects affecting Jamaica were funded in the past year.

6.1 A Grant of $569,000 to the UWI to Assist in Processing and Publishing the Data Obtained in the 1970 Caribbean Census (15 Countries)

Under the direction of Professor Roberts, this project utilizes the computer facilities provided earlier to UWI by CIDA, with subsequent assistance in demographic studies by the Ford Foundation. The first four volumes of data have been completed and are in print. Of major significance is the fact that this is the first such UN census project which calls for the work to be done locally. Mr. Hemmerick, UNFPA representative in Kingston, indicates that the UN regards the UWI's potential as a population research center in regional terms and that increased regionalization of the university generally would enhance the prospect of further UN support of this type.

6.2 A Workers Population Education Project, Approved in February, 1974 for three years ($237,000).

This project, organized and executed by the International Labor Organization in collaboration with the Trade Union Education Institute of the UWI, will reach the memberships of the three major trade unions of Jamaica, comprising some 250,000 workers. Accordingly, it has the potential to reach roughly half of the nation's families with family planning information provided in the context of education for total family well-being. Recruitment and training of project staff is now in process, and the initial courses for outreach workers were to begin in June, 1974.

6.3 Future Role of UNFPA

The UNFPA has the capacity to fill gaps in the totality of Jamaican external assistance needs occasioned by legislative, economic, or political limitations of bilateral donors. The provision of commodities such as depo-provera, or the supply of needed equipment and facilities for pregnancy termination represent such "targets of opportunity" which call for close collaboration among donor agencies. In addition,

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1. Saxton, Nadene, Report of a Visit to Jamaica, March 13-19, 1973.

projects having objectives shared by other UN or related agencies (PAHO, UNICEF, UNESCO, Caribbean Nutrition Institute) have resulted in expression of interest via the UNFPA in such activities as family life education in the schools, extension of the community health aide program, and education of indigenous midwives in Jamaica.

Finally, in keeping with the UN's interest in the development of UWI's capability as an international training center, the incorporation of a reproductive biology unit and a sterilization clinic into the new building to be constructed this year to house the Family Planning/Epidemiology and Post-Graduate Education units of the UWI has been suggested as a suitable project for UNFPA consideration. Comments on the collaborative relationships among donor agencies pertinent to these multidisciplinary activities have been made earlier in this section of the report (see pp. 63) and are reflected in the recommendations which follow.

Jamaican institutions are increasingly looking to UNFPA for assistance, and this donor's role in the national family planning program is expected to grow in importance.

7.0 PAHO

The Pan American Health Organization has played only a peripheral role in the Jamaican national family planning program during recent years. Its sponsorship of major regional health conferences has, however, contributed significantly to the development of regional interests and to analysis of needs which must be met if family planning is to be effectively integrated into comprehensive health care. A chance encounter at Victoria Jubilee Hospital by the evaluation team with a PAHO regional task force in MCH led by Miss Barbara Patterson also illustrates an increasing role of WHO in population-related activities.

With the integration of family planning and health services in Jamaica, PAHO's contributions may well assume even greater importance, especially through assistance in consultation and training for the development of organizational and human resources.

8.0 Other Donors

Other donors do not play major roles in the Jamaican family planning program, but make useful contributions in specific research, training, or development projects. The Population Council, for example, has assisted Jamaica with a postpartum research project and has the potential to assist the nation further in extending its postpartum program and in planning various kinds of related research. Reportedly some collaboration between a physician at VJH and the Population Council is currently under discussion

9.0 Conclusions and Recommendations

It is the evaluation team's impression that a wide range of freedom should be encouraged to permit access by Jamaican recipients to diverse sources of external support. The trend toward multilateral external assistance is particularly applicable in Jamaica, especially in view of its interdependence with its Caribbean neighbors. Technical

assistance from US/AID will continue to be important, however, and to shift too rapidly to other donor inputs could adversely affect the smooth development of a viable country program.

Closer coordination among donors is essential to avoid confusion and duplication of effort. In addition, closer collaboration among donors is obviously necessary in order that specific Jamaican needs may be "matched" appropriately with the unique resources or assistance philosophy of each donor agency. Moreover, the donor agencies themselves should model, insofar as possible, the type of cooperation and collaboration that they are trying to encourage in Jamaica. This needs to occur both within US/AID as well as among the US and other donor agencies, in Washington as well as in Jamaica.

Perhaps most important, however, is the need to shift major responsibility for coordination of external assistance in the direction of the host country. This is consistent with and essential to the aim of developing increasing capability among Jamaicans for planning, implementing, and evaluating their own family planning program. To continue providing extra-country support to the national family planning effort without greater participation of Jamaican leadership in determining the types of assistance needed and the ways in which it can best be provided would be to negate the substantial prior contributions donor agencies have made to building this capacity.

At the same time, it must be recognized that the coordination of external assistance to Jamaica is likely to be especially complex in the midst of the changes which are occurring with integration. Nevertheless these very changes make coordination all the more critical. Efforts to develop any single aspect of the program apart from a comprehensive understanding of overall program needs, strategies, and resources could be counter-productive. The highest priority for assistance therefore lies in helping Jamaica to develop coordinated operational planning, with specific activities supported only as these clearly will contribute to the overall program thrust. In making these judgments, the value of specific projects themselves is not the only issue, for each new activity will draw upon the leadership, time, energy, and other Jamaican resources available to advance the program - and development - as a whole.

Ministry Paper No. 1 - Family Planning, indicates that under integration the NFPB will, inter alia, be responsible for international matters and assistance. The Board's Executive Chairman interprets this to mean that the NFPB will, in effect, be the central secretariat and clearing house in dealing with international agencies, and that it will specifically coordinate requests for assistance from international organizations, arrange the programs of visiting donor agency representatives and consultants, prepare reports and briefs, and analyze all reports and recommendations, disseminating information about them as this has validity for the local situation. While the evaluation team agrees that the performance of such functions is essential, it feels that the Board's past performance of such activities is seriously lacking and questions whether it will now have adequate staff and operational program contact to discharge these obligations at the level required.

The mechanisms for improving the coordination of international assistance to Jamaica should be clarified as quickly as possible to assure that those who need it know where to seek it, and that the timing and design of projects approved are compatible with program priorities. In addition, when a project is funded, the donor agency responsible should make every effort to assure that adequate technical assistance and follow-up are provided to promote project success. Feedback from donor agencies on the reasons for delaying or disapproving project requests would also be helpful to Jamaicans in developing future plans, while such discussion could assist both Jamaican leaders and donor agency representatives to gain broadened understandings of short and long-range program needs.

Finally, caution must be advised regarding the expectation that as a precondition for funding, the GOJ evidence growing capability by assuming a progressively increasing share of costs over the life of a given project. Jamaica, along with other developing countries, is profoundly affected by the financial crisis occasioned by world-wide inflation and such critical events as the recent oil embargo. Accordingly, the rapid expansion of health/family planning resources anticipated in the matching requirements of bilateral agreements must of necessity be tempered by the realities of budget constraints and reordered local priorities for the immediate future. It would be unrealistic, and untrue, to regard the present inability of the GOJ to make increasing commitments for matching funds as indicating a lessening of the national will to curb population growth.

The difficult financial circumstances of the present must be taken into account in the review of on-going projects in addition to circulation of new ones. The team feels strongly that given the present enthusiasm and support of Jamaican leaders and the impetus given to the program by its integration into the health delivery system, a continued high level of external assistance at this time is essential if the momentum currently reached by the program is to be fully realized.

Within the context of the preceding discussion, the evaluation team makes the following recommendations:

> RECOMMENDATION: Priority should be given to strengthening capabilities within Jamaica for coordinating external donor agency assistance according to the needs and priorities of the Jamaican national family planning program as this relates to the total effort for social and economic development.
>
> > This will require the development of a comprehensive and widely accepted operational program plan, as well as a coordinating body which is intimately familiar with the plan (including changes which may be made in it due to program experience). The coordinating body must also be truly representative of the institutions, both public and private, which have a role in the plan's development, implementation, and on-going evaluation.
>
> RECOMMENDATION: The provision of donor agency assistance to the Jamaican family planning program should, insofar as possible, depend upon requests originated in Jamaica by Jamaicans and

endorsement of these requests by the above coordinating mechanism.

(The need for monitoring and accounting procedures originating within the donor agency as a required part of bilateral agreements is acknowledged.)

RECOMMENDATION: In examining requests for assistance, donor agencies should consider the need for phased change and be prepared to work on small projects which may lay the groundwork for more ambitious future endeavors.

RECOMMENDATION: At the time a project is funded, the donor agency should clearly designate to the Jamaican institutions responsible, the nature of the data which will be utilized in project evaluation and should assist with the establishment of workable mechanisms for the collection of such data where this must be conducted during the project period.

RECOMMENDATION: Provisions for technical assistance and backstopping, especially during the initial phases of new projects should be assured in the terms of project agreements.

RECOMMENDATION: US/AID/w personnel responsible for assistance to Jamaica should consider how internal coordination of Agency assistance efforts could be enhanced, e.g., through improved routing of documents and/or regular meetings for the purposes of exchanging perspectives on assistance priorities, programs and proposals.

RECOMMENDATION: US/AID/POP personnel responsible for assistance to the Jamaican national family planning program should take the initiative in exploring with representatives of other donor agencies how coordination among these agencies could be improved.

RECOMMENDATION: Donor agencies sending representatives and consultants to Jamaica should brief them thoroughly on the range of external assistance efforts as these relate to a holistic view of Jamaica's problems and priorities, as well as to the representatives' and consultants' particular assignments. The purposes and requirements of consultation should be clear on all sides.

VII. PROJECT INPUTS

1.0 Brief Background

On October 10, 1963, the United States Government and the Government of Jamaica signed a treaty providing for Jamaica to receive U.S. technical assistance. In each of the fiscal years since 1966, US/AID has made technical and commodity assistance available to the GOJ for its national family planning program. Beginning in 1968, US/AID also began to support overseas training and various local projects in program development, including education, training, research, and evaluation.

As of 1969, the program was being coordinated with capital assistance to the GOJ from the International Bank for Reconstruction and Development. Gradually assistance from other international donors was added, and today there are a number of such donors who have contributed and who are contributing to the family planning effort in Jamaica.

During this time, the GOJ has annually increased its voted expenditure for family planning, even though serious budgetary and balance of payment difficulties have created heavy financial demands which necessitated reduction in most governmental budgets.

2.0 Summary of GOJ and US/AID Project Inputs, 1968-1974[1]

Time Period (April 1 - March 31)	GOJ Voted Expenditures	US/AID Funding	Total	Cumulative Total
1968-1969	J$ 304,162	US$ 25,344	$ 329,506	$ 329,506
1969-1970	437,950	93,064	531,014	860,520
1970-1971	577,059*	132,753	709,812	1,570,332
1971-1972	871,901	142,270	1,014,171	2,584,503
1972-1973	1,110,300	202,500	1,312,800	3,849,308
1973-1974	1,342,000	516,600	1,858,600	5,755,908

3.0 Details of GOJ, US/AID, and Other Donor Inputs

The following pages provide details of inputs to the Jamaican family planning program from US/AID, the GOJ, and Other Donors. It must be emphasized that this list is incomplete. Information is not readily available on activities funded by US/AID outside of bilateral agreements. No master list of other donor projects exists. The financial value of family planning contributions by Jamaican agencies over and above government allocations has not been assessed.

The information contained on the following pages may also reflect minor inaccuracies, for it has been constructed from a variety of sources.

1. Source: National Family Planning Board
Pro-Ag 71-5 states budget request for JFY 70-71 was $864,000 and $674,000 was voted.

PROJECT INPUTS

U.S. Resources

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Personnel			
Technical consultation by a specialist in family life education on a short-term, intermittent basis	68-5		
Specialist in health education to advise and assist GOJ in family planning programs.	69-1	July 10, 1968 - June 30, 1969	$ 15,400
Short-term advisory services to help with expanded educational program under direction and supervision BHE	69-1	As of April 1, 1969	15,000
Two cytology assistants to GOJ Bacteriology Laboratory for training and service	69-1 (REv 1.)	May 14, 1969 - June 30, 1970	9,444
Contract services to evaluate the postpartum educational program at Victoria Jubilee	69-1 (Rev. 2)	June 30, 1969 - Dec. 31, 1970	7,000
Employment of 4 FPEOs and 1 statistical clerk/admin. asst. for postpartum program; consultant U.S. Bureau of the Census	69-1 (rev. 3)	April 29, 1970 - June 30, 1972	32,500
Extension on cytology consultant contract	70-5	June 16, 1970 - Dec. 31, 1971	11,000
Establish 2 academic positions in DSPM, UWI (health educator and social worker or sociologist), and to employ teaching staff as needed for training programs (e.g., 1 [illegible]	71-2	Sept. 1970 - March 31, 1974	80,000

Category and Purpose	Pro-Ag	Time Period Covered	Costs
<u>Personnel (Continued)</u>			
Contract services to UWI financed directly rather than through U.S. University	71-2 (Rev. 1)	Nov. 1970 - March 31, 1974	$ 88,240*
To establish revolving fund for DSPM, UWI to facilitate payment of personnel.	71-2 (Rev. 2)	March 17, 1971 -March 31, 1974	10,000
US/AID to provide consultants from International Demographic Statistical Center, U.S. Bureau of Census re: analysis of clinical data on acceptance of family planning by VJ patients.	71-5	May 6, 1971 - Dec. 31, 1972	_____
Contract consultant firm to assist NFPB in development of training team and training of 28 assistant family planning education officers	71-5 (Rev. 1)	June 29, 1971 - Dec. 31, 1972**	28,000
Consultant services to assist in team training capability in three phases: a) national level management training team b) expansion of team concept to regional FPOs and Parish family planning personnel. c) rotating regional seminars by (a) and (b) above.	72-3	May 17, 1972 -Dec. 31, 1973	20,000
To continue salaries of local faculty at UWI for up to three years, beginning Oct. 1, 1972	72-5	May 31, 1972 - Sept. 30, 1975	225,000

* later reduced as per Pro-Ag 71-2, Rev. 3
** Pro-Ag 71-5, Rev. 3 extends final contribution date to June 30, 1975

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Personnel (Continued)			
Westinghouse will assist GOJ in exploring possibility of commericial distribution of contraceptives.	73-2	Jan. 23, 1973 - Dec. 31, 1974	$ ——
Personal Services contract (short-term consultation) to assess training requirements and plans for training activities.	73-2 (Rev 1)	Feb. 23, 1973 - Dec. 31, 1974	14,300
Technical consultation on oral contraceptives.	73-2 (Rev. 4)	Jan. 23. 1973 - Dec. 31, 1974	21,000*

* Paid for by release from allocation for orals "now supplied in kind."

Category and Purpose	Pro-Ag	Time Period Covered	Costs
<u>Commodities</u>			
Educational commodity support to Bureau of Health Education, e.g., projectors, films, teaching aids, and help in defraying costs of producing local materials.	69-1 (Rev. 2)	June 30, 1969 - Dec. 31, 1970	$ 55,000
Equipment, instruments, and supplies (including contraceptives) for family planning clinics and cytology laboratory.	69-1 (Rev. 2)	June 30, 1969 - Dec. 31, 1970	$110,000
Purchase 2 vans for transportation of medical students from Cornell University and UWI working to improve community health services in St. Elizabeth's Parish.	70-2	Sept. 3, 1969 - Sept. 30, 1970	7,000
U.S. procurement of educational materials and equipment to support extension of educational services at the parish level and the development of family life education materials for use in teaching.	70-5	June 16, 1970 - Dec. 31, 1971	35,000
Local development of family life education materials, including a teachers' workshop for this purpose.	70-5	June 16, 1970 - Dec. 31, 1971	J$ 10,000
Equipment, instruments, and supplies for clinics	70-5	June 16, 1970 to Dec. 31, 1971	127,000*
Equipment and supplies for health card project to speed up clinic record keeping and to provide greater accuracy in processing service statistics	70-5	June 16, 1970 to Dec. 31, 1971	17,000

* Later reduced to $114,000

Category and Purpose	Pro-Ag	Time Period Covered	Costs
<u>Commodities (Continued)</u>			
Deobligates funds for commodities not utilized within 6 months	70-5 (Rev 1)	Dec. 17, 1970	$ - 70,000
Clinic equipment, instruments, and supplies, including contraceptives, and to initiate health card project programmed in FY 1970 but not implemented.	71-5	May 6, 1971 - Dec. 31, 1972	125,000*
Educational materials and equipment	71-5	May 6, 1971 - Dec 31, 1972**	25,000
Clinic commodities, including contraceptives, equipment, and supplies.	72-3	May 17, 1972 - Dec. 31, 1973	112,000
Management subsystems hardware (microfilming equipment, etc.)	72-3	May 17, 1972 - Dec. 31, 1973	8,000
Additional audio-visual and educational materials	72-3	May 17, 1972 - Dec. 31, 1973	25,000
Research commodities for UWI (procured through U.S. channels)	72-5	May 31, 1972 - Dept. 30, 1975	40,000
"Urgently needed commodities" in further support of Pro-Ag 72-3	73-2	Jan. 23, 1973 - Dec. 31, 1974	110,000
Teaching equipment	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	14,000
Teaching materials (films, audio-visuals)	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	8,000

* Pro-Ag 71-5, Rev. 2, Sept. 15, 1971 cancelled 400,000 cycles Ovral.
** Pro-Ag 71-5, Rev. 3, Dec. 29, 1972 extends final contribution date to June 30, 1975

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Commodities (Continued)			
Forms for tabulation and analysis of birth and death statistics.	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	$ 5,000
Contraceptive materials and clinic supplies.	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	90,000
Laparoscope and other equipment, contraceptive materials.	73-2 (Rev. 2)	Jan. 23, 1974 - Dec. 31, 1974	45,000
Oral contraceptives	73-2 (Rev. 4)	Jan. 23, 1974 - Dec. 31, 1974	71,500 "in kind"
PROPOSAL PENDING: Commercial Distribution of Contraceptives (Westingthouse)			1,300,000 (pending)

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Training			
Meetings and seminars for groups such as physicians and sex education personnel where these have particular and important relevance to US/AID supported family planning endeavors.	69-1 (Rev. 2)	June 30, 1969 - Dec. 31, 1970	$ 5,000
Participant training abroad for 35 persons (2-4 weeks each), including: Regional Family Planning Officers; Clinic medical officers; Senior nurses and nurses assigned to family planning clinics; Education officers of NFPB and other agencies; Communications and audio-visual personnel; Statistical and administrative personnel.	70-5	June 16, 1970 - Dec. 31, 1971	25,000
18 month contract with U.S. University for resident consultant, short-term adivosry services, U.S. training of UWI faculty, limited equipment and materials for teaching	71-2	Sept. 1970 - March 31, 1974	115,000*
Participant training for 28 Assistant Family Planning Education Officers, 2 phases of 5 weeks each, plus 10 days of pre-training activity.	71-2 (Rev. 1)	Sept., 1970 - March 31, 1974	12,000**

* Pro-Ag 71-2 (Rev. 3) reduces contract services item to ammount actually utilized for Contract AID/la-668.

** Pro-Ag 71-2 (Rev. 3) eliminates participant training item as no PIO/Ps were written within the 12 month waiver period.

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Training (Continued)			
Supplement to FY 1970 provision for workshops, etc.	71-5	May 6, 1971 - Dec. 31, 1972*	$ 5,000
Overseas training for participants (FY 1970 participants not processed until March and April, 1971, thus reducing sum needed for FY 1971).	71-5	May 6, 1971 - Dec. 31, 1972*	15,000
To extend Univ. of Pittsburgh contract with UWI for 1 year plus (subject to availability of funds) participant training grants for Jamaicans serving the unit.	72-2	May 12, 1972 - Dec. 31, 1973	90,000**
Overseas training for physicians, nurses, educational officers, statistical personnel, and others	72-3	May 17, 1972 - Dec. 31, 1973	35,000
Foreign currency costs of short courses in management for middle-level NFPB personnel.	72-3	May 17, 1972 - Dec. 31, 1973	5,000
Domestic travel for UWI faculty involved in training	72-5	May 31, 1972 - Sept. 30, 1975	5,000
Miscellaneous local support costs for UWI, including costs of community centered training programs, regional centers, and workshops.	72-5	May 31, 1972 - Sept. 30, 1975	20,000
Participant training, "team training" for national and parish personnel.	72-5	May 31, 1972 - Sept. 30, 1975	25,000

* Pro-Ag 71-5, Rev. 3, Dec. 29, 1972 extends final contribution date to June 30, 1975.
** U. of Pittsburgh contract terminated Oct. 31, 1972, and this sum therefore subsequently reduced.

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Training (Continued)			
Island-wide training in tubal ligation, overseas training in conjunction with Johns Hopkins and 2 other medical schools.	73-2	Jan. 23, 1973 - Dec. 31, 1974	$ ____(AID/W)
Overseas training for family planning leadership personnel.	73-2 (Rev, 1)	Feb. 23, 1973 - Dec. 31, 1973	30,000
Organizational development and leadership training to be provided through renewal of NTL contract for 18 months period.	73-2 (Rev, 1)	Feb. 23, 1973 - Dec. 31, 1974	42,700
Training social welfare workers for family planning.	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	6,000*
Establish model training clinics at a) VJ Hospital b) Other KSAC location c) Rural areas Primary purpose training of trainers.	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	50,000

* From FY 1973 funds.

Category and Purpose	Pro-Ag	Time Period Covered	Costs
<u>Other Costs</u>			
To assist the NFPB in development of a two-year postpartum program in St. James Parish, including costs of constructing a model low cost pre-fab family planning clinic adjacent to the maternity ward of the St. James Hospital.	70-5	June 16, 1970 - Dec. 31, 1971	J$ 10,000
To assist in paying for rental space, incremental salaries of staff, and other costs of a series of training courses for clinic staff, family planning home visitors, education officers, and key personnel in other health and related services, government agencies, and private organizations.	70-5	June 16, 1970 - Dec. 31, 1971	US$ 35,000
To assist in initiating operational research and program evaluation, including short-term consultation as requested on data processing and program design, or other aspects of internal communication involving service statistics, study of clinic performance.	70-5	June 16, 1970 - Dec. 31, 1971	40,000
To reduce "other costs" because of a post date (after 12/31/71) expenditure.	70-5 (Rev. 2)	Feb. 22, 1972	-44,600
To assist with the construction, furnishing, and equipping of Salvation Army facility.	70-6	June 16, 1970 - June 30, 1971	25,100

Category and Purpose	Pro-Ag	Time Period Covered	Costs
Other Costs (Continued)			
Other costs, including local salaries for research assistant and typist/clerk, 18 months each, UWI.	71-2 (Rev. 1)	Nov. 1970 - March 31, 1974	$ 94,760
Personnel and other costs for Family Counselling Center.	71-4	June 29, 1971 - Sept. 30, 1973	36,800
To follow two studies in progress at UWI and to support other priority studies from an array of research needs identified by UWI and NFPB.	71-5	May, 1971 - Dec. 31, 1972*	30,000
To provide local currency to assist NFPB in initiating intensive home visiting with emphasis on education and motivation in eastern and western KSAC.	71-5 (Rev. 1)	June 29, 1971 - Dec. 31, 1972*	35,000
Local production of audio-visual materials.	72-3	May 17, 1972 - Dec. 31, 1973	5,000
To add funds to the $70,000 still available from Pro-Ag 71-5 allocation for clinical research on Copper T and Dalkon shield compared to other devices.	72-3	May 17, 1972 - Dec. 31, 1973	15,000
To support DSPM faculty in research and operational studies relevant to needs of NFPB, including major KAP study and special studies to assist NFPB to make operational changes.	72-5	May 31, 1972 - Sept. 30, 1975	30,000
UWI overhead.	72-5	May 31, 1972 - Sept. 30, 1975	26,000

* Pro-Ag 71-5, Rev. 3, Dec. 29, 1972 extends final contribution date to June 30, 1975.

Category and Purpose	Pro-Ag	Time Period Covered	Costs
<u>Other Costs (Continued)</u>			
UWI rental of space, utilities, minimum operating costs, and expendable supplies.	72-5	May 31, 1972 - Sept. 30, 1975	$ 30,000
Tabulation and analysis of birth and death statistics.	73-2 (Rev. 1)	Feb. 23, 1973 - Dec. 31, 1974	20,000*
Film: Problems of Induced Abortion.	73-2 (Rev. 2)	Jan. 23, 1973 - Dec. 31, 1974	9,600
Continue funds for Family Counselling Center	73-2 (Rev. 2)	Jan. 23, 1973 - Dec. 31, 1974	25,400
UWI Building Project (Add-on)	73-2 (Rev. 5)	June 27, 1973 - June 30, 1975	
a) architect, other and survey			10,267 } 99,500
b) construction			82,139 }
c) air conditioning			7,094 }
Renovation of building across the street from VJH for family planning clinic.			50,000

* From FY 1972 funds.

GOJ Resources

Category and Purpose	Pro-Ag	Time Period Covered	Contribution
Personnel		1966 - 1974 (JFY)	$1,157,000
NFPB will continue to employ 10 staff members assigned to the BHE, MOH	69-1 70-5	July 10, 1968 - June 30, 1969 June 16, 1970 - Dec. 31, 1971	
NFPB will provide 1 additional staff member for training unit	70-5	June 16, 1970- Dec. 31, 1971	
UWI, if need to and/or want to continue the program of the DSPM will try to provide necessary financing to continue a) two academic positions b) meet other costs of expanded program	71-2	Sept. 70 - March 31, 1974	
Commodities		1966 - 1974 (JFY)	1,090,000
GOJ to finance commodity needs for cytology lab after June 30, 1969	69-1 (rev. 2)	July 10, 1968 - June 30, 1969	
Training			
Participants		1966-1974 (JFY)	149,000
GOJ generally to organize and finance small meetings and seminars of groups working on both clinical and educational aspects of family planning.	69-1 (rev. 1)	July 10, 1968 - June 30, 1969	
Any costs beyond US/AID $50,000 for establishing model training facilities.	73-2	Jan. 23, 1973 - Dec. 31, 1974	

GOJ Resources (Continued)

Category and Purpose	Pro-Ag	Time Period Covered	Contribution
Other Costs		1966 - 1974 (JFY)	$1,020,000
UWI to provide necessary supporting facilities, including office and classroom space for FP/Epidemiolcgy Unit, DSPM	71-2	September, 1970 - March 31, 1974	
UWI to provide support facilities such as office and classroom space for DSPM	72-2	May 12, 1972 - Dec. 31, 1973	
GOJ to provide local transportation for the resident consultant (Univ. of Pittsburgh) and short-term contract staff	72-2	May 12, 1972 - Dec. 31, 1973	
Total			$3,376,000

1. Source: US/AID Interim PROP, January 18, 1974

PROJECT INPUTS

Other Donors

Donor	Project and Recipient	Time Period Covered	Contribution
American Home Economics Association	Consultants on the Development of Home Economics/FP Activities		
Association for Voluntary Sterilization	Provide laparascopic sterilization training for approximately 10 physicians, and equip six FP and/or maternity clinics to perform laparascopies on an out-patient basis. AVS Sub-Grant #032-032-1 to the NFPB.	March 21, 1974 - March 20, 1975	$ 29,900
British High Commission	60,000 units of Depo-provera to NFPB		
Ford Foundation	Research grant	1964	$ 138,000
	Assisted NFPB Set up system of reporting and recording clinic visits of new and continued acceptors	1968	
	Mating and Fertility Study. To Professor G. W. Roberts, Dept. of Sociology, UWI.	1971 -	
	Research in Culdoscopic ligation. To Dept. of OB/GYN, UWI		
	International training in culdoscopic ligation. To Dept. of OB/GYN, UWI.	January, 1974 -	
	Martha Stuart Communications		

Donor	Project and Recipient	Time Period Covered	Contribution
International Bank for Reconstruction and Development	Addition to Victoria Jubilee Hospital and Construction of 10 rural maternity centers		$2,000,000 loan
	Consultant in Training	Fall, 1973	
	Annual external review of the national family planning program	July, 1972 -	
International Association of Schools of Social Work	Assistance in the development of a pilot project for the preparation of professional and voluntary social welfare personnel for wider responsibilities in population and family planning. To DSPm and Social Welfare Section of Extra Mural Dept., UWI		
International Development Research Center, Ottowa, Canada	Family Planning and Population Bibliography for the Caribbean, to FP/Epidemiology Unit, DSPM, UWI	January, 1974 -	Can $11,200

Donor	Project and Recipient	Time Period Covered	Contribution
International Planned Parenthood Federation	To JFPA	1960	$ 2,000
	To JFPA	1961	50
	To JFPA	1962	1,000
	To JFPA	1963	4,394
	To JFPA	1964	1,000
	To JFPA	1965	11,000
	To JFPA	1966	13,728
	To JFPA	1967	25,824
	To JFPA	1968	125,000
	To JFPA	1969	75,000
	To JFPA	1970	79,999
	To JFPA	1971	84,460
	To JFPA	1972	138,748
	To JFPA	1973	82,800
	To JFPA for Model Clinic, St. Ann's Bay	1974	50,000
	Sponsorship of Caribbean Conference on Implications of the Curative and Preventive Aspects of Family Planning	Dec. 15-16, 1972	
	To NFPB via JFPA, 10,000 units of depo-provera	1973	
Pathfinder Fund	Two consultants for training in use of Vacuum Aspirators in hospitals. To Dr. Patterson, NFPB		U.S. $ 3,038
	Equipment and materials for above project (4 vacuum aspirators)		2,196
	Contribution of 50,000 cycles of Ovral Contraceptives to NFPB		9,000
	Contribution of 1,000 Dalkon Shields for research project. To Dr. Hugh Wynter, Dept. of OB/GYN, UWI		1,500

Donor	Project and Recipient	Time Period Covered	Contribution
Pathfinder Fund (Continued)	Female sterilization project to Dr. Hugh Wynter, Dept. of OB/GYN, UWI. (Budgetary support and funding for remodeling sterilization clinic.)	18 months	
	Participation in Second Annual International Conference on Voluntary Sterilization, Geneva, Switzerland, to Dr. Hugh Wynter, Dept. of OB/GYN, UWI.		$ 1,200
	Mobile Unit/Male Motivators' Project, JFPA	August 1, 1973 - July 31, 1974	20,000
	PROPOSAL PENDING: Training programs for Nanas (untrained midwives), to NFPB	July 1, 1974 - June 30, 1975 (Pending)	10,515
	PROPOSAL PENDING: Jamaica Federation of Women's Conference on Family Planning.		2,500
Pan American Health Organization	Study on feasibility of providing health information to parents of children waiting for treatment at GOJ Children's Hospital		
	Various regional conferences with implications for family planning as part of comprehensive health care.		
Population Council	Postpartum program at VJH	1966 - ?	
Public Welfare Foundation	To JFPA	FY 1968 FY 1969	5,416 8,400

Donor	Project and Recipient	Time Period Covered	Contribution
Salvation Army	Construction of Salvation Army Facility Land Furnishings Equipment	1970	J $ 70,000 8,000 6,000 18,000 J $ 102,000
Smithsonian Institute	Study of Unilateral Contraceptive Decision-making among Women Clients of the JFPA. To Dr. Eugene Brody, Dept. of Psychiatry, University of Maryland PROPOSAL PENDING: Research on Women's Roles, Child Health, and Fertility in Jamaica. To Ms. Ida Daum, U.S. Citizen		5,000
Society for Health Education, London	Assistance with Study of Family Planning Clinic Drop-Outs	1969-1970	Support for Mr. Michael Bracken
Syntex Pharmaceuticals	To JFPA	FY 1968 FY 1969 FY 1972	3,600 3,600 3,600
Transnational Family Research Institute	Study of Perceptions and Attitudes of Health Workers Related to Abortion. To Dr. Karl Smith, FP/Epidemiology Unit, DSPM, UWI	May 21 - December 31, 1973	10,951
United Nations UNDP	Co-sponsorship of Family Life Education Workshop, United Theological College of the West Indies	July 19-31, 1971	

Donor	Project and Recipient	Time Period Covered	Contribution
United Nations UNFPA	Census Research Program for 15 Caribbean Countries, to Professor G. W. Roberts, Dept. of Sociology and Census Research Bureau, UWI.		$ 569,830
	ILO - Family Life/Population Education Project. To Trade Union Education Institute, UWI		250,000
	Fellowship in Statistical Analysis		2,200
	Three fellowships to be granted through the Ministry of Education for training in family life education.	1971	
UNFPA (and UNESCO)	Co-sponsorship of Workshop in Education for Family Living, held at the Trade Union Education Institute, UWI	July 17-29, 1972	
UNICEF	Action/Research Project on Needs of Young Children in the Caribbean		
World Assembly of Youth	Sponsored seminars in family life education with Jamaica Youth Council and the BAE.		
World Education	Workshop in preparation of family life education materials for low-level adult readers.	July, 1973	

APPENDIX A

LIST OF RESOURCE PERSONS CONTACTED

A. Resource Persons Consulted in Oakland, California, March 13, 1974

Mayhew Derryberry, Ph.D., Chief of Health Education, United States Public Health Service (Retired) and Previous Consultant to the Jamaican national family planning program.

Ann Wilson Haynes, Chief, Bureau of Health Education, California State Department of Public Health (Retired) and Previous Consultant to the Jamican National family planning program.

Mary Jo Kraft, US/AID (Retired) and Previous Consultatnt to the Jamaican National family planning program.

Malcolm Merrill, M.D., Director, International Division of the American Public Health Association.

B. Persons Participating in US/AID Briefing in Washington, D.C., March 17-18, 1974

Charles Johnson, Chief US/AID
Nadene Saxton, US/AID
Bill Lefis US/AID Evaluation
Robert Huddleston, US/AID, Desk Officer, Jamaica
Norma Parker, US/AID, Latin American Bureau
John Peabody, US/AID
Vernon Scott, US/AID
Alton Wilson, US/AID
Malcolm Merril, M.D., American Public Health Association
Howard Hough, AMerican Public Health Association
Representatives from:
- International Bank for Reconstruction and Development
- International Planned Parenthood Association (telephone contact)
- Pan American Health Organization
- Pathfinder Fund
- Martha Stuart Communications
- Westinghouse (telephone contact)

C. Persons Contacted in Jamaica (By Agency)

1. Ministry of Health and Environmental Control (MHEC)

Name	Position
Hon. Dr. Kenneth A. McNeill, MB, BS, FRCS, FRSC	Minister, MHEC
Dr. Browne	Senior Medical Officer:Hospitals
Dr. Mavis Gilmour	Parliamentary Secretary (resigned)
Mr. Terrence Goldson	Personnel Officer
Mrs. L. Hunter-Scott	Principal Nursing Officer (PNO)
Mrs. Daphne Kelley	Communications Officer

Ministry of Health and Environmental Control (Continued)

Mrs. Manahan	Assistant
Dr. A. Wynante Patterson	PMO: FP/Nutrition/MCH
Mr. Billy Powell	Permanent Secretary
Mr. R.A. Ramcharan	Assistant Under-Secretary
Mrs. Carmen Stewart	Chief, Bureau of Health Education
Dr. Verley	PMO: Hospitals
Dr. Wallace	PMO: Public Health
Dr. Wilson	Chief Medical Officer (CMO)
Dr. Lester Woolery	Procurement Officer

2. National Family Planning Board (NFPB)

Mr. Conroy H. Allison	Chairman and Executive Director
Dr. A. Wynante Patterson	Vice-Chairman and Medical Director
Mr. H.E.B. Jones	Businessman
Rev. Gilbert McKenzie	Minister of Religion, the United Church of Jamaica and Grand Cayman
Mrs. Angela Melhado	Social Worker, Volunteer
Miss Flo O'Connor	Public Relations, Communications and Media
Mr. R.A. Ramcharan	Assistant Under-Secretary, MHEC
Prof. George Roberts	Demographer, Head of Dept. of Sociology, UWI
Dr. Leslie L. Williams	Senior Medical Officer, Victoria Jubilee Hospital

3. National Family Planning Board Staff

Mr. Conroy H. Allison	Chairman and Executive Director
Dr. A. Wynante Patterson	Vice-Chairman and Medical Director
Mr. Eric Owen	Secretary
Miss Felicity Aymer	Assistant Training Officer
Mrs. Sylvia Goldson	Statistician and Demographer, Statistical Unit
Miss Joyce Harris, S.R.N.	Supervisor of Clinics
Mrs. Ena Neita, PHN, SCM	Assistant Supervisor of Clinics
Miss Hyacinth Stewart, SRN	Training Officer (formerly Assistant Supervisor of Clinics)
Miss Thelma Thomas	Director, IE&C

4. Victoria Jubilee Hospital

Dr. Leslie L. Williams	Senior Medical Officer
Nurse Nora Mann	In-Service Education Officer
Sister Denise Kelly	Sister-Tutor
Matron C.V. Phillips	Matron

5. University of the West Indies

Ms. Suzette Benn	Research Fellow, DSPM
Mrs. Sybil Frances	Social Worker, Social Welfare Unit, Extra Mural Dept.
Dr. Hugh MacKenzie	Pediatrician
Ms. Julie McFarlane	Program Administrator, DSPM (now Assistant to Professor Wynter, Dept. of OB/GYN)
Mrs. Ivy McGhie, M.P.H.	Health Education Specialist, DSPM
Dr. Phyllis McPherson	Senior Research Fellow, Institute of Education
Prof. George W. Roberts	Demographer; Head, Dept. of Sociology; Head, Census Research Bureau
M. Ragbeer, MBBS, MRCP	Dean, Faculty of Medicine

University of West Indies (continued)

Mrs. Sonja Sinclair S.R.N., M.Sc. Hygiene	Dept. of Sociology
Karl A. Smith, M.B., Ch.B., Dr.P.H.	Director, FP/Epidemiology Unit, DSPM
Kenneth L. Standard, M.D., M.B., M.H.P., F.F.C.M., F.R.S.H.	Director, DSPM
Miss Jean Tulloch-Reid	Health Education Specialist, Social Welfare Unit, Extra Mural Dept.
Ms. Robin Whittlesee	Frederickson Fellow, DSPM
Hugh Wynter, M.B., B.C., M.B.B.S., F.I.C.S., M.R.C.O.G., F.A.C.O.G., F.A.C.S.	Professor and Chairman, Dept. of OB/GYN

6. Ministry of Education (MOE)

Mrs. Trixie Grant-Sommerville	Guidance Officer

7. National Planning Agency

Ms. Pearl Gammon	Social Planner
Ms. Megan McLaughlin	Social Planner
Mrs. Lorna Murray	Social Planner, Demography
Ms. Marjorie Samot	Social Planner
Prof. Michael G. Smith	Advisor to GOJ, University of London

8. Montego Bay, St. James Parish

Dr. A.J. D'Souza	Parish MO(H)
Mr. Cleveland Miller	Family Planning Education Officer
Miss Beverly Morris	Community Health Aide

9. Morant Bay, St. Thomas Parish

Dr. Peat	Parish MO(H)
Mr. M.F. Berry	Family Planning Education Officer

10. Port Antonio, Portland Parish

Miss McCreath	PHN
Mr. Ralph Falloon	Family Planning Education Officer

11. Jamaica Family Planning Association

Dr. Lenworth Jacobs	President
Mrs. Hyacinth Bridgemahon	Administrative Aide
Mrs. Mavis Brown, S.R.N.	Program Coordinator
Mr. Kenneth Byfield	Interviewer for Brody Project
Mrs. Carmen Drysdale	Special Project Evaluation
Miss Foster	
Mrs. Howell	

Jamaica Family Planning Association (continued)

Mrs. Patsey Nesbitt	Research and Evaluation
Nurse V. Wallace	
Mrs. Eileen Ward	Board Member

12. St. Ann's Parish

Dr. Wilson	Supertintendent, St. Ann's Bay Hospital

13. US/AID

Mr. Wilbur Wallace	US/AID Population Officer, Jamaica
Mr. Charles Campbell	US/AID Affairs Officer, Jamaica
Mr. Robert Huddleston	US/AID/w Desk Officer for Jamaica
Mr. Charles Johnson	Chief, US/AID/POP/LA

14. Others

Mr. Harry F. Hemmerick	UNDP Representative
Fr. Arthur W. Kane	Family Counseling Center
Mr. Manning Lerner	National Training Laboratories (NTL)
Dr. James Burrowes	Private practitioner, OB/GYN
Dr. Joyce Tate	Private practitioner, Federation of Women's Clubs
Miss Barbara Patterson	International Confederation of Midwives
Miss Kate Lorig	International Confederation of Midwives

D. Attempted Contacts with Persons Not Available at Time of Team Visit

Mr. Barber	Ministry of Finance
Dr. Gladstone Bonnick	Head, National Planning Agency
Mr. Coore	Ministry of Finance
Mr. Diggery	PAHO Representative
Mrs. Lenworth Jacobs	JFPA
Mrs. Monroe	Head of Postpartum Clinic, Victoria Jubilee Hospital
Dr. Christine Moody	Parish MO(H), Portland Parish
Mr. Basil Morgan	Assistant to the Chairman, NFPB (resigned)
Mr. Albert Mowatt	Permanent Secretary, MHEC (resigned)
Prof. Rex Nettleford	Extra Mural Department, UWI
Mrs. June Rattray	Assistant Director of IE & C, NFPB
Mr. Roen Repp	UNICEF Representative
Ms. Pat Salmon	Training Officer, NFPB (resigned)
Mr. Shields	UNDP Representative
Mrs. Norma Crighton Soas	NFPB, Public Relations Officer
Dr. C.J. Stratmann	JFPA (resigned)

APPENDIX B

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Duty Statements of Various Staff Positions (only one dated)
- Administrative Officer
- Board Secretary
- Senior Administrative Assistant
- Executive Officer: Stores and Supplies
- Accountants Grades I and II
- Statistics Division:
  - Statistician
  - Senior Statistical Officer
  - Statistical Officer, Grade I
- Training Officer
- Trainers within the NFPB's Training Office
- Public Relations Officer, July 5, 1971
- Supervisor of Clinics
- Chief Communications Media Officer
- Family Planning Education Officer
- Assistant Family Planning Education Officer
- Parish Clinic Nurse
- Clinic Nurse

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Part I, Karl A. Smith, MB, Ch.B., Dr.P.H.
Part II, Ivy McGhie, Health Education Specialist
Part III, Julie McFarlane, Program Administrator
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APPENDIX C

PROPOSED FUNCTIONS OF THE DEPARTMENT OF SOCIAL AND PREVENTIVE MEDICINE, UWI, TO SUPPORT THE NATIONAL FAMILY PLANNING PROGRAM, March, 1972[1]

1. To carry out research according to priority needs identified jointly with the NFPB,

2. To identify program areas requiring research on an on-going basis,

3. To provide consultation to other groups engaged in research on behalf of the NFPB,

4. To help the NFPB establish procedures for evaluating the family planning program,

5. To keep an up-to-date record on all studies that have been conducted or are being planned which are relevant to the family planning program in Jamaica,

6. To help the NFPB identify training needs and set priorities,

7. To assess previous training and identify other training needs of specific categories of family planning workers,

8. To organize and conduct weekend seminars, one-day institutes, etc., for physicians in government service and/or private practice,

9. To develop training materials which can be used for various levels of training such as case studies, programmed workbooks, transparencies, etc.

10. To develop and offer courses in family planning open to all students of the UWI either as part of another Department's program or within the DSPM,

11. To develop in collaboration with the Education Department a course in family life education for teachers, youth leaders, religious leaders, etc.

12. To provide consultation to agencies and organizations which provide or plan to offer training in family planning to their employees,

13. To develop and conduct interdisciplinary training programs for the various categories of family planning staff,

14. To undertake long-term training programs for key personnel for the family planning movement,

15. To develop a model Family Planning Clinic within the Department in which innovative approaches in service, education and evaluation could be tested and which could serve also as a field experience center for family planning trainees.

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APPENDIX D

FUNCTIONS IN WHICH THE NATIONAL FAMILY PLANNING BOARD DESIRED ASSISTANCE FROM THE DEPARTMENT OF SOCIAL AND PREVENTIVE MEDICINE, UNIVERSITY OF THE WEST INDIES, October, 1972

Education and Training

1. Continue to take responsibility for education and training in family planning for medical students and post-graduate medical personnel, including pre-clinical and clinical students and candidates in the Diploma Programme.

2. Take initiative to assure maximum participation in family planning activities by other Departments of the Medical Faculty on a coordinated basis.

3. Continue to take responsibility for education and training in family planning for nursing and midwifery students in the University Hospital and for the students in the Advanced Nursing Programme of DSPM.

4. Take initiative in encouraging and aiding the incorporation of family planning content in the curriculum of other Departments and Schools of the University beginning with the School of Education, the Department of Social Work and the Extra Mural Department.

5. Upon request, continue to provide consultation and/or participation in family planning training conducted by NFPB and other community agencies and groups.

6. Develop and conduct summer courses on the various components of family planning.

7. Organize and supervise appropriate field experiences in family planning for students from overseas who request firsthand knowledge of the Jamaican programme.

8. Assume responsibility for the Team Building Programme at Parish level.

Research and Evaluation

1. Determine best methods of training family planning personnel for motivational work.

2. Evaluate the degree to which the goals of education and training programmes for various categories of personnel are achieved.

3. Undertake other research as agreed upon with the National Family Planning Board.

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1. Kraft, Mary Jo, "The Jamaican Family Planning Programme: Role of Department of Social and Preventive Medicine, University of the West Indies," Consultant's Report, October 2-November 9, 1972.

Consultation

1. Assist in working out a strategy to involve and prepare personnel of government agencies for participation in the family planning movement.

2. Assist in the design of a comprehensive family planning training plan.

Materials

1. Develop, test, produce, and evaluate teaching materials and aids used in the family planning training activities of DSPM.

2. Provide consultation to other agencies and groups on the selection and/or preparation and on the use of teaching materials and aids in family planning training.

APPENDIX E

PARTIAL LIST OF WORKSHOPS, SEMINARS, AND OTHER TRAINING ACTIVITIES IN FAMILY LIFE EDUCATION

July 31, 1969 — One-day Seminar for principals and teachers from eight KSAC Secondary Schools. Sponsored by the BHE, NFPB, and MOE.

1969 — Visits by 3-person panel representing the Ministry of Education, the Bureau of Health Education, and a Secondary School Principal to eight secondary schools for the purposes of helping teachers understand and explore ways of initiating family life education programs.

1969 — Symposium on the structure of the Jamaican family held at St. Hugh's High School. About 20 teachers from three KSAC schools attended.

Feb. 20, 1970 — Conference conducted jointly by the Ministry of Education and the Bureau of Health Education to:

a) exchange experiences in current problems and programs related to education for family living in teacher training colleges,
b) consider objectives of programs in family life education for teacher training colleges,
c) explore ways of improving teacher preparation in family life education,
d) consider ways in which teacher training colleges can contribute to community-wide programs in education for family living.

Six of the seven teacher training colleges were represented. The tentative syllabus for teacher training institutions prepared by the Ministry of Education's Working Committee was reviewed and the need for a manual to accompany the syllabus outline was expressed. The conference also pointed out the need for an intensified in-service education program for teaching personnel in teacher training colleges, as well as further development of pre-service education of teachers for their responsibilities in family life education.

Feb. 27, 1970 — A two-parish conference (Manchester and Clarendon) was held at May Pen under the sponsorship of the Ministry of Education working in cooperation with the BHE, the NFPB, and the Ministry of Youth and Community Development. Heads and selected teachers of Secondary and Junior High schools of the two parishes attended, as well as health personnel, probation and child guidance officers, and representatives of other community agencies. Planning committees were formed in these parishes to develop appropriate programs. Though not focused on teacher training, this conference and its follow-through has had many implications for teacher training.

May, 1970	Program of ten sessions for 162 first and second year students at Bethlehem Teacher Training College, Malvern. Plans made for second year students to include family life education as a subject area during their four weeks for practice teaching in both primary and junior secondary schools, beginning January 18, 1971.
Nov. 1970	Seminar held by the Ministry of Education, assisted by BHE, for 55 teachers from 14 schools and the Bethlehem Teacher Training College. Purpose was to prepare the schools by orienting their staff to receive the second-year students doing practice teaching. As a follow-up, sessions were planned with teachers of the feeder schools to help them carry on the program after the departure of the student teachers, as well as to carry on parent education.
Oct.-Nov. 1970	A certification course on Education for Family Living was held in Portland for teachers and community leaders.
Nov. 25-26, 1970	Conference on Family Planning in Social Welfare at the Social Welfare Centre. The Education for Family Living program was also presented for study to the Methodist Education Committee.
Nov. 28, 1970	The Senior Education Officer, Ministry of Education and two Bureau of Health Education representatives met with the Institute Board of Teachers Training to present a case for the inclusion of Family Life Education in the curriculum of teacher training colleges.
Dec. 3, 1970	A meeting was convened in St. Ann's Bay to discuss the programs for Moneague Training College to start in January, 1971.
Dec. 1970	Conference with Education Officers of the Ministry of Education.
Jan. 11-14, 1971	Seminar on Youth and Family Life, Jamaica Youth Council
Jan. 26, 1971	The Methodist pre-synod Education Committee discussed the Church leaders' role in Education for Family Living.
Jan.-Mar. 1971	Eight week course on Education for Family Living at Moneague Teacher Training College. Organized at the request of the principal and planned with the assistance of BHE and parish FPEO.
Jan.-Mar. 1971	A series of one-day seminars in Family Life Education given by Guidance Officer, MOE, for Primary and Junior Secondary school teachers in selected areas: Chapelton (Clarendon) Old Harbour (St. Catherine), Jan. 28, 1971 Highgate (St. Mary), Feb. 19, 1971 Balaclava (St. Elizabeth)

Feb. 1971	Conference with the Peace Corps Volunteers who work in the Guidance program of the Ministry of Education
Feb. 26, 1971	Mother and Child Care Centre opened by the NFPB and Portland Public Health Department in Port Antonio
Mar. 2, 1971	Visit with Mr. Menon, UNDP. Support promised by him for summer workshop and training of personnel.
April, 1971	Mr. J. Slack and Mrs. J. Rowe seconded to do preparatory work for summer workshop.
April 18-24, 1971	Caribbean Regional Seminar on Youth and Family Life Education at the Social Action Centre
May 18, 1971	Discussion with York Castle staff on Education for Family Living program for the school.
May 19, 1971	Discussion with Mr. Sealey and Mrs. B. Gloudon on possibilities of utilizing Children's Own and News for Education for Family Life series.
July 19-31, 1971	Workshop in which participants prepared guidelines for Education in Human Sexuality and Education for Responsible Parenthood.
July 17-29, 1972	Two workshops, run simultaneously, designed primarily to train participants in the preparation of teaching units and aids to be used respectively in schools and with adults of low level reading ability. Directed by the Ministry of Education with the assistance of the Bureau of Health Education, the schools program was funded by UNESCO through UNFPA. Other sponsoring agencies included the UWI, the BHE, and the NFPB. Both workshops were held on the UWI campus, using the facilities of the Social Welfare Training Centre and the Trade Union Education Institute. Seventeen participants represented training colleges, grammar, technical and secondary schools and all-age schools, as well as the BHE, the NFPB, and the firm of Johnson and Johnson.[1]
1972	A one-week program, consisting of an exhibition, film shows, lectures and panel discussions was arranged at the office of the Bureau of Health Education during Home and Family Week. Special groups invited to this were teachers and students of independent schools, basic school teachers, school nurses and parents. These activities were also open to the public.

1. Report on Workshop in Education for Family Living, held at the Trade Union Education Institute, UWI, Mona, Jamaica, July 17-29, 1972.

1972	A two-day Family Life Education exhibition was set at the St. Luke's Church Hall by the BHE in collaboration with the Jamaica Council of Churches. In addition to the Exhibit, films were shown and special literature distributed. Teachers and students from Grant-Aided and Independent Secondary schools attended.
Nov. 1973	PAHO-sponsored Caribbean Workshop in Health Education, in which one full day was spent examining and developing feasible ways to incorporate and/or extend school health education, including family life education as part of the school curriculum in the 17 countries represented.
Mar. 21, 1974	NTL-assisted workshop in St. Mary's to initiate community curriculum development in a pilot 3-stage model.

APPENDIX F

PARTIAL LISTING OF SPECIFIC RESEARCH AND EVALUATION NEEDS IDENTIFIED AND PROGRESS TO DATE

1.0 Operational Studies Required to Guide Administrative Management and to Improve Service Operations

The 1969 US/AID Project Proposal pointed out the need for "continuing evaluation of administrative procedures to assure the most efficient delivery system possible at the losest possible cost," and therefore stated that AID would assist in evaluating clinic operations, in improving the quality and scope of the educational effort by the NFPB, and in conducting a baseline study of knowledge, attitudes, and practices. The IBRD Population Project Appraisal Report (June 2, 1970) which led to the loan for expanding Victoria Jubilee Hospital and constructing 10 rural maternity centers also stressed the need for careful examination of the services provided, as well as of the factors encouraging or inhibiting people from using these services.

The IBRD appraisal identified the need for two specific studies related to the improvement of clinic operations: a study of optimum scheduling arrangements for the family planning clinics and staff serving the metropolitan Kingston area, and a job-study to look for ways of making the best use of highly trained doctors and nurses. This report included draft terms of reference for these studies and indicated that the Ministry of Health would assume responsibility for them, and that they hopefully would be conducted by a faculty member at the Mona campus, UWI. It also noted that US/AID had expressed interest in financing these studies.

1.1 Evaluation of Standards for Clinic Facilities, Staffing, and Clinic Operations

Project Agreement 70-5 specifies that in 1970 the NFPB will evaluate standards for clinic facilities, staffing, and clinic operations, and that a systematic, scheduled effort to bring all clinics up to minimum standards would be undertaken. Similarly, Pro-Ag 71-5 indicates that among the studies the NFPB proposed to initiate during the next 12 months was an in-depth analysis of selected clinics to observe clinic performance regarding the nature and quality of service and community socio-economic variables.

According to Kraft's consultant report for the period October 2-November 9, 1972, at the request of the NFPB two operational studies had been completed under Dr. Karl Smith, DSPM, UWI, which focused on family planning clinic operations, staff utilization, staff training, and patient counselling. The titles of these studies were not given, but Kraft probably was referring to the following:

Smith, Karl A., "Study of the Operations of the Kingston and St. Andrew Family Planning Centre," 1970.

———, A study based on 107 interviews with staff in a 25% sample of clinic locations, conducted in 1971.

Whether or not the results of these studies were actually used in reviewing and improving clinic standards was unclear to the evaluation team. While Dr. Smith reported that the findings had "been ground back into the program," Jamaicans involved in service delivery did not mention their influence, and representatives of two donor agencies in Washington, D.C. said that they had never heard how these studies were used.

This area of evaluation and research is considered of continuing importance by the evaluation team. Possibly assistance and support for qualitative studies of clinics might be obtained from the IBRD which reportedly is interested in this field.

1.2 Study of Job Functions in the Family Planning Program

A. Clinic Personnel

Project Agreement 70-5 indicates that a study of job functions (i.e., tasks performed by family planning clinic personnel and other health workers) would be initiated in 1970 in order to provide administrative guidance in job assignments, training, and supervision.

Pro-Ag 71-5 states that an operational study on the job functions of clinic personnel was being conducted under Karl Smith of the DSPM, UWI, in cooperative agreement with the NFPB, and apparently this was one of the studies which Kraft reported had been completed by the DSPM by the time of her visit in Fall, 1972. Again, however, whether the findings were utilized as intended by the NFPB was unclear from the information available to the evaluation team.

B. Community Health Aides

Currently Cornell University is conducting a study of the functions of Community Health Aides and their impact upon improving nutritional status and family planning practice among residents of St. James and Hanover parishes. A preliminary report makes a number of recommendations regarding the recruitment of CHAs and their work in the community.

C. Male Motivators and Encouragement Visitors

In conjunction with its Pathfinder-supported Mobile Clinic project in St. Ann's parish, the JFPA is collecting some data on the functions of its male motivators. Apparently, however, this will be limited to information about the numbers of contacts these personnel make with males and females, and thus the project does not promise to reveal how the performance of male motivators or their training might be improved. Unfortunately, the same limitation characterized efforts to evaluate the JFPA's Encouragement Visitor program.

D. Social Workers

Following a two-day conference on Family Planning and Social Welfare in 1970, the Jamaican Association of Social Workers also did a small study on the role of social workers in family planning and found that most were on the periphery of the NFPB's program. As a result, the Association, working from a strong interdisciplinary orientation, developed a plan for integrating family planning into the numerous Jamaican agencies where social workers are employed.

The Social Welfare Unit of the Extra Mural Department at the UWI also conducted a study for the Social Welfare Commission of the United Nations on the role of Social Welfare in Family Planning in Jamaica. This was one of ten country studies. A second meeting to examine the resulting reports and to make recommendations was scheduled for April 16, 1974.

E. Comment

Since the job functions of many personnel in the MHEC, including those who were formerly employed by the NFPB, are expected to change as a result of integration, new studies in this area could be very helpful in determining staffing patterns, training priorities, and supervisory needs. In addition, studies of the job functions of personnel working in other public and private agencies, such as the survey conducted by the Jamaican Association of Social Workers, could be strategic in expanding the involvement of these institutions in the national family planning program.

Jamaica's experimentation with the use of paramedical personnel to deliver MCH and family planning services should continue to be evaluated. Results, including those from the proposed training program for granny midwives, could prove valuable not only to Jamaica, but also to other countries.

1.3 Study of Utilization of Clinic Facilities and Services

Project Agreement 70-5 indicates that in 1970 research would be initiated on the utilization of clinic facilities and services in order to define expectations of both clinic staff and clients. The objective of the proposed study was to develop more effective and efficient clinic services under conditions most acceptable to the public. According to Pro-Ag 71-5, such an operational study on clinic utilization was being carried out under Karl Smith in cooperative agreement with the NFPB. Perhaps this was a part of the two studies on family planning clinic operations, staff utilization, staff training, and patient counselling which Kraft (Oct.-Nov., 1972) reported had been completed by the time of her visit.

Project Agreement 73-2 calls for assessment of clinic performance in terms of percentage of the target population served. This is currently being undertaken by Professor Roberts in conjunction with his up-dating of Jamaican vital demographic data (see pp.236 37).

The nationwide sample of fertile couples interviewed in connection with the Westinghouse Population Center's study of the feasibility of commercial distribution of contraceptives in Jamaica also provides some data on variables related to clinic utilization.

Continuing need for the study of clinic attendance and associated factors is reflected in the first external review of the Jamaican Family Planning Program.[1] This report recognized the need for local studies of

1. Sodhy, et al., Report of First External Review: Jamaica National Family Planning Program, IBRD, July, 1972.

inconvenience and dissatisfaction with service and particularly recommended ad hoc surveys of non-acceptors to find out why some clinics are underutilized, as well as some experimentation in Kingston and in at least one large rural area where integrated services would be combined with encouragement-visitor-type work and the involvement of local private doctors.

Now that the integration of family planning and health services has occurred island-wide, research on utilization of clinic services would be especially timely. Presumably, integration will result in increased acceptance of family planning because this service may now be obtained in conjunction with other services and because clinic attendance may now be attributed to multiple reasons, thus protecting the privacy of the patient who seeks family planning assistance. These assumptions need to be tested through research. In addition, increased understanding of client expectations and attitudes as these relate to service utilization is needed in order to continually adapt the program to better serve target population.

1.4 Evaluation of the Postpartum Program

Victoria Jubilee Hospital was one of the original participants in the Population Council's world-wide postpartum demonstration project initiated in 1966. Data collected in connection with this demonstration are available through the Population Council.

In connection with the expansion of the postpartum program at VJH and to other hospitals throughout Jamaica, US/AID Pro-Ag 69-1 provided for an evaluation study to be completed by June 30, 1969 which would include data on the number and percentage of hospital patients who visit family planning clinics, information on the motivation of postpartum clinic attenders, and information on objections to family planning of study patients who failed to visit clinics. Although this target data apparently was not met, Dr. Lee Husting, resident consultant to the DSPM, UWI from the University of Pittsburg, completed an analysis of the postpartum program during his stay in Jamaica in 1971-72 which provided information on these questions. This is supplemented by the Report for the Year 1972, prepared by Mrs. June C. Rattray, FPEO at VJH.

With the imminent completion of the new wing at Victoria Jubilee and the 10 rural maternity centers which are intended to make family planning education and services more available to postpartum patients, as well as the extension of the postpartum program to other hospitals in Jamaica, continued evaluation of this approach is needed in order to determine its impact on family planning acceptance and continued use, as well as ways in which the postpartum program may be improved.

1.5 Studies of Family Planning Acceptors

Project Agreement 70-5 states that US/AID and the GOJ will continue to consult on research projects, such as a proposal to conduct a three-year cohort study of 3,000 family planning acceptors. Who initiated this proposal and its outcome are unknown to the evaluation team, although the December, 1970 issue of Family Planning News reports that under the direction of Professor Roberts, the JFPB assisted the NFPB in a survey of at least 3,000 women patients in family planning clinics throughout the island.

In addition, an exploration of the social needs of 140 family planning clients was undertaken by the Family Counselling Center in August, 1972. Focus of this study was upon problems currently experienced in a variety of social, economic, educational, and relationship areas, together with identification of prior service-seeking patterns and outcomes. Findings revealed that over 85 percent of the persons attending the clinic during that time had other problems associated with family planning, and that over 57 percent had multiple problems.

Recently cross-sectional data on family planning acceptors have been made available through the study of the Westinghouse Population Center (August, 1973), which investigated the feasibility of commercial distribution of contraceptives. The current DSPM study of the knowledge new acceptors have about the contraceptive method they have selected also promises to provide useful information about family planning clients and how the program can better serve them (see pp. 225).

1.6 Studies of Continuing Users

Interest in studying the continued use of contraception was indicated in Project Agreement 71-5, which stated that the NFPB would initiate a study on the continuity of contraceptive practice during 1971-72. The report of the first external review of the Jamaican national family planning program (Sodhy, et al., 1972) also states that research and evaluation were needed to follow-up contraceptive users.

According to the October-November, 1972 report by Kraft, the DSPM had completed a study at VJH which had as its objective improving continuation rates among family planning acceptors in the postpartum program. In addition, one year ago the Catholic Family Counselling Center examined continuation rates of all its clients who had first accepted family planning 9 months, 6 months, and 3 months previously. A 50 percent dropout rate was found at all times, even though no more than two cycles of pills were given to a patient at any clinic visit in order to provide more frequent opportunities for counselling supportive of continued contraceptive use.

Also of interest is a study tracing the growth and development of clientele in the two earliest Jamaican family planning clinics, conducted by Miss Shirley Smith of the International Demographic Statistics Center of the US Bureau of the Census in cooperation with Dr. Carl Stratmann and Mr. Basic Morgan of the JFPA. According to the November, 1972 issue of Family Planning News:

> "The study is based on contents of early programme ledgers and clinic records, covering the admissions of 12,856 clients of the Family Planning League in Kingston (1939-1964) and 1,171 women in the Beth Jacobs Clinic, St. Ann's Bay (1954-1964). These records comprise 95% of the total private admissions prior to 1965. The authors also briefly refer to 4,663 records for the period 1965 to 1968; however, these represent only a partial account of admissions for that period, and are treated accordingly. From extensive profiles maintained on individual records, it has been possible to study the age, parity, marital status, employment pattern,

current fertility and previous contraceptive experience of early Jamaican contraceptors. Number of clinic visits are compared for women in various groups, ascertaining the characteristics of the most reliable clients."

This study is entitled The Evolution of a Family Planning Movement in Jamaica.

The evaluation team is not aware of any other studies focused primarily on continued users, although KAP-type studies provide some relevant data. The team advises, however, that more longitudinal studies of acceptors are needed to assess factors associated with the high discontinuation rates which have characterixed the Jamaican national family planning program to date. Such research is especially indicated as new modes of service delivery are tried. Thus, for example, as commercial distribution of contraceptives is initiated, comparison of continuation rates among acceptors through commercial as compared to MHEC sources will be critical in evaluating the relative merits of these approaches.

1.7 Studies of Clinic Drop-Outs

Project Agreement 70-5 recognizes the importance of research on clinic dropouts to provide basic information for program planning, training, clinic operations, client education, and follow-up services. This agreement indicates that a study in this area was to be initiated in 1970.

Bracken and Kasl (1973) did, in fact, undertake research on this problem, utilizing a sample of some 600 active users and drop-outs identified from clinic records for the months of May and September, 1969 (the first year of NFPB program operation), as well as interviews with an additional sample of 300 drop-outs. This work was financed by the Society for Health Education, London, the NFPB, and US/AID (contract number 532-126-PIOT 523-030-3-00042). This study, however, deals primarily with demographic variables, and as the authors of the published report themselves indicated, their research did not include measurement of "the many motivational and attitudinal variables which could clarify some of the intervening processes which are operative and which describe in greater depth the psychosocial setting in which contraception is practiced." Thus they recognize the need for further research in this area.

Another study relating to the drop-out problem is referred to in the Family Counselling Center's proposal for a Multi-Service Center. According to this source, a 1971 study showed that over 30 percent of the women attending ante-natal clinic in Kingston had been prior attenders at family planning clinics but had subsequently dropped out. Nevertheless, a majority of women expressed a wish to have no more children. The investigator and sponsor for this research are not identified.

Kraft (1971) also reported that the two studies of family planning clinic utilization made by Dr. Karl Smith in 1970 and 1971 provide some valuable clues on the drop-out problem. She recommended that the data accumulated by the Statistical staff of the NFPB should be culled for additional

clues, and that all available information about drop-outs should be shared with clinic and education field staff.

The first external review of the Jamaican family planning program[1] and Pulley's 1973 consultancy report further state the need for follow-up studies of family planning drop-outs to identify reasons and possible remedies. Insofar as the evaluation team could determine no research other than that mentioned above has been completed on this problem. Some additional efforts to study it apparently have been made, however, as indicated by Wolfer's report that the Government "rather cruelly handed over to JFPA its drop-out study when this ran into trouble, but the Association was not able to do much with it." 2

The need for studies of family planning drop-outs thus has been recognized for a number of years. In view of the large percentage of initial acceptors who discontinue contraceptive use, priority should now be given to such research, with particular attention to the socio-psychological dynamics involved. In addition, as previously recommended by Kraft, the information on drop-outs which is currently available should be consolidated and discussed with program staff in order to search for new ways to alleviate this problem.

1.8 Studies of Contraceptive Methods

The report of the first external review of the Jamaican National family planning program (Sodhy, et al, 1972) indicates that research and evaluation were needed on retention and side effects of contraceptive methods. Project Agreement 72-3 specifically notes the need for IUD studies and indicates as a target "special IUD clinics, counselling, medical services, record keeping, and data analysis for IUD research."

In January, 1973, the NFPB launched a two year clinical study of intrauterine devices to test the acceptability, effectiveness, side effects, and expulsion rate of the CopperT, the Dalkon Shield, and the Lippes Loop. THe target group includes both nulliparous and multiparous women between the ages of 16 and 30 years. It is expected that eventually some 3,000 women will be involved in the study.

Victoria Jubilee Hospital, the OB/GYN unit of the UWI Hospital, the East Street Clinic of the JFPA, and the Operation Friendship Clinic are participating in this study. Between January and September, 1973:

812 IUDs were inserted
26 IUDs were removed
29 IUDs were expelled
10 pregnancies occurred.

These figures show an overall 17 percent failure for the IUD in the nine month period.

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1. Sodhy, et al, Report of First External Review: Jamaica National Family Planning Program, IBRD, July 1972.
2. Wolfers, "Consultant's Report: Jamaica", IPPF, 1973.

Discontinuation of IUD use, however, does not necessarily signify discontinuation of contraceptive use.

As of September, 1973, the possibility of expanding the IUD study to three other clinics in KSAC was being considered. (Minutes of Policy Co-ordinating Committee, September, 1973).

1.9 Research in Tubal Ligation

Research in culdoscopic sterilization as an outpatient procedure by the Department of OB/GYN at UWI has established the safety and feasibility of this procedure in Jamaica. The work has been supported by the Ford Foundation and the Pathfinder Fund, and several papers have been published, including the results in a series of two hundred cases, by Professor Hugh Wynter and his colleagues. (See Appendix).

To date the performance of this operation is confined to two surgeons at the UWI hospital. With the introduction of the Laparascopic approach to tubal ligation (see the recently concluded agreement with the AVS international project), Jamaica now provides an opportunity for controlled studies comparing these modalities. Professor Wynter's culdoscopic research should now be expanded to provide such a comparative study under Jamaican field conditions.

1.10 Studies of Abortion

During his resident consultancy with the DSPM, UWI, Dr. Lee Husting of the University of Pittsburg, completed a study which focused on the incidence and cost of induced abortions among a selected group of patients admitted to VJH.

In 1973, Karl Smith of the DSPM, UWI was approached by the International Center for Abortion Research about the possibility of participating in a world-wide study of attitudes toward abortion. This required approval from the Executive Director of the NFPB and political clearance from the MOH. Although considerable delay was involved in obtaining this approval (reportedly due to administrative lethargy in forwarding the proposal to the MInistry level), the project eventually was agreed to.

By the Spring of 1974, the DSPM therefore had in progress another abortion study which assessed the opinions of physicians, nurses, and midwives about the whole issue of abortion, including incidence, psychological factors, attitudes towards the law and proposed legal changes, as well as other aspects. This project was funded by the Transnational Family Research Institute (of which the International Center for Abortion Research apparently is a subsidiary), with co-sponsorship of the Jamaican Medical Association, and the agreement of the NFPB and US/AID. Because of problems with data processing at UWI, information was sent to the International Research Development Center for computer runs. Although returns were expected by the end of January, 1974 (according to minutes of the Policy Co-ordinating Committee, September, 1973), they had not arrived at the time of the evaluation team's visit. Study results will be most timely in view of current efforts to clarify Jamaica's abortion law.

Professor Roberts has said that he is interested in certain other aspects of research in abortion and envisaged taking notes as to women's reactions to abortion, both personally and on a general basis. He stated in the Fall of 1973 that he would submit a proposal to the Policy Co-ordinating Committee indicating how such study might be undertaken. (Minutes of the Policy Co-ordinating Committee, September, 1973).

The team feels that such studies are highly important in view of changing social, legal, political and religious attitudes toward abortion. Moreover, it recommends that in forwarding the reports of abortion studies to the MHEC, the NFPB, and other concerned institutions, the researchers should highlight the practical significance of their findings and the need for abortion reform, e.g., by including data on the number of maternity beds occupied by complicated induced abortions, costs of caring for these patients, etc.

1.11 Evaluation of Educational and Training Components of the Program

A. Evaluation of the Mass Media Program

Project Agreement 71-5 notes that the UWI had proposed a study to carry out evaluation of the NFPB public information program begun in October, 1969, although this study was not to be funded by US/AID. According to the report of the first external review of the Jamaican national family planning program (Sodhy, et al, 1972, IBRD), the Ford Foundation offered assistance for such a study, but this was not accepted.

Instead, evaluation was commissioned by McCann Erickson itself (the advertising firm with which the NFPB contracted for the public information program) and carried out by Cram International (WI), Ltd. A summary of results is included as Annexes 19 and 20 in the report of the 1972 IBRD-sponsored evaluation team. Nevertheless, the team which prepared that report questioned the quality of the evaluation in terms of the high literacy rate of the sample, the directive nature of the interview schedules, and the attribution of awareness levels to the media campaign. Their report therefore recommended the evaluation of the mass media campaign in terms of its place in the overall educational campaign, including whether it was reaching the target audience and whether the audience had already reached the level of awareness the campaign was trying to bring about. In addition, the team stressed that outside consultation for this purpose should be sought.

Currently a new evaluation of the NFPB's public information program is planned. Once again, however, the Board reportedly intends to conduct this through McCann Erickson. In view of the obvious conflict of interest involved, as well as the methodological questions raised by the IBRD team after the initial McCann Erickson evaluation, the fruitfulness and objectivity of a second study commissioned by this firm are doubtful. The evaluation team therefore recommends against proceeding with this effort and further advises that an overall assessment of educational needs and opportunities in the family planning program should be conducted prior to investing resources in the evaluation of this single IE&C program component.

B. Evaluation of Education and Training

Early in October, 1972, the NFPB affirmed its desire for the DSPM to assist the national family planning program in four areas, of which research and evaluation was one. Among specific research priorities requested was study of the degree to which the goals of education and training for various categories of personnel were being achieved. Interest was also expressed in research to determine the best methods of training family planning personnel for motivational work. (Kraft, Oct.-Nov., 1972).

Apparently formal studies of these problems have never been initiated, most probably because of the requirements of other research projects under way and problems in obtaining research personnel. The report of the Family Planning/Epidemiology Unit of the DSPM for the latter half of 1973, however, indicates that an experimental teaching approach was tried with pre-clinical medical students in which it was hoped that family planning and population dynamics would be taught in the context of experiences which the students would have in a community setting, while applying themselves to a community problem of their choice. This experiment did not generate the quality of input anticipated, but it will be tried again next year.

The DSPM had two educational research projects in progress at the time of the team's visit. Both projects are assisted by US/AID funds for academically oriented research. One, begun in March, 1973, is to ascertain whether or not after visiting KSAC family planning clinics, new acceptors of contraceptive methods are equipped to effectively use the method they have selected and to cope with possible side effects. Work on this project was slowed down by difficulties in obtaining computer time, as well as by the departure of Miss Mackett for three months of training at the University of Michigan. Nevertheless, the survey work was completed as of March, 1974, and the write-up was scheduled to be done by the end of April. Findings will be used to strengthen the training program for nursing, education, and CHA personnel.

The other project concerns the feasibility of providing health information to parents of children waiting for treatment at the Casualty Department of the GOJ Children's Hospital, as well as study of parental beliefs and attitudes concerning causes of illness and parent motivations for bringing children to the hospital. This information is expected to be associated with the number of children parents want.

Funded by PAHO, this latter project began before formation of the Family Planning/Epidemiology Unit. Phase 1 has now been written up and the resulting paper was presented by Mrs. Ivy McGhie at a recent scientific conference in Guyana. Phase 11 is in progress and involves experimentation with group education of mothers waiting for the pharmacy (selected because this was the longest waiting period for parents, the best physical facility for education, and presumably the best psychological setting in that anxiety about the children's conditions should have been reduced by medical consultation) Identical messages presented by CHAs using visuals and by sound-on slide equipment are alternated on various clinic days. Effects of both approaches

will be compared in capturing the attention of mothers, in learning which occurs, and recall one month later. Cross tabulations were being done in early April, 1974 and a paper on this project was to have been presented to the Medical Research Council later that month.

In its proposed work plan for 1974-75, the Family Planning /Epidemiology Unit of the DSPM, UWI identified three research and evaluation projects related to training:

a. Identification of Indices for Evaluation of Training Methods in Family Planning

b. Development of Evaluation of Training and Education Performance in Family Planning

c. Assessment of Family Planning Curriculum at UWI.

The evaluation team believes that these projects are all worthwhile, and further recommends that an experimental approach with accompanying evaluation characterize all education and training efforts.

1.12 Program Demonstration/Action Research Projects

A. Hope Tavern and Elliston Flats

The FP/Epidemiology Unit of the DSPM, UWI has been conducting an experimental action research project in Hope Tavern and Elliston Flats, two communities located near the Mona campus. One is a middle class area, the other predominantly a poor one. The objective of this project is to determine if family planning activities can be enhanced by first studying social and demographic characteristics of the population and then by making inputs into a family planning program through all the social agencies and organizations which exist in the communities, i.e., through a community development approach.

Census-type information and such data as sources of medical care, including family planning, have been collected to establish a data base about the population, but as of the evaluation team's visit, computer time was neededto complete the study. The team was told that the report was expected to be ready by the end of April,1974. Once census data are available in some detail, plans are to use these communities for research projects and for teaching and training activities conducted by the UWI. The 1974-75 proposed work plan for the FP/Epidemiology unit anticipates continuation of this demonstration.

Projects of this nature should, in the opinion of the evaluation team, be given high priority. Much operational research in methods of program delivery is needed to find the most effective, efficient, and acceptable models for Jamaica. In some cases, help may be needed in working out the areas and dimensions of experimentation, as well as in building the mechanisms to get the results of successful demonstration institutionalized in the program as a whole.

B. Experimentation with Integrated Family Planning and Health Services

As previously mentioned, the 1972 IBRD-sponsored evaluation team recommended experimentation with integrated family planning and health services.

Pro-Ag 71-5 provides for similar experimentation with the efficiency and effectiveness of an integrated health, welfare, and family planning approach in meeting the needs of the people by conducting pilot tests in two depressed areas, one in eastern KSAC and one in the western sector of the corporate area. As conceptualized in that project agreement, each pilot area would have a Family Planning Education Officer to serve as co-ordinator, a field supervisor, and three full-time home visitors. These home visitors would be recruited at a level just below the Assistant Family Planning Education Officer and would be especially trained to identify the health and social needs of families and to make referrals. The project would consist of intensive home visiting, with emphasis on education and motivation. Prompt feed-back on attitudes and the adoption of family planning was to be provided.

When the evaluation team asked about this experiment, it received only vague answers. Apparently something is being done, but just what is either not clearly experimental or else not systematically evaluated and reported. (see pp. 5 7)

C. Model Clinics

According to the JFPA Project for the IPPF-funded Model Clinic project now being developed in St. Ann's Bay (see. 70), the usual clinical evaluation of activities will be conducted, using NFPB record forms to collect data on the number of new acceptors by method, number of active acceptors at the end of the year by method, and reasons for drop-out and discontinuing method use. In addition, sample surveys ofacceptors will be completed to evaluate the effectiveness of different methods of distribution. This will include evaluation of:

1. Different persons in charge of the distribution (male motivators, encouragement visitors, etc.)
2. Place where the distribution takes place (home, sports clubs, labor unions)
3. Acceptability of different contraceptive methods distributed
4. Continuation rates for acceptors receiving 3-6 month supplies of orals.

Details of the design and time frame for this study were not available to the evaluation team.

D. Mobile Clinics

THe JFPA is also currently field-testing the effectiveness of a mobile clinic combined with outreach by male motivators in reaching rural residents of St. Ann's parish. Part of the pilot program, which is supported by Pathfinder,

will be to determine whether data collection is compatible with the use of these auxiliary personnel.

The JFPA mobile clinic project has an evaluator associated with it on a part-time basis. According to the project proposal, the evaluator will obtain baseline data on clinic attendance in areas where the unit will operate for four months prior to beginning project activity. During the action phase of the program, evaluation will focus on:

1. The number of people talked to individually by the male motivators, who will have at the outset a quota of at least ten contacts per day;

2. The number of people seen, reached and served by the mobile unit both for purposes of contraceptive services and supplies and for motivation and education;

3. The number of people counselled by the mobile unit as recorded by the clerk;

4. Changes in attendance at the established family planning clinics which are nearest areas covered by the male motivators and the mobile unit;

5. Numbers of condoms distributed(recognizing that total distribution for the area will be affected by other sources of supply).

At the conclusion of the project, clinic attendance will be followed for another four months to see if the project has had any effects on this variable.

Another mobile clinic is operating in the parishes of St.James and Hanover in connection with the Community Health Aide experiment in progress there. In Spring, 1974 two UWI students completed a study of patients who accepted contraceptive methods from the mobile clinic, but results were not yet available at the time of the evaluation team's visit.

E. Catholic Multi-Servic Center

The Catholic Family Counselling Center is currently developing a Multi-Service Center where help with family planning and an expanded number of social services will be provided under one roof (see pp. 78) Drs. G. Conner and N. Veeder of the Boston College of Social Work have proposed a research project in connection with the Center which would study the concept that paramedics can be utilized to deliver continuing family care and to effect significant increases in social, economic, and health benefits for the family. The proposal has been submitted to the Pathfinder Fund for review and possible funding.

F. Child Development Center, UWI

An inter-faculty committee of the UWI is, with assistance from UNICEF, the GOJ, and other sources, establishing a Regional Child Development Centre on the campus of the University of Jamaica. The Centre will be primarily for research and training related to the needs of the children four years of age and under. Day care of children and parent education, including family

planning, will be important components in this program. The project is being developed through the Extra Mural Department, Social Welfare Section, of the University.

G. Influence of Community Development Projects on Family Planning Practices

According to Mrs. Sybil Frances of the Social Welfare Unit in the Extra Mural Department of the UWI, the Sugar Industry Labor Welfare Board is interested in testing out a community development approach, with family planning as one component, in a selected rural area. In this project, all agencies and the community itself would work together to identify and solve local problems over a three or four year period. If this proposal is implemented, Christian Action for Development in the Eastern Caribbean, a newly formed social action agency, has agreed in priciple to support it. Additional funds for the project's research aspects would be needed, however.

This project could provide an interesting comparison to the urban community development study being undertaken by the Family Planning/Epidemiology Unit in the DSPM. If it is initiated and a research component is included, the design should facilitate such analysis.

1.13 Study of Family Planning Functions Performed by Other Agencies

In the summer of 1970 a survey was conducted under the auspices of the Interdenominational Church Committee for West Kingston in order to identify programs available to meet social welfare needs of citizens of Kingston, resources available to support these programs, and demographic characteristics of clients being served. Of the 57 participating agencies, drawn from the private and public welfare sectors, only a small nucleus was found to be involved in family counselling and planning. A follow-up study in May, 1971 examined referrals of 249 clients to 5 of these agencies.

These types of studies can be useful not only in providing basic information about the contributions of various agencies to the total family planning effort, but also in identifying gaps or problems in services and referrals which need to be overcome. Their most valuable function, however, may be in stimulating the agencies surveyed to re-evaluate their own roles in family planning in relationship to their clients' needs, and thus possibly to extend or improve their programs accordingly. Since Ministry of Health Paper No. 1 - Family Planning states that the involvement of other agencies in family planning is to be expanded, such studies of current and potential agency functions in family planning could be very productive.at this time.

1.14 Study of Maternal and Child Health Needs in the Caribbean

Acting upon a resolution of the Caribbean Health Ministers Conference at its fifth annual meeting in February, 1973, the Executive Secretary of this organization and the Head of the DSPM, UWI requested a grant from UNICEF "to assess some of the urgent needs in maternal and child health services in the

Caribbean and to examine possible methods of tackling the problems." UNICEF has provided $15,000 for this purpose and in late 1973, PAHO arranged for the services of a short-term consultant, Dr. John Karefa-Smart, to assist in the early stages of the study by helping to clarify and specify its objectives.

This study, including Dr. Karefa-Smart's recommendations for a regional planning conference and consolidating of existing data, should be very helpful to the MHEC in planning for integrated MCH services in Jamaica.

2.0 BASIC RESEARCH INTO KNOWLEDGE, ATTITUDES, SOCIO-CULTURAL CHARACTERISTICS, AND BEHAVIOR PATTERNS

The need for basic research into knowledge, attitudes, socio-cultural characteristics and behavior patterns related to family planning practice has repeatedly been recognized, as reflected in various Project Agreements, consultant reports, and conference proceedings. The initial importance of such study was described in the 1969 Project Proposal as follows:

> "Although the program is three years old, no systematic baseline has been made for use in measuring progress. Very little is known as to why some women come to clinics and others do not, why some stay in the program while others drop out. Information is needed in the nature of male attitudes toward family planning and in respect to their oppositions to partner or spouse participation in the program."

More broadly, the report on the *Social Welfare Aspects of Family Planning* prepared for the U.N. states (p.70):

> "Social welfare and family planning agencies share a need for greater understanding of the dynamics of family life in the Caribbean, and the current effects of change on the family. Very little research has been done in this field in recent years, or in the social aspects of the family planning program.
>
> There is also need for ongoing research on the inter-related subjects of family laws, housing, employment, etc.. Social Welfare and community development agencies could both contribute to and benefit from this research."

Although it is beyond the purview of this report to summarize all research with implications for the family planning program, it should be noted that the FP/Epidemiology Unit of the DSPM has in progress the preparation of an annotated bibliography on family planning, population, and family life articles from the Caribbean area. This project is funded by the International Development Research Center of Ottawa, Canada, and should provide a most useful contribution to family planning programs throughout the region.

2.1 Knowledge, Attitudes, and Practices Relating to Fertility and Family Planning (KAP Study)

Although the 1969 Project Proposal identifies the need for a KAP study to provide baseline data for measuring subsequent program progress, Pro-Ag 70-5 shifts emphasis slightly in pointing out the importance of a modified

KAP study to provide the basis for program planning, as well as for evaluation. This Pro-Ag states that such a study would be initiated during 1970 and repeated at one-to-two year intervals thereafter.

Since the KAP study was not initiated that year, Project Agreement 71-5 also indicates that among the research the NFPB proposed to begin within the next 12 months were studies on:

1. The source and extent of family planning knowledge, and the degree to which this knowledge has resulted in change of attitudes and use of contraceptives.

2. Prevalence of contraceptive practice in the community through both governmental and non-governmental channels.

3. Continuity of contraceptive practice.

4. Family planning patterns in Jamaica and prevailing attitudes toward birth control.

Pro-Ag 72-5 again provides for a major study of male and female attitudes in order to assist the NFPB in making operational changes.

In view of the high priority assigned to KAP research, the DSPM started gearing up for such a study in 1971 and progressed to the point of recruiting interviewers. According to Dr.Karl Smith, however, no funds for this purpose were available from US/AID in early 1972. Moreover, because of the impending national elections, certain questions were thought inappropriate and the DSPM was denied access to demographic data necessary to design the sampling frame. In spite of these difficulties, by Fall, 1972, the DSPM had developed a proposal for an island-wide study and staff members were preparing a detailed sampling plan and questionnaire. By this time it had also been decided that an initial study would seek to identify attitudes of males and teenagers toward family planning. (Kraft, Oct-Nov., 1972). In 1973, the study was again postponed because it was thought advisable to wait for the 1970 census data to complete the sampling frame.

Because of these delays, the KAP questionnaire has gone through several revisions to fit the issues and temper of changing times. By Spring, 1974, the interview schedule was again newly revised and 120 questions were ready for pretesting. The 1970 census data had arrived, and work was progressing on a new sample design. The major problem remaining was funding, upon which the recruitment of staff and vehicles also depends.

In September, 1973, the US/AID Population Officer in Jamaica requested the DSPM to provide an up-dated estimate of KAP study costs.*. This was submitted during the evaluation team's visit in March, 1974, but was not as specific as expected by AID personnel on the island. It is our understanding from AID representatives in Washington that the proposal recently has been forwarded from Jamaica and that it is recommended for funding. The team

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* According to the Minutes of the Policy Co-ordinating Committee, Sept.19,1973.

endorses this action, for the KAP study has long been designated as a priority by the NFPB and has the support of all persons with whom the team discussed this matter. PAHO has also recommended a KAP for Jamaica. As one informant told us, "It is the one thing that everyone agrees on."

While the DSPM is apparently ready to move ahead with the study as soon as funds are approved, and while this project is included in the 1974-75 work plan for the FP/Epidemiology Unit, it should be noted that according to that work plan, the KAP is already behind the anticipated schedule.

2.2 Teenage and Male KAP

According to Dr. Karl Smith, a KAP on mating and fertility patterns and the use of birth control among teenagers and males is nearly completed. This study, too, has had its difficulties. On June 20, 1973, Dr. Smith reported to the Policy Co-ordinating Committee that although the research was considered high priority, his unit could not proceed until staffing problems were resolved. In September of the same year, he reported that his unit was preparing for teenage and male studies and that he would confer with Professor Roberts about these.

The current status of this research is somewhat puzzling to the evaluation team. Although some information indicated that data were collece and being assembled, the US/AID Population Officer in an informal evaluation of the FP/Epidemiology Unit in early 1974 implied that data collection had not yet begun. Thus, he recommended that the study "should proceed as soon as possible and be conducted on a sampling basis in both urban and rural settings.

2.3 Relationship of Male Peer Group Associations and Mating and Family Attitudes and Behavior in a Select Community

Another male study is currently in progress under the direction of Mr. Tony Whitehead, Doctoral Candidate in Anthropology at the University of Pittsburgh, who now is based in the DSPM at the UWI. This self-financed research is investigating the role of the male as a possible impediment to female adoption and continued use of family planning methods, and aims to update and test earlier findings. *

Since these previous studies were conducted before family planning became a national concern in Jamaica, and since methodological questions have been raised about the popular Blake work, Whitehead's research will potentially provide needed insight into male roles which should be helpful in designing effective program approaches.

2.4 Other Male Studies

Several other studies of male attitudes toward family planning have been conducted in Jamaica. In 1969, the JFPA conducted a research project

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* e.g. Blake, Judith, Family Structure in Jamaica, 1969;
Stycos, J.M. and Back, K., The Control of Human Fertility in Jamaica, 1964

on this subject, in which some 4,000 males were interviewed. The results reportedly provided the basis for subsequent projects directed specifically toward males.

Also in 1969, Mr. Robert Lightbourne for his Master's thesis in Demography at the UWI interviewed 118 men to examine factors influencing working class contraceptive use. Respondents were selected from patient records at public health facilities in Kingston, St. Catherine, Clarendon, and Portland. The following year, Dr. Karl Smith completed another study on contraceptive use and desire for further children among working class Jamaican men. The team believes that this is the study entitled "Social, Cultural, and Psychological Factors Affecting the Use and Effectiveness of B rth Control in Jamaica," an unpublished paper cited in the Social Welfare Aspects of Family Planning: Jamaica.

2.5 Unilateral Contraceptive Decision-Making Among JFPA Women Clients

Complementary to the several male studies is a small study to investigate unilateral contraceptive decision-making among female clients of the JFPA. This research is being directed by Dr. Eugene B. Brody of the University of Maryland, with the collaboration of Professor Michael Beaubrun and others from the UWI Department of Psychiatry and personnel from the JFPA. Funding is provided by the Smithsonian Institute.

2.6 Reproductive Behavior and Fertility Patterns of Females

. Project Agreement 71-5 notes that the UWI in collaboration with NFPB initiated a project (not US/AID funded) designed to study reproductive behavior and fertility patterns of 5,000 women of selected age groups. At the June 20, 1973 meeting of the Policy Coordinating Committee, the NFPB's active interest in the status of women in family planning was reaffirmed, with the suggestion that this be reviewed for purposes or research. At this time it was also reported that the UN had approached Dr. Karl Smith about doing a small pilot study on the contraceptive practices of women, although the need for NFPB clearance was recognized. In September, 1973, Dr. Smith indicated that a proposal had been submitted to the UN for a study on the status of women and their contraceptive practices! *

2.7 Research on Women's Roles, Child Health, and Fertility in Jamaica

Currently a proposal for research on women's roles, child health, and fertility in Jamaica is pending from Ms. Ida Daum, a U.S. citizen, who would conduct this research under the sponsorship of the Smithsonian Institution. The evaluation team recognizes the importance of such research, but recommends that it not be approved until questions have been clarified concerning possible overlap of this study with the proposal submitted to the UN by Dr. Smith (see item 2.6) as well as the acceptability of Ms. Daum and the methodology she would employ to research units at the UWI.

*Minutes of the Policy Coordinating Committee, September 19, 1973.

2.8 Fertility, Mating and Conception Study* (FMC)

A study undertaken by the Department of Sociology in conjunction with the NFPB and the JFPA was organized in 1971 with financial support from the Ford Foundation. It aimed at detailed study of fertility at two levels. One was fertility of women of child-bearing age, that is those less than 45 years, while the other concentrated on women of completed fertility. In addition, the knowledge and use of contraception among women under age 45 were studied, as well as these women's assessment of the work of the NFPB, and related topics. Total sample size was 4,321 women.

This study, planned to analyze in detail issues raised in earlier studies based on census and other material, is yielding a considerable volume of information and a number of hypotheses which invite further exploration. In general, it can be said that an appreciable amount of material on trends, differentials, and characteristics is available and the direction that further research should take is clearly towards amplification of these findings in terms of sociological interpretations.

Papers and reports on the FMC project so far produced include:

Roberts, G.W.	Proposed Study of Fertility, Mating, and Contraception in Jamaica.
- - - - - -	Progress Report.
- - - - - -	A Gross Mating Table: A Comparison Between Trinidad and Jamaica.
- - - - - -	Fertility Differentials by Educational Attainment: A Comparison Between Barbados, St. Vincent, Trinidad, Tobago and Jamaica.
Powell, D.	Knowledge and Use of Methods of Contraceptives.
Woo-Ming, P.	An Analysis of Attitudes to Methods of Contraception Used.
Hewitt, L.	Desire for Children and Contraceptive Use.
Sinclair, S.A.	Aspects of Tubal Ligation.

2.9 Socio-Cultural Factors in Fertility (Research Proposal)

At the suggestion of Dr. Vera Rubin of the Research Institute for the study of Man, Professor George W. Roberts in early 1974 prepared a proposal for a study of socio-cultural factors in fertility. This research would provide an in-depth follow-up of 400 women interviewed in the 1971 Fertility and Mating Study, as well as of 100 male partners.

In a memorandum dated February 19, 1974, the US/AID Affairs Officer in Jamaica endorsed this research, indicating that it could provide information on factors preventing wider use of contraceptives, factors responsible

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* Narrative taken directly from G.W. Roberts, Proposal to Study Socio-Cultural Factors in Fertility of 400 women drawn from the survey of Fertility, Mating and Conception in Jamaica and of 100 male partners in visiting and married unions.

for high dropout rates, prevailing attitudes among women and men about abortion and tubal ligation, and attitudes of males toward the use of contraceptives. This officer also felt that the findings could be useful in training. He further recommended that the Family Planning/Epidemiology Unit of the DSPM should assist with the study, which should be used as a demonstration and training program "to enhance capability of UWI staff to conduct future studies of this nature on their own."

Dr. Smith is interested in participating in this study, however, a major question is whether this would conflict with the KAP study the DSPM is currently re-submitting for funding. The workload of present staff and anticipated personnel additions should be carefully analyzed prior to making a decision about involvement in this study. The benefits to be achieved from DSPM participation in the study, however, are recognized by the evaluation team.

2.10 Demographic, KAP, and Other Data Related to the Commercial Distribution of Contraceptives

The study completed in 1973 by the Westinghouse Population Center concerning the commercial distribution of contraceptives in Jamaica contains a good deal of information which is also relevant to other aspects of the national family planning program. The survey of retail outlets, for example, provides new insight into the knowledge and attitudes of small business owners toward contraception, and thus concerns an important segment of the population.

Perhaps even more important, the study includes interviews with 895 cases selected through multi-stage sampling of fertile couples in which the female was of child-bearing age. Data are reported on demographic and socio-economic characteristics, knowledge about and attitudes toward contraceptives, and family planning, contraceptive behavior, information sources and perceived credibility, sources of contraceptive products, and preferences for contraceptive methods.

The results should be reviewed for their immediate program implications, in addition to which they should be helpful in designing further research on fertility and factors affecting contraceptive acceptance and use in Jamaica.

2.11 Attitudes Toward Family Life Education in the Schools

Dr. Phyllis MacPherson, of the UWI Institute of Education, is reportedly directing a small study with social welfare students on the attitudes of 15-19 year-olds towards the introduction of family life education into the schools. Estimated sample size is 100 interviewees.

3.0 Vital Demographic Data

The report of the first external review of the Jamaican national family planning program* points out the need for the Registrar General's Office to update the tabulation and analysis of vital registration data. Project Agreement 73-2 provides for this to be done by the Department of Sociology at the UWI.

Professor Roberts is in charge of this work, and the NFPB requested $30,000 from the GOJ to support his efforts in processing vital data and

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*Sodhy, et al., 1972

tabulating and analysing birth and death statistics. In early March, 1974 the US/AID Affairs Officer asked the Minister of Health about the status of this request, and the Minister said that time that he wanted the funds released. This, however, necessitated clearance from the Minister of Finance. Reportedly the NFPB wrote six separate times under the current Pro-Ag seeking such clearance, which was recently obtained with a commitment from the GOJ to provide $25,000 this year and an equal amount in 1975.

Pending this action, US/AID personnel in Jamaica said during the evaluation team's first visit that US funds for Professor Robert's needs could be released without awaiting approval from the Minister of Finance. By the team's second visit, however, the AID money earmarked for this purpose had been de-obligated since the Board had not used it. Now once again the NFPB is requesting AID assistance in the amount of $20,000 for the processing and analysis of vital demographic data.

Currently Professor Robert's staff is proceeding with the key-punching of records in the Registrar General's Office, and Professor Roberts anticipates that vital regisration data will be available shortly for Jamaica through 1973.

In addition, as previously noted, the Census Research Bureau of the UWI under the direction of Professor Roberts is processing and publishing 1970 census data for 15 Caribbean countries with the assistance of UNFPA in the amount of $569,000. Four of the 10 volumes planned were completed when the evaluation team last talked with Professor Roberts in June, 1974.

Professor Roberts has written a number of papers which help to interpret vital demographic data for the purposes of planning, as well as for the general education of decision-makers. One of his more recent papers, Provisional Estimate of Population Movements, was prepared for the NFPB in early 1974 to help focus attention on the population problem and to contribute to World Population Year activities.

4.0 Other Research Needs

In addition to the projects discussed in the preceding sections, a number of research needs for which studies have not yet been initiated were identified by individuals interviewed by the evaluation team, as well as by prior evaluation and consultant reports. These needs include (partial list):

A. Possible changes in sub-fertility and counter-acting factors. (Professor Roberts, at June 20, 1973 meeting of the Policy Coordinating Committee).

B. Factors preventing wider use of contraceptives, such as current beliefs and customs about child-bearing and access to advice and supplies.

C. Prevailing attitudes among women and men about abortion and tubal ligation, including what influences women to accept these alternatives rather than contraceptives.

D. Feasibility of encouraging male sterilization.

E. Studies to verify assumptions concerning folk beliefs affecting sexual and fertility practices, e.g., how widespread is the belief that a girl needs to demonstrate her fertility prior to marriage.

F. The role of religion in influencing family planning behavior.

APPENDIX G

Partial List of Consultant Visits

Mid-1973 through Mid-1974

Name	Date	Purpose of Visit	Sponsor
James Lory	May 10, 1973	Consultant with Catholic Leaders on Program Development/FP	PPFA/FPIA Pop/Affairs IED
Charles Blackman	May 20/73 (1 wk)	Consult with NFPB/UWI official on FP	Pop/AID/W
Dr. Gloria Kamenski	May 30/73	Consult with Min. Officials on Nutrition Program	AID/W
Dr. Theodore King	June 17-22/73	Consult with Physicians at Victoria Jubilee Hospital Ob/Gyn.	AID/W
Prof. Eugene Brodie	July 16 -?, 1973	Discuss study being undertaken by him on psycho-social determinants of sexual and reproductive behavior among Jamaican women.	Smithsonian Institution
Mr. John Nagel	July 23, 1973	General discussions about family planning activities at UWI and in Jamaica.	Ford Foundation
Mrs. Flora Davis	Sept. 16/73 to Oct. 8/73	Consult with Jamaica Home Economics Assoc. on FP activities.	AHEA
Dr. Richards Dickey	Sept. 17-20/73	Consult with UWI and NFPB on Contraceptives (Orals).	Louisiana State University
Mr. Ramond Johnson Mrs. Patricia McCormick	Sept. 20-22/73	Consult with Karl Smith UWI on Phase II of Abortion Study.	Transnational Research Institute
Dr. Hamlet Pulley	Sept. 19/73 to Oct. 23/73	Plan for in-service Training with NFPB staff.	APHA for AID
Dr. Marjorie Wybourn	Oct. 25-28/73	Development of Home Economics/FP Activities.	America Home Economics Assoc.
Dr. Aquiles Sobrero	Sept. 19 - ?, 1973	Consultation on Training	IBRD

Partial List of Consultant Visits

Mid-1973 through Mid-1974

Name	Date	Purpose of Visit	Sponsor
Dr. Marjorie E. Shima	Nov. 22-24/73	Consult with Doctors on Sterilization	America Vol. Sterilization Assoc. (AVS)
Janet Anderson	Nov. 19-24/73	Attend Conference on HED (PAHO sponsored Workshop)	HEW/AID
Dr. George Evans	Nov. 29/73	Discussions about teaching for post-graduate students in the Department of Social and Preventive Medicine, UWI, including the contributions of PAHO personnel.	PAHO
Mr. William Spengler	Nov. 29/73 - Dec. 1/73	Population Activities	AID/W
Dr. Jean Morehead	Dec. 26-31/73	Consult with NFPB officials	Pathfinder Fund

Note: Visit of Malcolm Odell - University of Connecticut visited with 7 Nepalese participants for period of two weeks: Arrived: November 19, 1973.

Name	Date	Purpose of Visit	Sponsor
Dr. Vera Rubin	Jan. 3-10/74	Consultation on Study of Man	Research Institute for the Study of Man
Norman Lawrence James Brackett	Jan. 12-18/74	Consult on Census/Statistics with UWI/NFPB and Registrar General, Ministry of Health.	AID/W
Dr. Edwin Berrios	Jan. 16/74	Consult on IEC	East West
Ms. Joyce Thompson Dr. Phillip Stubblefield	Feb. 16/74 (2 wks)	Operation/Techniques	Pathfinder Fund
Dr. Richard Wheeles Mr. Logan	March 15-17/74	Aspirators	Pathfinder Fund
Dr. Ira Lubell	March 15-17/74	Laparascopic Techniques	Johns Hopkins Univ.

Partial List of Consultant Visits

Mid-1973 through Mid-1974

Name	Date	Purpose of Visit	Sponsor
Mandy Lerner	March 25/74	Consult with Training personnel NFPB-FP Education program	(NTL)
Dr. Carol D'Onofrio Dr. Donald Minkler Dr. Hamlet Pulley	March 19/74 - April 6/74	Evaluation of the national family planning program.	APHA for AID
IBRD Team	April 29/74- May 3/74	Supervising Construction of VJH addition and 10 rural maternity centers.	IBRD
Dr. Carol D'Onofrio Dr. Donald Minkler Dr. Hamlet Pulley	June 17-18/74	Discussion of draft report on evaluation of national family planning program.	APHA for AID
Mr. Charles Johnson			US/AID