EVALUATION OF THE JAMAICAN FAMILY PLANNING PROGRAMME

FINAL REPORT

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For the Jamaican Ministry of Health and
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INTRODUCTION

PURPOSE, METHODS AND SCOPE OF THE EVALUATION

PURPOSE

1. This evaluation of the Jamaica Family Planning (FP) programme was commissioned by the Ministry of Health and Environmental Control (MOHEC).[1] The scope of the evaluation includes specific programme developments since 1974, up to which time integration of the health services had entered its initial phase.

2. According to the Ministry representatives, the fundamental purpose of the evaluation is to provide a basis for improving extant programme design and performance. The Ministry through its Evaluation Task Force, provided the guidelines which embraced three main areas for review and analysis. These were:

(i) To determine the present status of the FP programme in the island. Specifically this would include:

(a) the level of effort going into the FP programme;

(b) the level of services;

(c) the use of services and the contraceptive prevalence within the population (i.e., the number of active contraceptive users in the FP programme);

(d) fertility pattern in the population, particularly related to age or parity.

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[1] Now Ministry of Health and Social Security. To avoid confusion, this Ministry is referred throughout the text as the Ministry of Health.

(ii) To identify major problems in the implementation of the FP programme:

(a) Organizational;

(b) Resources - availability and use;

(c) Attitudes and practices in the community;

(d) Impact/Demographic etc.

(iii) To make recommendations for strengthening of the programme and expanding those aspects of the programme that could have greater impact on the fertility pattern and general health of the population.

3. In the pre-evaluation discussions with the Evaluation Task Force, it was agreed that only themes and issues central to the guidelines would be addressed in this exercise. This approach would avoid lengthy historical review and concentrate on concerns germane to improving programme design and performance.

COMPOSITION OF THE EVALUATION TEAM

4. (a) Dr. Edwin S. Jones, Team Co-ordinator; Senior Lecturer in Public Administration and Political Analysis, Department of Government, U.W.I. He concentrated on administrative and management issues.

(b) Dr. Elsie LeFranc, Lecturer in Sociology, Department of Sociology, U.W.I. She concentrated on Education/Training of Health Workers as well as on Information within the Health System.

(c) Mrs. Sylvan Alleyne, Lecturer in Social Work in the Department of Sociology, U.W.I. Her input was primarily in the areas of KAP of Health Workers, profile of male users of contraceptives and delivery of service in the public sector.

(d) Mr. Wayne Iton, Lecturer in Management Accounts and Financial Analysis, Organizational Theory and Behaviour, Department of Management Studies, U.W.I. He conducted the analysis of the Management of the Commercial Distribution of Contraceptives programme.

(e) Dr. Doris Habberman, Sociologist and Communication Specialist, University of Erlangen - Nuernberg. She focused mainly on themes and issues relating to Education, Information and Communication.

METHODS OF WORK

5. Basic research into the family planning programme was conducted over approximately a three-month period between August and October 1979, but many crucial interviews were conducted during the month of November 1979. This 'basic' research strategy embraced six approaches.

6. The first involved three comprehensive briefing sessions with the Ministry task force which included health administrators, aid consultants, health workers, and medical practitioners - all associated with the FP programme. These briefing sessions were held between July and August.

7. The evaluation team also engaged in extensive desk research, reviewing reports and studies prepared by previous evaluation teams and consultants. In this way, we familiarized ourselves with many important background data/documentation and were able to identify research gaps.

8. A third part of the research strategy focused on interviewing personnel critically placed at every level of the FP network. Naturally, we interviewed persons structurally linked to the Ministry and others outside of the organization.

9. An additional component of the research strategy involved the conduct of survey studies. Separate surveys were designed and conducted into knowledge, attitude and practice (KAP) of male users of contraceptives and clinic profile. Prior to engaging in any of the field research, all the 'field officers' underwent a one week training course so as to sharpen their skills and ensure uniform interpretation of the process. Mrs. Sylvan Alleyne conducted the training sessions. Most of the field officers were university graduates; others were undergraduate students. Additionally, Dr. Doris Habberman conducted a survey of schools' guidance counsellors to test their knowledge, attitudes and practices relating to family planning and family life education.

10. Throughout the research exercise the evaluation team met from time to time to discuss preliminary findings, report difficulties besetting the research agenda, and, in particular, to identify and plan to deal with 'research gaps'. Beginning about the first week in December, the team began to draft the (preliminary) evaluation report. Individual members wrote specific sections which were collectively reviewed. Parts of these individual reports necessarily overlapped, but we have retained most of the initial presentations as the task force might want to express itself before a refined synthesis is provided. This was the fifth aspect of the research strategy.

11. While the entire team share collective responsibility for the evaluation, particular individuals constructed specific sections in accordance with their expertise (see paragraph 4) and in order to satisfy a tightly structured time-table. The preliminary draft report was fully discussed with the task force and their comments were taken into considera-

tion in preparing the final report, as the sixth aspect of our methodology.

SCOPE

12. As a team, we perceived and have been reassured by the local health establishment that our findings would be important in helping to re-route the family planning programme in more "rational and productive directions". The understanding, too, was that our analysis of the post-integration experience in particular, would be useful and serviceable to the various external agencies supporting the Jamaica family planning effort.

13. From the outset, therefore, the evaluation team perceived the need for programme review, but also indicated to the task force that the instrument of programme review should be sensitively used. We had, for instance, noted in the "Report on Status of Evaluation #1", that multiple evaluations of the FP programme tended to "imply uncertainty about the efficiency of extant arrangements" (p. 1). Additionally we emphasized that frequent investigations of the programme tended to cause "organizational functions to atrophy on several levels ... as well as to congregate conflicting recommendations ... with negative consequences for their implementation ...." (p. 1). This was the context in which it was agreed not to concentrate on or "reassemble common knowledge"", but rather to analyse "aspects of the original outline which are immediately likely to generate effective organization and management of the Family Planning programme" ... (p. 1).

14. This perspective, however, required us to identify gaps in previous macro and micro studies of the FP programme. In general we

found that the 1974 Report[1] has, perhaps, been the most comprehensive to date, but was particularly deficient, in part because "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 Jamaica FP programme 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 FP programme in particular, further complicated completion of a task already recognized as large and complex for the limited time (13 March through 6 April 1974) available to the evaluation team (p. 3). Of course, these obstacles and the absence of survey research into important aspects of the programme detracted considerably from the overall quality (in policy terms) of the report.

15. Other reports since then have been primarily micro in scope, addressing specific issues relating to the integration process (e.g. Powell et al./Dick - both in 1979)[2] and the 'dropout' problem. When these reports were viewed collectively we perceived five specific gaps. These gaps did not necessarily express themselves in the form of omissions, but more generally they represented partial or incomplete analysis. It is clearly not the fault of these various evaluation teams

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[1] Carol N. D'onofrio et al., "Evaluation of the Jamaica Family Planning Programme 1974", US-AID.

[2] Report of Assessment of the Information, Education and Communication Activities of Jamaica's National Family Planning Programme by Dorian Powell et al., February 1979;
Management Services Division, Ministry of the Public Services, Review of Proposal to Integrate the IE & C Division of NFPB, January 1979.

that their recommendations have not been implemented: but non-implementation is a specific problem associated with the research agenda.

16. These specific gaps, then, include:

(a) Partial analysis of knowledge, attitude and practice of the FP process;

(b) Incomplete study of behavioural and policy changes with respect to FP, broadly defined;

(c) No comprehensive report has been done on the institutional, policy and related components of the integration process;

(d) To date there have been no comprehensive analyses of clinic profile and management systems. (We understand that one such study is currently being undertaken);

(e) Approaches to financial analysis and aid policy in respect of the FP programme have, so far, been ad hoc, and therefore, non-comprehensive.

17. Our own efforts have, unhappily, not satisfactorily plugged all thes these gaps. However, the special contributions we think we have made to the analysis of the Jamaica national family planning programme include the survey studies of Guidance Counsellors; KAP of Health Workers and, particularly, the quantitative discussion of the clinic operations. Throughout the study, moreover, there are several analytical propositions regarding the nature of the integration process and its impact on the role, status and future direction of the family planning programme, which we consider to be new and factually based. Nor is this all.

18. Included in the body of this report also is a comprehensive set of tables - all emerging out of a broad investigative data base - that are

potentially useful in understanding the status of the programme, they are also capable of reliably informing its public policy dierctions for the 1980s. Notice, too, that attempts have been made to ascertain the extent of behavioural change resulting from the impact of the FP programme.

19. Unfortunately, however, the problems of financial management of the programme have not been addressed in this phase of our work. We intend to give this aspect of the programme some preliminary treatment in our final draft.

20. The report has been organized, as much as possible, according to the guidelines provided by the Ministry and its task force. We have documented elsewhere (Report on Status of Evaluation #1) basic problems which were associated with the research agenda.

CHAPTER ONE

RECOMMENDATIONS

These are general recommendations. More detailed, specific recommendations are to be found in the Draft Report of the Evaluation of the Jamaican Family Planning Programme 1979.

Overall Policy

1. A comprehensive policy document incorporating a coherent definition of the scope, role and status of the family planning programme and its relationship to the national development process should be designed immediately.

2. Such a comprehensive national policy should incorporate clear guidelines and strategies from the Ministry of Education for the introduction and teaching of Family Planning and Family Life Education in the nation's schools at a more coordinated level than exists at present. A national policy should take fully into consideration the need for introducing FP and FLE into the nation's schools at much earlier ages than at present.

3. Further planning and decision-making efforts by the Ministry of Health in respect of integration should include the broadest possible range of inputs from all levels of the health network. In any event, the integration process should cease at this point until the family planning programme is modernised along the lines of our recommendations. However, given the past experience with integration, we also recommend reversal

of some processes. Specifically, those wings of the library and statistical divisions that relate specifically to family planning should be returned to the NFPB.

4. Simultaneously, the NFPB should be reorganized with a view to strengthening its personnel system as well as its coordinating role, especially among community organizations. Within the new format, emphasis should be placed on the Board's research function and it should have a more liberal hand in subcontracting other technical functions.

5. Without expanding the clinic bureaucracy, the management systems of clinics should immediately be streamlined, beginning with the selection of internal personnel with management training and experience who should monitor processes relating to supplies, record keeping, work plans etc. There is need not only for more materials, supplies and stationery in the clinics, but for more accountability than now exists of the way in which these are utilised.

6. As a matter of public policy the Bureau of Health Education (BHE) should design and submit its own budget and should be made accountable to the Ministry for managing it. New arrangements should also be made whereby the BHE can interfere more meaningfully with midwives and other family planning personnel attached to the hospitals.

7. Given all these considerations (1-6) a small Technical Task Force should be appointed to monitor the implementation of these and other recommendations within nine months.

Training of Health Personnel - General

8. If the NFPB is to remain a separate institution then consideration should be given to return the functions of education and training for FP to that body. If the function is to be retained in the MOH division then greater effort must be to the provision of specialised FP programmes to larger numbers of persons.

9. The training programme needs to be better integrated - centralised so as to achieve some consistency and equitable distribution of trained personnel.

10. The choice of persons for training needs to be rationalised and accelerated.

11. Greater co-ordination between training divisions, and job designing units/personnel is necessary.

12. There should be better and greater use of persons within the service who have the necessary expertise - perhaps as consultants and resource persons.

13. Serious attention must be made to clearly define the role and function of the NFPB. Until this is done the staffing of that body will continue to be inadequate and ineffective.

Training - Specific

14. Information officers responsible for the NFPB's 'Answering Service' should be given upgraded training in counselling skills.

15. There is need for training of clinic personnel with special reference to advice on contraception and the precautionary indicators

and the specific instructions that should be given to clients about the various methods of contraception.

16. There is need for a Training Manual, especially in relation to recommendation 15 above. Answers prepared by one consultant (see Appendix II) could probably be developed into a manual for use by clinic personnel. Consideration should also be given to the use of the same Manual by others who are engaged in counselling, particularly guidance counsellors in schools and information officers who deal with the public through the Bureau of Health Education and the National Family Planning Board programmes.

17. Bearing in mind that there is also the need for training school teachers in family life education and family planning, ways should be explored by which training programmes, training manuals, visual aids and handout material could possibly be developed to serve all those personnel involved in imparting FP and FLE in both the Ministry of Health and the Ministry of Education at all levels. This would not only help to reduce costs but also provide a coherent and integrated programme at all levels.

18. Special attention should be paid to the level of functioning of community health aides. If their role is one of motivating clients, then they too should be equipped with the relevant knowledge of side effects and the tools which will enable them to encourage clients to comply with contraceptive methods.

Clinical Services

19. There needs to be improvement in the two-way system of communications between the clinics and the central organizations, with special effort from the central organizations providing training and feedback of documentation

at the clinic level. Priority should be given to uniformity in the collection of data.

20. There is need for permanent liaison to be established between the MOH field and clinical services and the 'Answering Service' provided by the NFPB whereby clients of the 'Answering Service' can be referred to the clinics, with provision of adequate mechanism for feedback of information to the service and joint effort toward follow-up activities, as necessary.

21. Special attention should be paid to alleviate some of the problems leading to dissatisfaction of clinic staffs, such as salaries and promotion opportunities.

22. The role and functioning of the community health aide needs to be clearly defined. (See also 18).

23. Attracting more male members of the staff to the clinics is highly recommended, especially for the motivation of male clients.

24. Records should be kept of the vital statistics of male clients who attend the clinics.

25. Clinic staffs should try to attract a younger age group of clients to the clinics, with special reference to those who have not had any children.

26. A suitably qualified person should be selected very soon (a month's time) to perform the duties of marketing officer to ensure effective programme management.

27. There should be more effective coordination of critical functions of the programme, i.e. distribution, advertising, packaging and NFPB Marketing Division.

28. The product line should be expanded to include the sale of a premium-priced condom product comparable with Durex. The specifics re a marketing plan for the same must be carefully prepared.

29. An immediate effort should be undertaken to counter the shrinking retail outlets trend. A complete retail outlet audit may be necessary since present records are dubious.

Mass Media programmes

Responsibilities of the various MOH agencies involved in public education must be exactly defined. The following divisions are recommended:

30. Responsibility for the design and production of printed educational and informational material for FP and FLE should lie with the BOHE since it has the technical expertise and some printing facilities available.

31. Responsibility for the production and distribution of audio visual material to support field services should also stay with the BOHE which is responsible for the field work.

32. Responsibility for all other educational and informative mass media programmes, including press articles should be left with the NFPB which has the necessary experience and the links with the advertising agencies which produce a great deal of the programmes. Personal and group consultancy, advice and teaching in FP and FLE should be carried out mainly by the NFPB to maintain its public image as an FP agency.

33. Consideration should be given to whether more mass media programmes in FP and FLE could not be produced by staff members of the NFPB. Although this would mean an increase in staff it would on the other hand save money which would otherwise be spent on outside contractors.

34. Collaboration between the various MOH agencies involved in FP and FL information and education needs to be improved. In this context we suggest a revival of the educational and training sub-committee to promote cooperation between the BOHE and the NFPB.

Answering Service of the NFPB

35. The 'Answering Service' can play a vital role as a source of research, evaluation, programme feedback and mass media production and should have special attention within the NFPB's total information and communications programme. Greater use should be made of the information that comes in via this programme.

36. The service needs to be improved by upgrading the counselling skills of staff, setting up scheduled times for counselling, establishing liaison with MOH field and clinical staff so that the necessary feedback mechanisms can be developed and developing better feedback internally.

Information Material

37. It is clear that there is need for the provision of new and up to date information material for distribution to the public, through clinics, schools, guidance counsellors, the answering service etc. There is also need for the provision of visual aids such as flip charts to various categories of health personnel, such as guidance counsellors. It is suggested that consideration be given to providing material that can fulfill multiple functions in schools, clinics etc. This same kind of coordinated effort is suggested for a Training Manual (see 16).

FP and FLE in the Educational System

38. The need for a clearly defined comprehensive strategy for teaching FLE and FP in the nation's schools has already been referred to (see 2). At the same time there is urgent need to promote coordination and co-operation between the various divisions of the Ministry of Education involved with the teaching of FP and FLE. Such agencies include the Educational Broadcasting Service, the Curriculum Development Unit, the Guidance Counselling section etc.

Teacher Training

39. The Ministry of Education should actively promote the integration of FP and FLE into the programmes of teacher training colleges. In-service training in FP and FLE for teachers at all levels should be increased.

Guidance Counsellors

40. The FP and FLE components within the guidance and counselling sections should be strongly supported and sufficient financial resources be allocated for training purposes.

41. The guidance counselling service should be extended to all schools down to primary level.

42. Job descriptions for counsellors and for school nurses, with clear definitions of responsibilities for each group in promoting FP and FLE, seems necessary.

43. A curriculum for counsellors needs to be developed. It is recommended that this should be in two parts: one part structured by the Ministry of Education, the other part left open to be developed by the counsellor, based on actual need.

44. Counsellors should be given fixed schedules in the timetables of educational institutions for teaching FP and FLE in a systematic way.

45. Upgraded training in FP and FLE should be offered to the guidance counsellors, particularly in FP methods, human reproduction and FLE (see also 16).

46. Counsellors should be provided with adequate printed material including posters and flipcharts, booklets, leaflets, and pamphlets for distribution to parents and students (see also 37).

47. Consideration should be given to supplying counsellors with limited types of contraceptives - condoms, jellies, foams or creams - for distribution to students on request.

Educational Broadcasting Service (EBS)

48. EBS radio programmes in FP and FLE should be given more emphasis than TV, in view of radio's wider reach.

49. The EBS science programme on TV should be used not only to transmit information. Greater emphasis should be placed on developing programmes to positively motivate changes in certain FL or FP habits.

50. Programmes for teacher training and programmes for classroom support aimed at students should be separated. Since there exists an obvious need for teacher training in FP, consideration should be given to the possibility of producing an extra teacher training series.

51. EBS transmission times and number of programmes as well as maintenance and repair services need to be reviewed. Transmission times should be better coordinated to counsellors' classes.

52. Possibilities for the improvement of production facilities or the use of facilities of other agencies for film or video production should be considered so as to enable local production of short motivational films, in FP and FLE.

CHAPTER TWO

MANAGERIAL ISSUES

A. FRAMEWORK FOR ANALYSIS

According to theory and experience, effective project management necessarily requires 'comprehensive' and systematic approaches. Basically, this proposition implies at least five overlapping concerns. These would apply equally to the management of the national family planning programme. Firstly, and fundamental to the development and working of a FP policy machinery, is the clear specification/definition of policy objectives. Allied to this must be a strategy for policy review and evaluation. Of course, a viable policy framework should provide opportunities for rational adjustments and for the exercise of local initiative.

A second precondition for effective project management concerns the careful 'mobilization of crucial resources' - including financial, manpower, physical, technological, informational, together with political support.

Third, conceptualization of 'project problems' and their possible solutions requires committed, expert leadership: leadership capable of commanding respect, skilled in directing and controlling. A degree of decisional autonomy at the leadership level is also germane to this process. Equally it is important to build up reinforcing leadership cadres at the intermediate and community levels.

Fourth, is the requirement of 'concerting' the various organizational units and instruments responsible for management of the project.

This approach is to facilitate easy communication and avoid under-coordination and wasteful duplication. Official and organizational sensitivity to the interests, skills and inputs of top project managers and other workers is critical to viable programme development and implementation.

Fifth, is the necessity for constructing durable linkages between project organizations and the broad client system. However, the involvement of the relevant publics must be planned and monitored. Clients themselves must be 'prepared' for meaningful and disciplined participation.

Both the pre- and post- integration experiences of the national FP programme contradict some of those crucial guidelines. A 'correction' process has been initiated but it appears somewhat uneven.

B. POLICY ISSUES UP TO 1974: PRE-INTEGRATION

Formal Government of Jamaica policy toward fertility control or population planning began in 1964. Official commitment, policy and the outlines of a population control strategy were articulated in the Five Year Independence Plan published in 1966. Policy leadership fell to the Ministry of Health and it established an 'active' family planning unit in 1966. In 1967, however, a National Family Planning Board (NFPB) was provisionally constituted to coordinate and direct population policies that had fixed targets.[1] These are indicators that the FP programme

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[1] In the Three Year Programme of the NFPB (1968/71) the objectives of the FP programme included: lowering Jamaica's birth rate from the 1968 level of 35.94 per 1,000 to a level approaching 25 per 1,000 by 1977; having in operation enough clinics (160) to serve the needs of all the people who wish birth control information, facilities and devices; involving about 75,000 patients in FP methods by the end of the period, 1971 and; organizing and implementing facilities for the early detection and treatment of cases of uterine cancer.

was developing a coherent and 'national' character. Later, deliberate attempts were made to refine programme content and objectives as well as to emphasize the relationship of the FP programme to the national development process.

Accordingly, the NFPB was to be the key management instrument of the government's FP policies. Between 1967/74 attempts were made, structurally, to develop the NFPB's capability to meet the expansion of FP services. The resource base of the NFPB was made more secure in order to give it status and problem-solving capacity (c.f. Powell et al., 1979; D'onofrio, 1974).

Radically different health policies and plans were proposed by the government in its 1974 Family Planning Act. Among these was the proposal for integration of FP into the regular health services of the NFPB with the services of the Ministry. Ministry Paper No. 1 of 1974 rationalized this policy change in terms of a search for "an adequate framework within which a comprehensive and expanded programme would be carried out". Ministry Paper No. 1 also explicitly linked FP to national development policy. It, in effect, accorded FP 'priority' status.

Three basic phases have been associated with the integration process. The first, operationalized in April 1974, located responsibility for the actual delivery of FP services with the Ministry. Correspondingly, the Board retained responsibility for programme coordination, information and education, training, statistics, supplies and evaluation of FP activities. In an apparent move to strengthen the Ministry-Board linkages, the Principal Medical Officer's position was formally institutionalized on the Board. Phase two of the integration process was

initiated in July 1976. Resignation of the existing Board and the appointment of an 'in house' Board, composed of senior Ministry officials, concretized the initial tendency. Subsequently staff responsibility for most of the information, education and training activities, together with responsibility for statstics and programme evaluation, were transferred from the NFPB to the Ministry. The transfer was not always well planned and smooth, but rather ad hoc and often hasty. Phase three is yet tentative and inexplicit. Recent 'evaluation exercises' (e.g. Dick, 1979), however, indicate a tendency. The steps envisaged appear to include relieving NFPB of its remaining training function and also relocating the Information, Education and Communication (IE & C) functions and personnel into agencies within the Ministry. This would mean that the NFPB would only have direct responsibility for the commercial distribution of contraceptive programme as well as management responsibilities for the laparoscopic equipment repair and maintenance centre and the administration of supplies.

With the definition by the Government of Jamaica of its rudimentary family planning policy went attempts at building a 'management system'. These two attempts largely explain the level of external support for the FP programme. But the government's FP strategy has not been problem-free. Many pre-1979 evaluation reports[2] on this project have identified several areas of management weaknesses. One such weakness was the lack of central coordinating systems. Another was that management efforts were too narrowly confined to the spread of birth control

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[2]See, for example, D'onofrio, Evaluation, 1974.

information and services - implying that recruitment of acceptors substituted for management concerns and the continuation of contraception use. A third management deficiency was that the programme was too clinically oriented; that reliance on voluntary inputs into the programme was too pronounced and that the direct relationship between FP and national development was neither fully perceived nor understood at every level of the family planning management system. Indications are that many of these problems still persist to some degree. (See section D of this chapter.)

Not only were the problems general to the FP programme, some were specific to organizational units.

The Act of 1970 had established the NFPB as an independent statutory body. It provided, moreover, for the Board's collaboration with other organizations engaged in the FP programme. In practice, then, the Board shared policy responsibility with the Ministry and this arrangement was potentially problematic. A 1974 Report (D'onofrio) found the Board's role to be "minimal at the policy making level". Four reasons were advanced to explain that condition.

First, the communication linkages with the Ministry of Health and other ministries were so structured as to discourage creative, productive management. The Board related primarily to the middle management strata within Ministries and not with the upper echelons that determined policies, fixed priorities or defined implementation strategies. This weak linkage system induced a degree of policy immobilism.

Secondly, crucial private and public organizations were either under-represented or not represented at all on the Board. This lack

inhibited capacity to formulate and implement the comprehensive FP programme required by context. Although women were the programme's main, almost exclusive target group, women were under-represented on the Board.

Thirdly, under-coordination among pivotal FP agencies weakened the Board's field orientation. The rural emphasis was also clearly insufficient. Non-health workers were given insufficient opportunities to shape general or specific management strategies. As a result, the overall salience of FP to national socio-economic development was not promoted concertedly.

Fourthly, the entire management structure evidenced difficulties in conceptualizing important problems and in planning their solution. This was reflected in the apparent inability of leadership to distinguish between processes of 'co-ordinating' and 'directing'. The predictable result, in this case, was that the Board developed "the image of being arbitrary and demanding, rather than open, facilitating and co-operative".

Responses gained from interviews (Sept.-Nov. 1979), identified other management weaknesses of the NFPB with the absence of fully developed mechanisms for internal review and evaluation of structures and policies. Relatedly, the Board's orientation to research was weak. All of this meant that the NFPB's capacity for self-correction within all areas of its programming was limited. Specifically it did lack the data-base for rational decision-making and its co-ordinating capacity was correspondingly limited.

Although we have found that many of these problems have persisted, their overall character have changed somewhat. (See Section D).

CLINIC MANAGEMENT: Poor clinic management greatly weakened the FP programme. It made the programme ineffective and largely symbolic. This fact was recognized long before integration began in 1974. Prior to integration, the Jamaica health system utilized many concepts designed to improve and expand the scope, performance and effectiveness of clinics. (cf. D'onofrio, 1974, pp. 50-55). Between 1966 and June 1972 the number of clinics increased from 25 to 169. With the changing numbers came new concepts and new management concerns. Basically, three clinic models developed within the health system. There were full-time clinics: five of these located in the Kingston metropolitan area and twelve in rural parish capitals. These opened 8.30 a.m. to 4:30 p.m. week days and for four hours till 12.30 p.m. on Saturdays. Co-existing with these were over 130 sessional or part-time clinics and others engaged in satellite operations. Mobile clinics, offering a wide range of general health and F.P. services and providing night service were also an important adjunct of the clinic network. These mobile units were designed primarily to arrest and solve problems of ineffectiveness and inefficiency experienced by the other clinic models.

With this expanded network, the number of FP acceptors increased island-wide up till 1974. In general, however, independent evaluation teams have concurred in their findings that these clinic models were not cost effective; that several clinics were underutilized; that there was wasteful duplication of efforts by clinic personnel; that there was unduly narrow preoccupation with the distribution of contraceptives; that training and the promotion of family planning education were lagging behind desirable levels; and that the drop-out problem was inadequately managed. Staff shortages have been a persistent problem.

EDUCATION: An important aspect of the FP programme was the management of its educational activities. The agency responsible for promoting FP education was and still is the Bureau of Health Education (BHE). It has been instrumental in helping to design and develop the original comprehensive FP educational strategy. It has participated in training efforts. It has been prominently engaged in educational activities at the community level, interfacing with various agencies and committees. It has been associated, too, with research and evaluation activities as well as with the production of material necessary for the FP programme.

Even though the BHE managed to involve itself in this range of activities, it was beset by certain managerial weaknesses. Staff shortages created by rapid turnover, secondments and badly timed leave arrangements considerably limited the ability of BHE to deliver maximum field services. In particular, the scope and quality of the training exercises were below required standards. If its training programmes appeared ambitious in the context of narrow resource base, the quality of the guidance and supervision offered by BHE staffs suffered equally from resource limitations and organizational weakness. Furthermore, both the nature of the relationship between the BHE and the NFPB on the one hand, and the BHE's relative isolation from programme direction on the other, undermined its capacity to perform successfully. The BHE was never allocated an annual budget by the NFPB. This fact predictably constrained its ability to plan, organize work and to direct in any authoritative manner. Most of the other major problems stemmed from the fact that the BHE "lacked effective mechanisms for continuing

identification of areas of programme need; for providing adequate support and supervision of field staff; for refining organizational arrangements and for the kind of field reporting that could lead to creative problem-solving". (See D'onofrio 1974).

THE JFPA: Much of the work and management of the FP programme hinged on inputs from the Jamaica Family Planning Association (JFPA). Organized in 1957, it has consistently helped, voluntarily, to mobilize important inputs into the FP programme. Historically it has attracted financial contributions as well as assisted in the delivery of FP services. Thousands of acceptors were mobilized through its efforts even as it urged and encouraged increasing government activity in the whole range of family planning concerns. It has moreover, been available for consultation and advice to individuals and institutions connected with FP.

Accordingly, it became highly respected within the health establishment and had also managed to organize clinic committees, on a national level. Over time, however, these committees, with the exception of the one in St. Ann's Bay, have become largely inactive. Certainly up till 1974 JFPA leadership was strong, dedicated, flexible and forward-looking in its attitude to the changing family planning techniques and technology. Within recent times its original profile has changed somewhat. It has not been able to forge and sustain viable linkages either with community-based organizations or with the FP centre. Staff shortages and financial stringency limited its effectiveness in this regard. Increasing official involvement in FP management has also deflected much attention and voluntary resources from the JFPA.

ORGANIZATIONAL LEADERSHIP: By and large, organizational leadership of the FP programme up till 1974 was uneven in quality, distribution and programmatic outlook. Within this framework however, the quality of the Ministry's top leadership has been adjudged technically equipped and professionally oriented. Both the technical and political wings of the Ministry appear highly motivated and committed to the FP programme. This, together with the fact that since 1964 most of the crucial management resources have been made available to the Ministry meant that it developed the collective experience and status to plan and operationalize its FP policies.

From time to time, however, salary disputes, poor physical conditions at the work place, staff shortages and the shifting, and hence unstable, nature of administrative leadership (i.e. the Permanent Secretary) have generated serious problems for the Ministry's management team.

Intermediate and lower level leadership cadres within the FP network have also been adjudged technically qualified and entrepreneurial in outlook and approach (D'onofrio et al., 1974). These qualities have been sustained by exposure to relevant training exercises. Intermediate leaders would be those functionaires who link the centre to the field operations.

COMMUNITY LEADERSHIP: Parish leadership is typically offered by the Ministry's Medical Officers of Health (MOHs). These have been described as dedicated and competent, but generally overtaxed because of shortages of personnel. A 'dedicated' team of Public Health officials with generally 'strong community orientation' (INTERVIEWS/Oct. 1979)

reinforces this leadership level. Public Health officers who successfully complete the Diploma in Public Health course are all exposed to a University curriculum that includes Caribbean Politics, Sociology as well as Organizational Theory and Behaviour.

At the community/client level, a leadership knowledgeable about the FP programme and its relationship to the national development process has emerged over time. Institutions such as the Trade Union Education Institute at U.W.I. have been critical in mobilizing support for the FP programme as well as disseminating educational messages relevant to the programme. As the norms of community participation and community self-management gain currency, the foundations are being built for firmer bases of community support for the programme.

This organizational/management profile (pre-1974) has undergone certain changes - some qualitative (e.g. partial integration), others symbolic (e.g. programme expansion without expanded management resources). Integration presumably was designed to resolve most of the management problems which have been identified. We must therefore look to that process for possible improvements in management structures and processes.

C. POST-INTEGRATION: PROCESS AND ISSUES

Generally, integration meant the transfer of services and staff from the NFPB to the Ministry itself for the implementation of FP policies. In practice, integration stressed the incorporation of FP into "a comprehensive family health format" in which most health workers and institutions share FP responsibilities. The integration process therefore meant the redefinition of institutional responsibility, restructuring of organizational arrangements and an approach to FP management that was

more field-oriented. Integration was contemplated as a phased exercise.

Now this approach is not inconsistent with the commonly accepted meaning of the concept. For literally 'integration' means "...to unite with something else to form into a whole; to incorporate into a larger unit or to bring into common and equal membership in society or an organization". But it was, as we shall see, the process of integration that was particularly defective.

Integration was apparently motivated by a confluence of inter-related factors. One factor was an attempt to increase the scope, quality and efficiency of FP services. Another motivating factor was strategic: integration was viewed as a most secure method of attracting aid from international sources. Thirdly, the idea of 'integrated health services' had become a popular theme within the international health network. This idea was, for example, strongly promoted at the Bucharest Health Conference in the early 1970s. Both the political and the technical leadership of the local health establishment apparently perceived the idea as workable, acceptable and wise.

The Ministry's view of integration as a management process is therefore important. Evidently the Ministry viewed the integration process substantially as one in which complete physical units should be shifted and housed together. This notion did not contemplate integration in terms of linking processes and procedures without physical movement. Although the Ministry opted for a phased process, no meaningful feasibility/pilot strategy was practised. Neither was priority given to establishing new coordinating mechanisms. Such an approach to integration therefore dangerously overlooked what would be the reactions and attitudes of personnel affected by the process.

There was no clearly defined government policy on integration. The overall conception that emerged however, was premised on the basis that the total health service would fully support the FP component. More persons would therefore transmit the FP message. It was also expected that the provision of FP as part of a daily service would replace the weekly or monthly pattern of service delivery. A doctor would be more accessible to clients and clients themselves would obtain FP services in some privacy.

It is therefore necessary to investigate some of the effects of integration on the management arrangements of certain key family planning institutions.

It has already been indicated that the preliminary phase of integration involved the transfer of the educational component of Information, Education and Communication (IE & C) to the Ministry. In this exercise approximately 120 educational and clinical staff were transferred. The Bureau of Health Education (BHE) assumed prime responsibility for FP education within the framework of the Ministry's general health education activities. Within the BHE the education field officers functioned as Health Educators and their clinical counterparts entered the Ministry's nursing service.

Redefinition of the role and functions[3] of the NFPB was an effective part of the integration process. It is documented elsewhere

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[3]The re-defined functions (cf. Powell et al., 1979 & Interviews) included concentration on: public information and communication in all its various forms; co-ordination of activities of the various Ministries, namely, Health, Youth, Sports and Community Development, Education and voluntary organizations, with particular reference to the harmonization of the

in this study that before integration the NFPB had its own complement of staff, hierarchical structure, management style and salary scales. In general, salaries paid, especially when special allowances are included, were higher than those paid to Ministry of Health counterparts or equivalents. With integration, many persons holding relatively well-paid and prestigious positions with the Board were immediately affected. These were now subject to Ministry classification and consequently suffered decline in status, cuts in emoluments and sometimes reallocation of responsibilities. Many skilled staff left the service for these reasons, but also because their special identity with the FP programme was clouded.

According to the Board's Executive Director the integration process, at this level, meant that the Board's special status as a Statutory Body (read relatively greater management autonomy than the Civil Service) was somewhat compromised. The net result was frustration of its management team.

Many of the changes which were associated with integration determined that NFPB's implementing role became somewhat 'fluid', imprecise and less directly focused. The decision to construct an in-house body composed of nine senior Ministry officials and an Executive Director,

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information and education programme with (other) service activities; international matters and assistance; research; statistical data and the monitoring and evaluation of the programme; training; stores and supplies management. This pattern of integration meant that the only remaining and recognizable units that reflected the NFPB's 1974 profile, were the commercial distribution of contraceptives programme and what became known as the Information and Communication Division. Of course, the process had certain effects on both the policy goals and the performance and behaviour of the key family planning institutions. But it is extremely difficult to measure certain kinds of performance as the integration strategy had defined few measurable objectives.

itself gave expression to weakened management orientation. This in-house Board replaced the more broadly based policy-oriented structure. It was highly equipped technically but lacked a wide social-community base. Thus, together with the narrow scope of its membership and its weakened operational departments denied it the community-wide management inputs necessary for effective functioning. In effect, the Ministry assumed policy leadership and virtually monopolized the available decisional resources. These developments together eroded the Board's status. The NFPB could not be expected to relate in a direct managerial way to a nation-wide FP programme.

In practice, whatever preparatory exercise was undertaken appeared to us incomplete and somewhat defective. Policy priorities were ill-defined and those who would share responsibility for FP services were insufficiently motivated. Thus, the FP officers tended to feel committed to their traditional job functions and staff members of Ministry of Health at the community level and in the health centres, did not necessarily see FP as a priority.

Lines of communication e.g., between the NFPB and BHE which were formally established before integration and were functioning effectively, were largely eliminated on the premise that integration would make them irrelevant. This premise was, of course, incorrect. For example, before 1974 an education and training sub-committee was set up by NFPB and BHE. After integration the committee lost its function as the education department of NFPB was now integrated into BHE. Thus, the situation developed where client groups still identify the provision of most educational and training services with the NFPB and accordingly make requests on the Board for these services.

The resultant lack of formal communication linkages within the F.P. network has meant that collaboration in the planning and designing of programmes is minimal. It has also meant that general formal communication between the policy centre and the field is imprecise, delayed or in some cases non-existent. It is our impression that communication and collaboration in the planning and designing of programme is minimal.

Integration seriously interfered with the Board's information system. Divisions were transferred from the NFPB with little consideration of the possible consequences for the functioning of the remaining sections. The integration of the statistical division and the library is an example. With their transfer the NFPB lost essential services to support research and the work of its Information and Communication (I & C) Division. This wholesale transfer of physical units was too drastic, especially since the Ministry's newly established statistical department is still in a developing stage. The implementation of a new system of data collection is planned for 1980. At the moment, however, the department is not yet fully equipped to offer comprehensive health statistics. It therefore cannot help to satisfy critical research needs, especially those relating to behavioural change.

A large body of statistical data is available to the NFPB. Typically, however, these data are in a crude form and not immediately utilizable by the research programme of the NFPB. There are no specialist staff at the NFPB to properly analyse these data. It follows that the activities of the I & C division are severely hampered by this condition.

Certain aspects of the management system within NFPB have lost vitality as a result of the particular integration strategy. For one

thing, fragmentation of the Board's staff appeared drastic and the deployment of remaining personnel has been somewhat unimaginative. Thus, of the 44 staff positions remaining within the NFPB all but eight are in the support category. Such an arrangement has not really produced dynamic management. Moreover, the technical quality of the staff as well as the available number appear unequal to the administrative responsibilities of the Board. Only the Executive Director is a degreed person and the collective management experience of his top assistants is extremely limited. Furthermore, the management philosophy and practice within the NFPB are prominently of the 'civil servide' kind. Almost all of the Board's departments have persisted in the use of retired civil service personnel and their procedurial norms are typically those of the orthodox and non-managerial civil service type.[4] All of this has meant that NFPB can neither engender nor sustain meaningful management relationships with the various ministries and the private commercial sector. Additionally, these developments have undermined capacity to plan, coordinate and direct.

Partial and short term strategies have been used by the NFPB to manage these deficiencies. Attempts have been made to upgrade the technical competence of staff by exposing them to short-term training programmes. Such exposure is rudimentary in the managerial sense and does not satisfy immediate management needs. The approach also heightens the promotional expectations of functionaries and these cannot now be satisfied.

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[4]Since the October interviews the character of the staffing has been changing qualitatively. There has been a de-emphasis on retired personnel and a greater stress on the employment of personnel with relevant managerial training and experience.

Some admirable motivational work aimed at cementing team work and expanding productivity is being undertaken by the Executive Director. These efforts have not, however, qualitatively altered the managerial outlook of the staff largely because many of the management problems are structural ones. The NFPB has no Public Relations Officer - a position which is crucial for shoring up the Board's image. It is badly lacking in library resources which have been integrated into the Ministry. It possesses no independent research/evaluation personnel and this means that some of its core functions are left by default. Additionally, the classification grade of certain key departmental officers, such as the Marketing Officer, is a relatively low PMA II. This specific arrangement has had negative implications for the marketing officer's relations with private sector counterparts.

These management deficiencies are themselves symptomatic of a badly planned integration strategy. In particular, the absence of any carefully planned timetable for completing the integration process has compounded the management problems. Uncertainty of the projections for further integration heightens feelings of insecurity amongst functionaries. The presence of "many evaluation teams within the organization" reinforces the uncertainty and insecurity. In effect, then, incomplete planning has conduced to long delays, privatization of issues and has limited staff involvement in many critical processes. In turn, these tendencies have had disruptive, demotivating, disorienting consequences among staff. There have, accordingly, been expressions of protest and non-cooperation from personnel whose remuneration and job classification might be (adversely) affected. As the national economic condition worsens, individual and group

insecurity and anxiety become more manifest at the workplace. The result is under-production.

Reference has already been made to the fact that the reconstituted NFPB has only a marginal 'service function' in the family planning system and that there are serious management communication gaps between the different components of the Board. These findings assume special significance when they are linked to the 'financial role' of NFPB. The NFPB is an important vehicle for channelling funds to the FP programme. In effect, the Board has financial power that is not consistent with its weak policy determining and coordinating functions. Potentially therefore, an insecure Board, one conscious of its relatively low status, could slow down and even stultify the FP programme and especially the integration exercise.

Whilst this response has not become manifest, it nonetheless remains a potential problem. But the arrangement is overtly problematic in another sense. A prominent and constant irritant, indeed a management concern, relates to certain unorthodox fiscal arrangements between the NFPB and the functionaries transferred from it to the Statistics Department in the Ministry. The arrangements are 'unorthodox' in that they afford the NFPB nominal control over staffs for which the Ministry is now actually responsible. Moreover, certain of these staff secure selective benefits from NFPB in the form of uniform allowances for which traditional employees of the Ministry do not qualify. The result of these anomalies is a severe erosion of staff morale and the undermining of the team approach to FP management.

But that is only one expression of the management difficulty.

Operationally, the NFPB has responsibility for certain ill-defined training functions. Confusion results from this poor definition of training responsibility as the Board is uncertain about its clientele. It also seems to respond selectively to requests for training from 'any source', so that its own training strategy is ad hoc. We feel that a more rational division of training responsibility should allocate to the NFPB specific duty to train persons within community based organizations such as Trades Unions. The NFPB should, moreover, be mandated to develop specialized corps of FP educators who should help superintend such training exercises.

Among the more crucial functions of the NFPB is the management of the Stores. Any management weaknesses in this area can be expected to disturb the entire FP programme. We found major weaknesses in both the supply strategy and the control system in the administration of the Stores. Usually supplies are dispatched from the NFPB directly to the clinics. The distribution process is often so haphazard and ad hoc that the Ministry is unaware of the movement of supplies to its clinics. But the NFPB also makes unplanned distribution of stocks to individuals and groups 'upon request'. This situation is made worse by the fact that the clinic network has developed no uniform or worthwhile record keeping systems. Shortage of equipment necessary for the examination and treatment of female client constitutes a serious problem for management.

Certain aspects of the personnel system within the Stores are particularly defective. The persistent use of retired civil service personnel indicates no urgency in building a long-term management team. The Store's top leadership is also generally 'unfamiliar' with the inter-

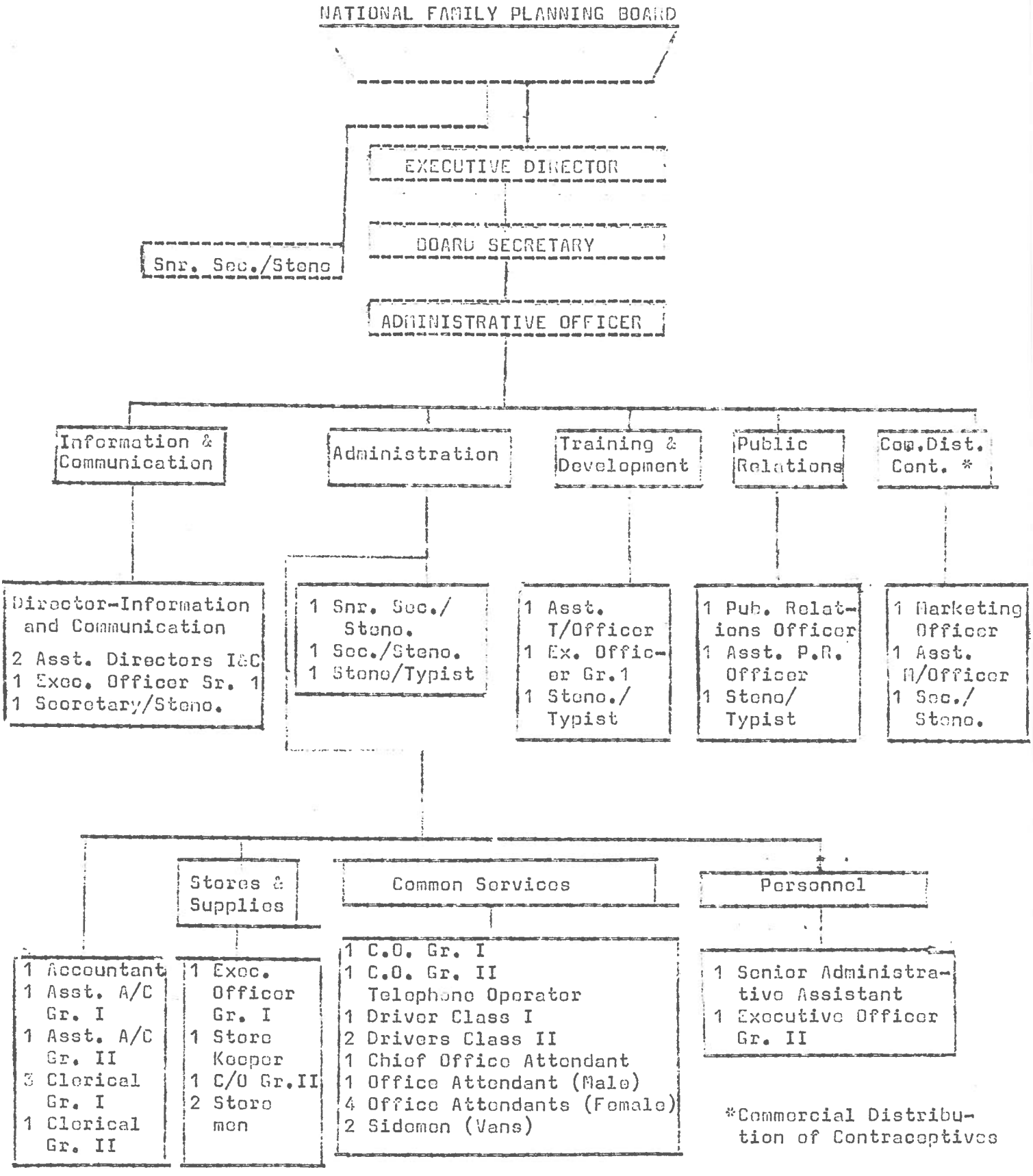
mediate management processes within his unit. The absence from work of assistants, for example, means that top leadership would not be able to 'manage' meaningfully.

We found that the lack of a comprehensive and coherent population and a related social policy framework contributed to the NFPB management difficulties. This lack has meant that the Board's activities are not fully disciplined towards meeting specific, measurable objectives and priorities. Partly, that is why the NFPB tends to react willy nilly to clients' demands for supplies and training. Partly also it explains why the Board has developed no stable, productive orientation to FP research.

Theoretically, however, the reduction of executive responsibility following integration should augment the NFPB's management capability as its span of control has been narrowed and it now concentrates on fewer subjects. But the loss of critical staff, limited resources for conducting on-going research, together with the diminution of the status of the NFPB all underwrite weaknesses in ability to plan, co-ordinate and to institutionalize checks and balances in programme management.

In this regard, we examined the new organizational chart proposed by the Executive Director of the NFPB (Figure 2.1). We discussed the new arrangements in the context of available staff and past management experience. In general it is workable. The line relationships are clear and precise. These would facilitate necessary communication/reporting links and could be permissive of easy staff and staff-client interaction. Quite clearly the span of control is manageable. Much of managerial efficiency, however, will depend on the quality-experience, motivation and training of the Board's administrators.

FIGURE 2.1 ORGANIZATIONAL STRUCTURE



*Commercial Distribution of Contraceptives

Some attention was paid to clinic profile and management. Two fundamental changes in service delivery at the clinic level accompanied integration. First, by linking family planning into the general health service outlets the hitherto single-purpose character of the clinics changed. In this regard, the official guidelines stressed that increased FP services should be dispensed "wherever and whenever maternal and child care is delivered". Second, resort to commercial distribution of contraceptives relieved the formal health delivery system of some responsibility for distribution. In this way condoms and oral contraceptives became more readily available to a wider range of potential acceptors, particularly in the rural areas.

To be sure, integration had mixed results on the entire management process at the clinic level. On the positive side there has been noticeably more productive use of clinic time and available personnel (see Chapter 4). Our investigations revealed improvements in the cost-effectiveness of clinic operations. There have been deliberate attempts at streamlining the health care services, including attention to training, public education and a more professional approach to the drop-out problem. Client-centredness has become a more pronounced value within the clinic network. Clinic managers and their assistants are, in general, more sensitive to their clients' need for secrecy, are more patient in offering guidance and have a broader conception of the male as an important target group. Management approach to FP has also become less clinical, more field oriented.

In addition, the institution-building process has improved quantitatively as well as qualitatively with integration. The clinic network

has expanded from the pre-integration number of 169 to over 250 in 1979. A positive tendency has been a wider spread over the rural sector. Integration required and produced a larger number of nursing and para-nursing personnel. The projected expansion to 3,200 nursing cadres - public health nurses, midwives and nurse practitioners - has not been fully realized, but the expansion rate has been 'encouraging'. In general, the integration of hospital and public health nursing functions has been mostly smooth.

Another positive tendency has been the training and induction of para-nursing services into the health delivery system. These developments have helped to ease the staff problem. All nursing personnel now engage in the teaching of FP and the strategy has been to expose the health team to both basic and advanced nursing education.

An expanding cadre of community health aides (CHA) who function at the parish and grass roots levels has both strengthened and broadened the FP delivery network. We also found that among all these categories of health workers there is at least a basic, but also growing awareness of the core concepts implicit in the FP strategy. Thus, for instance, there has been increasing emphasis on preventive and less on curative services as well as fuller appreciation of the need to combine maternal and child care with family planning needs.

In most daily clinics a public health nurse has responsibility for running the FP clinic. Nurse practitioners give leadership in some clinics. Their support staff typically include the staff nurse, midwife and nurses' aides, depending on the type of clinic. That this management arrangement has tended to generate mostly satisfactory clinic performance

is in part related to the maintenance of stable, fairly energetic staffs who are mostly adequately trained and well supervised. Partly also, these staff are strongly committed to working in the rural sector; they carry a manageable work load and are permitted to contribute to the decisional process at the work place. These positive factors have helped to engender and maintain staff morale at an acceptable level.

On the negative side we found clinic delivery of services to be somewhat uneven. Some clinics were crowded. Others opened irregularly. A few lacked adequate space to offer private consultation. Relatively few daily clinics have the services of a doctor every day, although many of the daily and sessional units were routinely visited by the doctor. Shortage of cabinet space and unreliable distribution of FP supplies gave rise to poor record-keeping systems and a degree of worker and client frustrations. Indeed, many clinic workers feel that deterioration in the flow of supplies to FP clinics has become pronounced since integration. No generalized system of record keeping has developed within the clinic network. Usually the available information is kept at the private residence of the nurse in charge of the clinic.

Despite integration, many clinics do not offer FP services on a daily basis. This would seem to suggest that "the mechanisms for allowing rural clinics to function on a daily basis have not been implemented" (Powell: First Field Report 1979). A related limiting factor is shortage of staffs which constrains the delivery of daily FP services. Some clinic workers are also dissatisfied with 'low levels of salary' and 'insufficient' scope for promotion. We found, moreover, that the accelerated selection and training of community health aides could

become potentially counter-productive. The perceived problem is that standards could easily become diluted if the selection and training programme continues to be rushed. This could undermine the legitimacy of the aides and the programme. This is an aspect of clinic profile that should be constantly monitored.

Germane to the FP programme is its Educational component. The 'management' of this aspect of the programme falls to the BHE. Integration affected both the premises and the trajectory of family planning/health education. Similarly, it has affected management approaches.

With integration all Education Officers were transferred to the BHE, thereby giving it a stable complement of field staff for the first time. The professional responsibilities of these staff now encompassed education for total health - going beyond FP.

According to the integration strategy, the BHE must recruit and place health education personnel; define an education promotional strategy and provide technical support for their educational activities. Health educators in the parishes are now also directly responsible to their respective MOHs for day to day activities. MOHs report on performance, manage disciplinary problems and monitor the educators' work. Certain management problems emerged out of this process. Travelling officers, including health educators suffered an erosion of status. For health educators who were transferred from the Board generally received reduced emoluments. Some lost and resented their special and specialized identification with the FP programme. They became subject to the rules and requirements of career advancement of the general civil service. The cumulative effect was reduced motivation, resentment, insecurity.

Integration also meant that the linkage between the management directorate of the BHE and the programme planner within the Ministry and the top officials within NFPB became more remote and tenuous. The BHE, for example, had no control over nurses, midwives, public health inspectors linked to hospitals, there being no formal machinery for this to happen.

Problems of uneven interpretation of the educational thrust as well as poor coordination of activities emerged as consequences of these arrangements. As presently structured, therefore, the BHE cannot provide the technical support services to education officers in hospitals. The BHE's managerial efficiency is also impaired by insufficient reliance on formal organizational arrangements. Organizationally the BHE is dominated by 'informal' networks among its top personnel and its 'personalist' style is not always adaptable to efficient problem-solving.

D. GENERAL MANAGEMENT TRENDS IN THE FP PROGRAMME

We have briefly examined salient aspects of the profile of the FP programme and have utilized similar concepts of administration to those employed by previous evaluation teams. In general these teams have tended to conceptualize the management function rather broadly. The concerns they emphasize include "clarification of job requirements, staff assignments, time accountability, work review, discipline and coordination within MOHEC and outside"... Additionally, they have assessed the quality of management by examining "work plan, work reports, statistics, budgetary responsibilities and the morale factor" (cf. D'onifrio 1974, p. 36).

Official population/family planning policy has been designed and presented in a rather incoherent way to the health sector. The interpre-

tation of the parameters of this 'policy' is correspondingly incoherent. Certain important policy guidelines, however, exist. These are available via Health Plans, Acts and official statements. But nowhere are clear policy goals, implementation priorities, budgetary management strategy explicitly defined. Absence of coherently stated policy objectives has both facilitated uneven interpretation of the 'guidelines', produced 'personalist' management that limits institutional cooperation. We have therefore been led to the conclusion that the human factor is the hub of the management problem within the FP network. That is not to say that resource insufficiency, technical and other factors are insignificant. But human-related factors such as uncertainty as to career status, demotivation, institutional dependence on informal relationships, personal identification with 'old' management units and so on, constitute the critical problem.

In the overall management process there is a pronounced tendency towards personalist administration. This is evidenced within clinics, the BHE, the Ministry, and the NFPB. However, this tendency cuts two ways: positively and negatively. On the positive side the growth of a 'personalist' management culture has helped to cement informal lines of communication and these have been found to contribute to the maintenance of amicable relationships within and among the respective programme agencies. Depressingly rapid staff turnover, however, gives rise to the negative tendencies.

Personnel changes at every level of the organization are invariably accompanied by redefinition of programme emphases. These changed and changing emphases (in terms of inputs and outputs) tend to be poorly com-

municated throughout the health network precisely because of the absence of formal lines of communication. One overt negative expression of these developments relates to the largely imperfect way in which integration is understood throughout the health network. (Many requests were still being made in 1978, to the Ministry for permission to open FP clinics.)

The institutionalization of the 'personalist' management culture in the context of rapid staff changes has also facilitated 'career jealousies'. Career jealousies are normal in large organizations, but are exacerbated in the health system by insecurities generated by an ill-planned integration process as well as by the apparently selective criteria used for promotion. The predictable result has been a degree of unhealthy competition among programme units: units that should actually discharge complementary functions compete among themselves. We have also found that collectively these tendencies give rise to policy confusion and slow down the pace of programme implementation.

Another source of management inefficiency is grounded in the existence of under-coordinated, multi-agency involvement in the FP programme. Some 32 different agencies are functionally involved in the management of the FP programme. Many of these agencies perform overlapping functions - but in a competitive and non-complementary manner. There is, thus, wasteful duplication of time and other resources. It is in the area of training, undertaken by the Ministry and the NFPB that this problem features most prominently. A special management problem which results from this approach is that of inability to secure proper accountability.

Communication throughout the management system appears deficient on other levels. In other words, the 'personalist' management culture is not

the only communication barrier. Organizational inertia is, apparently, a part of the problem. For, in general, the flow of information from the centre as well as from field agencies tends to be slow and at best sporadic. For example, the Inter-Agency Committee (IAC) comprising representatives from the central FP agencies and originally designed to exchange FP information, promote collaboration and cooperation on general programme issues, has become inactive. Even before the functions of the IAC had completely atrophied, their media and other activities were badly coordinated and critical information possessed by individual units was often privatized. From the outset good interpersonal relationships among members making up the IAC were their effective cement. These have broken down over time, and suggest the need for more formal lines of communication among these agencies.

Assuredly, integration was conceived by the health establishment as an integral aspect of its development policy. The policy implicitly aimed at rationalizing the health delivery system so that it would become more efficient and productive; more accountable and more managerial in approach. The integration strategy was, however, badly managed. The exercise was too rushed. It was generally uninformed by feasibility studies. Too few health workers, particularly those at the middle and lower echelons of the system, were involved in planning the process. The integration idea was badly communicated throughout the health network. Its phases and their timing were poorly conceptualized. For these reasons, the bureaucratic character of the entire exercise resulted in staff frustration and insecurity, diminution of the status of certain institutions and staffs, and, consequently a weakening of the work ethic, morale and team spirit.

Additionally, integration highlighted new problems about staff deployment and financial management. For example, the situation discussed earlier involving staff of the Statistics Department of the NFPB transferred to the Ministry. This transfer was nominal in the sense that the Ministry had incomplete control over these members of its staff. The NFPB has continued to pay their salaries, provide uniform allowances and generally command their loyalties. The Ministry can therefore neither fully direct nor control some of its staff. Such a situation, we found, reproduced tensions and sharply reduced organizational capacity to satisfactorily plan and implement policy.

Within the health delivery system the formal feedback, research and evaluation mechanisms have never been satisfactory (cf. D'onofrio 1974). Integration, of course, contributed to the inadequacy of these mechanisms. For instance, clinic/field staffs do not report regularly and organizational pressures to improve this aspect of programme management are not evident. No standard reporting procedures, or forms, exist for the clinics and the format and frequency of reporting are left to local initiative. Since integration, FP statistics have been fused with general health statistics, managed by the Ministry. It is now increasingly difficult to separate these statistical profiles. In practice, then, the whole body of statistics is very crude, mostly unreliable and therefore incapable of adequately informing crucial management decisions.

Also inhibiting creative family planning management is the persistence of ad hoc evaluation strategies. Since 1970 several evaluation studies have been commissioned by the health establishment to investigate

and report on aspects of its operations. Often studies are commissioned before the recommendations of previous teams are implemented. Usually the terms of reference of succeeding evaluation teams are similar. This strategy is symptomatic, we feel, of uncertainty as to what direction the FP programme in general and the integration process in particular should actually take. But the strategy also slows down organizational vitality and reinforces feelings of insecurity among health/family planning workers.

To summarize: these findings, taken together, lead to the conclusion that the more serious management problems are associated with the human factors partly with high incidence of staff turnover within the health network. Furthermore, the high incidence of role confusion among employees and uncertainty about tenure and status as well as salary dissatisfaction all constrain effective personal and team performance. Moreover, fragmentation of role and functions as well as competition among programme agencies encourage private, bureaucratic decision-making processes that result in slowness and uncreative routine. Additionally, under-coordination among management units not only accounts for planning difficulties, but also reinforces weaknesses in supervision, communication and the conceptualization of existing problems.

Even more disturbing, perhaps, is the fact that these management problems are recorded in a context where the span of control is not objectively incompatible with the amount of available expertise. This is a context, moreover, where theoretically, the key administrative lines of supervision bear sensible relationship with most of the organizational structure. However given the fact that line relationships are being

increasingly redefined (via integration), it must be taken to mean that there are bottlenecks within extant structures. We have, in fact, identified some of these.

Despite all these real difficulties, we found the FP programme to be highly visible; that there is an acceptable level of client satisfaction with several aspects of the programme; that public knowledge of and attitude to the FP programme are largely positive and that in terms of the quality of output, the programme merits continued official and external support.

The thesis of this chapter remains nonetheless that the core problems associated with the FP programme are essentially Management problems.

CHAPTER THREE

EDUCATIONAL AND COMMUNICATION ISSUES

INTRODUCTION

Since there are more than 30 public and private agencies involved in the Jamaica family planning programme, and most of them deal with the educational aspects in some way, we will only analyse the educational and communications programmes which are most important for education in family planning and have the widest outreach. These are the educational family planning (FP) and family life education (FLE) programmes of the Ministry of Education - in particular the guidance counsellors programmes and the Educational Broadcasting Service (EBS) programmes; and programmes undertaken by the Ministry of Health through the Bureau of Health Education (BHE) and the National Family Planning Board (NFPB).

We will analyse some of the more important activities undertaken by these agencies and try to assess the efficiency of their different communication approaches regarding their possible influence on knowledge, attitudes and habits of the target populations.

Whereas the target groups of the Ministry of Education are mainly students and teachers, the target group of the Ministry of Health is the general public.

A. MINISTRY OF EDUCATION'S INPUT INTO FP AND FLE

There is general agreement about the need for FP and FLE to be incorporated into the curricula of Jamaica's schools. This is especially

important in view of increasing teenage pregnancies.[1] However, a clear government policy and a comprehensive strategy to provide islandwide coordinated teaching in the subjects are lacking. A number of efforts have been made since the late sixties when the idea of including FP and FLE in schools was first introduced in Jamaica. But they remain still in an uncoordinated state. Some of these efforts are described below.

1. Personal Development Education/Family Life Project (PDEP)

The Personal Development Education/Family Life Project (PDEP), launched in 1976, is financed by USAID through the NFPB and is carried out by the Ministry of Education. The project plan for 1976-1980, aimed at the integration of FLE into the programmes of primary, secondary and tertiary educational institutions, through teachers, counsellors and lecturers. The plan was only partly implemented, mainly with the training of education officers, school guidance counsellors, primary school teachers and principals. Fourteen training workshops were conducted between 1976 and 1977.

In late 1977 the objectives and strategies of the project were reviewed. Emphasis is now being placed on guidance counsellors and educational broadcasting programmes (EBS). But this is a limited approach as guidance counsellors do not reach the total 12-17 age group. The use made of EBS, FL and FP programmes by schools also seems to be rather limited as our guidance counsellors survey indicates. (See below.)

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[1] See for example, Hermione McKenzie and Dorian Powell, Report on First National Conference on Fertility and the Adolescent, 1980.

A Resource Centre for the use of guidance counsellors was set up within the guidance and counselling section. It is still being enlarged.

The integration of family life concepts within the existing school curricula has been planned. However, full implementation seems to be of lower priority because of staff shortages and financial constraints.

2. Curriculum Sections

Various curriculum committees are working on the integration of FLE and FP into the related curricula. Family life education as well as family planning messages are already included in some of the traditional subjects like science and home economics.

The current curriculum in science for instance, provides about one-third of its classes for Grade 9, Term 3 for FP and FLE topics. The bigger part of it is devoted to human reproduction. About 9 per cent of the science for Grade 9 classes is supposed to deal with straight FL topics like population, birth control and birth control methods under the frame of family care.

The core curriculum in Science, Grade 7, Term 3, Units 5 and 6 prepared for pilot schools, April and September 1979, also includes some FP and FLE topics but is introduced to the teachers very cautiously. In the Teachers Guide, Unit 6, September 1979, it says for instance: "The methods of birth control should be seen as part of the planning of a family .... Exactly how much detail the teacher discusses will depend upon the class".

Anticipating that the teacher might need additional help or information, the Teachers Guide refers to the NFPB. This can be seen

as a positive attempt at coordination. But at the same time, the Guide mentions a booklet, Miracle of Life - an Introduction, as reference for information material, a booklet which is currently no longer available either at the NFPB or the BHE. In this case as in others, minimal communication between the various agencies seems to hamper the attempts at coordination and cooperation.

In general, it can be seen that FP and FLE are by now integrated into the curriculum of various subjects (e.g. science, life skills, home economics) and grades (from 7 to 11). Whereas human reproduction was always covered in the curriculum, fields like family planning methods and VD have been integrated quite recently, starting in 1975, in line with Ministry Paper No. 1 of the Ministry of Health. Currently, efforts are being made to integrate FLE into the curriculum for Grade 5, and discussions are going on to apply FLE topics to Grades 1 - 3.

Since FLE and FP are rather new fields there is a need for teacher training. The instructions given in the teachers guides of the core curriculum in science are no substitute for training. Some teacher training colleges already offer courses in these fields, but these efforts are not coordinated islandwide. The various sections of the curriculum unit necessarily include the subjects in their workshops and seminars especially when the new curriculum is presented. But this cannot substitute for comprehensive training in a field which many teachers do not master easily because of their own traditional attitudes and insecurity.

The development of realistic strategies and content outlines for the introduction of FLE into teacher training institutions, although

desirable, does not seem to be easily reached:

> Since the existing teacher training colleges are relatively autonomous bodies such adoption is not simply a matter to be dictated as the Ministry of Education. Exploration through the guidance counsellors seems to be a useful course to take. Since in previous years these schools have generally shown a strong interest in FLE it may be possible for the Ministry to use its representation and influence on the committees which set standards for teacher certification to require minimum knowledge and skills in FLE as a part of the requirements for certification.[2]

3. Guidance Counselling

Whereas the efforts of the curriculum unit are somewhat dispersed, there is a serious attempt by the guidance counselling section of the Ministry of Education[3] to integrate FP and FLE into the work schedule of guidance counsellors in secondary and tertiary institutions.

The guidance counsellors programme for secondary, high schools and tertiary institutions was launched in 1974. Currently there are posts for 158 guidance counsellors provided within 154 educational institutions: 141 secondary and high schools and 13 tertiary institutions (7 teacher training colleges, 2 technical colleges and 4 community colleges), Some schools and colleges have two counsellors. About 20 posts are vacant at the moment. A total of about 144 guidance counsellors are currently employed.

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[2]Dorian Powell et. al., "Report of an assessment of the Information, Education and Communication Activities of Jamaica's National Family Planning Programme 1979," p. 47.

[3]At the time the data for the report were collected, the guidance and counselling section was part of the research, evaluation and counselling unit within the educational planning division of the Ministry. Since 1980 the guidance and counselling section has become part of the curriculum unit.

As far as special training in counselling is concerned, about 60 guidance counsellors qualified at Western Carolina University U.S.A. between 1975 and 1978. Others attended a one-year guidance counsellors training course at the Educational Training Centre, U.W.I.

The Ministry of Education guidance and counselling section is planning to provide all counsellors actually working with adequate training in guidance and counselling. Three diffcrent training approaches are undertaken:

(a) A one-year guidance counsellors course at the Educational Training Centre, U.W.I. Twenty students have already attended and 19 are currently participating. All have already worked as guidance counsellors, but did not have enough training. Some worked as school nurses or in rolated fields at other government institutions before. They all have to have an educational background that permits study at a university. One additional course for 20 students is planned for next year. So that after three years 59 guidance counsellors will have received special training at university level. It is however doubtful whether the third course can be conducted due to financial constraints.

The students for those courses are being selected by the Ministry of Education, which is providing the funds. At the end of the course the counsellors are encouraged to go back to their schools.

The one-year university course for guidance counsellors does not stress FLE and FP to a great extent because the emphasis lies more on the teaching of technique than content. The teachers have expressed a need for FP and FLE teaching material.

(b) In the in-service workshops organized by the guidance counsellors unit, FP and FLE are relatively more stressed than in the university course. These workshops are held twice a year in each of the four parishes, one in May and one in November. The workshops last $2\frac{1}{2}$ days. About 20 per cent of the programme deals with administration. Eighty per cent represents instruction time. About 75 per cent of the professional instruction time is devoted to FLE including FP topics.

(c) The third training approach is sporadic on the job training whenever field visits are done. The amount of FP and FLE input varies and is also related to the actual need that comes up during the field visit.

Whether or not these training approaches are sufficient will be judged by the related answers of the guidance counsellors survey described below.

The guidance counsellor's position and function at school are different from those of the teachers. Although most counsellors have regular hours provided for their classes in the school schedule, they must be flexible. Therefore it is much easier to integrate a new and controversial field like family planning into the guidance counsellors schedule than into any curriculum of a traditional school subject.

It therefore seems reasonable to support and extend the guidance counselling programme in schools as the means whereby knowledge of FP and FLE are imparted.

Because of their key role, the counsellors' attitudes, habits and knowledge of FP and FLE are of critical importance. Results of a survey undertaken to test these are presented in Appendix VI.

4. EDUCATIONAL BROADCASTING SERVICE (EBS) - Programmes in FP and FLE

The Educational Broadcasting Service is part of the educational planning division of the Ministry of Education through its integration into the multi-media unit. It produces radio and television programmes aimed mainly at school children and teachers.

EBS Radio produced half-hour programmes for FP and FLE some time ago but is now not producing such programmes.

On EBS-TV two different programme series dealing mainly with FP and FLE are produced and transmitted.

The two TV series are:

(a) A series of 10 programmes per term produced during 1978-9 in collaboration with the staff of the guidance and counselling section. These programmes are intended to support the counsellors' efforts.

(b) A series of 10 programmes per term produced in collaboration with the Ministry of Education staff responsible for the core curriculum in science. The programmes are intended to support the teachers' efforts and give them help in dealing with a difficult new field.

Both sets of programmes are discussed below, followed by an analysis of possible effects.

(i) Programmes to Support Guidance Counsellors in Teaching for FP and FL

(a) Description of programme and teachers guide

These programmes are aimed at grade 7-11 students. They were broadcast on JBC beginning with the Christmas term 1978. The second and third series are now being re-broadcast, while the first series will be reviewed.

All three series deal mainly with FL topics, with special relevance to teenagers. However, one of the series discusses the more technical aspects of FP and sexual development and relationships, for instance, menstruation, reproduction, pregnancy and childbirth, contraceptive methods, sexually transmitted diseases.

The other two series stress FL including personal development problems such as puberty, maturity, population and you, self concept, responsibility, parent/child conflict, sex education in school, contraceptive technology and youth, teenage pregnancy, sexual offences, homosexuality, myths about sex.

For each series a TV teachers guide was developed for use by the guidance counsellor, to give background information and to provide ideas for activities to prepare for and reinforce each programme.

The objectives of the programmes as outlined in one of the teachers guides and in some of the programme scripts available to the team are: to make students aware of certain problems during adolescence and to encourage and enable them to assess and research the reasons and conditions of the problems with a view to overcoming such problems and establishing their patterns of values and responsibilities.

To attain these objectives, the programmes give only a limited amount of technical information. However, they offer a variety of different and usually contrasting opinions on the subject. The format uses a variety of different techniques. The standard format is an introduction and a final word by the presenter, and foreign film inserts or interviews, panel discussions, plays with local people, students, or experts like psychiatrists, lawyers, etc.

(b) Analysis

Following is a short analysis of the scripts and teachers guide to one of the three TV series on personal development for guidance counsellors. It is the 1979 series - "Let's Talk".[4] Table 28 gives an overview of the programmes.

We can see that the programmes deal with FL and personal development not with FP techniques. Even the programme titled Contraceptive Technology and Youth is not intended to inform about different contraceptive methods. Instead it discusses the question whether knowledge of contraceptives encourages promiscuity among teenagers.

The programme series is not directly aimed at stimulating FP. Taking into account the special social obstacles and traditional objections to FP in Jamaica, the programmes aim instead to enable the students to take rational personal decisions through critical assessment and research. The programmes are thus preparing the way for responsible FP in the long run.

Although the outcome of this approach might not be directly visible, it seems to us more effective in the long run than any advertisement or straight information on FP methods, since it intends to attack the roots of overpopulation. It tries, for instance, to build up alternatives to childbearing as a means of proving adulthood, by emphasising social responsibilities and personal instead of physical qualities.

To find out whether and how the programmes meet the recorded objectives we analysed the scripts. Although the scripts do not include

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[4]This was the only series with nearly all scripts and teachers guide available to the team.

the film or video inserts, they describe these inserts, the form and content, so that they give in fact a good picture of the TV programme.

The objectives aim at an awareness of problems, an encouragement of research and rational decision making. A limited offer of technical information combined with an exposure to different opinions and the analysis of those opinions during discussion, seem to be adequate to meet the objectives.

Furthermore, it seems to us that the programmes carry some potential to motivate and stimulate the students to change opinions and habits. The use of student participants helps the viewers to identify themselves with the problems. The use of local experts promotes credibility, an important factor in influencing change of opinion and habits. The confrontation with different opinions, while emphasising one, helps to convince in a rational way.

However, the format of presentation is somewhat stereotyped. Although the video tape inserts differ, the setting is usually the same: an exchange of opinion or an answering of questions in whatever form (talk, discussion, trial). Participants are students and experts. This is the setting the students are accustomed to in school, and it seems to us that there is need for structuring the programmes so they would be different from the classroom atmosphere in order to maintain interest and motivate students.

The TV teachers guide complementing the programme series also needs re-structuring. The amount of suggested activities to support and reinforce the programmes through classroom teaching varies from one to seven. In fact the number is even higher for some programmes since the

activities are sometimes numbered according to various teaching techniques, for instance, 'discussion' might include suggestions for various topics (e.g. programme 2, activity 2). For some of the programmes the objectives are named in the guide (e.g. programmes 6 and 9) but not for all. For some programmes the guide gives background information (e.g. programmes 7 and 8) but not for all. Some programmes describe before and after activities, others only activities after.

The suggested activities should be obviously linked to the programme and the reason for each activity and its relation to the programme objectives should be explained to the teacher, to offer more direct guidance and help in selecting the activities in a rational way. Psychological tests (as suggested for instance, for programme 5) should be adequately described and guidelines for the evaluation must be added. In general the use of those tests for classroom teaching should be carefully considered, since used in the wrong way they can do more harm than help.

Finally, we want to mention a general problem concerning the production of mass media programmes for FP in general. Since there is still a taboo on face to face communication about sexual matters within a large part of the population, there are not many everyday terms to name sex organs and the sex act. There exist only the scientific terms and a number of expressions considered vulgar. This makes mass communication about FP, physical development and explanation of the reproductive system, extremely difficult. The producers of mass media programmes try to overcome the problem mainly by using the scientific terms. But this might lead to problems of understanding and interfere with reception of

the message. To improve the effectiveness of the programmes by raising the level of understanding, we suggest that more use be made of vulgar words in combination with the scientific terms, so that the viewers get used to the different vocabulary. This may increase even face to face communication about sex and related fields, and promote communication with health staff about FP. Since the use of vulgar words in this delicate area can however easily provoke objections against the programmes, these programmes will have to be carefully planned, scripted and pre-produced.

(ii) Programmes to Support the Core Curriculum in Science

These consist of three series of 10 science programmes, aimed at grade 9 students. The programmes are now being repeated. These programmes deal in a descriptive way, with the scientific aspect of the human body, its development and sexuality. Recently the FP segment of the programmes has been expanded to include aspects of social awareness and responsibilities for FP. The programmes are aimed at students of secondary level aged 14-16, (Grade 9) as well as at teachers.

Two of the ten programmes for grade 9, term 3 or 20 per cent deal with birth control methods and VD. Five of those programmes or 50 per cent refer to human reproduction. A total of 70 per cent of the EBS science programme deals with FP and FLE messages, as compared to 33.3 per cent referring to these fields in the science curriculum for Grade 9 Term 3. This again seems to indicate clearly that there is a felt need for supporting teaching in the fields of FP and FLE. This is also reflected by the fact that the EBS programmes are not only aimed at students but also at teachers. It must however be mentioned that the

10 EBS television programmes per term can by no means substitute for teacher training courses in FLE and FP, since the programmes do not reach all schools, are supposed to be mainly aimed at students, and do not include information on special teaching methods.

Along with the programmes, a guide was developed for the classroom teacher. This guide includes for each programme: general objectives; topics for discussion and demonstration; suggestions for pre-programme activities; suggestions for reinforcement activities after the telecast; background information for the teacher which goes far beyond the explanation of the progremme content. This guide seems to be very useful even for science teachers with little training. This comment refers, however, only to the type of information given. The guide does not provide any teaching methods for teachers who were never trained in FP education. So that if the guide, for instance, suggests that one includes in the discussion of VD "any moral questions involved" this might not be very helpful for the teacher unexperienced in FP topics. The contents of some of these programmes as outlined in the teachers guide were listed in the Draft Report and will not be repeated here.

The scripts of seven programmes examined were analysed in terms of: extent to what the objectives outlined were met; amount of information given; assessment of whether the programmes can help to motivate, change habits or inform only. Each programme lasts about 20 minutes with a 5 to 10 minute film insert. These film inserts were not included in the script but the programmes which contained film inserts were shown to the evaluation team by EBS. The film inserts served mainly to repeat and reinforce what was said before. They could also serve motivational purposes through

identification. But they are obviously foreign productions, mainly from the United States. Identification with some of the actors as a means for motivation is therefore not possible for Jamaican students. Funds and facilities for adequate productions of their own are not available at EBS. Dependence on these films therefore continues.

The programmes are scripted by the producer/presenter of the programme. Four of these programmes are scripted in the form of speech with a film insert between 5 - 10 minutes. One programme has a short introductory speech, goes into detail with an interview and ends with a film insert. Two programmes are introduced in speech form and go on as an interview.

The change of format serves mainly to gain attention and to reinforce what was said before, since messages given during the speech are repeated in the film or interview that follows. We list below our main findings.

No programme seems to meet all of the outlined objectives. The objective of transmitting knowledge is largely met by the programmes. Information is given and reinforced several times through repetition with other words and forms. But it seems doubtful whether the relatively straightforward format of the programmes can provoke appreciation of qualities such as the role of the father in determining the sex role of the child, a value which is not at all self-evident in Jamaica. In general we found that the objectives concerning appreciation were not, on the whole met.

In discussing these findings with the producer it was learnt that the programmes are only seen as supplementary to classroom teaching.

They are mainly intended to provide information. Stimulation and motivation for change are expected to be covered by the discussions or lectures before and after the TV programmes. From that point of view the programmes meet the goal. However, it will have to be investigated whether the programmes together with the teachers guide provoke classroom teaching that really meets the overall objectives. Since only a few science teachers were trained in FP, this might be doubtful.

The other goal of the TV programmes is to provide teachers with additional information on FP. The programmes are also supposed to provide teachers with methods and techniques of how to teach FP. This last aim might not be fully achieved; since it is nowhere directly expressed, the teachers might not be aware of it. They therefore do not have the chance to reflect on the various techniques used in the programme. Then again, the various methods are not presented in a systematic way that might be easily understood by the teachers.

In general we saw that the programmes were designed mainly to pass on information about FP to students and teachers and not so much to provide teachers with teaching methods for FP. The appreciation of certain values is not stimulated by the programmes on their own. In cooperation with a well trained science teacher discussing and strengthening the programme content, this objective might be met. Teacher training in FP and FLE is therefore a precondition for achieving greater effectiveness of the EBS FP programmes in science.

The amount of information given in each programme seems to be rather high, particularly for students as a target group. Counting the amount of new information given in each programme we found an average of

19 different information bits given in each programme with a range from 6 to 31 items per programme. This difference can be explained by the varying format of the programmes, since only the amount of information in the scripts could be counted, and film inserts as well as exact answers in interviews were not available for evaluation. Nevertheless, it seems to us that the amount of information offered for a 10 - 15 minute programme is rather high.

The programmes might be more effective if they were to offer less information, when it is remembered that we are dealing with a student population. There is the danger that they might only pick up some information. And since one cannot control which bits of information are picked up and which are not, there might be the danger of confusion and misunderstanding. On the other hand, the producer said that the transmission of this wealth of information was intentional. And that although not all might be recieved and/or recalled after the programme, it could probably serve to stimulate questions and discussions.

It should, however, be considered whether the goal, that is, to stimulate questions, might not be met by other means than by giving too much information, since there is the danger that too much information raises not only questions but also confusion.

Our analysis showed that the programmes as such are not really geared to motivate the appreciation of certain values, nor to stimulate a change of habit. A change of habit cannot be stimulated by offering information only. And there are not many motivational and stimulating techniques employed in the programmes.

However, the programmes do offer information for teachers as well as for students.

It should be mentioned that the cooperation between EBS and the core curriculum science unit seems to be good.

B. THE MINISTRY OF HEALTH'S EDUCATION/COMMUNICATION INPUT IN FP AND FLE

Since Chapter Four deals with the Ministry's field service, we will concentrate here on the mass media oriented education/communication activities undertaken by the BOHE and the NFPB.

We will limit our description and in particular the analysis to communication activities which intend to educate. Public relations efforts or advertisements for contraceptives will not be analysed here.

1. The NFPB's Input in FP and FLE

(i) The Development of the IE & C Division

The Information and Communications Division (IE & C) is responsible for the NFPB's education and communication input. Although information, education and communication were part of the NFPB's activities from its very beginning, a separate division to deal with these areas was established only in 1972. In the beginning the educational duties of the division were carried out mainly by the field workers of the NFPB and the Ministry of Health through face to face communication. The information aspect was dealt with through the mass media. The use of all mass communications media for advertising was originally intended to create an awareness of family planning, its services and benefits. When these objectives seemed to be met by 1972/73, a comprehensive review of the mass communication design was carried out in order to determine

modifications necessary for a sustained impact. As a result, in 1973/74 the full scale advertising campaign was reduced. Advertising was confined mainly to radio and press. Relatively more emphasis was put on the design and production of educational materials in collaboration with the BOHE supported by the NFPB's statistical, research and library services.

Up to the time integration started in 1974, the educational component of information, education and communication had been strongly emphasised through face to face communication as well as through mass communication. The transfer of clinical and educational services and staff responsible for face to face education in FP, to the Ministry meant a significant loss of function to the IE & C Division. The Division was cut down to Information and Communication only, although part of the educational responsibilities stayed with the division through its mass media approach. However, the transfer of the statistical department and the reference library, two important supportive services, to the Ministry of Health affected the working conditions within the division considerably. Finally, four more staff members left the division, with the result that since 1976 the I&C staff has been cut 50 per cent. There are currently only five staff members, including one secretary, who are still trying to maintain their information and communication responsibilities.
As a result of integration, the educational component of the then IE & C Division was split and as a consequence reduced in its total effort, and efficiency. The most important part of the educational component carried out by field staff through face to face communication stays now with the MOH health service and with the BOHE.

Integration took place on the premise that the total health service would be fully supporting family planning so that the total FP impact would be greater. Due to insufficient preparatory work for integration however, the FP educational impact seems to have suffered. Whereas the former FP Education officers had to take over other health education responsibilities and therefore had to reduce their FP efforts, the MOH field staff did not include FP and FL education to the same extent, into their programmes.

Another component of FP and FL education through mass communication (e.g. production of printed material, use of video tapes and their production) falls now under the responsibility of the BOHE which is however limited in its activities due to lack of staff and equipment.

(ii) Current Activities of the I & C Division

The NFPB's I & C Division is currently designing, producing or promoting educational, motivational or informational programmes in FP and FL for radio, press, mail service or personal communication. It collaborates with the Ministry of Education in carrying out activities, mainly on FLE, in schools. It provides advice and resource persons on demand to schools, to the educational broadcasting service (EBS) and other institutions, or groups (e.g. youth groups, urban development projects, women's clubs, parent education workshops etc.). In short, staff members of the I & C division function as resource persons for various institutions or groups on request. Although in 1974 FP education was integrated into the BOHE, requests for advice and educational support are still addressed to the Board which is the agency identified with such education in the public mind since nearly all such educational mass

media programmes are transmitted under its sponsorship. With its limited staff the I & C tries to meet most of these requests, but not all requests on educational and training services can be met. There are also links with another public education programme, the Ministry's Nutrition Education/Communication Programme, launched in 1978, which promoted family planning as one of its five objectives.

Following is a list of regular media activities of the I & C Division.

(a) Mass Media Activities

Radio: 1. In coordination with the FLE programme, radio spots were produced by an advertising agency, Dunlop Corbin Compton Ltd., and transmitted on radio from 1978. The spot messages were intended to promote communication between parents and their adolescent children and sexual responsibility. They were intended to provide motivation for FP and stimulate awareness for improved family life. The transmission of the radio spots ceased in March 1979.

2. In 1975 a series of 5 minute programmes started. They were originally produced by the I & C Division. In 1978/79 however the style and length of the programmes changed, when the production was contracted out to Dunlop Corbin Compton Ltd. as a result of critical commentaries to the programmes. The agency changed the series into 10 minute dramatized radio programmes on FLE geared mainly to teenagers. The programme content is based on suggestions of the I & C Division reflecting the needs of teenagers as expressed in their letters to the answering service. The messages deal with teenage pregnancies, love, contraceptive advice, male responsibility and venereal disease. The programmes are presented

in Jamaican Dialect and transmitted on Jamaica Broadcasting Corporation (JBC), Mondays and Wednesdays from 6:05 to 6.15 p.m. and on Radio Jamaica (RJR) on Saturdays from 9:30 to 9:40 p.m. and on Mondays from 7:10 to 7:20 p.m. The programmes are now being repeated. There are no plans for future production.

3. In 1977 RJR offered to the I & C Division between 10 and 30 minute programme time free of charge to be slotted into the "Jamaica Today" programme, once a week on Thursday mornings. The programmes titled "My Problem" and presented under the pseudonym "Marge Roper" are currently running between 20 and 25 minutes. They are produced by the I & C divisions Information Officers, in dialogue or discussion form. Up to August 1979 "My Problem" was transmitted live, and dealt mainly with FL problems, based on letters sent to the Answering Service.

In response to objections of RJR presenters to dealing with some of the more delicate areas of FL, the programmes stopped for about one month. Since they started again in October 1979, they have been taped beforehand and deal with more technical FP matters. The subjects chosen are still reflecting problems found in letters to the answering service.

All radio programmes under the responsibility of the I & C division invite listeners to contact the NFPB for further information or advice. Feedback to the programmes is therefore received through the answering service. The end of the radio spots in March '79 was reflected in a sudden drop of letters to the answering service. The same phenomenon was observed by the I & C staff during the one month stop of the 10 minute FL programmes, in September '79.

TV: At the moment the I & C division does not transmit any programmes on TV. There are commercials on TV to advertise two contraceptives - the pill - "Perle" and the condom - "Panther". These advertisements are transmitted several times a day to meet CDC demands. Similar commercials are transmitted on radio. Although these spots are not regarded as a part of the I & C division, they seem to support and reinforce the I & C programmes since the public does not make any distinction between the different FP and FL programmes promoted by the NFPB.

Press: From time to time the NFPB uses the press to spread FP and FL messages. There are two different types of press information:

a. Press releases of informative material.

b. Paid advertisements. Advertisements in this context are not necessarily for contraceptives. They are intended to create awareness of and motivation for FP and promote the services of the NFPB. The black and white posters produced about 2 years ago by the NFPB under the title "Have a Heart" are used for the press advertisements. Due to limited staff and budgetary restrictions the press messages are at present sharply reduced.

Print: At the moment no printed material is being produced. The posters in circulation are about two years old. Billboards and market signs no longer receive attention. Booklets and brochures are bought on order from the BOHE's stocks. Dunlop Corbin Compton prepared a booklet "Let's Rap" as a revision of the booklet "Miracle of Life", but the printing had to be dropped due to lack of funds.

Exhibitions: From time to time the I & C division prepares material to be presented in exhibitions or fairs.

(b) Answering Service

The answering service developed out of public response to the radio programmes on FLE which began in 1975. "Within a month letters were being received primarily from teenagers and young people asking for advice and information on FP and related matters. In August 1975 an Advice Service was begun to meet this public demand. This was limited only to answering letters. Since letter answering was the major activity, the service in December 1976 took the name "Answering Service" and members of the public were invited via press and radio to write, telephone or visit the NFPB office for advice and/or information pertaining to FLE/FP. However a variety of topics constantly emerged which as it became necessary, were subsequently referred to appropriate agencies".[5] The pseudonym "Marge Roper" was used for the radio programmes, allowing the public to address the NFPB in a personal way. The answering service can help to attain four objectives:

1. to promote FP and FL through personal advice on questions and problems coming from the public.
2. to establish a feed back mechanism for the mass media programmes. Many questions or comments from the public come as a response to the radio programmes.
3. The amount of response as well as the quality of questions might be an indicator of whether and how the programmes are understood and whether they cover the total range of public need in information and education for FP and FL. The answering service can therefore be useful for programme evaluation.
4. An analysis of the queries and problems addressed to the answering

[5] See Dorian Powell et al., "Report of an Assessment of the Information Education and Communication Activities of Jamaica's National Family Planning Programme, Kingston, February 1979.

service in qualifying the public need in FP and FLE can also be useful for future programme planning. In fact, material for the 1977/78 FLE radio programmes was developed through analysis of the queries sent to the answering service.

The answering service functions in three different ways:

1. through letters
2. by telephone
3. through personal counselling at the Board's office.

Quality of requests

The service's activities grew gradually and continuously from August 1975, starting with letters only at the first stage. In December 1976 the telephone service and personal counselling were introduced. The letter service is still the biggest part of the programme, as Table 1 indicates, partly due to the difficulties of telephone communications. Another reason for the relatively low number of telephone calls might be the fact that long distance calls are much more costly than letters. It can therefore be assumed that most of the phone calls come from the Kingston and St. Andrew area. With regard to personal visits, the low number of contacts might be due to the fact that personal advice for FP and FL is available at each health clinic, from nurses and community health aides throughout the country.

Table 2 shows that the majority of the letters come from the Kingston and St. Andrew corporate area. This might be due to the fact that this area has the largest population, the largest number of clinics, and largest urban area, which means that a wider pool of information resources is available and the literacy rate might be higher.

The majority of persons using the service are teenagers and young adults. Students and teachers are also using the service to acquire information and material on special FP or FL issues. Reportedly 50 per cent of the clients write in more than once. Table 3 shows the nature of requests, listed by categories currently kept by the service.

It can be seen that more than 50 per cent of the letters seek advice or information on reproduction. The high percentage might however be explained by the fact that the category "reproduction" includes a larger number of issues than the category abortion or sterilization, for instance. It seems therefore necessary to restructure these categories to enable more significant analysis.

In general, it was reported by I & C staff members that the nature of the requests demands a great deal of detailed information and technical advice on a wide range of FP and FL matters.

Operation of the Answering Service

Two staff members are responsible for the answering service. Since they are also responsible for other tasks such as the production of the "My Problem" radio programme, they take turns. There is in many cases, only one person at a time available. This hampers continuous service and leads to disillusionment of clients who phone or come a second time to the answering service under the impression that 'Marge Roper' was a real person, to find another 'Marge Roper' at the desk. This might spoil the effect of the personal component of the answering service introduced by the pseudonym. It seems necessary to have at least one person permanently responsible for the answering service with part time assistance of another staff member.

The answering service tries to respond to the letters in a personal way, including direct personal or technical advice and answers to questions. In addition, printed material like booklets, leaflets, brochures partly from the BOHE, or if these are not available, copies of radio programmes dealing with the problem are attached to the replies.

The need for more informational material was expressed by staff members. The fact that copies of radio programmes instead of printed material have to be sent, is significant. Although this shows flexibility, a commitment of the staff to their task and the effort to keep the service alive despite shortages of material and staff, the situation is not satisfactory in the long run.

Sometimes the clients are referred to the Medical Officer of Health or Health Education Officer of the appropriate parish. However there is no permanent liaison with the Ministry's field staff and feedback from these referrals is hardly ever received.

The responsible staff members try to answer urgent letters immediately. In special cases the answer is even sent by telegram, in particular when it seems necessary that the client should come for a personal visit. Answers which require special technical advice are however often delayed due to the fact that the reference library as well as the statistical service is not at hand. It sometimes takes weeks to get specific data on FP from the statistical department which has been integrated into the Ministry since 1978. Therefore even urgent requests from international institutions for special data cannot be immediately filled. This again shows the importance of reintegrating at least parts of the reference library and the statistical department into the NFPB, if effective work is to be undertaken.

The lack of a nearby library is even worse in regard to telephone calls, or personal visits when technical questions cannot be answered off hand by the responsible staff member.

Problems aired in a phone call are usually dealt with at the time of the call. However if delicate matters are mentioned or the clients hesitate to discuss an issue on the phone, the caller is invited to visit the NFPB.

Phone calls and letters have been documented since March 1977. All letters are recorded in an in-take book. The name of the writer, the parish of origin, the nature of the request, date of receipt and date of reply are identified. The letters are then filed alphabetically by parish. They are however not regularly and formally analysed probably due to the recording system which does not allow sufficient methodological analysis. There is also no feedback mechanism.

It was found that the staff members responsible for the answering service do not have specialized clinical counselling skills. In addition the counselling service does not seem to be formalized as such. Drop-in visits and phone calls seem to be dealt with in an ad hoc personal way, the effect of which is hard to estimate.

In general we find that the answering service is a necessary and useful alternative to other FP services using face to face communication. It meets the needs of those clients who cannot or do not want to reach a FP service otherwise. In particular the letter and telephone service of the NFPB give people who do not have access to other FP services or who are too shy for face to face communication an opportunity for receiving advice. The telephone service, in addition, enables the client to obtain

quick information, without having to reveal his identity. The answering service can influence people and contribute to their decision making for FP and an improved FL as much as face to face communication in general, although its most important means (letter and telephone) are not based on personal contact. Mass media programmes are far less likely to actually change habits. There, emphasis lies more on information. This again proves the importance of the answering service which fills a gap by combining the more comprehensive effect of personal communication with some advantages of media communication.

2. The BOHE's Input

As described above, the educational component of the NFPB's FP programme was supposed to be transferred to the BOHE, in 1974. In reality however, the BOHE took over responsibility for personal education in FP by changing the original FP officers into Health Education Officers and integrating them into the total health education service. In the area of mass media, the Bureau had responsibility only for the printing and distribution of some FP and FL leaflets, booklets, brochures and posters. The existing video equipment was supposed to be used mainly for training of staff members.

At present the Bureau is not involved in the production, printing or promotion of any FP or FL education programmes or material through mass media, due to limited staff and funds, although such material is of vital importance in generating new impact in FP and FLE.

Some FP and FL material which was produced some time ago is still available at the BOHE and can be ordered. The delivery system is however

mal-functioning because of lack of transport and funds for paper and mailing services. The distribution system is in need of review. In particular, one person should be made responsible for the distribution of material.

The existing video equipment is underutilized since there is no communication and media specialist who would be able to make adequate use of the equipment for production and education.

The Bureau's FP and FL education/communication service is presently carried out by the following staff members:

Responsible for field service

7 HEOs,: responsible for face to face education at the grassroot, with FP and FL as part of their schedule.

Responsible for mass media: in particular printing

1 artist

2 printers

1 silkscreen operator

1 post for a communication media officer and 1 post for a writer are vacant.

Responsible for audio visual training

1 audio visual technician

1 projectionist

1 driver projectionist

1 senior driver projectionist

It is obvious that without a writer and a media officer the development of printed educational material is nearly impossible. The same is true concerning the audio visual unit. Without a media officer with special knowledge in video technique educational video material cannot be

developed and produced in a systematic and professional way, to be used either at field level or for TV.

A Health Publications Committee was recently established at the BOHE. The main objectives are: to find a new approach for health publications, considering the shortage of staff and funds, with the aim of helping to develop and advise in an appropriate way in all areas of health education, including FP and FL; to investigate the needs for material and draw on resources in the society for the production of materials to reach maximum output on minimal costs; to advise on pre-testing, evaluation and production.

Between 8 to 12 specialists from various institutions are supposed to be represented on the committee, among them BOHE, the NFPB, the Institute of Mass Communication at the UWI, JAMAL, School of Public Health, representatives of high schools and of communities. The committee is expected to present a report on health publications in the summer of 1980 which will hopefully promote the production of new, appropriate printed material on FP and FL education.

Collaboration between the BOHE and the NFPB seems to have suffered with integration.

The formerly existing education and training sub-committee which had promoted cooperation and technical assistance between both agencies was dissolved when integration started, under the premise that integration would emphasize such collaboration. Meetings are still called from time to time to maintain links between both institutions and to coordinate the production of material, the provision of resources for seminars etc. chiefly to ensure that the messages which are going out are consistent. These irregular efforts do not, however, seem to be sufficient.

CHAPTER FOUR

PERSONNEL AND SERVICES

A. 1. TRAINING AND EDUCATION OF HEALTH STAFF MEMBERS

In this section attention will be focused on the primary health care system as provided by the Ministry of Health, and on the National Family Planning Board. The deployment of personnel within these institutional settings, and their qualifications and suitability to perform expected tasks and functions will be examined. Of necessity, the whole question of the efficient utilization of available skills will be raised as one of the important issues here.

Primary health services and in particular those relating to FP are ideally available at maternity hospitals, through post-partum programmes at general hospitals, and at all health clinics in the island. Health clinics are further subdivided into types, the variation being in terms of the level and range of skills, and the kinds of facilities offered. The immediate effect of their hierarchical arrangement of course is that the more highly qualified staff, and the greater range of services and skills, tend to be concentrated in the parish capitals.

Most Type 3 clinics, for example, must depend solely on the district midwife and a community health aide (CHA). But since it cannot be assumed that the nature (even if not the volume) of the demands of the potential clientele in the rural areas served by the Types 2 and 3 clinics will be significantly different to that in more urban centres, then it might be expected that clinic staff are often required to stretch

themselves beyond their normal capabilities. In addition, the problem of recruiting staff in sufficient numbers and with suitable qualifications, is one faced by all rural areas in most countries. An assessment of the competence of primary health care personnel must therefore take into consideration the inevitable shortages and vacancies associated with this problem. But it also has to recognize that the institutional arrangement is itself a deficient one and creates its own problems.

(i) The Primary Health System

In the next section the actual distribution of personnel and the spread of clinics according to type are shown. Set out in Table 4 are the vacancies which now exist given the cadre established by the Ministry. However, these figures do not really indicate the extent of the shortages. If the real shortage were to be measured in terms of the difference between the total number of staff required to service the range of clinics, centres, etc. now in existence or being proposed, and those actually employed, the critical nature of the problem would readily be appreciated. In Table 4 we have also attempted to indicate the extent of the deficiency. It should also be noted that the deficiency is greatest at the middle-lower nursing levels. The figures for PHN-NG III are somewhat high due to the large number of Type III clinics being proposed. There are specific reasons for this which will be discussed below. But it is necessary at this point to bear in mind that given the pyramidial structure of the system, problems caused by vacancies at one level easily replicate and multiply themselves further down the hierarchy.

Family nurse practitioners - normally stationed at Type III

health centres - function as assistants to the directors. They are supposed to see referred cases, visit Type II clinics and are trained in the theoretical and some of the clinical aspects of FP. Yet as we see in Section B, they are mostly to be found in the inner city clinics (e.g. the Comprehensive and Hageley Park Clinics) and in the main urban centres of Clarendon, St. Catherine and Manchester. Most of the other parishes must make do with one and in some cases none at all. Consequently, there are a number of instances in which, for example, the district midwife or the community health aide is forced to take on responsibilities for which they have had inadequate preparation. The situation in Hanover, Portland, Trelawny and St. Thomas would seem to illustrate the point. The low numbers of midwives, staff nurses and public health nurses suggest that the midwife and/or CHA is often without the supportive and referral services necessary for a meaningful operation. Indeed, there are some clinics which are staffed by a CHA only.

In some cases PHN - NG II must act as PHN NG III. In others, there seems to be a less than efficient and fair rationing of the skills available. All of this must affect the work load of the existing staff and their capacity to carry out the functions assigned - to say nothing of the FP service, which as was shown earlier tends to be shifted to the bottom of the work priority list.

The coexistence of a dependence on low level staff (especially in outlying rural areas), and shortages at these levels is not without precedent in other countries. The reasons will be many and varied. But before discussing some of these, it is necessary to look at the actual distribution of training and skill levels. This is presented in

Tables 5 - 10. These data are based on information collected from Ministry of Health files and on the findings of a survey of health service staff carried out by the evaluation team.

Because we are dealing with a type of service for which certain minimum skills are required for entry, we will find that by and large staff nurses, public health nurses, nurse practitioners do begin service with the basic pre-requisites. However, the discrepancies begin to emerge when we examine the training histories of higher grade personnel, and when we look for the qualifications necessary for the provision of a FP service. Although it is known that many clinics/centres were not at the time of this study actually providing this service, the assessment has been based on the assumption that all should have been doing so - that is, as prescribed by 'post-integration' directives.

The data in the tables above suggest the following conclusions

(1) Although promotion of the public health nurse to higher nursing grades ideally requires the completion of a four-month nursing administration course, and of one year certificate or diploma courses for the higher grades, the gap between qualification required and position held is fairly substantial. For example, only 26.0 per cent of the public health nurses (II, III & IV) had completed the nursing administration course. At the same time, while staff at this level are encouraged to pursue courses in management and supervisory techniques, only 4.7 per cent had been involved in courses designed for supervisors and 13.0 per cent in management courses.

(2) The number of persons holding a nursing degree is very small. The Government does not now support persons reading a degree course.

(3) The number of persons reporting no special training in family planning is remarkably large. Data from the Ministry of Health suggest for example, that 15.6 per cent of all public health nurses, 8.8 per cent of all staff nurses, and a mere 6.5 per cent of midwives had benefited from any kind of training in this area. This is perhaps not entirely correct as the Ministry and FP programme mounted by the training division since 1974 was designed to and did in fact cover the entire island so that the data drawn from the sample survey probably presents a more accurate picture. Here, it was found that 35.3 per cent reported no special training in FP. But this is still an unsatisfactory percentage. Thus, it would appear that it is the basic training in midwifery acquired by some which must fill the gap. Approximately 21.4 per cent of all public health nurses (II, III, IV) had been so trained. It is of some significance that so many did not seem to find the FP courses attended necessary and/or important enough for recording in the Ministry's files - a point to which we shall return.

(4) There are a few instances where the courses pursued or skills acquired appear to bear little relationship to the job in hand.

(5) The more highly qualified staff tend to be concentrated in the parishes which have the two main urban centres viz. St. James and Kingston and St. Andrew (see Table 5).

(6) There is a fair degree of regional variation in the types of further training pursued. Thus for example, persons trained as health visitors are to be found in St. James and Trelawny only. Those who had participated in courses/programmes concerned with supervision and management were more or less concentrated in Hanover, St. Catherine and the

KSAC area. The delivery of primary health care training programme has so far touched only Westmoreland and St. Catherine.

(7) Refresher courses are taken mostly by midwives.

(8) Most of the public health nurses, midwives and staff nurses have benefited from secondary level education. On the other hand the average community health aide has only been able to add CHA training to a basic primary education. (See Tables 8, 10.) So that, although Ministry manuals suggest that the CHA must "continue learning and developing her skills" the available data do not suggest that they benefit in any significant numbers from in-service training programmes (see Table 10).

In general, it seems safe to conclude that the level of formal preparation of staff who must find time to provide a family planning service is less than adequate. The reasons for this vary.

First, and as might be expected, there are not sufficient funds within the Ministry to allow for a complete training of all members of staff. This insufficiency affects not only the numbers who are able to undertake additional training, either in or out of service, but also the mounting of in-service training programmes. For example, between 1976-79 a wide range of residential and non-residential workshops and seminars (27 in the first year, 19 in the second and 21 in the third) were planned, and were expected to involve at different times, medical officers, public health nurses, managers, administrators, implementors, training officers, health educators, public health inspectors, nurse education officers, midwives and assistant nurses. However, only at least one and certainly not more than four of these sessions were in

fact held. A limited number of hospital and health centre nurses, public health inspectors and midwives participated.

Recognition of the lack of coverage has led to increasing emphasis on establishing a core or nucleus of trainers who would then be responsible for designing and organizing training programmes at the parish levels. Each nucleus should be comprised of a public health nurse, a public health inspector, a nutrition officer and a health educator. To date this arrangement has not been particularly efficient. For one thing the reduced contact between the central office and the parish level implied by this approach tends to exacerbate regional disparities, incomparability and degree of inconsistency in the level and types of training programmes offered. As trainers of trainers are essentially taught how to design programmes, this assumes that the necessary support services will be available at the local level and that the facilities will "allow the acquisition of the necessary clinical skills". But local level staff who are supposed to provide follow-up and support programmes are often not adequately prepared to do so. Take for example the case of the midwife. Job descriptions at the Ministry state that she must be: Responsible for advising in nursing education programmes in relation to midwifery and family planning; able to advise on planning, organizing and conducting midwifery and FP training programmes; able to assist in developing in-service education programmes relating to the field of midwifery and FP. Yet, up until very recently the numbers who had any kind of further training (apart from refresher courses) was very small (5.7 per cent). The 370 recently brought in for seminars should go some way toward solving the problem. Furthermore,

and as will be seen later, the local facilities for clinical training are generally poor. Funds are made available through international agencies such as USAID and PAHO for the training of health personnel. But again, the spread has been limited both in terms of the regions involved, the categories of staff sent overseas, and the types of courses taken. For example, the Cornwall Region was the principal beneficiary of the training of nurses given by PAHO consultants. With respect to USAID funded programmes, the data presented in Table 11 show that most attention was given to courses concerned with the management and administration of FP programmes, and the techniques for communicating general FP information, at the expense of specific clinical courses. Further, the numbers of practising nurses/midwives and lower-level family planning officers who were able to receive further training by this route remain very limited.

In spite of the apparent inability of the Government and other agencies to support the level and extent of the training required, it is interesting to note that if the Ministry's records are complete, very little post-basic training has been acquired independently or privately. This is partly due to the fact that persons wishing to acquire such training must often break their service. And even where this is not the case, re-entry at higher levels may be difficult and is sometimes the cause of internal resentments and conflicts. Nevertheless, the almost total dependence of staff members on the Government, Government-affiliated organizations and one or two international agencies means that promotion within the service has to depend on the availability of establishment posts, the ability of the Government to support these positions

and the expenditure that the recurrent Budget can allow for training exercises. Under difficult financial conditions, one might expect that the priority will simply be to maintain the existing establishment. The data in Table 12 give some idea of the lengthy period between entry into the service and appointment to a particular post. This increases as one moves up the hierarchy, although it is interesting to note that the pace of promotion appears to be much slower in the rural areas - a situation which would be associated with the lower level of training among rural staffers as a whole.

A second reason for the inadequate level of training is directly related to current conceptions about the type of person required to staff the FP clinics. At the present time it is not possible for nurses to proceed beyond the NGI level as long as they remain at health centre clinics. Nurses wishing to advance their careers must either return to the hospitals, become a nurse practitioner or move directly into public health. Consequently the more competent and ambitious eventually shift into other areas, and out of the FP service altogether. Those who remain more often than not do so because it is domestically convenient, the hours are shorter and no night duties are involved. This will certainly not necessarily guarantee the clinics' access to the most able and best qualified staff. There has been some lobbying within the Ministry to get the posts up-graded. An early solution is imperative, as the survey data show that job satisfaction in the clinics is not as high as it ought to be. Approximately 71.51 per cent said that they were not satisfied with the scope for promotion.

It is not difficult to appreciate the rationale behind the integration of the FP service with the general health care systems. However, the process of integration has often created problems, thereby adding to those already in existence. Some of these bear directly on the efficient allocation of suitably qualified staff.

The NFPB at the peak of its existence, had its own complement of staff, hierarchical stature and salary scales. Salaries paid here, especially when special allowances are included, were usually higher than those paid to their counterparts or equivalents in the Ministry. Integration therefore had one immediate effect. Persons who had held fairly well paid and prestigious positions with the Board now found themselves subject to Ministry classifications which almost inevitably meant a loss of status, a likely cut in emoluments and probably a reallocation in responsibilities. The other side of this coin was that the Ministry suddenly found itself with additional posts on the establishment. Information of the precise geographical location and function of these 'new' staff members was very limited. And more importantly the level of education and qualifications of the 'new' staff members were more often than not quite different and sometimes lower than that required for the position now held. Travelling officers, including health educators were particularly affected by this problem. Yet at the same time there were instances where the new classification meant that an individual was over-qualified for the job. Resentments on both sides resulted and on occasion some would refuse to do particular jobs. Some of the 'new' staffers had to be sent to be trained as public health nurses. The net effect of all of this was the denudation of the family planning service of its most specialized, skilled and competent staff and the departure of some nurses from the service altogether.

In spite of the fact that integration has meant that the demands of the wider health care system and the rules and requirements of career advancement to be found here have increasingly reduced the special identity once held by the FP programme, the NFPB nevertheless finds itself in a situation where it continues to pay the salary to persons over whom it has little or no responsibility and the choice of whom is made without their participation.

This point takes on added significance in the light of the gradual movement away from specialized FP programmes. During the late 1960s to early 1970s public health nurses complained about their inability to give sufficient attention to FP. In response, the Board employed their own staff to deliver these services and all public health nurses received FP training. In 1971 for example, a very comprehensive programme which covered theoretical, general educational and clinical aspects was offered. This emphasis continued up until 1974, after which it shifted to the provision of the Ministry programme. By 1977 the emphasis of training programmes had again shifted toward those concerned with the delivery of primary health care. It is fair to say that the FP component in the last two programmes is small to the point of being non-existent. The clinical dimension is almost totally ignored. For example, on the list of macro-objectives of the MOH/FP/Nutrition training programme as set out by the Ministry, the only two which seem to have any bearing on the question of family planning are: to have knowledge of fundamental principles and develop awareness of their significance in terms of the quality of life and available resources; to apply their knowledge of FP to all relevant situations.

There is a growing recognition of the problem as district midwives who are now recruited to have supervisory FP skills, and lower level staff who must face the patients on a daily basis have been more vocal in their domands for a proper FP service. Somo efforts are therefore being made to expand the FP component in the primary health care programme. As mentioned earlier, relevant staff members are being brought in for an orientation programme which will give a theoretical basis in the subject area. To be sure, given the growing insignificance of specialized FP programmes, those who now come in for this type of training are not receiving a great deal, as the trainers themselves have very little knowledge in this area.

This programme is however still in a proliminary phase, and a great deal of attention is still devoted to simply defining and determining needs, and working out a plan of action. More specifically, the programme suffers from inadequate infrastructure and facilities. Thus while the general objective is to provide the theoretical part of a programme at the central offices, to be followed by clinical training at the parish level, the absence of suitable facilities makes this follow-up almost impossible. It must be pointed out that the poverty of the facilities is in large part related to and encouraged by the concentration on the unrestricted and scarcely regulated distribution of condoms and the pill.

Attempts are being made to set up and improve the infrastructure, but until those are more advanced the provision of a FP service properly tied into a primary health care system will continue to be on an ad hoc basis.

There is one important implication which follows from what has been said so far. Given that the specialized training and personnel used to be greater under the NFPB and that movement within the wider health service tends to deflect attention away from this particular area; it is perhaps safe to say that there are within the system, persons who do have many of the skills required for a comprehensive FP service, but who no longer have interest in this area, are engaged in other pursuits, or do not think it to be of particular importance. Skills will not be used nor passed on, if they are not thought to be necessary. Most public health nurses ought to be able to carry out the clinical aspects of a FP service. Nurse practitioners are not trained to insert IUDs, partly because it is felt that there is insufficient demand for this particular skill. But they are supposed to be adequately prepared in most of the areas of FP. Yet according to prevailing job prescriptions, health centre clinic nurses - with the possible exception of the nurse health educator and the nurse practitioner - are not specifically required to carry out the relevant physical examinations (of breast, abdomen and pelvis) nor to take pap smears. It is not very surprising therefore that ratings on knowledge of FP among staff members are so low (see Section B on KAP among FP clinic staff).

The non- or under-utilization of particular skills is further encouraged by a situation in which there are crossed or bifurcated lines of responsibility and accountability. For example, district midwives and public health inspectors are normally employed by Local Government. At the same time public health nurses are paid by central government, although they work in a local government setting and are directly

responsible to the MOH, but the MOH is employed by the Ministry even though he is linked to Local Government through his attachment to the Parish Council. Internal status and salary distinctions inevitably emerge; there will be conflicting ideas about what amount and type of work effort should call forth what kind of reward, and about the real sources/ points of authority.

There is one final reason for the inadequate level, use and deployment of skills which ought to be mentioned. It was suggested earlier that the apparent regional variations in the type and extent of training received by staff members could perhaps be partly explained by the decentralized nature of the process of designing and planning of some of the programmes. However, it must be admitted that the actual process of selection of candidates for further training was not always clear. A number of the Ministry officials interviewed felt that it tended to proceed in an ad hoc and uncoordinated manner and was often subject to personal considerations.

In concluding this section, it may be said that FP clinics must often depend too heavily on lower level staff, who are insufficiently prepared for the tasks at hand. The community health aide is a striking example of this problem.

> According to current Ministry of Health Manuals:
>
> The Community Health Aide is a front line member of the health team .... She forms an important link between individuals and the community and the health services, and has a prime responsibility for making sure that people know and take advantage of the services available to them.

Thus, the CHA is expected to be the immediate, direct, and first contact between patient and clinic with respect to the provision of both nutritional and FP advice. Given the insufficient deployment of personnel described above, it seems necessary that the whole question concerning the preparation given to CHAs be re-examined and reconsidered. In actual practice, they are doing far more than was originally intended.

2. The National Family Planning Board

It is perhaps not a gross exaggeration to say that most of the problems currently faced by this board are directly related to the ill-defined character of its status and function within the wider primary health care system. The process of integration resulted in the real loss of most of its qualified and more able staff. So that the Board now appears to be in a peculiar position - wherein it has a staff which is overladen with clerical and secretarial skills and which is not suitably equipped to carry out the three areas of responsibility left to the Board, viz., distribution, communication and finance. The data in Tables 13 and 14 show the distribution of personnel according to training, histories and occupational background.

If we look at distribution and communication as related functions, then the problem is really two-fold: one having to do with the design and implementation of a proper marketing strategy and the other with financial responsibility. Taking the second one first: The preference of USAID for dealing with statutory authorities has meant that the NFPB continues its control of the available funds, but without the staff needed to adequately carry out analyses of projects that come before it for funding, or to efficiently and extensively monitor the use of funds

disbursed. In other words, as long as the NFPB retains its control of the purse, there will be a real need for financial and management accountants. At the present time, it is the director of information and communication who must perform these duties.

With respect to the second area - marketing - at the present time the Board has sub-contracted the advertisement programme to a private organization, and materials are delivered to private and public bodies as demanded. Presumably, the private firms research the market prior to the broadcast of advertisements, etc. The continuing lack of congruence between messages carried and prevailing attitudes, goals and values held by members of various sectors of the society would seem to suggest otherwise. And indeed, some dissatisfaction was expressed by NFPB officials about the level of research carried out prior to these programmes. It therefore seems necessary (and more rational) that there be one body which is responsible for on-going research into population trends, attitudes and values of potential users as they relate to FP and FL, for identifying marketing outlets and the areas and market damand, and for designing and implementing advertisement and communication strategies. These areas are all interrelated and ought to be carried out by personnel with the requisite marketing and communication skills, and who have ready access to persons who have a detailed knowledge of FP methods - their pros and cons.

It must be said that at the present time the NFPB does not really have the skill capacity for undertaking these functions. Up until very recently its marketing officers, like the accountants, have not had the qualifications necessary to carry out more than routine and lower level

operations in these areas. The loss of status and function together with peculiarity of its current situation have made it even more difficult for the Board to attract suitable marketing officers and accountants away from the private sector.

In conclusion, then, it may be conceded that most of the staff seem to be adequately prepared for the kinds of tasks currently expected of them. Most have at least a secondary level education; training and information officers have had some further training in areas relevant to their field of activity, as well as some exposure to specialized family planning and family life education courses (see Table 13). Further, previous experience in nursing, health education and child care which the information and training officers have, should be useful in the performance of their duties. It is the job specifications and expectations themselves, which are being questioned here. There are tasks that need to be done, but which are not now being satisfactorily carried out by anyone. It seems to us that until this particular institution's place and function within the wider FP service is properly rationalized, staff morale will continue to be low, and large sums of money will continue to flow through a body which more often than not functions as a simple distribution outlet, and which has little control over and awareness of the activities it supports.

2. PATTERN OF CLINIC METHOD AND USE

Public Sector Family Planning Services, 1979

(i) Methods of Data Collection

Data were collected from Annual Reports and Statistical Reports[1] as well as clinic records, to determine the present status of the family planning programme in Jamaica - the level of services.

From the clinic records documentation was done in 171 of the 189 clinics (90.5 per cent) offering family planning during April, May and June 1979. Data were collected by 15 interviewers in 12 of the 14 parishes. Hanover and Westmoreland were excluded because they were flood-stricken areas.

Initial contact was made with Dr. C. Moodie, at the Ministry of Health, who communicated with the Medical officers of Health in the parishes. Mr. Gordon from the Central Health Statistics Department advised that the nurses in charge of the four zones be contacted. These zones were:

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[1] Family Planning Statistics 1977-1978: Statistics Division, Ministry of Health; NFPB Annual Report for years ending 31st March, 1975 and 31st March, 1976; NFPB Annual Report for Year ending 31st March, 1974; Statistical Report for year ending December 1972; NFPB Statistical Report 1975.
Figures for Number of Revisits for 1976 were obtained by multiplying the figures for the Total March Quarter by four.
The figures for the Number of New Acceptors and Revisits in 1979 were obtained by multiplying the figures for the Total June Quarter by four.
Acknowledgements: Many thanks to the following persons who assisted in the data collection: Emorsia Hill, Christopher Plummer, E. Talbot, V.I. Duncan, Leslie James, L.A. Rowe, C. Whinstanley, L. Forbes, J. Lawrence, H.O. Anderson, R. Gregg, A. Golding, M. Lozama, R. Gyles, E. Lyn, A special thank you to Mr. Ronald Gregg for his dedication in tabulation and assistance with the analysis and presentation of data.

(i) Kingston, St. Andrew, St. Thomas
(ii) Portland, St. Mary, St. Ann
(iii) St. Catherine, Clarendon, Manchester
(iv) St. James, Westmoreland, St. Elizabeth, Trelawny, Hanover.

The four zone nurses were contacted and they provided lists of the clinics and the parish nurses. The parish nurses gave interviewers a list of the clinics and a schedule of the frequency of services. The interviewers then proceeded to collect data from all or as many of these clinics as were available or accessible.

Limitations: The main limitations were that two parishes (Westmoreland and Hanover) had to be excluded from the study, and within the remaining 12 parishes there was a 9 per cent non-response. There were four reasons for the high rate of non-response:

(i) Inclement weather
(ii) Inaccessibility of some clinics
(iii) Unavailability of records. Either the person responsible for the records was away on holiday without someone replacing her or the records were stored elsewhere. In a few instances interviewers turned up at clinics according to the schedule only to find that in practice the clinic was being held on other days or at a different time.
(iv) An additional problem was encountered in St. Thomas because the interviewer had a car accident.

Difficulties were also encountered in obtaining data, because of the lack of uniformity in compilation of monthly reports. In addition, the data collecting sheet age-grouping was not the same as those classified in the clinic records. In some instances, the interviewer had to tally

the number of visits from the patients' dockets and family planning records were not kept separately from the total family (household) files. Lack of stationery was also a problem. In some of the clinics, records were not available for all three months, during the study period. Records were not kept for male users. For further details see appendix - log and progress report. Data were collected on:

(i) The number of outlets, type of services according to staff structure and frequency of delivery of services;

(ii) The geographic distribution;

(iii) The methods used;

(iv) Special services;

(v) Characteristics of users i.e., age, new vs revisits.

The data for the number of clients classified as revisits for 1976 were not available as an annual figure. In order to obtain comparable data, figures for the quarter January to March were multiplied by four. This procedure gave an approximation and not the actual numbers of users who attended family planning clinics in 1976. Similarly, when the figures for 1979 April-June quarter were used for comparisons with the annual figures for other years, the Number of New Acceptors and Revisits were obtained by multiplying the figures collected from the clinic records for the Total April-June quarter by four.

(ii) Findings

Pattern of Clinic Use during 1972 and 1979

Figures 4.1-4.6 are showing a comparison of the number of New Acceptors and Revisits for parishes within the three counties for the period 1972-1979. In all of the parishes in Jamaica there was a slight

fall in the number of New Acceptors for 1974, and in 1976 the pattern was similar in that 10 out of 13 parishes reflected a fall in the number of New Acceptors, as shown in Figures 4.1, 4.2 and 4.3. In the County of Cornwall, Hanover showed a steady decrease in the number of New Acceptors for the period between 1973 and 1978. Trelawny and St. Elizabeth increased since 1976, while St. James has been increasing but has not yet reached the level of 1973 and 1975 performances. Westmoreland has maintained a fairly steady level of performance since 1974.

The most marked change in the County of Middlesex was the large increase between 1976-77 for the parish of St. Catherine. In the next two years St. Catherine maintained the same number of New Acceptors. Manchester showed a decrease since 1975, while the other parishes remained fairly constant.

In the County of Surrey, Portland and St. Thomas showed a similar pattern of attendance between 1972 and 1976 in that there was the same type of fluctuation in both parishes. Portland showed a noticeable increase in 1977 then steadily declined since then. St. Thomas on the other hand has increased. Apart from an increase in 1977, the parishes of Kingston and St. Andrew have shown decreases for the entire period, the lowest level having been reached in 1976.

When the data on the clients classified as Revisits were examined (Figure 4.4) it was found that within the County of Cornwall, St. James and Hanover reached their peak performance in 1975 and have steadily declined since then. Trelawny had a steady increase from 1972 until 1977. Figures fell for 1978 and increased again in 1979. Westmoreland showed slight increases over the years. St. Elizabeth increased until 1975,

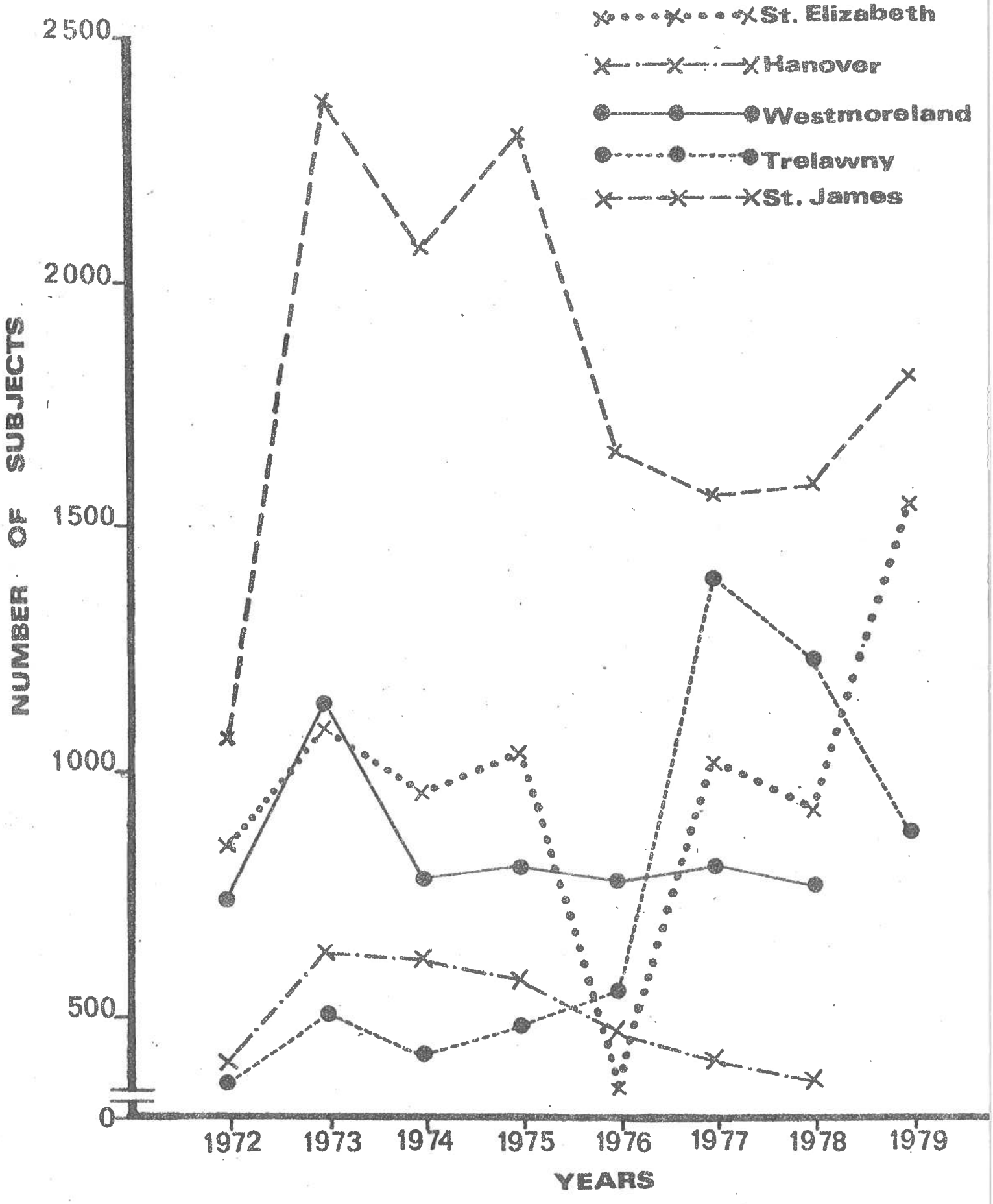
showed a slight decrease in 1976 and the numbers fell in 1977. It has steadily been increasing since then.

In Middlesex, Manchester and St. Catherine had steady increases from 1972 to 1976. They both declined in 1977 and 1978, Manchester continued to decline in 1979, while St. Catherine increased by over 7,000, as shown in Figure 4.5. Clarendon had a steady increase from 1972-79 but declined in 1979. St. Mary increased during the period 1972 to 1975 then showed alternate decreases and increases up to 1979, the largest increase being in 1979. St. Ann showed little change up to 1975 then showed a marked decrease from 1976 to 1978. By 1979 there was an increase, which brought the performance to the level of 1975. It must be noted that the large increase in 1979 for St. Mary may be questioned because an estimation was made by one of the clerks in St. Mary for the number of condoms issued to revisiting patients. This estimation seemed to be unreliable.

All parishes in the County of Surrey had a steady increase up to 1975, as shown in Figure 4.6. St. Thomas continued this trend to 1978, but showed a slight decrease in 1979. Portland and Kingston and St. Andrew declined in 1976 and increased in 1977. Whereas Kingston and St. Andrew continued to increase in 1978 and decreased markedly in 1979, Portland on the other hand decreased in 1978 and increased in 1979.

Although all the clinics in the primary health care system are supposed to offer family planning services, some of these clinics were not in practice offering such services, according to the data collected (Table 15). The converse was also true, in six parishes the data showed that more clinics were offering family planning services than those listed, in February 1979, by Central Statistics Department.

Fig. 4·1-New Acceptors - Cornwall Parishes 1972 – 1979



New Acceptors - Middlesex Parishes 1972-1979

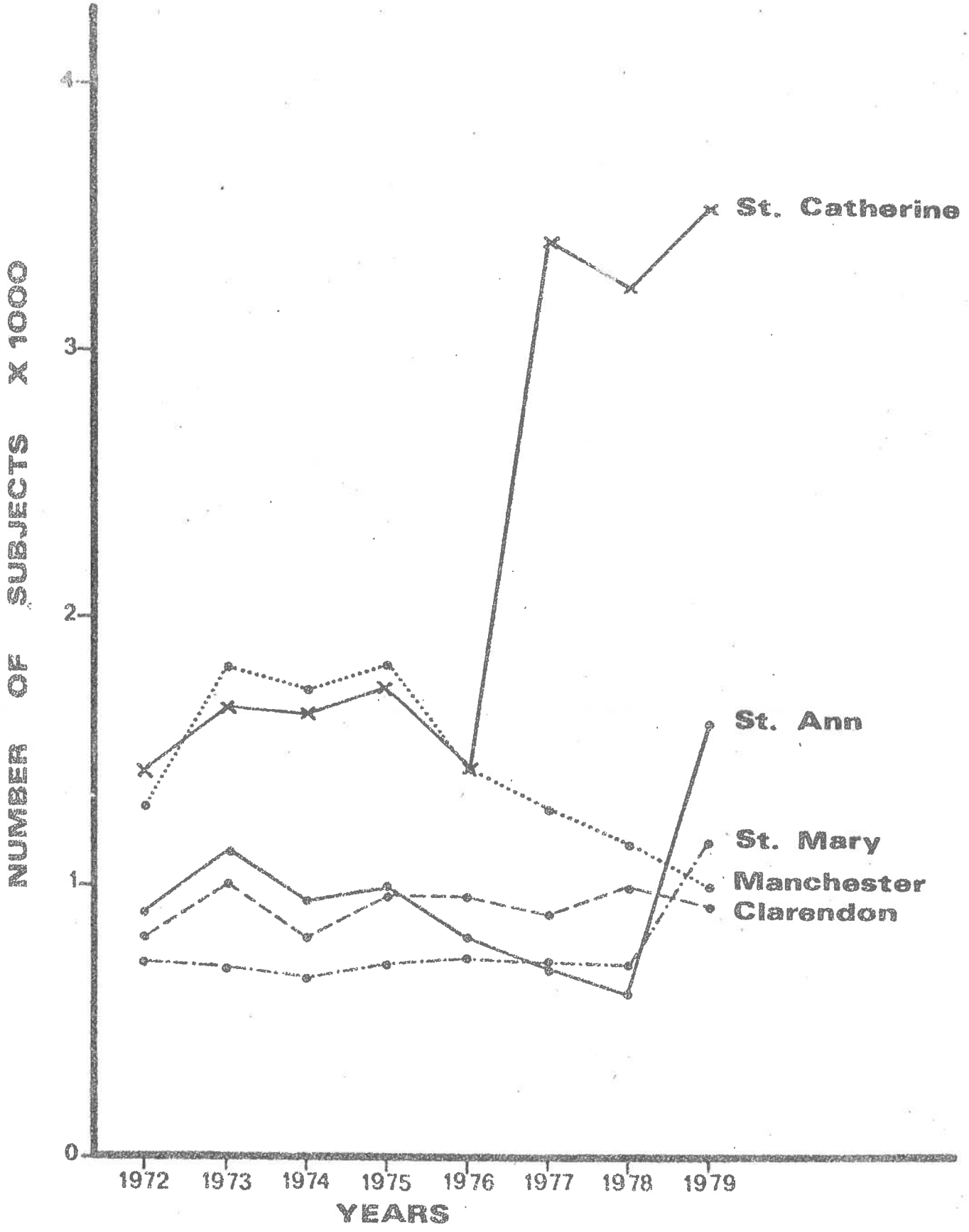


Fig. 4·2

New Acceptors – Surrey Parishes 1972-1979

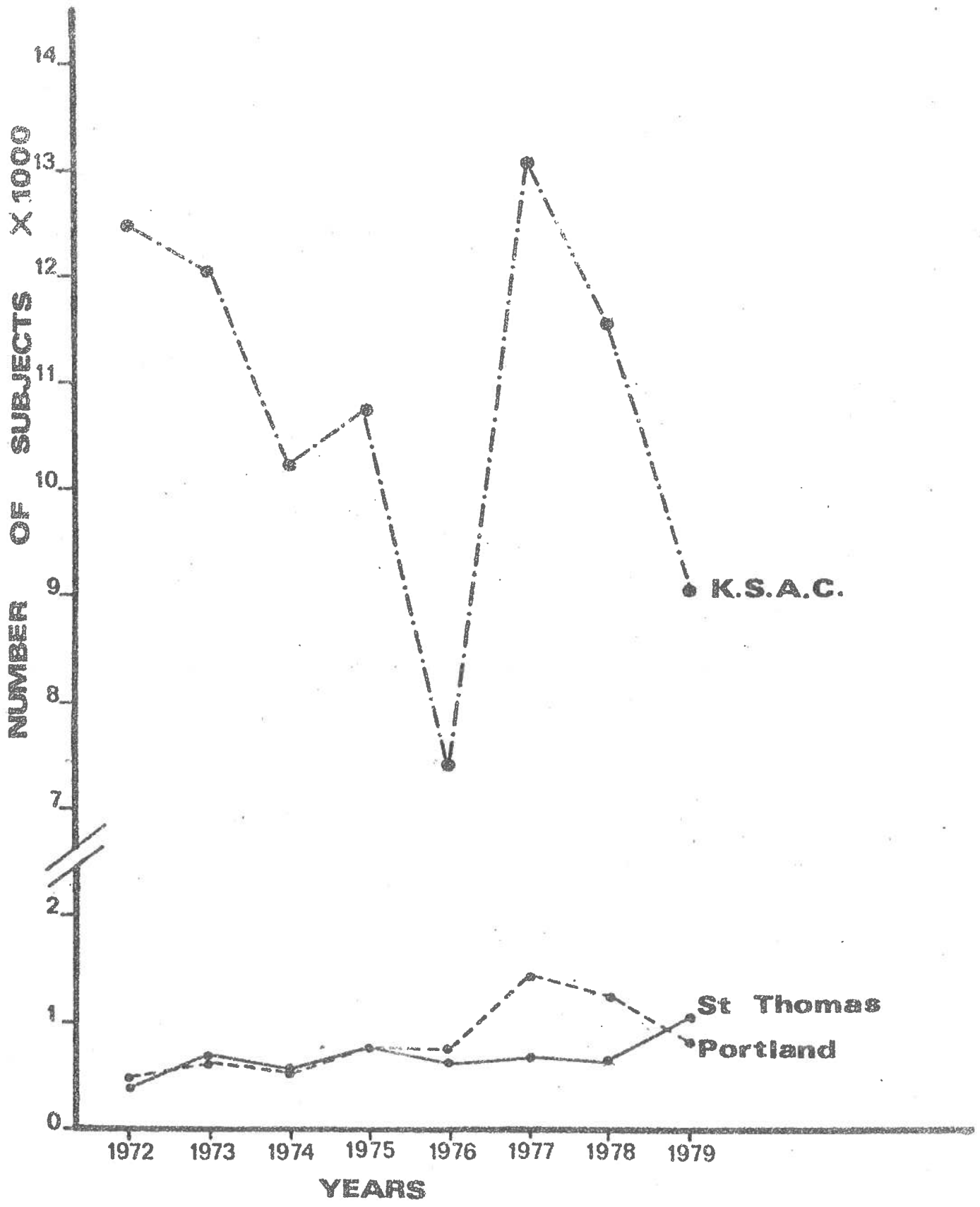


Fig. 4·3

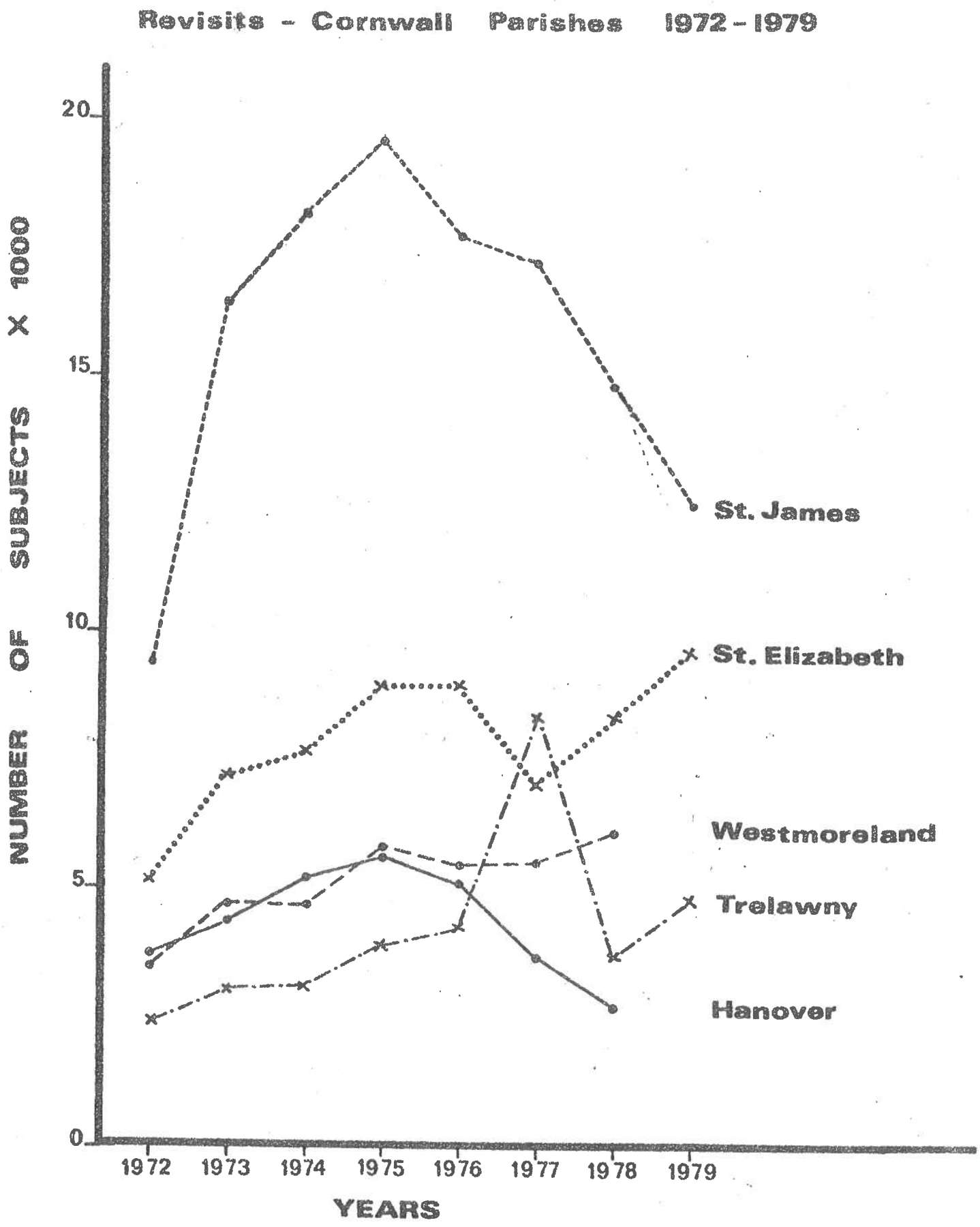

Revisits - Cornwall Parishes 1972 - 1979
NUMBER OF SUBJECTS X 1000
20
15
10
5
0
1972
1973
1974
1975
1976
1977
1978
1979
YEARS
St. James
St. Elizabeth
Westmoreland
Trelawny
Hanover

Fig. 4·4

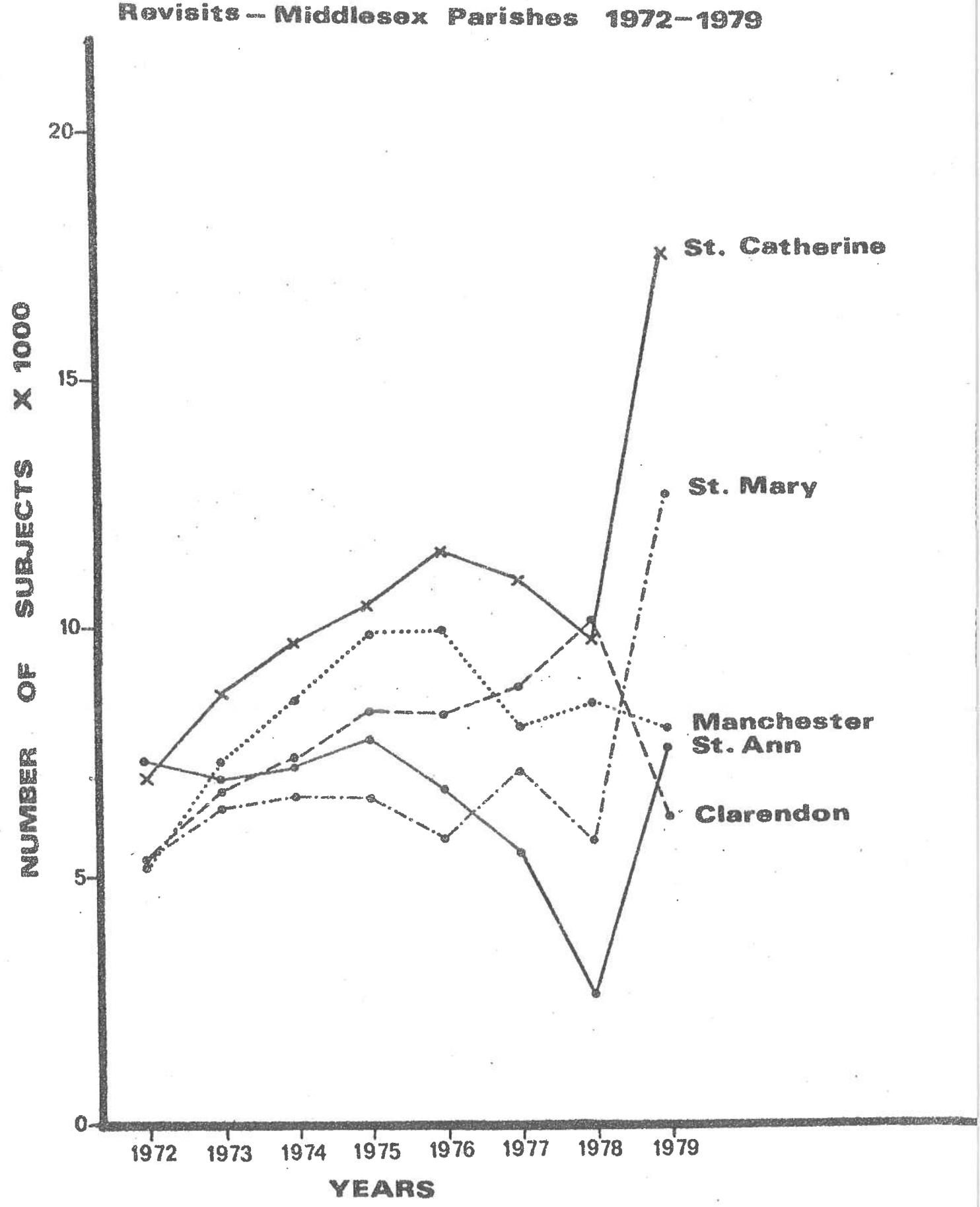

Revisits – Middlesex Parishes 1972–1979
NUMBER OF SUBJECTS X 1000
20
15
10
5
0
1972
1973
1974
1975
1976
1977
1978
1979
YEARS
St. Catherine
St. Mary
Manchester
St. Ann
Clarendon

Fig. 4·5

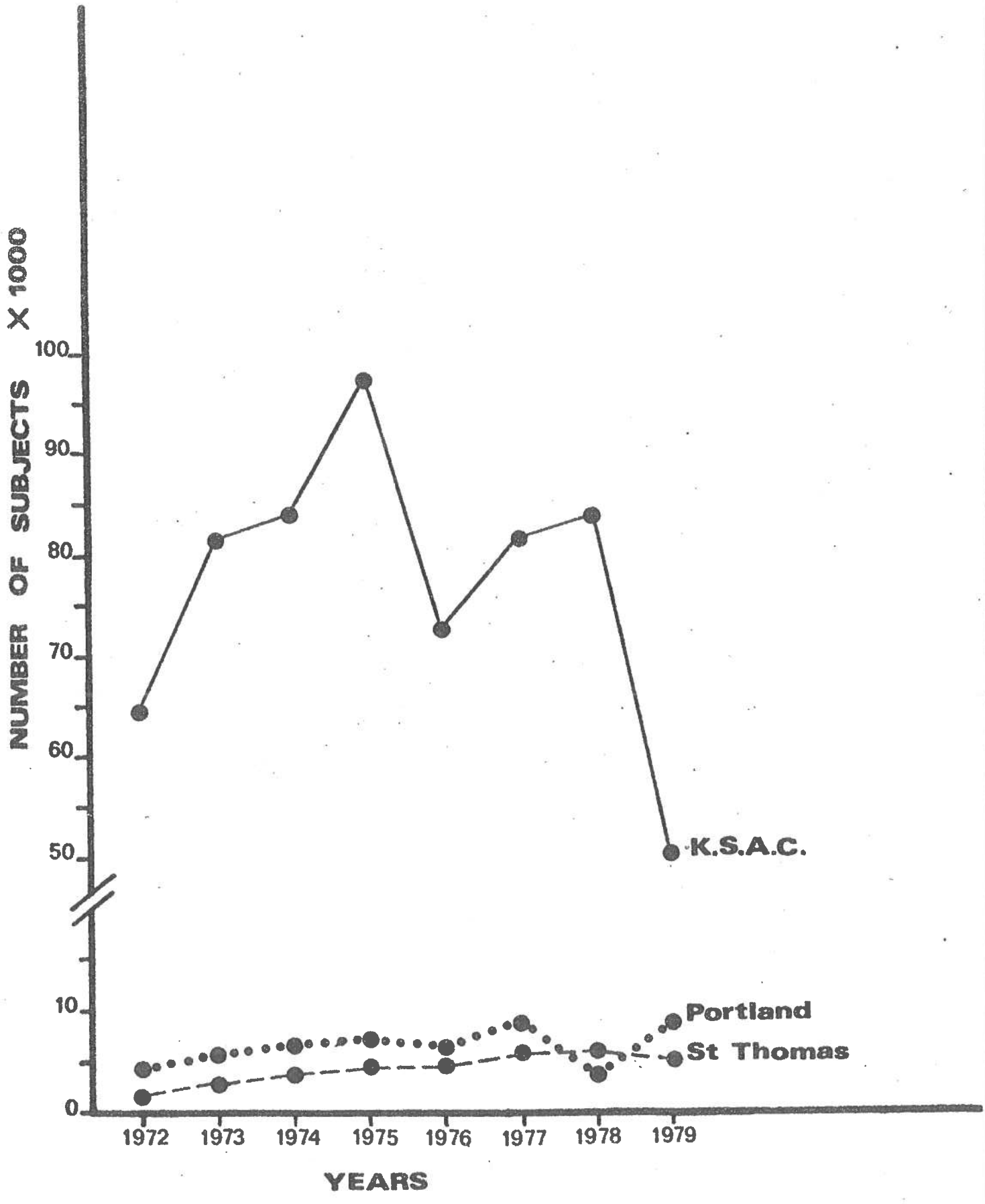

Revisits - Surrey Parishes 1972-1979
NUMBER OF SUBJECTS X 1000
100
90
80
70
60
50
10
0
K.S.A.C.
Portland
St Thomas
1972
1973
1974
1975
1976
1977
1978
1979
YEARS

Fig. 4·6

Sixty-nine (37.5 per cent) of the 189 clinics were classified as Type I clinics in comparison with only four (2.1 per cent) which were Type IV and hence were better staffed as shown in Table 16. The type designated to a clinic did not mean that in practice the full complement of staff was there when the interviewer visited.

In one clinic in rural St. Andrew, there was only a female orderly at the clinic when the interviewer visited that clinic. The other staff members were on holidays without even one trained person as replacement. Another example of the severe staff shortage was that of the Victoria Jubilee Hospital where three trained nurses were on holiday and only one trained nurse was sent to that section to replace them. When the interviewer visited the section the nurse had to restrain herself from screaming. The interviewer understood the genuine plight of the nurse and cancelled data collection at that hospital. Some of the interviewers in rural areas located the nurses at their homes while they were on their vacation and interviewed them at home.

Service was delivered daily in 56 clinics, once per week and once per month in 37 and 33 clinics respectively (Table 17). St. James had the most daily clinics. In Kingston and St. Andrew, St. Ann, St. James, the clients used the pill more than any other form of contraceptives. In the more rural parishes the injection was the most popular choice (Table 18).

The clinics were distributed all over the island and even in remote areas as shown on the maps of each parish. In some of the more rural areas the religious influence against family planning was very strong in the general population as well as among staff members (See Appendix III). The age groups cannot be given as comparable data between parishes and

within each parish. Some data were collected in 10 year age groups and some at an irregular step interval as shown in Tables 20 and 21. In only three parishes were the data collected by specific ages, and the age ranged from 14 to 49. The modal ages were 19 and 20 for new acceptors and revisits respectively. The mean age for new acceptors in these parishes was 23.74 years and for the revisits the mean age was 26.4 years. For details see Figure 4.7.

(iii) Discussion on the Findings

In general the variations in the number of clinic users in each parish were considered mild from 1972 to 1976 but the fluctuation since then seemed more severe. This could mean that there has been a weakness in the reporting system since 1976 or it could be that clinic use varied for many reasons.

In Kingston and St. Andrew the decline in the number of clinic users may be a reflection of internal migration to St. Catherine which showed a marked increase in new clients between 1977 and 1979. Another explanation for the Kingston decline could be cultural and social unrest in West Kingston and other depressed areas, causing either the closure of clinics or preventing clients from easy access to the Health Services. A third possibility may be that the people were using the commercial outlets without attending the clinics.

St. James was another parish which showed a marked decline since 1975.

Clinics were widely distributed throughout the island. The staff structure showed a need for more personnel trained specifically in family planning.

Age Distribution of Clients classified as New Acceptors and Revisits (St. Mary, Portland and Trelawny)

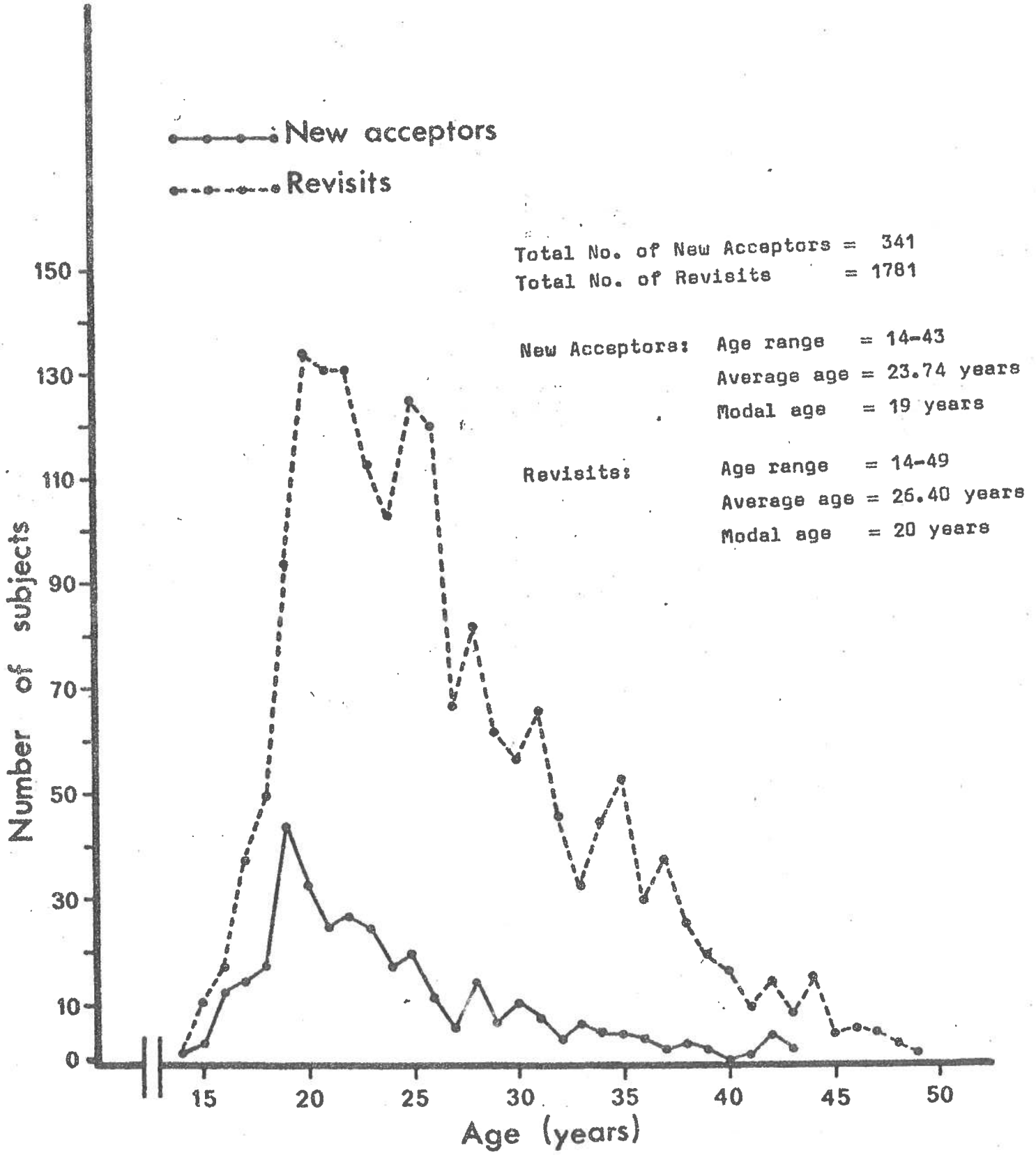


Fig. 4·7

The use of the injection as a method of contraception was more marked in the clinic which met less frequently. The pill was used more in the urban areas, with more daily clinics. The use of the injection which has a 3-month effective protection is more suitable in the areas where clients' non-compliance is a real problem.

It is difficult to make a general statement in relation to age because age was collected in three different ways. This was unfortunate. However, it can be accepted that family planning was reaching more new clients up to the age of 30 years and for revisits the clients were from the higher age groups. One point that should be considered is that for those clients whose individual ages (raw scores) were collected, the mean age for new acceptors was 23.74 years which is much higher than the mean age for first pregnancy in the Jamaican population which has been found to be 17.4 Victoria Jubilee Hospital; 17.11 High School girls; 16.85 years new secondary school girls, and 21.04-23.51 years general population.[2] These findings suggest that the women may be attending the clinic after the first pregnancy.

It is difficult to estimate the impact the clinics are having on the male users since records are not usually kept of the males. From the small sample taken in the street, it would seem that 50 per cent got their supplies from the clinic.

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[2]S. Alleyne, R. D'Horeux Rausee, G.R. Serjeant, "Sexual Development and Fertility of Jamaican Women with Homozygous Sicke Cell Disease" Submitted: Arch Int. Med. 20/5/80.
Hermione McKenzie and Dorian Powell, Report on First National Conference on Fertility and the Adolescent, 1980.

It is clear that the record keeping system needs to be standardized. Staff, supplies and instructions should be available, the latter not just sent to the nurses in the clinic. This proposition may mean improving the provision of travelling records officers and intensive training for uniformity.

It is also clear that the staff need to involve more young men in the family planning clinic. This may mean employment of more males on the staff so that they could "rap with youths" without too much embarrassment about male contraceptives.

3. PROFILE OF MALE USERS OF CONTRACEPTIVES - CLINIC CLIENTS AND "STREET" SAMPLE

A profile of male users attending the clinic was attempted, but response rate was low, mainly because male users had little contact with clinic staff and their visits were very short. Also, the number of male users was small. It is not possible to analyse the data on the profile of the male users per clinic. Instead, all the male respondents interviewed in the clinic are regarded as "clinic sample" and these data are compared with a 'street' quota sample of 100 male users which was done in Montego Bay.

Observation by the interviewer for one week at the Beth Jacobs Special Clinic, showed that 38 male clients attended the clinic. Observations in the other clinics showed a range of 0-5 male clients within one week. A total of 83 male clients was interviewed from the clinics.

In order to fill the quota of 100 male users of contraceptives, 147 males, aged 15 years and over, were interviewed by one interviewer on two streets in Montego Bay.

The modal age of the respondents from the clinic was higher than that of the 'street' respondents as shown in Table 22. The ages ranged from 16 to 63 years for the clinic and 16 to 35 years for the 'street' male users of contraceptives. The age range for 'street' non-users of contraceptives was 16 to 51 years. The clinic male clients were in a more stable union than both the male users and non-users from the street survey, as shown in Table 23.

The educational level of the males who used contraceptives in the 'street' survey was higher than those who did not, as well as the clinic

male users. As shown in Table 24, 82 per cent male users in the street had had post-primary education.

The occupation of the male users in the street survey carried a higher socio-economic status (professional - clerical) than both clinic male users and 'street' non-users, as shown in Table 25.

The clinic male users reported having a larger number of children ranging from 1 to 12 than the 'street' male users who reported a range of 1-3 children per user, as shown in Table 26. A higher proportion of 'street' male users (77 per cent) in comparison with 12.0 per cent of the clinic male users said they had no children. Of the non-users, 65.9 per cent claimed that they had no children. The majority of the children were between the ages of 1-5 years in all 3 groups examined, as shown in Table 27. The street survey showed that 30.4 per cent and 28.6 per cent male users and non-users respectively had children less than one year old while only 15.5 per cent of the clinic male users had children in this age group.

Table 28 shows that the majority in both groups used condoms for protection from germs as well as prevention of pregnancy, but 31.3 per cent of the clinic male users in comparison with 8 per cent of the street male users used the condoms as a means of prevention of pregnancy. Reasons for not using the condoms varied from - No special reason to the unreliability of the condom or allergy, as shown in Table 29. It is interesting to note that the second most common reason was that of the 'Italist' views and the third most common was that of reduction of pleasure.

One half of the male users from the street survey said that they obtained their supplies from the clinic or health personnel (Table 30).

B. CLINICAL SERVICES

DELIVERY OF SERVICES

1. STAFF KNOWLEDGE, ATTITUDE AND PRACTICE (K.A.P.) STUDY

METHOD OF DATA COLLECTION

(i) Methods and Materials

A point assessment survey was carried out to determine the attitudes of health workers and level of knowledge and skills related to family planning.

A total of 56 health clinics (33 per cent) were selected for the staff K.A.P. study, by using a stratified cluster sampling technique. A sample of 4 clinics in each parish, with the exception of Kingston and St. Andrew, where 16 clinics were done, was selected from the total 171 clinics in which documentation was done. Stratification was based upon the frequency of the delivery of services: one daily, the least frequent, and two other sessional clinics. When choice was necessary within these categories, a straight random selection was used.

A structured response schedule was administered to all staff members who were working in the family planning programme and were available.

In addition data were collected from staff of the University of the West Indies Family Planning Unit, and the Glen Vincent Clinic. It was not possible to interview the staff at Victoria Jubilee Hospital, because the severe staff shortage (nurses on holiday without adequate replacement) combined with the pressure of work made it inconvenient.

A knowledge rating scale was devised by allocating two points to each correct answer on the assessment prior to recommending each method

and a minus one point for an incorrect answer. A rating of specific instructions was also used. A consultant, who is actively engaged in the Family Planning Unit at the University Hospital, provided the range of points in assessment as well as specific instructions relevant to each method.

Both knowledge of assessment and specific instructions are included in the appendices.

A total of 259 staff members were interviewed. See Appendix I.

A further sub-sample was taken by interviewing the nurse in charge of each health clinic included in the sample, to gain insight into specific organizational processes and use of materials in the clinic. Forty-nine of the 56 nurses in charge (87.5 per cent), responded to this section. See Appendix V.

The areas examined in this staff K.A.P. study, were attitudes towards administrative procedures, policy and communication system, integration and the client, training, work, job satisfaction, knowledge of effectiveness and complications of methods of family planning, specific instructions re methods, personal feelings towards family planning and the family planning programme. The staff members were asked to complete a form giving an account of the time spent during one week in family planning aspects of their work schedule. The response to that exercise was low. Fifty per cent of the staff members returned the completed schedule.

Limitation - There was a high rate of non-response to the section dealing with the integration of services because 143 of the staff members were employed for less than 5 years in the family planning programme and there-

fore did not have the knowledge to compare services before the merger with the situation at the time this study was done. In addition the response schedule lacked specific instruction to skip that section if the respondents were not employed in the programme before integration.

(ii) Findings

Profile: The largest category of health workers was the community health aides (Table 31).

The ages of the staff members ranged from 17-67 years with a mean age of 34.7 years and the modal age of 24 years. When staff members were grouped in 10 year age groups, the modal age group was in the 20-29 age group (38.9 per cent) as shown in Table 32. There were 251 females and only 8 males, a ratio of 32:1, interviewed in the 56 clinics.

Of the 259 respondents, 51.3 per cent were cohabiting with a spouse (Table 33). Sixty-five per cent of the staff had post-primary education (Table 34).

In terms of special training in family planning, Table 35 shows only 66 (26.0 per cent) received special training, while 36.6 per cent had received no family planning training. Most staff members were involved in other areas as well as family planning (Table 36). As shown in Table 37, 143 members had been employed in family planning for less than 5 years.

Effect of Integration of Services on work: As stated earlier, the response was low for this section. However, when the data for 130 individuals who responded were analysed in terms of volume of work, 57.7 per cent said that there was more work (Table 38). Two of the four health educators felt that there was less work and less family planning since the integration of services.

One hundred and twenty-three individuals responded to the effects of integration in terms of the kind of work. Of these respondents, 57.7 per cent felt that there was no change in the kind of work while 40.6 per cent felt that there was more variety (Table 39).

In general the quality of supervision and the staff relationship with clients were not affected and in some instances were improved with integration of the services (Table 39).

Working Areas: Analysis of Tables 40 and 41 shows that the majority of the persons located either in the clinic or in domiciliary areas, or both, were happy with their area of work. The majority also preferred working in rural Jamaica (Table 42).

Job Satisfaction: Most staff members were satisfied with the type of supervision and the patient load in relation to the working hours (Tables 43 and 44), but they were dissatisfied with their salaries and the scope for promotion (Tables 45 and 46).

One half of the staff saw themselves as being given adequate decision-making opportunities, whereas 40 per cent felt that they were competent to make certain decisions but they were not given the opportunities (Table 47). Two out of three medical officers of health, and 54.5 per cent of 33 staff nurses held the latter view.

Attitudes Towards Clients: The ideal age group in which family planning should be introduced was seen as the 15-19 age group as shown in Table 48 (multiple answers were given for this question). It is interesting to note that the medical officers of health and the health educators did not

recommend a younger age than 15 years, while 32 community health aides recommended introducing family planning before the age of 15 years.

There was no significant difference between trained and untrained staff in their attitude towards school children coming to the clinic (Table 49); 33.7 per cent had reservations or did not accept school children in uniform. Within categories of health workers, however, there were differences of opinion. All the nurse practitioners accepted the children while the medical officers of health indicated the need for parental consent and support. One M.O.H. stated that he did not give family planning to a girl who was less than 18 years of age without parental consent. Eighty per cent of midwives, 73.9 per cent of public health nurses and 66.6 per cent of community health aides accepted school children wearing uniforms to the clinic; 94.4 per cent of the staff members had the same views about boys as they had of girls and the other 5.6 per cent tended to be more lenient with the boys.

The staff members felt that ignorance was the main reason for people not using family planning (Table 50) while religion and 'side effects' ranked second and third respectively. In Table 51, 'side effects' is seen as the main reason for clinic 'drop-outs', while ignorance and 'fed up with the method', were second and third. Although cultural pressures ranked fourth in the reasons for 'drop-outs', it is an important factor, and if cultural and social pressures were combined (see Table 50) these factors would add up to the second most common contributing reason for not using contraceptives.

The main problem perceived by the entire staff was non-compliance of the clients (Table 52). The lack of supplies was the second problem.

When the data were further analysed in Table 53, there was a significant difference between the trained and the untrained staff in their interpretation of problems. Of the trained staff, 53.3 per cent perceived equipment, materials and facilities as the main problem encountered, 21.3 per cent said staff related problems and disorganization, and 25.3 per cent said clients' non-compliance, while the untrained staff reported that 34 per cent of the problem was due to clients' non-compliance.

Staff Attitude to the Family Planning Programme: Staff attitude to the family planning programme was favourable. Forty per cent of the respondents felt that the family planning programme was very effective and a further 14.3 per cent felt that it was effective, 38.6 per cent felt it was slightly effective and the remaining 6.6 per cent either said they did not know, or they did not reply to that question (Table 54).

Practice: The majority of the staff members said they paid special attention mainly to the 'drop-outs', and also to the new recruits (Table 55). Of those who responded to the question of distribution of methods other than in the clinic, 161 of the 255 replied in the affirmative. The usual means of this type of distribution, was that the staff members carried the contraceptive method around in their handbags and gave it out on request (e.g. someone may meet a nurse in the supermarket and ask for some condoms). Another avenue for distribution was via the policemen in a particular area where they are coming in contact with young men.

Knowledge: The injection was regarded as the most reliable method of contraceptive, the foam tablet the least reliable, and the injection had the most complications, as shown in Tables 56, 57 and 58.

The knowledge of precautionary indicators related to the various methods of contraceptives was relatively low, when the respondents' responses were measured according to the indicators given by a consultant at the University Family Planning Unit - the highest possible score being 54 points (see Appendix II). Scores ranged from 0 - 36 as shown in Table 59. Community health aides had the lowest scores as most of these workers said that they were not the ones who recommended the methods to the clients. It is very important to note that eight of the 40 staff nurses (SRN/S.R.N., SCM) scored more than 15 points, while none of the more senior staff members scored above 15 points. The scores for specific instructions before the recommendation of various methods of contraceptives were also low and a similar distribution as that of the knowledge about the indicators before recommending a method was observed, as shown in Table 60. (The highest possible score being 67.)

(iii) Nurses in Charge of Clinics

This section will analyse data collected from the 49 nurses who responded to the schedule sent to nurses who were in charge of the clinics.

New Clinic: In response to the question of how the type of clinic and the frequency of service was determined, 38 (77.6 per cent) of 49 nurses in charge of clinics said that clinic attendance, pregnancy rate and population size within a community were the basic factors for determination of type and frequency. Other factors such as available building and location played a lesser role (Table 61).

There was a significant difference between the responses of nurses in Kingston and St. Andrew and those in the other parishes with regard to

the determination of the need for a new clinic (Table 62). In the rural areas it was the expression of the needs felt by the people in the community to the clinic staff or others in authority. In Kingston and St. Andrew the clinic staff, the head office or the politician made such a decision. Staff recognition of the needs for a new clinic was determined either by the number of clients or research into population size and socio-economic conditions in the community. The clinic staff or parish nurse took the initiative in the majority of the cases (Table 63). Thirty per cent of these nurses in charge of clinics said that they did not know the procedure for establishing new clinics, and only four (9 per cent) said that integration of family planning into existing clinics was the means by which new clinics were established. Thirty-three of the respondents said that communication of information about the establishment of new clinics to the Central Health Statistics Department was sent from the clinic nurse to the parish nurse then on to the Medical Officer of Health who informed the Central Health Statistics Department. Of the clinic nurses, 22.7 per cent either gave vague answers or said that they did not know the procedure for reporting this factor (Table 64).

General Communication: The flow of communication between the clinic and the central statistics department was regarded as being problematic. The main criticism was that it was a one-way system with no feedback (Table 65). Another important point was that communication was mainly at parish level or through the parish office, which meant no direct contact with the statistics department. Only 10 of the 49 nurses regarded the system as a two-way system and presumably satisfactory. Problems reported were mainly in the scarce supply of material for the various methods of contraceptives or the slowness of communication. However,

22 of the 45 nurses who responded to this question said that they had no problems (Table 66).

Integration of Services and General Administration: In general it was felt that the integration of the family planning programme with primary health care was good (Table 67). In Table 68 it is shown that only 17 per cent of the nurses felt that central administration was effective. The main problems were those related to communication, for example, lack of telephones at some clinics, blocking/delaying of communications; and the shortage of materials, equipment and staff, which impeded quality and quantity of services. These problems were more marked in the rural parishes.

Attitudes towards Community Health Aides: The majority of the nurses in charge of the clinics had favourable views of the community health aides in both the urban and the rural areas. Community health aides were regarded as being effective but in certain areas of work they needed more training (Table 69). However, 53 per cent of the nurses felt that the functions of the community health aides should not be extended (Table 70).

Non-compliance of the Clients: There was no consensus on the definition of a clinic 'drop-out' from the family planning programme (Table 71), and no mention of follow-up visits by staff members before the client was regarded as a 'drop-out'. The reasons that the nurses gave for the clients' non-compliance were, firstly, the complications of the family planning methods and secondly, the psycho-social pressures brought to bear on the clients either by their spouses or their peers (Table 72).

Lack of Non-Governmental Resources: The majority (70.8 per cent) of the clinics did not attract resources other than governmental resources. This lack of attraction of non-governmental resources was more marked in five parishes (Table 73).

(iv) Discussion

The staff knowledge and specific instructions ratings were very low. This is alarming, but perhaps understandable considering that 37 per cent of the staff who were interviewed had had no special training in family planning. The answers prepared by one consultant in relation to special attention before recommending the various methods and specific instructions which should be given to the clients (See Appendix II) could form the nucleus for an inservice manual which could be used as material for orientation of staff members or in an ongoing programme.

Staff members were satisfied with supervision and areas where they were employed but they were extremely dissatisfied with the lack of promotion opportunities and their salaries. The impact of this type of frustration lends itself to a possibly high rate of attrition. In addition, working conditions seemed unsatisfactory, especially those related to shortage of staff, equipment and materials for the various methods.

The staff viewed integration as beneficial to the clients and although it meant more work for the staff, the variety of work and quality of supervision was good.

Central administration had severe problems, related mainly to communication and supply of material. This factor suggests the need for

a closer link between the source of the materials and the front-line delivery of services. In general, staff members felt that the family planning programme was effective.

The untrained staff who are in constant contact with the clients were more aware of the non-compliance problems than were the trained staff. This could be an area of strength for the untrained staff and they could be trained to follow up the clients who did not turn up at the clinic for their appointments.

The community health aides were considered as effective members of the team which suggest acceptance of them by the trained staff. Perhaps more males could be employed in this programme to extend the programme to the male clients.

Staff members supporting the introduction of family planning at an early age (15-19 years) suggest that they were aware of the problems of teenage pregnancy.

The staff members of the clinics included in the total sample for the K.A.P. study were asked to chart the time spent in family planning for one week during the data collecting period of this study. As stated in the section on methods, the response rate was low: only 85 (33 per cent) filled in these forms. The total average time spent in the programme was 23.6 hours, and longest time was spent on advice and counselling (Mean = 5.78 hours) and the least time was spent on administration duties (Mean = 1.92 hours) as shown in Table 74.

C. NON-CLINICAL SERVICES

Contraceptive Retail Sales Programme

INTRODUCTION

The Contraceptive Retail Sales programme (CRS) was established in 1974 by a North American organization, Westinghouse Health Systems, working in collaboration with various Jamaican agencies in the family planning field. The Ministry of Health's input in preparing the ground for this programme was crucial. Westinghouse successfully implemented their three year marketing plan and handed over programme management to the National Family Planning Board (NFPB) in September 1977. This chapter explores the operations and management of the programme from the takeover date to the present, using August 1979 as a cut-off point for data collection.

The CRS programme must be viewed in its context as an additional component to the broader national FP programme, as developed by the Ministry and the NFPB. There are clear demographic targets to be achieved. The desired birth rate for 1980 is 25 per 1000. The present birth rate hovers around 27.5 per 1000.

The CRS programme has as its primary objective, accelerating the increase in the number of acceptors and users of contraceptives, thus reducing the birth rate. Using the commercial distribution network, the CRS programme is expected to have very extensive coverage, thus providing a perfect complement to the public clinic programme. It was also originally intended that the programme would be commercially viable, i.e. able to pay for its operations. Westinghouse had expected that at the point of handing over the programme to the NFPB, it would be independent of external financial donors.

CRS September 1977

It is instructive to note certain programme statistics at the point of handover:

CRS Sales 1977	
Panther (pieces)	880,000
Perle (cycles)	184,000

Contraceptive Brands Sales (Jan.-Sept. '77)	
Condoms (pieces)	490,000
Pills (cycles)	125,000

No. of Outlets Sept. '77	
Panther	1,108
Perle	267

One year after the 1975 product launch, the total number of condoms sold in Jamaica had more than doubled, a factor which clearly establishes that the CRS programme was being effective. Incremental sales were very much evident. Westinghouse made a few specific recommendations that they thought were important for the continued viability of the programme. Some of these are reproduced here if only to serve as a contrast to some present programme trends. These were to:

(a) Secure an additional distributor for Panther and Perle.

(b) Institute modest price increases for Panther and Perle.

(c) Solicit retailers through press advertisements in an effort to increase the number of outlets.

(d) Introduce a Panther 12-pack.

The Product

The condom, Panther, is the identical product that has been used since product launch. Supplies are still being donated by USAID. It is

interesting to look carefully at what is happening in the condom market as a whole. At the time of product launch there were quite a few premium priced condoms on the market, e.g. Durex. In addition there were one or two medium priced brands. Essentially the market could have been segmented along price lines: high, medium, low (Panther).

Research findings no longer validate this segmentation. A check with the various private sector firms which import contraceptives, shows that none has imported condoms for some time now. Occasionally one can find Durex or some other brand in pharmacies, but there does not appear to be continuous legal importation of other brands. Bureaucratic hassles and foreign exchange constraints may be major contributors to the disappearance of premium priced/quality condoms.

Panther, because of its low (highly subsidized) price has a corresponding low quality image. There is a vacuum in the market. The premium and medium-priced segments are not being serviced effectively. This could be a very profitable opportunity for the CRS programme to expand and upgrade its product line, by marketing a premium priced product in addition to Panther. Such a move would be immensely advantageous in ensuring that the programme achieves self-sufficiency soon(er).

The pill, Perle, is also the identical product that has been used since the programme started. Unlike the Panther market, there are several competitive brands available. All of the four private sector firms importing contraceptives deal exclusively with the pill. Hence there is much more competition for market share. Perle's relatively low price suggests that it is targetted at females in the lower economic strata.

The Price

Both Panther and Perle are sold at highly subsidized prices that are not really comparable with the prices of competitive brands. Westinghouse had recommended a 1978 price increase for both products. Their major pre-occupation was a self sufficient CRS programme.

It appears that the initial launching prices were arbitrarily selected and were possibly too low, but given prevailing economic conditions in Jamaica, a price increase for Panther and Perle is impractical. The target audience would not be able to afford the product. This factor further supports the introduction of a premium priced product that would return a good margin and thus shoulder some of the programme's financial burden. This is made more urgent when one examines some cost escalations.

Item	1979 Cost $	1975 Cost $
1 Panther Box	.04	.01
1 Panther pop-up Display	.49	.16
1 Panther Shipping Carton	.89	.43
1 Perle single cycle pack	.07	.02
1 Perle pop-up Display	.44	.15
1 Perle Shipping Carton	1.15	.56

Source: NFPB records.

Prices for the corresponding years are shown

Item	1979 price $	1975 price $
Panther (3 pieces)	.15	.15
Perle (1 cycle)	.30	.30

Promotion/Advertising

The CRS programme's advertising has always been handled by Dunlop Corbin Compton Associates. General brand awareness re both Panther and Perle can attest to the effectiveness of past advertising. Whether the programme is now getting the type of advertising support it needs is open to debate.

Independent interviews with the advertising agency and the distributor involved in the CRS programme, blatently suggest the need for coordinating the various functions. Since Westinghouse's departure the advertising budget has been reduced commensurate with budgetary constraints. Nevertheless a relatively large sum has been spent on advertising in both 1978 and 1979. In each year approximately $70,000 was spent. Some other programme costs are shown below.

1979 Estimates

Packaging Material (Panther & Perle)	$47,000
Packaging Labour	$4,500
Merchandising	$12,000

Distribution

This is a very important element of the CRS programme. The rationale behind a CRS programme is the greater efficiency/effectiveness of the private sector's distribution network compared with the public sector's.

The initial distributor, Cecil de Cordova Ltd. is now a Grace Kennedy Subsidiary, so that the official name of the distributor has changed to recognize this fact. Grace Kennedy is one of the largest commercial enterprises in Jamaica today, having a sales distribution network that covers the entire island. Maybe only Desnoes and Geddes Ltd.

can claim to have a distribution network of comparable coverage. The distributor does not make a considerable sum of money from handling Panther and Perle. The schedules below show how revenue is allotted (per unit).

	$J
Panther Sales price (3 pieces)	.15
Amount Returned to Programme	.09
Distributor Margin	.02
Retailer Margin	.04

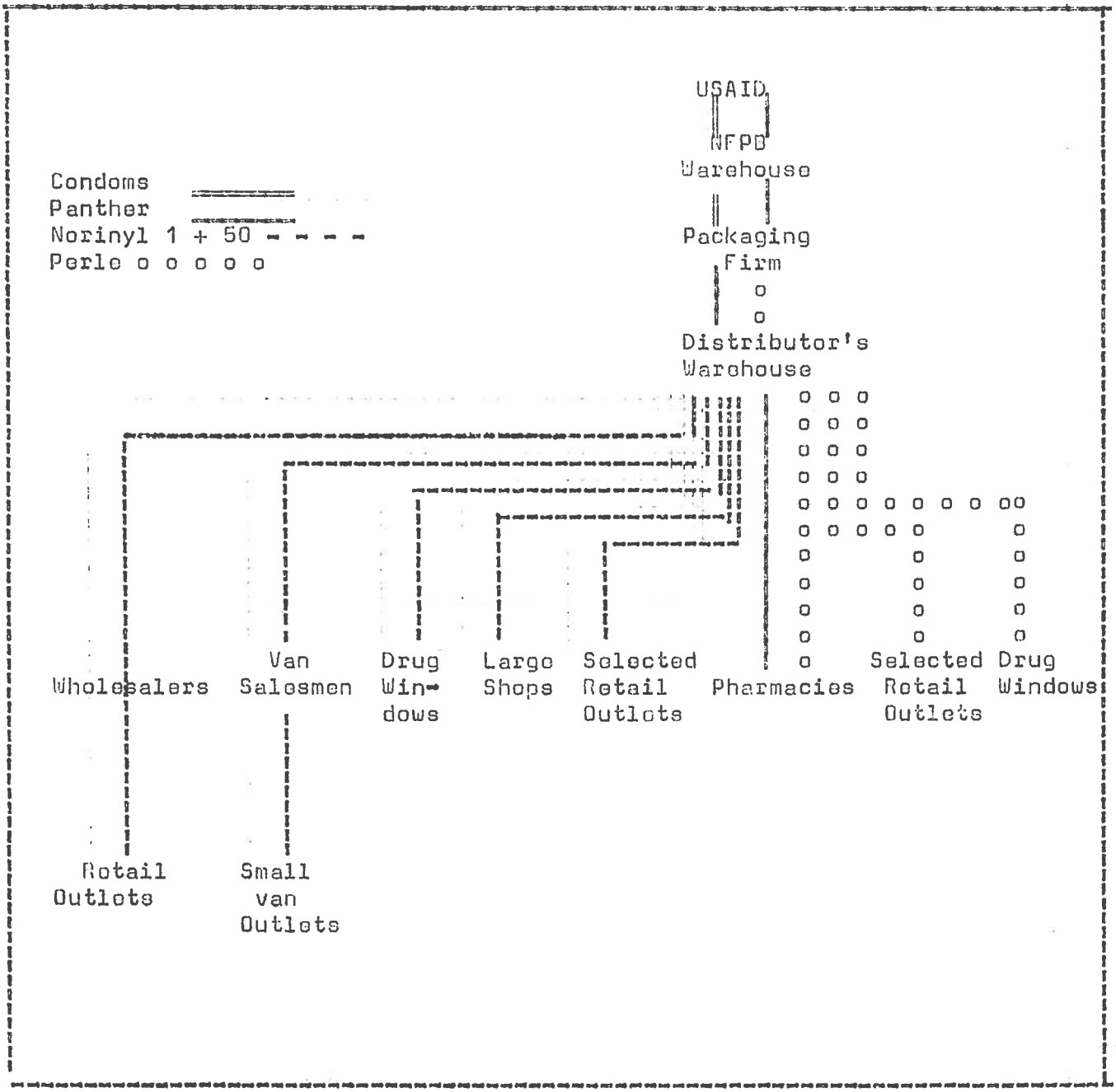
	$J
Perle Sales price (1 cycle)	.30
Amount Returned to Programme	.15
Distributor Margin	.05
Retailer Margin	.10

It is clear that there is little monetary incentive for the distributor to push these products. In fact it was stated by the distributor that the decision to accept the CRS account was influenced primarily by corporate social responsibility considerations, not financial returns. The physical movement of goods is depicted in the flow diagram reproduced from a Westinghouse report.

One crucial programme indicator, the number of retail outlets used, is presently shrinking. This is an undesirable trend, since overall programme effectiveness is greatly influenced by product availability, particularly rural availability. To underscore this fact there has been greater rural shrinkage than urban shrinkage.

	Number of Outlets	
	Sept. '77	August '79
Panther	1108	500 (estimate)
Perle	267	166 "

FIGURE 4.8 Movement of Goods Through the Distribution Network



Source: Westinghouse Health Systems

The 1979 numbers are approximations, since there is no doubt as to the accuracy of outlet records in the Marketing division of the NFPB. It is being suggested that most of this shrinkage can be accounted for by the prevailing unfavourable economic conditions. Many marginal retail outlets have simply disappeared since they can no longer afford to stay in business. There has been no perceived effort to counter this negative shrinkage trend. It is not clear who shoulders the responsibility for enlisting new retail outlets or whether the distributor and marketing officer share this responsibility.

New Perle retail outlets differ from Panther in that there is a training function to be performed before a new Perle outlet becomes operational. For some time now this training function has presented problems.

An interview with key distributor personnel suggests that the weakest link in the programme is coordination. Since Westinghouse's departure and the loss of the NFPB's first Marketing Officer, there has been very little coordination of functions. Essentially the distributor is 'doing his own thing', the advertising agency likewise and the NFPB's marketing division is similarly on its own path.

The distributor cannot recall the last occasion when all three critical programme agents sat and discussed critical programme variables/ decisions. A simple example highlights the need for coordination of effort. The distributor decides to offer some special volume discounts to get the product moving. Without the appropriate advertising support the effectiveness of the distributor's deal is greatly impaired.

Programme Sales

An evaluation of the CRS programme must pay especial attention to sales, i.e. sales of Panther and Perle and all other competing brands. The programme's sales figures that are reflected in the schedule below recognize sales to the retail trade, not sales to the final consumer.

CRS Sales Summary, '77 - '79

	'77	'78	'79 (9 months)
Panther (pieces)	880,000	820,397	570,000
Perle (cycles)	184,000	175,644	138,972

Competitive Brands Sales Summary, '77 - '79

	'77	'78	'79
Condoms (pieces)	490,000	-	-
Pills (cycles)	125,000	121,207	93,045

The schedules above show some interesting facts about the CRS programme. Panther sales have maintained a fairly stable level over the three year period. The whole picture is only revealed when sales data for competing brands of condoms are considered. Accurate sales data for competing brands of condoms for 1978 and '79 could not be obtained, nor could condom import statistics for the corresponding period be had. It is definite that some competing brands were sold, but it is highly unlikely that the numbers would compare with 1977 figures. Twenty per cent of the 1977 figure seems a reasonable estimate in each year.

The analysis is therefore suggesting that the total condom market has shrunken in the last two years. The reduction in sales of competing brands has not been offset by a proportional increase in the sales of Panther. A shrinking condom market is inconsistent with the original

objectives of the CRS programme. If sales of competing brands have fallen off (for whatever reason) the CRS programme has got to fill the gap. It is in this context that an enlarged product line makes eminent good sense.

Perle sales over the period have been relatively stable. The sales of competing brands of pills have also maintained a fairly stable level. Shrinkage in this figure reflects the results of scarce foreign exchange and bureaucratic hassles in procuring import licences for the same. In analysing Perle sales one must also be cognizant of the increasing acceptance of new contraceptive methods, e.g. the depo-provera injection.

Public Sector Clinic Performance

In addition to sales of competing brands of contraceptives, an evaluation of the CRS programme's overall effectiveness must pay attention to the public clinics' activities. Two measures of clinic activity are useful in this respect:

a) the number of new acceptors

b) the distribution of condoms and pills to clinics.

Securing reliable clinic data is a real problem and reflects the difficulty of implementing effective record keeping functions in the clinics. Accurate new acceptors' data for the period covered by this report were not readily available.

The measure of clinic activity most similar to the CRS programme is the distribution of condoms and oral pills from the NFPB's warehouse to the public sector clinics. This distribution is only to the 'outlet' and not the actual consumer which is similar to sales of the CRS programme, which reflect sales to the retail trade, not the final consumer.

Data from the NFPB's warehouse suggest that the distribution of oral contraceptives has been increasing marginally over the years, as shown below.

Clinic Distribution of
Oral Contraceptives '77 - '79

Year	No. of Cycles
1977	379,525
1978	403,964
1979	419,351

Source: NFPB Records

Clinic Distribution of Condoms
'77-'79

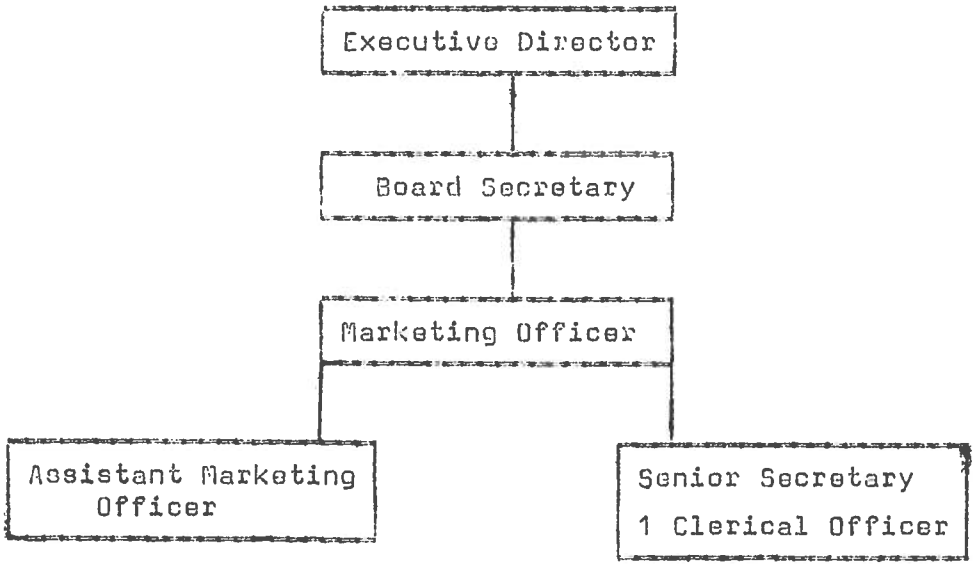
Year	No. of Pieces
1977	182,000
1978	207,000
1979	364,800

Source: NFPB Records

The distribution of condoms from the NFPB warehouse over the last three years has increased significantly.

Programme Management

In September 1977 the NFPB accepted full responsibility for the management of the CRS programme. The Marketing Division evolved for this express purpose, i.e. management of the CRS programme. It was staffed as follows: a Marketing Officer, an Assistant Marketing Officer, a Senior Secretary and a Clerical Officer. The partial organisation chart below shows these positions.



As manager of the programme, the Marketing Officer reports to the Executive Director via the Board Secretary. He/she should be responsible for the following general functions:

- Inventory control of all packaging and raw material component stocks.
- Budget control of programme's expenditures.
- Sales monitoring of programme's progress.
- Coordinating advertising agency, distribution and market research contacts.
- Monitoring of Perle referral programme.
- Assisting in the organization and monitoring of retailer and distributor training sessions.
- Liaising with Government and private agencies concerning programme progress and needs.

Management of the programme appears to have been effectively pursued from the date of handover up to the beginning of 1979. The first marketing officer left the job in January of 1979, since then three different persons have filled the position, including the present acting officer.

For brief periods during the year, the position of marketing officer has been vacant and it would appear as though management of the programme was completely neglected during these periods. At best the rapid turnover of marketing officers reasonably suggests that management of the programme suffers.

The area of management that has suffered the most appears to be the coordinating of activities of programme agents. The distributor complained repeatedly about this deficiency. The record-keeping function has also been seriously affected. There is doubt as to the accuracy of some programme statistics presently on record in the division.

TABLE 1: Answering Service Requests, 1978

Request Form	Number of Requests
Letters	2,158
Telephone calls	468
Visits	437
TOTAL	3,063

TABLE 2: Origin of Answering Service Letters by Parish, 1978

Parishes	Number of Letters
Kingston & St. Andrew	451
St. Thomas	48
Portland	63
St. Mary	116
St. Ann	133
Trelawny	54
St. James	130
Hanover	63
Westmoreland	183
St. Elizabeth	231
Manchester	160
Clarendon	208
St. Catherine	274
TOTAL	2,114

TABLE 3: Content of Requests (Letters, Phone Calls & Visits) to Answering Service, 1978

Content of Request	Number of Request
Reproductive Information	1,577
Request Abortion	364
Request Sterilization	42
Request Material	414
Human Relationship	296
General Health	252
Miscellaneous	118
TOTAL	3,063

TABLE 4: Vacancies and Additional Requirements in Health Centres by Category and Parish

		West.	St.E	M/cr	Clar	St.C	St.T	Port	St.M	St.Ann	Trel	St.J	Han	KSAC	Total	
SPHN	V	-	-	-	-	-	1	1	1	-	1	-	1	-	5	
	AR	-	-	-	-	-	1	1	1	-	1	-	1	-	5	)
PHN NG.III	V	-	-	NA	NA	NA	NA	-	1	All PHN V = 5	-	NA	-	-	1	(a) Exclusive of St.A figures
	AR	4	5	4	4	3	2	3	3		-	2	2	-	32	)
PHN NG.II	V	-	-	2	1	-	NA	NA	2	AR = 10	2	NA	-	2	9	(a)
	AR	-	5	1	-	-	-	4	5		4	-	2	3	24	)
Staff Nurse	V	3	-	2	NA	NA	NA	2	2	-	1	NA	1	-	11	(a)
	AR	4	7	13	12	12	3	7	3	8	1	5	4	-	79	
Nurse Pract.	V	-	-	1	NA	NA	2	-	-	1	-	NA	1	-	5	(a)
	AR	5	6	1	2	2	2	4	1	5	-	4	3	8	43	
Mid-wife	V	-	6	-	-	-	1	1	2	-	-	-	4	4	18	
	AR	4	9	10	-	-	-	7	3	2	-	5	7	6	49	
AN/RN	V	-	-	NA	NA	2	NA	-	NA	-	-	NA	-	1	3	(a)
	AR	2	6	-	5	5	2	2	1	4	1	3	2	8	41	

Note: (a) These figures are probably understated as the data are incomplete for some parishes.

Assumptions (i) The Additional Staff Requirements (AR) were calculated on the basis of the ideal staffing for each type of Clinic as indicated by MOH manuals, (see App. I). If reports from individual parishes suggested a higher figure, this was used instead. These APS represent the numbers required in addition to those now on the ground.

(ii) The vacancies represent those reported in MOH files.

TABLE 5: Type of Training:Further Training of Health Centre Personnel

Staff Category	N.A.	IS	Mgt	FP related	C+y Health & Nutrition	Mental retardation	Pediatrical	Intensive Care	NPT	Primary Health Care
SPHN	(3)	(-)	(2)	(1)	(3)	(-)				
	14	3	10	8	5	-	-	-	-	-
PHN II	(5)			(8)	(22)	(2)		(1)		
	15	6	12	19	34	6	3	2	3	3
PHN III	(3)		(1)	(-)	(1)					
	15	-	3	3	7	-	-	-	1	-
NP	(1)				(1)				(1)	
	1	-	1	1	1	-	1	-	5	-
SN	(4)		(1)	(3)	(4)	(1)			(1)	
	5	1	7	13	7	1	-	-	4	-
AN/EN	-	4	-	3	1	-	-	-	-	1
Midwives	-	22	11	24	-	-	-	-	-	-

TABLE 5 (CONTINUED): Type of Training

Further Training of Health Centre Personnel

Staff Category	B.A.Gen/ ANA/ Advanced nursing	Psych Nursing	OTT	OH	Midwifery	Health visiting	Trop med	Audiology	Ou Nursing	Refreshers
SPHN	(4) 5	-	-	(1) 3	(3) 4	(2) 3	-	-	(-) 1	(-) -
PHN II	-	(3) 4	-	-	(29) 33	(7) 11	1	(1) 1	-	5
PHN III	1	(3) 3	-	3	(3) 4	(2) 3	-	-	-	3
NP	-	-	-	-	(2) 2	-	-	-	-	-
SN	-	(1) 2	(2) 2	(1) 1	(27) 38	-	(1) 2	-	-	-
AN/EN	-	(1) 1	-	-	-	-	-	-	-	(2) 4
Midwives	-	-	-	-	NA	-	-	-	-	47

Source: Ministry of Health Files

( ) Figures in brackets represent the numbers from KSAC and St. James

ANA = Advanced Nursing Administration
OH = Occupational Health
FP = Family Planning
C+y = Community
NPT = Nurse Practitioner Training
OTT = Operating Theatre Techniques
IS = Intro to Supervision
NA == Nursing Admin.
Mgt = Management

TABLE 6: Health Service Staff: Respondents Reporting Special Training in Family Planning

In Service	General Training	Special Training in FP	None
47	43	64	84

Source: Survey Data

DK = 4

TABLE 7: Health Service Staff: Level of Education of Respondents

Primary School	New Secondary	Traditional Secondary
84	70	86

Source: Survey Data

DK = 2

TABLE 8: Health Service Staff: Level of Education by Staff Category

	Primary	New Secondary	Traditional Secondary
PHN	1	3	16
SN	5	7	24
Midwife	10	24	12
Asst. Nurse	4	2	2
CHA	69	30	15
PH I	-	1	1
Receptionist	3	4	6
NP	-	-	2
MOH	-	-	3
HE	-	-	4
Other	2	1	-

Source: Survey Data

DK = 2

TABLE 9: Health Service Staff: Specialized Training by Staff Category

Type of Training	Asst. Nurse	PHN	SN	M/W	NP
Public Health	2	10			2
Nurse Practitioner					
Theatre Nurse					
Operating Theatre Tech.	2				
ICN		1			
Registered Pract. Nurse			1		
Premature Baby Nurse			2		
Advanced Nursing Admin.			1		

Source: Survey Data

TABLE 10: Health Service Staff: Further Training by Type of Training and Present Job

Type of Training	PHN	SN	Midwife	Asst. Nurse	Student Nurse/ midwife	CHA	PH I	Recept- ionist	Nurse Pract	MOH	HE	Totals
J.S.C.					1	5						6
CHA C					1			1				2
At least General Nursing and Midwifery	22	33	45	3	2	80		1	3		2	191
Nursing Educ.												
Asst. Nursing				4								4
Child Care/ Home Nursing						2						2
Youth Service Training						5						5
Commercial Courses/ Housecraft								7				7
Public Health							2					2
Medical Deg.										3		3
A Levels								1				1
None			1			11		2				14

TABLE 11: USAID Sponsored Training - by Type of Training and Staff Category

Staff Category	Popn. Pro-gram-mes	FP Clini-cal	Manage-ment & Admin. of FPP	C+E of FPP	Other FP	Evalu-ation Pro-gram-mos	Data Proces-ing/ Actg.	Other	
Administrator	3		8	2	2			3	
Health Educators	1		3	11				2	
FP Officers	1		2		1				
Nurses/ Midwives (Practicing)	1	6	3	6	1	3			1
Social Worker									1
Doctors		9	1		8			1	4
Medical Technologists		1							
Statisticians	6						3		
Accountants			1				1		
Researchers	5			1	4			1	1
Technicians								1	
Home Economists					1				
Other								7	

Source: Training Division, Ministry of Health

DK = 6

C & E = Communication and Education

TABLE 12: Lag Between Entry and Appointment to Particular Post by Category and Location (KSAC, St. James, the Rest)

Staff Category	1 year or less			2 - 4			5 - 7			8+			NS		
	KSAC.	St. J	The Rest	KSAC.	St. J	The Rest	KSAC.	St. J	The Rest	KSAC.	St. J	The Rest	KSAC.	St.J	The Rest
SPHN	1	2	-	1	-	-	-	-	1	-	-	12	-	-	-
PHN II	11	6	20	2	2	13	-	-	13	-	-	8	-	-	14
PHN III	3	-	-	-	1	1	-	-	-	1	-	11	-	-	2
SN	15	4	31	4	1	8	-	-	1	-	-	2	6	3	18
AN/EN	6	-	3	-	-	4	-	-	-	-	-	-	-	-	4
NP	-	-	3	-	-	-	-	-	-	-	-	-	-	-	7

Source: Ministry of Health Files

Note: These figures are not complete as at the time of writing not all new appointments had been recorded.

TABLE 13: Levels of Education and Training Received - NFPB Staff - All Categories

	Level of Education			Additional Training		Total
	Primary	Secondary	Post. sec.	In Area of Present Occupation	In FP & FLE	
Director			1	1		1
Admin. Asst.	1	2		2	1	3
Marketing Officers	1			1		1
Training "		1	2	2	3	3
Information "		2		2	2	2
Clerical/ Secretarial	2	2	10			14
Accountants		3		1		3
Technicians		1	1	1		2
Office Attendants	6	2				8
Stores and Supplies	3		1			4
Drivers/ Sidemen	5			1		5

Source: NFPB Files

TABLE 14: Previous Experiences of NFPB Staff

	Sales Rep.	Econo-mist	Nurs-ing	Health Educa-tion	Child-Care	Cleri-cal	Tea-cher	Wel-fare Offi-cer	Acctg.	Admin-istra-tive	FP
Director		1							1		
Marketing Officer	1										
Training Officers			1	1		1					
Information Officers			2		1						1
Clerical					1	7	1				
Acct.						1			2		
Admin. Asst.						2				1	
Technician							1				
Stores/ Supplies							1	1			

Source: NFPB Files

Note: These figures have not been totalled since the result would not bear much relationship to staff totals. Quite a few individuals held more than one type of job prior to their employment by the NFPB.

TABLE 15: Number of Clinics Offering Family Planning, from Which Records Data Were Collected, in Comparison with February 1979 List from the Central Statistics Department

PARISH	CLINICS			CENTRAL STATISTICS DEPARTMENT
	Number done	Number not done	Total Number	Total No.
Kingston & St. Andrew	29	-	29	40
St. Thomas	6	6	12	10
Portland	14	1	15	13
St. Mary	23	-	23	10
St. Ann	18	2	20	29
Trelawny	11	6*	17	11
St. James	19	1	20	24
St. Elizabeth	17	-	17	24
Manchester	14	2	16	12
Clarendon	7	-	7	30
St. Catherine	13	-	13	12

* No records for 2

Percentage of clinics done = 90.50%

TABLE 16: Type of Clinic According to Staff Structure by Parish

PARISH	TYPE OF CLINIC					
	Type I	Type II	Type III	Type IV	Type V	N.A.
St. Catherine	3	3	5		2	
Clarendon		6	1			
Manchester	5	2	4			5
St. Elizabeth	6	5	5			1
St. James	11	4	2		1	2
Trelawny	3	6	2			6
St. Ann	8	3	1	1	2	5
St. Mary	14	8	1			
Portland	9	3	2			1
St. Thomas	2	3	2			5
K.S.A.C.	8	9	6	3	3	
TOTAL	69	52	31	4	8	25

TABLE 17: Frequency of Service by Parish

PARISH	FREQUENCY					
	Daily	2-3 times per week	Once per week	2-3 times per month	Once per month	N.A.
St. Catherine	1	-	4	3	4	1
Clarendon	1	1	1	3	1	-
Manchester	6		1	1	3	5
St. Elizabeth	5	1	2	3	6	
St. James	15	-	-	2	1	2
Trelawny	5	-	2	4		6
St. Ann	1		4	4	7	4
St. Mary	6	1	9	2	4	1
Portland	2		1	5	5	2
St. Thomas	1	1	2	1	1	6
Kingston & St. Andrew	13	2	11		1	2
TOTAL	56	6	37	28	33	29

TABLE 18: Contraceptive Methods Used (April - June 1979)
Classified by Parish

PARISH	NO. OF CLINICS	NO. USING A PARTICULAR METHOD							
		Pill	Injection	I.U.D.	Diaphram	Condoms/ Spermicidals	Sterilization	Other	Total
St. Catherine	12	2091	2483	92		535	35		5236
Clarendon	7	793	765	57		146	9		1770
Manchester	11	811	1049	109	3	233	21		2226
St. Elizabeth	17	1155	1116	40		460	16		2787
St. James	19	1799	1325	48		304	97		3573
Trelawny	11	750	571	1		102	3		1427
St. Ann	14	1172	438	243		392	43		2288
St. Mary	23	795	917	12		1790*	21		3535
Portland	14	1059	1292	5		82	54		2492
St. Thomas	6	702	748	25	3	130	33		1641
Kingston & St. Andrew	25	6208	6013	502	11	1580	197	347	14858
TOTAL	159	17335	16717	1134	17	5754	529	347	41833
PERCENTAGE		41.44	39.96	2.71	0.04	13.75	1.26	0.83	

Total Number of Users = 41833

*Port Maria accounted for 1773. These figures may be very unreliable. The Secretary said she "struck the average" for condoms distributed over the period.

TABLE 19: Clinics and Use, by Parish

Parish of St. Ann

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Watt Town	Twice per month	1	7	67	74
Beth Jacobs	Daily	3	186	1204*	1390
Claremont	Weekly	2	6	91	97
Sturge Town	Monthly	1	5	9	14
Bamboo	Twice per month	2	10	32	42
Moneague	Twice per month	2	3	38	41
Bensonton	Monthly	1	0	7	7
Brown's Town	Weekly	4	24	119	143
Bohemia+	Monthly	1	2	7	9
Borobridge	Monthly	1	0	0	0
Ocho Rios	Weekly	2	82	106	188
Clarksonville	Monthly	1	0	3	3
Muirhouse/ Buxton	No FP services offered				
Alexandria Hospital	Weekly	5	52	126	178
Runaway Bay	Twice per month	3	0	8	8
Friendship	Monthly	1	0	18	18
Gibraltar	Monthly	1	28	48	76

*248 were given as continuing
These may be new acceptors who were on a 3 month trial period.
+No family planning services have been offered since 1978 with the exception of one client receiving 5 packets of "Perle" oral contraceptive on 15/3/79. The District Midwife reported that those who are interested in Family Planning go to the Spaldings Hospital.

TABLE 19 Cont'd

Parish of St. Thomas

Name of Clinic	Frequency	Type	Total No. of New Acceptors for April, May & June	Total Revisits for April, May & June	Total No. of Users for April, May & June
Cedar Valley	Monthly	2	0	42	42
Lyssons	Daily	2	164	944	1108
Seaforth	Weekly	2	38	42	80
Port Morant	6 times per month	2	19	156	175
Bath	Once weekly	2	22	83	105
Orange Walk	Twice per month	1	18	113	131

TABLE 19 Cont'd Parish of St. Mary

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Retreat	Weekly (Monday)	2	14	31	45
Cane Heap	Monthly	1	4	10	14
Clonmel	Daily	1	2	26	28
Port Maria	Daily	1	60	2325*	2385* (Approx)
Castleton	Weekly	1	10	44	54
Bonny Gate	Twice Monthly	1	0	5	5
Fellowship Hall	All Mondays	1	3	8	11
Hunts Town	4th Thursday	1	6	0	6
Gayle	4th Friday	3	12	113	125
Windsor Castle	Mondays	2	13	21	34
Clarke Castle	Daily	1	5	22	27
Wood Park	Daily	1	13	45	58
Islington	Tuesdays	2	20	65	85
Enfield	1st Thursday	2	19	17	36
Highgate	Weekly	2	22	120	142
Bellfield	Twice Monthly	2	2	21	23
Annotto Bay	Daily	2	36	93	129
Robins Bay	Every Other Day	1	6	12	18
Flint River		1	3	10	13
Oracabessa	Wednesdays	2	22	235	257
Long Road	3rd Tuesday	1	6	5	11
Rock River	Once Weekly	1	17	0	17
Hampstead	Daily	1	1	11	12

*These figures may be unreliable. See note for Table 18.

TABLE 19 Cont'd

Parish of Trelawny

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Jackson Town	Once per Week	2	22	89	111
Wakefield	Twice per Month	2	11	84	95
Wait-A-Bit	Twice per Month	2	-	5	5
Stewart Town	Once per Week	1	-	19	19
Ulster Spring	Twice per Month	2	29	162	201*
Rio Bueno	Daily	1	7	84	91
Sherwood Content	Daily	1	19	32	51
Clark's Town	Daily	2	5	146	151
Duncans	Daily	3	19	108	127
Falmouth	Daily	3	98	415	513
Duanvale	Twice per Month	2	1	62	63

*For 9 users, it was not ascertained whether they were new acceptors or revisits.

TABLE 19 Cont'd

Parish of St. Catherine

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. Users on Record for April, May & June
Bog Walk	Thrice Monthly	2	28	170	198
Cumberland	Daily		153	2155	2308
Glengoffe	Thrice Daily	3	27	32	59
Ewarton	Monthly	2	26	51	77
Linstead Hospital		5	47	1	48
Sp. Town Hospital	Weekly	5	Not Recorded	Not Recorded	
Rodwood/Guys Hill	5 Sessions Monthly	3	101	134	235
Harkers Hall	Monthly	2	14	41	55
Watermount	Monthly	1	11	78	89
Old Harbour	Weekly	3	214	861	1075
Linstead	Weekly	3	82	223	305
Riversdale	Thrice Monthly	1	171	594	765
Point Hill	Monthly	3	15	7	22

TABLE 19 Cont'd

Parish of Clarendon

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
May Pen	Daily	3	66	1135	1201
Lionel Town	2 Times Weekly	2	102	238	340
Mocho	Monthly	2	3	10	13
Chapelton	Twice Monthly	2	5	21	26
Race Course	Twice Monthly	2	10	40	50
Frankfield	Twice Monthly	2	26	34	60
Kellits	Weekly	2	24	56	80

TABLE 19 Cont'd

Parish of Manchester

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Cross Keys	Daily	3	7	18	25
Christiana	Thrice Daily	3	45	159	204
Mandeville Comprehensive	Daily	3	62	1105	1167
Banana Ground	Monthly	1	7	5	12
Craighead	Daily	1	13	54	67
Robins Hall	Daily	1	2	76	78
Porus	Daily	3	16	60	76
Mile Gully	Monthly	2	0	14	14
Spalding Hospital	Weekly	1	87	342	429
Downs	Daily	1	9	95	104
Pratville	Monthly	2	3	47	50
Lincoln)					
Bombay)					
Bellefield					
Harmons					
Alligator Pond					

TABLE 19 Cont'd

Parish of Portland

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Fruitful Vale	Monthly	1	7	73	80
Manchioneal	2nd Tuesdays, 4th Wednesdays	3	-	136	136
Skibo	Twice per Month	1	Not Ascertained	Not Ascertained	21
Moore Town	Once per Month	1	6	5 Not Ascertained 13	24
Hectors River	Once per Month	1	7	58	65
Fellowship	(2nd Tuesdays) Monthly	2	30	141	171
Fair Prospect	1st & 4th Mondays	2	13	137	150
Fairy Hill	Once per Week (Mondays)	1	1	6 Not Ascertained 10	17
Windsor Castle	Daily	1	3	44	47
Hope Bay	3 times per Month	1	2	67	69
Swift River	Monthly	1	13	-	13
Buff Bay	Twice per Month	2	23	224	247
Port Antonio	Daily	3	114	1309	1423
Comfort Castle		1	5	24	29

TABLE 19 Cont'd

Parish of St. Elizabeth

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Black River	Daily	3	22	582	604
Newell	3rd Wednesdays	3	24	250	274
Fyffes Pen	Twice Weekly	1	22	56	78
Lacovia	Daily	3	26	301	327
Newton	2nd & 4th Fridays	1	6	70	76
Middle Quarters	Daily	1	7	78	85
Pepper	2nd Fridays	2	3	69	72
Appleton	1st Tuesdays	2	15	83	98
Newmarket	4th Wednesdays	3	9	102	111
Santa Cruz	Twice per Month	3	193	119	312
Balaclava	Once per Month	3	12	98	110
Maggotty	1st Tuesdays	2	12	108	120
Malvern	Daily	2	-	87	87
Elderslie	Once per week	2	11	211	222
Braes River	Once per week	1	10	54	64
Munroe	2nd & 4th Wednesdays 2nd & 4th Fridays	1	6	50	56
Nyersville	Daily	1	9	82	91

TABLE 19 Cont'd

Parish of St. James

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Cornwall Regional Hospital	Daily	-	214	804	1018
Somerton	Once per Month	1	7	12	19
Goodwill	Daily	1	6	37	43
Glendovon	Daily	1	-	36	36
Lottery	Daily	1	18	38	56
Adelphi	Daily	2	10	26	36
Hopeton	Daily	1	8	15	23
Orange	Daily	1	6	26	32
Salt Spring	Daily	2	4	25	29
Mt. Carey	Daily	1	4	47	51
Dickersteth	Sessional (once per month)	1	26	-	26
Union Street (Mo-Bay)	Daily	3	82	1520	1602
Cambridge	Daily	2	-	53	53
Flanker	Daily	1	1	49	50
Barrett Town	Daily	1	4	40	44
Springfield	Daily	1	16	49	65
Catadupa	Twice per Month		7	21	28
Roehampton	Daily	2	7	117	124
Maroon Town	Twice per Month	3	35	203	238

TABLE 19 Cont'd

Kingston & St. Andrew

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Golden Spring	Sessional	1	13	179	192
Stony Hill	Daily	3	28	185	213
Essex Hall	Sessional One day/month	1	10	10	20
Lawrence Tavern	Sessional once weekly	2	42	138	180
Red Hills	Weekly	2	No Paper to keep Records	No Paper to keep Records	
Parks Road	Weekly	1	19	7	26
Glen Vincent (Surg)	Daily	4	165	0	165
University Hospital	Daily	5	328	669	997
Victoria Jubilee Hospital	Daily	5	194	4546	4740
Gordon Town	Weekly	3	8	118	126
Woodford	Daily	1	0	8	8
Dallas	*				
Mavis Bank	Daily	2	29	0	29
Glen Vincent	Daily	4	150	479	629
Kingston Comprehensive	Daily	4	38	471	509
Norman Gardens	Once per week	1	36	106	142

*No new acceptors since March 1979

(Continued)

TABLE 19 Cont'd

Kingston & St. Andrew (Continued)

Name of Clinic	Frequency of Clinic	Type	Total No. of New Acceptors for April, May & June	Total No. of Revisits for April, May & June	Total No. of Users on Record for April, May & June
Bull Bay	Once per week	1	+13	+180	193
Michael Manley	Monday Afternoons	2	63	308	371
Windward Road	Daily	2	114	2399	2513
Edna Manley	Twice per week	1	52	390	442
Harbour View	Once per week	3	33	255	288
Rollington Town	Daily	3	155	166	321
Allman Town	Daily	3	347	441	788
Operation Friendship	Daily	3	47	620	667
Greenwich Town	Once per week	2	60	82	142
Whitfield Town	Once per week	3	214	905	1119
Denham Town	Once per week	2	13	25	38
Maverly	Daily	4			
Hagley Park	Twice per week	1			

+ Totals for May, June and July 1979.

TABLE 20: Age Distribution for Clients Using the Clinics April to June 1979. (Data Collected in 10-year Age Groups)

	AGE IN YEARS					
	14-20	21-30	31-40	41-50	More Than 50	Total
% New Acceptors	33.3	42.2	19.3	5.2	-	100.0
% Re-Visits	14.54	49.0	30.24	6.02	0.2	100.0

TABLE 21: Age Distribution for Clients Using Clinics April to June 1979. (Data Collected in Irregular Step-intervals)

	AGE IN YEARS					
	15-19	20-24	25-34	35-44	45+	Total
% New Acceptors	27.2	37.5	27.5	7.3	0.5	100.0
% Re-Visits	12.0	33.0	40.1	12.5	1.6	100.0

TABLE 22: Age Distribution of Male Users of Contraceptives From Clinic and 'Street' Studies

AGE GROUP	CLINIC	'STREET'	
	Male Users	Male Users	Male Non-Users
15-19	12	26	16
20-24	17	49	16
25-29	21	17	4
30-34	4	7	3
35-39	6	1	2
40-44	12	-	4
45-49	6	-	1
50 & over	5	-	1
TOTAL	83	100	47

TABLE 23: Marital Status of Males in Clinic and 'Street' Studies

MARITAL STATUS	CLINIC	STREET	
	Male Users	Male Users	Male Non-Users
Married	23	3	4
Common Law	12	-	-
Single/Visiting	48	97	43

TABLE 24: Educational Level of Males in Clinic and 'Street' Studies

EDUCATIONAL LEVEL	CLINIC	STREET	
	Male Users	Male Users	Male Non-Users
Primary	55	18	24
Post Primary	28	82	23

TABLE 25: Occupation of Males in Clinic and 'Street' Studies

OCCUPATION	CLINIC	STREET	
	Male Users	Male Users	Male Non-Users
Professional/ Managerial	3	16	2
Clerical/Sales	2	15	4
Skilled/Technical	36	27	8
Service Workers	16	15	14
Unskilled	12	5	5
Student	5	17	6
Not Ascertained	9	5	8
TOTAL	83	100	47

TABLE 26: Number of Children Born to Males in Clinic and 'Street' Studies

NUMBER OF CHILDREN	CLINIC	STREET	
	Male Users	Male Users	Male Non-Users
0	10	77	31
1	6	15	4
2	6	5	3
3	2	3	2
4	4	-	2
5	7	-	-
6+	9	-	1

TABLE 27: Age of Last Child for Male Users of Contraceptives Who Had Children in Clinic and 'Street' Studies

AGE	CLINIC	STREET	
	Male Users	Male Users	Male Non-Users
< 1 year	9	7	4
1 - 5 years	28	15	8
Over 5 years	21	1	2
TOTAL	58*	23	14

*10 persons had no children Not ascertained = 15 (Clinic)

TABLE 28: Male User's Reasons for Using Condoms

REASONS	CLINIC	STREET
Protection from Germs	9	11
Prevention of Pregnancy	26	8
Both	49	81

TABLE 29: Reasons for Not Using Condoms

REASONS	NO. OF RESPONDENTS
No special reason	10
"Italist"/does not believe in artificial stuff/ Birth control	9
Doesn't like it/Takes away pleasure	7
Woman must protect self/Use other methods/ wife T.L./Abstenance	7
Religion/against premarital sex	5
It is dangerous	2
Doesn't deal with gear suspected of V.D.	1
Condom is for young people	1
Allergy	1
Condom burst - unreliable	1
TOTAL	46

Not ascertained = 1

TABLE 30: 'Street' Male Users Source of Supply of Condoms

SOURCE OF SUPPLY	NO. OF MALE USERS
Clinic and Health Personnel*	50
Pharmacy	29
Friends and Relatives	28
Shop and A.M.C.	17

*6 persons got condoms from health personnel but not in the clinic setting.

TABLE 31: Staff of the Family Planning Clinics Classified by Jobs

Position Held	Percentage
Community health aide	43.24
Midwife	18.53
Trained nurse/midwife	13.90
Public health nurse	8.88
Assistant nurse	3.47
Student nurse	1.54
Health educator	1.54
Nurse practitioner	1.16
Doctor	1.16
Others	6.56

TABLE 32: Age Distribution of Staff in Family Planning Clinics

	AGE GROUPS OF STAFF IN FP CLINICS				
	20	20 - 29	30 - 39	40 - 49	50 & Over
Number	3	98	80	51	23

TOTAL = 255

Age not ascertained = 4

TABLE 33: Marital Status of Staff in Family Planning Clinic

	MARITAL STATUS						
	Married	Common-Law	Widowed	Divorced	Single	Casual	TOTAL
Number	120	13	4	3	116	3	259
Percentage	46.3	5.0	1.5	1.2	44.8	1.2	100

TABLE 34: Education of Staff

	EDUCATION			
	Primary	Secondary	High	TOTAL
Number	90	78	89	257
Percentage	35	30.4	34.6	100

Not Ascertained = 2

TABLE 35: Staff Members' Training in Family Planning and Source

	ANY SPECIAL TRAINING IN FAMILY PLANNING			
	Inservice Training	General Training	Special Training in FP	None
Number	50	45	66	93
Percentage	19.7	17.7	25.0	36.6

TOTAL = 254

Not Ascertained = 4 + 1 = 5

TABLE 36: Staff Involvement in Service

	AREA OF PROGRAMME IN WHICH INVOLVED		
	FP Only	FP and some others	FP and all others
Number	26	92	139
Percentage	10.0	35.5	53.7

Not Ascertained = 2

TABLE 37: Duration of Time Employed in Family Planning Section

	TIME WORKED IN F.P. SECTION					
	6 months	6-11 months	1-4 yrs	5-8 yrs	9-12 yrs	12 yrs
Number	10	13	120	72	28	6
Percentage	4.0	5.2	48.2	28.9	11.2	2.4

Not Ascertained = 10

TABLE 38: Effects of Integration in Relation to Volume of Work and Kind of Work

POSITION HELD	How merger has affected volume of work			How merger has affected kind of work		
	No Change	Less Work/ Less FP	More Work	More Variety	No Change	Less Variety
Doctor						
Health educator	1	2	1	2	1	
Nurse Practitioner			2	1	1	
Public health nurse	4		6	4	6	
Staff nurse	11		13	12	12	
Midwife and nurse	1				2	
Midwife	12		20	17	15	1
Assistant nurse	1		2	1	2	
Student nurse/ Midwife						
C.H.A.	22		23	10	27	1
Others	1		8	3	5	
TOTAL	53	2	75	50	71	2
PERCENTAGE	40.77	1.54	57.69	40.65	57.72	1.63

Not Ascertained = 129

Not Ascertained = 136

TABLE 39: Effects of Integration of Supervision and Staff/Client Relationship

POSITION HELD	How merger has affected type of supervision			How merger has affected relationship with Client		
	Same	More	Less	Same	Better	Worse
Doctor						
Health educator	4			3		1
Nurse practitioner		2		1		1
Public health nurse	4	6		7	3	1
Staff nurse	14	6	2	15	8	2
Midwife and Nurse	1			1		
Midwife	21	5	5	19	10	3
Assistant nurse	3			2		1
Student nurse/ Midwife						
C.H.A.	30	6	1	29	6	3
Others	8	1	1	8	1	1
TOTAL	85	28	9	85	26	13
PERCENTAGE	69.67	22.95	7.38	68.55	20.97	10.48

Not Ascertained = 137

Not Ascertained = 135

TABLE 40: Staff Members Working Areas at the Time of the Study

MAIN WORKING AREA			TOTAL
Field	Clinic	Both	
20	62	173	255
7.8%	24.3%	67.8%	100%

Not Ascertained = 4

TABLE 41: Staff Members Preference in Working Area

Main Working Area	No.	Preferred Working Area		
		Clinic	Field	No Preference
Field	20	2	13	5
Clinic	62	32	6	24
Both Areas	173	27	24	122

TABLE 42: Staff Members Preference in Urban/Rural Location

PREFERRED WORKING AREA		
RURAL	URBAN	NO PREFERENCE
140	57	60

Not Ascertained = 2

TABLE 43: Staff Members Satisfaction in Relation to Supervision

SATISFACTION WITH TYPE OF SUPERVISION		
ADEQUATE	TOO LITTLE	TOO CLOSE
212	39	4

Not Ascertained = 4

TABLE 44: Staff Members Reaction to Allocation of Time for Number of Patients

WORK TIME VS PATIENT LOAD		
ADEQUATE	INADEQUATE	DON'T KNOW
198	52	3

Not Ascertained = 6

TABLE 45: Staff Members Feelings Towards Salary

SATISFACTION WITH PRESENT SALARY		
DISSATISFIED	UNDERPAID	SATISFIED
174	110	28

Not Ascertained = 5

TABLE 46: Staff Members Perception of Promotion

SATISFACTION WITH SCOPE FOR PROMOTION		
YES	NO	DON'T KNOW
37	181	33

Not Ascertained = 3

TABLE 47: Self Concept of Decision Making Classified by Positions Held in the Health Service

POSITION HELD	INPUT IN DECISION MAKING			
	Adequate	Some decisions I am not competent to make	Some decisions I am competent to make but I am not given opportunity	Total
Doctor	1	-	2	3
Health educator	2	-	2	4
Nurse practitioner	2	-	1	3
Public health nurse	7	5	11	23
Staff nurse	14	1	18	33
Midwife and Nurse	1	-	1	2
Midwife	24	3	18	45
Assistant nurse	5	1	3	9
Student nurse/ Midwife	2	1	1	4
C.H.A.	59	11	32	102
Others	4	-	10	14
TOTAL	121	22	99	242
PERCENTAGE	50	10	40	

Not Ascertained = 17

TABLE 48: Staff Attitude Towards Age for Initiating Family Planning Practices Classified by Position Held in the Health Services

POSITION HELD	IDEAL AGE FOR INTRODUCING FAMILY PLANNING					
	< 15	15-19	20-24	25-29	30+	TOTAL
Doctor	-	2	3	3	-	8
Health educator	-	2	2	-	-	4
Nurse practitioner	2	2	-	-	-	4
Public health nurse	8	19	6	2	3	38
Staff nurse	10	30	10	7	6	63
Midwife & Nurse	-	1	1	-	-	2
Midwife	15	38	16	10	10	89
Assistant nurse	1	7	1	-	-	9
Student nurse/ Midwife	-	2	-	1	-	3
C.H.A.	32	93	26	15	14	180
Others	3	16	4	1	-	24
TOTAL	71	212	69	39	33	424
PERCENTAGE	16.7	50	16.3	9.2	7.8	100

TABLE 49: Staff Attitude Towards School Children Coming in Uniform to the Clinic

POSITION HELD	REACTION TO CHILDREN COMING FOR F.P. ADVICE IN SCHOOL UNIFORM					
	Accepted	Should Change before coming	Should come with parent	Bad reflection on school	Not accepted	Total
Doctor	-	-	3	-	-	3
Health educator	3	-	-	1	-	4
Nurse practitioner	3	-	-	-	-	3
Public health nurse	17	6	-	-	-	23
Staff nurse	20	6	1	2	5	34
Midwife & Nurse	-	2	-	-	-	2
Midwife	40	5	1	1	3	50
Assistant nurse	6	1	-	1	3	11
Student Nurse/ midwife	1	-	-	-	3	4
C.H.A.	68	19	-	-	15	102
Others	9	4	1	-	2	16
TOTAL	167	43	6	5	31	252
PERCENTAGE	66.27	17.06	2.38	1.98	12.30	100

Not Ascertained = 7

TABLE 50: Staff Members Opinion of Reasons for People's non-use of Clinic

REASONS FOR PEOPLE NOT USING F.P. SERVICES						
Ignorance	Side Effects	Dissatisfied with method	Social Pressures	Religion	Culture	Others
163	106	11	82	115	45	12
62.9%	40.9%	4.2%	31.6%	44.4%	17.4%	4.6%

TABLE 51: Staff Members Opinion of Reasons for "Drop-outs" From Clinic

REASONS FOR CLINIC "DROP-OUTS"						
Change of Address	Side Effects	Unavailability of material/ method	Fed up with method	Cultural Pressures	Ignorance	Other Reasons
62	179	40	116	104	129	79
23.9%	69.1%	15.4%	44.8%	40.2%	49.8%	30.5%

TABLE 52: Staff Members Statement of Biggest Problems Encountered In the Clinic

POSITION HELD	BIGGEST PROBLEMS IN THE CLINIC							
	Lack of facilities	Lack of supplies	Lack of medical equipment	Shortage of staff/ inadequately trained staff	Clients non-compliance	Relationship with other staff members	Clinic disorganized	No problems
Doctor	-	-	-	-	-	-	2	-
Health Educator	2	2	-	-	1	-	-	1
Nurse Practitioner	1	-	-	1	1	-	-	1
Public Health Nurse	6	6	4	8	10	-	-	-
Staff Nurse	3	12	4	11	8	2	-	4
Midwife & Nurse	1	1	-	-	1	-	-	-
Midwife	11	16	11	8	17	-	-	4
Assistant Nurse	1	3	1	2	4	-	-	-
Student Nurse Midwife	-	-	-	-	2	-	-	-
C.H.A.	19	15	5	7	25	1	5	43
Others	4	1	1	1	3	-	-	3
TOTAL	48	56	26	38	72	3	7	56

TABLE 53: Trained and Untrained Staff Opinions of Types of Problems Encountered in the Family Planning Programme

	BIGGEST PROBLEMS IN THE FAMILY PLANNING PROGRAMME		
Staff Position	Physical Facilities, Material and Equipment	Staff Related	Clients non-compliance
Trained Staff	80	32	38
Untrained Staff	50	16	34
TOTAL	130	48	72

$X^2 = 11.54$ d.f. = 2

$p < 0.01$

TABLE 54: Staff Attitude Towards the Effectiveness of the Family Planning Programme

PERSONAL FEELINGS TOWARDS EFFECTS OF F.P. PROGRAMME			
Not Effective	Slightly Effective	Very Effective	Don't Know
37	100	105	3
14.3%	38.6%	40%	1.2%

Not Ascertained = 14

5.4%

TABLE 55: Emphasis Within the Programme

USERS TO WHICH SPECIAL ATTENTION IS PAID			
New Recruits	Current Acceptors	Dropouts	Others
138	39	185	24

Not Ascertained = 6

TABLE 56: Staff Members Opinion of the Reliability of Various Methods of Contraceptive

MOST RELIABLE METHOD					
Pills	Foam Tablets	I.U.D.	Sterilization	Injections	Diaphragm	Condoms
69	16	33	138	4	7

Not Ascertained = 10

TABLE 57: Staff Members Opinion of Most Unreliable Method of Family Planning

LEAST RELIABLE METHOD						
Pills	Foam Tablets	I.U.D.	Sterilization	Injections	Diaphragm	Condoms
36	112	6	-	2	2	68

Not Ascertained = 40

TABLE 58: Staff Members Opinion of the Method Which Presents Most Complications

METHOD WITH THE MOST COMPLICATIONS						
Pills	Foam Tablets	I.U.D.	Sterilization	Injections	Diaphragm	Condoms
51	5	41	4	143	4	-

Not Ascertained = 1

TABLE 59: Knowledge of Precautionary Indicators Classified by Position Held in the Health Service

POSITION HELD	SCOPE							
	0	1-5	6-10	11-15	16-20	21-25	26-30	31 & Over
Doctor				3				
Health Educator		1		1				
Nurse Practitioner		1	2					
Public health Nurse	1	3	12	8				
Trained nurse/ Midwife	3	9	14	6	2	2	2	2
Midwife		14	21	9	3			
Assistant nurse		1	3	2	1			
Student nurse/ Midwife			2					
C.H.A.	66	28	15	2	1			
Others	9	5	1		1			
TOTAL	79	62	70	31	8	2	2	2

Not Ascertained == 3

TABLE 60: Specific Instructions Before Recommendation of Various Methods of Contraceptives

POSITION HELD	SCOPE							
	< 0	1-5	6-10	11-15	16-20	21-25	26-30	31 & Over
M.O.H.		3						
Health educator	1			1				
Nurse practitioner			1	2				
Public health nurse	1		7	10	4	3		
Trained nurse/ Midwife	3	6	13	7	6	2	2	
Midwife		11	21	12	3			
Assistant nurse		1	3	2	1			
Student nurse/ Midwife				2		1	1	
C.H.A.	51	36	23					
Others	7	6	3					
TOTAL	63	63	71	36	14	6	3	

TABLE 61: Determination of Type of Clinic and Frequency of Service

	HOW IT IS DECIDED WHAT FREQUENCY AND TYPE CLINIC REQUIRED			
	Clinic Attendance/ Pregnancy rate/ Pop. size	Building and Equipment Facilities/ location	M.O.H's decision Head office decision/Above clinic level	Don't Know
Kingston & St. Andrew	10		2	1
St. Catherine	2			1
Clarendon	4	1	1	
Manchester	1			
St. Elizabeth	4	1		
St. James			2	1
Trelawny	3			
St. Ann	4			
St. Mary	3		1	
Portland	4	1		
St. Thomas	3			
TOTAL	38	3	6	3

Not Ascertained = 2

3 respondents gave 2 answers

TABLE 62: Determination of Need for New Clinic

	People Express Need	Clinic Staff	Head Office	Politician	Don't Know
Kingston & St. Andrew	1	7	1	1	4
Other Parishes	26	3	-	-	3
TOTAL	27	10	1	1	7

Not Ascertained = 3

TABLE 63: Procedure for Establishing New Clinic

	PROCEDURE BY WHICH NEW CLINIC IS ESTABLISHED				
	People Express need	Clinic/Parish Staff take initiative	Integration of F.P. into existing clinic	People approach politician	Don't Know
Kingston & St. Andrew	1	4		1	7
St. Catherine					1
Clarendon		5	1		
Manchester		1			
St. Elizabeth		3	1		1
St. James					1
Trelawny		1		1	1
St. Ann		3			
St. Mary		1			2
Portland	1	1	2		
St. Thomas	1	2			
TOTAL	3	21	4	2	13

Not Ascertained = 6

TABLE 64: Communication with Central Health Statistics Department With Regards to New Clinic

	HOW INFORMATION ABOUT NEW CLINIC COMMUNICATED TO C.H.S.D.			
	Through Parish Office	Vague Answer	Don't Know	Directly to C.H.S.D.
Kingston & St. Andrew	10	1	2	
St. Catherine		2	1	
Clarendon	4			1
Manchester	1			
St. Elizabeth	2		1	
St. James	2		1	
Trelawny	3			
St. Ann	3			
St. Mary	1		2	
Portland	4			
St. Thomas	3			
TOTAL	33	3	7	1

Not Ascertained = 5

TABLE 65: General Communication With Central Health Statistics Department

	NORMAL COMMUNICATIONS OCCURRING BETWEEN CLINIC AND C.H.S.D.					
	One way up	Two way Communication	Communication at Parish level only/ through parish office	Meetings only	No Communication	Don't Know
Kingston & St. Andrew	3	3	3	2	1	1
St. Catherine	1	1				
Clarendon	2	2			1	
Manchester					1	
St. Elizabeth	1	2	1			
St. James			1	1		
Trelawny	1	1	1			
St. Ann	3		1			
St. Mary	2		1			
Portland	1		3			
St. Thomas		1	2			
TOTAL	14	10	13	3	3	1

Not Ascertained = 5

TABLE 66: Problems of Communication Between Clinic and Central Health Statistics Department

	Can't get supplies	Report sheets defi-cient	Requests for infor-mation already sent	Clinic Report-ing system slow	Loss of reports	No problem	No feed-back	Don't Know
Kingston & St. Andrew	1			3		6	2	1
St. Catherine		1				2		
Clarendon	3			1		1		
Manchester								
St. Elizabeth	1			1		2		
St. James					1	1		
Trelawny				1		1	1	
St. Ann	1					3		
St. Mary				1		2		
Portland		1	1			2		
St. Thomas	1			1		2		
TOTAL	7	2	1	8	1	22	3	1

Not Ascertained = 6

TABLE 67: General Opinion on Integration of the Family Planning Programme with Primary Health Care

	OPINION OF INTEGRATION OF F.P. AND PRIMARY HEALTH CARE			
	It is good	Good idea, but not working in practice	Should be separate	Good, but there should be separate administrative body
Kingston and St. Andrew	8	3	2	
St. Catherine	1	1		1
Clarendon	4	1		
Manchester				
St. Elizabeth	4			
St. James	3		1	
Trelawny	3			
St. Ann	2	1		
St. Mary	4			
Portland	2		1	1
St. Thomas	1	2		
TOTAL	32	8	4	2

Not Ascertained = 3

TABLE 68: Nurses' Opinions of Central Administration

PARISH	Effective	Effective with limitations (material/ equipment, staff	Less Effective since integration	Should be Decentralised	Problems of Communication	Poor	Other
Kingston & St. Andrew	4	1	2	-	2	2	-
Other Parishes	3	3	-	7	12	2	2
TOTAL	7	4	2	7	14	4	2

Not Ascertained = 9

TABLE 69: Nurses' Opinions of Effectiveness of the Community Health Aides

	OPINION OF ABILITY AND EFFICIENCY OF C.H.A.				
	Effective	Effective in certain areas/need improvement/more training	Some are able while others are not	Inefficient/ bad relationship with patients/lack understanding/ low ethics	Political support/ decision/ special works programme
Kingston & St. Andrew	6	2	2	2	
St. Catherine		2		1	
Clarendon	2	2	1		
Manchester			1		
St. Elizabeth	1	3			
St. James	1		2		
Trolawny		1		2	
St. Ann				1	1
St. Mary	1	1			2
Portland	1	2	1		
St. Thomas	2		1		
TOTAL	14	13	8	6	3

Not Ascertained = 5

TABLE 70: Reactions of Nurses in Charge of Clinic in Relation to Extension of Duties of Community Health Aides

	COULD DUTIES OF C.H.A. IN RELATION TO F.P. BE EXTENDED	
	YES	NO
Kingston & St. Andrew	8	5
St. Catherine	1	1
Clarendon	2	3
Manchester		1
St. Elizabeth	2	2
St. James	3	1
Trelawny		3
St. Ann	2	
St. Mary	1	3
Portland	2	2
St. Thomas		3
TOTAL	21	24

Not Ascertained = 4

TABLE 71: Nurses Definition of a "Drop-out" Client from the Clinic

	DEFINITION OF A "DROP-OUT"						
	Not attended for less than 3 months	Not attended for 3-5 months	Not attended for 6-8 months	Not attended for 9-11 months	Not attended for 1 year or more	Client who has stopped coming (no specific time given)	Other (Refuse all methods) fed up with all methods
Kingston & St. Andrew		1		1	2	5	3
St. Catherine		3					
Clarendon		2	1		1	1	
Manchester						1	
St. Elizabeth	1	1	1	1			
St. James	1		1		1	1	
Trelawny						3	
St. Ann		2			2		
St. Mary	1					3	
Portland		1	1			2	
St. Thomas			1			2	
TOTAL	3	10	5	2	6	18	3

TABLE 72: Reasons Given by Nurses for Clients' "Drop-out" from the Family Planning Programme

	Inefficiencies from the clinic	Side effects/ failure of method/ fed up with method	Want to have a baby	Financial constraints/ Transportation difficulties	Change of address /get supply from other source	Ignorance	Psychosocial pressures (partners, peer group	Religion
Kingston & St. Andrew		7	2	2	1	2	4	1
St. Catherine	2	2	1			1	2	
Clarendon		4	2	1	3		3	1
Manchester				1				
St. Elizabeth		2		1			3	
St. James					1		1	
Trelawny		3			2	1	1	
St. Ann	1	1	1	1	1			
St. Mary		1			1	1	2	
Portland		4			2		3	
St. Thomas		3				1	1	
TOTAL	3	27	6	6	11	6	20	1

Not Ascertained = 7

TABLE 73: Attraction of Non-governmental Resources in Each Parish

PARISH	Do you attract non-Government Resources	
	Yes	No
Kingston & St. Andrew	5	8
St. Catherine	2	1
Clarendon	-	5
Manchester	-	1
St. Elizabeth	1	3
St. James	-	4
Trelawny	-	3
St. Ann	2	2
St. Mary	2	2
Portland	-	4
St. Thomas	2	1
TOTAL	14	34

Not Ascertained = 1

TABLE 74: Time Spent in Family Planning Within a 1-week Observation Period

Service	Total Time in Hours	Total mean time in hours
Advice & counselling	491.46	5.78
Distribution of materials	331.93	3.91
Assistance to doctors/ health personnel	288.25	3.39
Follow up work	266.33	3.13
Family planning education	238.75	2.81
Special services	221.75	2.61
Administrative work; returns reports, etc.	163.5	1.92
GRAND TOTAL	2001.97	23.55

Total number of staff members = 85

33% of total sample

APPENDICES

APPENDIX I

NATIONAL FAMILY PLANNING PROGRAMME
STAFF QUESTIONNAIRE

DATE .....

Serial No. ..... INTERVIEWER .....

1. Parish .....
2. Clinic ..... Frequency ..... Type .....
3. How old are you? .....
4. Sex .....
5. Marital Status .....
6. Number of children .....
7. How far did you reach in school (highest grade)
   - ☐ Primary .....
   - ☐ Secondary .....
   - ☐ High .....
8. Further training after leaving school .....
9. Have you had any special training in Family Planning? .....
10. What is your present job? .....
11. What specific Area of the Programme are you involved in at present?
    - Antenatal Clinic ☐
    - Post Natal Clinic ☐
    - Maternal & Child Health ☐
    - Child Welfare ☐
    - Family Planning ☐
12. How long have you worked in Family Planning section of the Programme? .....
15. Has the function of the Clinic changed since the Merger of Family Planning and other Primary Health Care Services?
    - ☐ No change .....
    - ☐ Yes, in what ways? .....

14. How has the Merger affected you?

(1) In terms of Volume of work .....

(2) In terms of kind of work.....

(3) In terms of Supervision .....

(4) In terms of your relation to client .....

15. Do you work mainly in

The Field ☐

The Clinic ☐

Both ☐

.....

16. Do you have any preference in terms of where you work?

Work in Clinic ☐

Work in Field ☐

No preference ☐

Give reason .....

17. Which area do you prefer to work in?

Rural ☐

Urban ☐

No preference ☐

Why? .....

18. Are you satisfied with the type of supervision that you get?

.....

Adequate ☐

Too little supervision ☐

Too close supervision ☐

.....

19. To what extent are you satisfied with your present salary?

Dissatisfied ☐

Underpaid ☐

Satisfied ☐

Other (specify) .....

20. Fringe benefits. Which of the following fringe benefits are available to you?

BENEFIT	AVAILABILITY		SATISFACTION		
	Yes	No	Satis.	Dissat.	Does'nt matter
(a) Vacation					
(b) Maternity Leave					
(c) Travelling and other allowances					
(d) Loans					
(e) Medical Attention					
(f) Uniforms					
(g) Other					

21. Are you satisfied with the scope for Promotion which exists in this Programme?

Yes ☐
No ☐
Don't know ☐
Probe why? .....

22. How do you feel about your input in the decision making process of this organization?

☐ It is adequate
☐ Some decisions I am not competent to make
☐ Some decisions I am competent to make but I am not given the opportunity

23. How do you feel about the amount of work time available in relation to the size of your patient load?

.....

24. (a) In your opinion what motivates a client most to use Family Planning? .....

(b) Which age group do you think needs Family Planning most?

Age ( )	Male	Why.....
less than 15		.....
15-19		.....
20-24		.....
25-29		.....
30+		.....

25. In some Clinics school children come in uniform for Family Planning advice. What is your reaction to this? .....

PROBE: Do you have the same views about Boys as well as Girls?

.....

26. In your programme which of the users do you pay special attention to?

1. ☐ New recruits
2. ☐ Current acceptors
3. ☐ Follow up work on dropouts
4. ☐ Other (specify).....

27. What possible reasons can you identify for people not using the Family Planning Services? .....

28. What are the Basic reasons for "Clinic drop-outs" from the Family Planning Clinics, and what strategies do you use to get them back into the programme?

☐ Change of address
☐ Side effects
☐ Unavailability of material method
☐ Fed up with method
☐ Cultural pressures
☐ Ignorance

Other reasons .....

29. From your experience how many clients on an average use the following methods in one month?

Pills .....
Foam tablets .....
I U.D. .....
Sterilization Male .....
" Female .....
Injections .....
Diaphram .....

30. In your estimation which one of these methods is

(a) Most reliable .....

(b) Least reliable .....

(c) Most complications .....

EXPLAIN: .....

31. What are some of the things you would look for before recommending each of the following methods?

METHODS

(a) Pills .....

(b) Condoms .....

(c) Foams & Jellies .....

(d) IUD .....

(e) Diaphram .....

(f) Injections .....

(g) Female Sterilization .....

(h) Male Sterilization .....

32. What specific instructions do you give to the Clients when you recommend the following methods?

(a) Pills .....

(b) Condoms .....

(c) Foams & Jellies.....

(d) IUD .....

(e) Diaphram .....

(f) Injections .....

(g) Female Sterilization .....

(h) Male Sterilization .....

33. Apart from Clinic Services do you have other means of distributing Family Planning Methods?

Yes .....

No .....

Please Explain .....

34. What are your personal feelings towards using Family Planning?

.....

PROBE:

Does your Spouse/Husband agree with you on these views?

.....

35. What are your personal feelings towards the effects of the National Family Planning Programme?

.....

36. What are the biggest problems you face in the Clinic and how do you think these problems could be improved?

.....

APPENDIX II

SCORING APPLIED TO ANSWERS TO QUESTIONS 31 and 32 (APPENDIX NO. I)

What are some of the things you would look for before recommending each of the following methods:

SCORE		METHOD	
+14	(a)	Pills	Hypertension, Thromboembolism, Jaundice, Heart disease, Diabetes, Asthma, Depression.
+2	(b)	Condoms	Hypersensitivity to latex.
+2	(c)	Foams and Jellies	Hypersensitivity to the chemicals contained in foams and jellies.
+12	(d)	I.U.D.	Pelvic infection, h/o heavy periods (menorrhagia), uterine abnormalities, pregnancy, heart disease, previous uterine scars (incisions).
+8	(e)	Diaphram	Hypersensitivity to latex, laxperineum, cystocoele, rectocoele.
+2	(f)	Injections	Irregular menstrual cycle.
+6	(g)	Female Sterilization	Age and parity, pelvic abnormalities, (but depends a lot on what type of procedure is planned) Chronic illnesses and complications.
+8	(h)	Male Sterilization	Varicocoele, age and parity.
54			

What specific instructions do you give to the patient when you recommend the following methods (Highest possible score: 67).

SCORE

+12 (a) The Oral Contraceptive Pill:

(i) Take one pill every day.

(ii) If you miss one day's pill, take two on the following day.

(iii) If you do not have a period after one packet of pills report to your clinic.

(iv) If you have any bleeding before the packet is finished, make a note of it and report this to the clinic at your next visit.

(v) Have your blood pressure checked every 6-12 months.

(vi) If you go to see a doctor, or you are admitted to hospital for any reason, inform whoever is looking after you.

+9 (b) Condoms:

(i) These are designed to be worn by you (for the male), or by your partner (if the client is female).

(ii) It must be placed on the erect penis prior to intercourse (sexual relations).

(iii) Leave a small portion empty at the tip for semen to collect in after ejaculation.

(iv) Withdraw the penis with the condom in place as soon as ejaculation occurs.

(v) Make sure it is air tight.

SCORES

+6 (c) Foams and Jellies:

(i) Use two applicators-ful prior to intercourse by filling the applicator and inserting it into the vagina up to the hilt and then pushing the nozzle into the applicator so that the foam or jelly goes high up in the vagina.

(ii) If used together with condoms or a diaphram, one applicator-ful is enough.

(iii) If there is a break in intercourse, insert a second applicator-ful of jelly before resuming intercourse.

+8 (d) Intrauterine devices:

(i) Feel for the strings after each period in the manner demonstrated.

(ii) If the device comes out, return to the clinic and report this.

(iii) Your periods may be a little heavier than is normal for you.

(iv) You should return to the clinic every six months so the position of the device can be checked.

+8 (e) Diaphram

(i) Insert the diaphram in the manner demonstrated at least 30 minutes prior to intercourse.

(ii) Before intercourse, it is wise to put an applicator-ful of foam or jelly high up in the vagina to supplement the jelly which is in the cup of the diaphram.

(iii) Keep the diaphram inside the vagina for 6-8 hours after intercourse is completed.

(iv) It should be removed at this time, washed with soap and water, and stored in a clean dry place until it is to be used again.

+6 (f) Injections:

(i) You must come to the clinic every 12 weeks for an injection.

(ii) While you are getting the injection, you may not see any periods.

(iii) If you have irregular bleeding, please report to the clinic, especially if it is heavy.

+12 (g) Female Sterilization:

(i) General counselling regarding the methods of sterilization available (e.g. by an incision in the abdomen, by a telescope inserted under the umbilicus (laparoscopy) or through the vagina (culdoscopy).

(ii) Considerations of age.

(iii) Number of children.

(iv) Specifically: The operation is not reversible. You will not be able to have any children after the operation.

(v) You should finish the packet of pills you are presently on at the time of the operation (for patients on the pill).

(vi) More specific instructions relate to the type of operation which is done.

+6 (i) Male Sterilization:

(i) Counselling again.

(ii) After the operation you should have a sperm count done three months later, and have this repeated a second time.

(iii) If both of them show that there is no sperm to be seen then it is safe to have intercourse without the fear of fathering a child.

APPENDIX III

PROGRESS REPORT RE FAMILY PLANNING EVALUATION PROJECT - ST. ANN

The directory of Family Planning Clinics for the parish of St. Ann show a total of 19 Public Health F.P. Clinics, 20 with Beth Jacobs Clinic added.

The first week (that is July 16-20) was spent primarily making the necessary contact with the zone nurse, parish nurse and the MOH. Despite delays here and there, to date the Parish of St. Ann has been covered for all phases, with the exception of two clinics that have been proving difficult to handle and another two clinics not yet reached because of the time when these operate.

The interviewing of male clients at the Beth Jacobs Clinic is also yet to be done but the necessary arrangements have been made for this.

In order to collect the relevant data all clinics with the exception of Bamboo, Bohemia and Bensonton had to be revisited, some more than twice because staff members were absent or on leave or the time for the clinic had been rescheduled.

A few clinics were found to be out of operation. There were others which, as the records show and the staff reported, were operating minimally. These include Borobridge, Clarksonville, Alexandria, Muirhouse, Buxton and Calderwood out of operation and Bohemia, Bensonton and Sturge Town operating very minimally.

For Borobridge, Clarksonville, Alexandria and Muir House Buxton, the reasons given by the PHN and/or the Midwife include:

(1) No serial number for the clinic.

(2) The clinic being out of supplies for a long time.

(3) The churches around being opposed to family planning.

(4) In some cases there being no district midwife in the area to help with motivational work.

(5) People making use of the facilities at either the Alexandria Hospital or the Spauldings Hospital.

(6) The 'removal' or 'withdrawal' of the incentive which was given to the nurses for each FP session.

In the case of one clinic where the output was considered very low, the D.M. gave the following reasons: She said when she came to the district about six years ago she was interested in FP and more people made use of the services, but since then she has become a member of a church that is totally opposed to the use of FP and her interest has dropped. She has promised though that as soon as she is back from maternity leave she will re-vitalize the clinic. Incidentally, she is married and the mother of five children.

After several visits to the Runaway Bay Clinic it was learnt that the records for Runaway Bay were kept at the Keith Clinic. The clinic was locked and the keys were lost and the D.M. was on maternity leave and outside of the area. The promise was given however that the CHAs would inform the D.M. for Runaway Bay that the next visit would be on the 22/8/79, in order to get to the records and complete interviewing

the staff. However, the next visit was fruitless as the building at Runaway Bay was opened but no one was there and after waiting from 2:30 to 3:00 p.m. on the 22/8/79 without any success the decision was taken to move on to somewhere else and return at a later date.

On the 23/8/79 the Alexandria Hospital F.P. Clinic was visited but the Matron was on leave and no one present could help with the necessary information. Instead, I was asked to return on 29/8/79 when the Matron would be available.

In concluding it is necessary to remark that despite these and other difficulties, as the log book will reveal in more detail, the collection of data is under full control and will be completed to meet the deadline.

Jasper G. Lawrence
26/8/79

APPENDIX IV

SOME OBSERVATIONS MADE IN PORTLAND CONTRASTED WITH SOME MADE IN ST. ANN

1. Whereas most of the FP clinics in Portland have adequate supply of 'methods' and stationery, most of those in St. Ann have very limited supplies or no supply at all.

2. Whereas most of the Portland clinics have proper filing cabinets, many of the St. Ann clinics are without this facility.

3. While most of the Portland clinics seem to serve a large number of clients, most of the St. Ann clinics serve a few clients. There are quite a few clinics out of operation in St. Ann.

4. There seems to be a great deal of keenness in record keeping in Portland while in St. Ann it could be the poor facilities which create the absence of this keenness.

5. All Portland clinics visited by the observer have community health aides attached while many of the clinics visited in St. Ann have no community health aides.

6. Generally, the St. Ann clinics seem to place more emphasis on males than the Portland clinics, although the emphasis on males could be considered minimal in both parishes except for one clinic in St. Ann.

APPENDIX V

QUESTIONNAIRE FOR CLINIC NURSES (IN CHARGE)

INPUT

Total quantity of supplies delivered to clinic per month (boxes or packets):

Pills .....

Condoms .....

Foams and other Spermicidals .....

IUDs .....

Diaphrams .....

COMMUNICATIONS

1. How is the need for a new clinic determined? .....

2. How is it decided what frequency and type of clinic is required?

.....

3. What is the procedure by which the new clinic is established?

.....

4. How is information about this new clinic communicated to the Central Health Statistics Department? .....

PROBE: Or any other Department.
Specify: .....

5. Are there any problems with this communication? .....

6. What normal communications (both ways) occur between the Clinic and the Central Health Statistics Department or any other Department? .....

7. Are there any problems with such communications? .....

ATTITUDES

What is your opinion of the following:-

8. The integration of Family Planning and primary health care?
.....

9. Central Administration? .....

10. Community Health Aides with respect to:-
(a) their ability
(b) their efficiency
.....

11. Could their duties in relation to Family Planning be extended?

☐ Yes ☐ No.

Explain:- .....

12. What is your definition of a "drop out" (from a Family Planning Clinic)? .....

13. How many patients/clients drop out per month? .....

14. Why do they drop out? .....

15. Do you attract non-Government resources?

☐ Yes ☐ No

If No, then why not? .....

If Yes, then

(i) From what sources? .....

(ii) What is the nature of the resources? .....

16. How many Male clients visit the Clinic per day? .....

APPENDIX VI

GUIDANCE COUNSELLORS SURVEY

A total of 158 questionnaires were sent to the guidance counsellors of secondary, high and tertiary institutions, asking them to complete and return them. Some of the counsellors were personally contacted. Seventy-one questionnaires were returned, which means about a 50 per cent response rate from the 144 counsellors then employed. The response was much higher than the usual rate of returning questionnaires sent by mail, which might indicate a high level of interest on the part of the counsellors in the subject.

The sample is not representative. We can assume that the guidance counsellors with special interest in FP and FLE responded. The answers will be analysed with regard to that fact.

The questionnaire contained 92 questions, some with multiple choice answers and some open questions. It took about one hour to fill in.

In the following we analyse the results of our survey with the aim of assessing the capability and ability of the 49.7 per cent responding guidance counsellors to teach FP and FLE topics, their problems and needs. Although we cannot generalize our results since the sample is not randomized, they do seem to have a certain validity considering the high response and the fact that our sample reflects reality in respect to two variables investigated which are sex and education. Taking also into consideration that the respondents were probably very interested in FP and FLE (otherwise they would not have taken the time and energy to fill in the relatively long questionnaire and send it back) we can assume that the results of our sample give a somewhat more positive picture of the guidance counsellors' knowledge and ability than it is in reality.

Findings

(a) Description of Respondents Related to Sex, Age and Education

The 154 secondary and high schools and tertiary institutions in Jamaica employ about 144[1] guidance counsellors. Some schools employ two counsellors, others have vacant posts. The response to our questionnaire came from 49.3 per cent of all guidance counsellors.

Sex: Twelve men and 59 women responded as compared with 25 men and 119 women actually working as guidance counsellors. Which means that our sample comes close to reality comparing the percentage of 16.9 men and 83.1 women in our sample with 17.4 men and 82.6 women in reality. Only 23.9 per cent of the respondents are aged 30 and under (Table A.1). The majority is over 30 years old. The average age is 33.3. A relatively high percentage (16.9 per cent) of the respondents are over 51 years old. Nine of these are women, which means that they are above child-bearing age, and do not have to practise family planning any more. It might also be assumed that they would tend to have more traditional attitudes than the other respondents. This has to be taken into account when the related fields or number of children and FP habits and attitudes are being analysed.

Educational Level: Only 5 interviewees or 7 per cent of the responding counsellors did not finish high school with a certificate. This shows that in regard to education, our sample comes close to reality since most of our guidance counsellors employed have a high school certificate and many attended a college or university. All counsellors have a degree or certificate in the fields of teaching, counselling, nursing, theology or social work.

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[1] The MOE/Guidance Counselling Section did not have exact figures available at the time of data collection since the GC lists were under review.

(b) Family life pattern of respondents

Marital Status: With 74.6 per cent of the respondents being married and only 4 respondents or 5.6 per cent in visiting unions or divorced (Table A.2) marital status seems to be much higher than in the Jamaican society as a whole. Only five of the married counsellors in our sample (7 per cent) had other unions before.

Number of children: Our married respondents have 2.2 children on an average. Sixty per cent of them have no more than 2 children. Only 17.1 per cent of our respondents have more than 3 children. The average rate of 2.2 children per married counsellor seems to be extremely low in comparison with the average of 3 to 4 in the total population - even if we consider that most respondents are still in the child-bearing age, and 11 of them (20.8 per cent) expressed the wish for more children.

The average number of total pregnancies is only slightly higher with 2.5 pregnancies per guidance counsellor. It should be mentioned that only 1 of the 14 singles has children which is not the norm in Jamaica where being single does not necessarily mean not having children.

The low number of children is even more astonishing if we consider that 95.8 per cent of the respondents belong to churches, and many churches do not promote other family planning methods than abstinence.

On the average, respondents had their first child at age 27.4 which is extremely late compared to the total population. And in fact 53 per cent of the respondents to that question think that they were too old when they had their first child.

Age of child-bearing: The ideal age for having the first child is considered to be age 23.9 for women and 27.6 for men. Both figures as well as the low number of children indicate a responsible attitude towards family life, and successful family planning. As many as 42.6 per cent of the responding persons consider one to two children to be the ideal for a couple. Only 7.3 per cent think that the ideal number of children is 5 and more. On an average, 2.8 children is considered to be the ideal number for a couple. It can be seen that the ideal number of children is slightly higher than the actual number of children (with an average of 2.8 as against 2.2). That supports our assumption that the actual number of children will grow since the respondents are still in the child bearing age with an average age of 33.3 years, even though they are somewhat beyond the most productive years.

Communication with the partner: habits and attitude: Attitudes towards partnership and communication between partners seems to be very positive among the respondents. All of them think that man and wife should talk about sex and related fields. 42.3 per cent of them state that they talk often and 59.3 per cent that they sometimes talk to their partner about sex and related fields.

There was a similar response to the question about whether or not a woman should tell her partner about a decision to have sterilization. Only one respondent answered no. Mutual understanding, honesty, sharing of information, decisions, problem solving and responsibility were mentioned as reasons why the partner has to be informed of such a critical subject as sterilization, and why partners should talk about sex. This again indicates a most responsible attitude to family life.

Communication with children and attitude to sex education: The same positive attitude towards communication with children seems to exist. There is however a slight difference between sons and daughters when it comes to the critical field of sex. To the question "Would you talk about sex and related fields to your son"? 6.1 per cent of the respondents answered no. But none of them would not talk to their daughters about sex. This may be explained by the fact that most of the respondents are women. But it still indicates that even within our selected sample of respondents there exists the tendency towards upholding different educational patterns for sons and daughters which later on might be the cause of misunderstanding between partners and lack of communication. Only 4.3 per cent of the respondents stated that they would not talk to their children about sex and related fields of human development before the age of ten. 92.7 per cent would talk to their children as soon as they start questioning, between the ages of 3 to 6.

The same responsible attitude can be seen in the answers to the questions "When would you talk to your daughter about menstruation" and "Would you talk to your son about menstruation". Only one respondent (male) would not talk to his daughter about menstruation. All the others would talk to their daughters about menstruation and 91.5 per cent of them even before the age of 12. They would explain in detail how everything functions when she gets her period. Only one respondent would not talk to her son about menstruation. The answers to the questions: "How would you react to your daughter if she becomes pregnant at the age of 15", also indicate a very positive attitude to family life. 16.9 per cent of the respondents would be disappointed or get mad. However, 66.7 per cent would,

after being disappointed, try to help and accept the baby. 10.2 per cent would try to discuss a solution and 5.1 per cent would even consider an abortion. This means that all respondents would dislike the idea of having a pregnant daughter at 15. But most of them would try to overcome the problem one way or another.

To the question "What would you tell your 21 year old son if he calls his girlfriend a mule because at the age of 20 she has not yet given birth to a child"? 81.5 per cent of the respondents to that question would try to convince him that he and his girlfriend are still too young for a child. Three persons (4.6 per cent) would express anger and 4 persons (6.2 per cent) would directly or indirectly support the son in his statement. Again the answers indicate a responsible attitude towards education for family life. But it has to be seen that our sample seems to be a positive selection and if 4 persons in that sample support the statement, there might be more in reality, which might indicate a need for change of attitude of some of the guidance counsellors before they are able to spread FL and FP messages in their schools.

(c) Attitudes and Habits

Family Planning Attitudes: 85.5 per cent of the respondents consider FP in Jamaica to be most necessary. Only 14.5 per cent consider it as necessary. Nobody thinks that there are many needs of higher priority for the country. This is a clear vote for the importance of family planning in Jamaica.

43.7 per cent of the respondents would explain FP to their daughters before the age of puberty, 22.5 per cent when she has her first

period, 11.3 per cent when she has her first boyfriend, and 15.5 percent on other occasions. Only one person would explain FP to her daughter as late as after the second child. That means that most respondents would explain to their daughters about FP, at a pretty early stage.

The figures for responses to the question "When would you really encourage your daughter to practise FP" are a little less positive. As Tables A.3 - A.5 show: the interviewees would encourage the practice of FP at a later stage than they would explain about it, 2.8 per cent as late as after the third child. 7.9 per cent would not encourage their daughters to practise FP at all. But still the majority would encourage her in FP. This indicates some doubts when it comes to changing habits, but total agreement in offering knowledge necessary for the decision on FP.

There is only a slight difference concerning the attitude towards sons as compared to daughters in encouraging FP, as can be seen in Tables A.4 and A.5. The respondents seem to encourage their daughters to undertake FP at an earlier age than their sons. 34.21 per cent want to encourage their daughters before the age of puberty or at her first period, whereas no respondent wants to encourage his/her son before he has his first girlfriend. This seems to be the main difference in their attitudes towards the behaviour of their daughters and sons. For most respondents the time when a son or daughter has his/her first partner seems to be equally important for encouraging FP. 53.8 per cent want to encourage their daughters at that time or even before and 56.3 per cent their sons.

9.9 per cent of the respondents do not want to encourage their daughters and sons to practise FP. There is no difference here in the

treatment of sons or daughters. In general we found that all respondents want to explain FP to their daughters and most of them wanted to encourage them to practise FP. Only a small number of respondents was against encouraging their children to practise FP.

This positive attitude can also be seen in the answers to a question concerning FP after the second child. (Table A.6). Only 9.9 per cent of our respondents would not want to practise FP after the second child if the partner asks for it, although the ideal number of children was stated to be 2.8 on an average, which means more than two children per couple. This discrepancy might indicate a wish for spacing the children. It also indicates that the partner (in our case mainly the male) is able to influence attitudes towards FP, which might justify a greater emphasis on FLE and FP for males.

59.7 per cent of the respondents are in favour of seeking FP advice together with the partner. This high percentage indicates not only a very positive attitude towards FP but also towards sharing of responsibilities with the partner - a positive FL attitude.

The opinions about male contraceptives (expressed mainly by women) which are shown in Table A.7 are similarly positive. The answers indicate clearly a demand for more male participation and responsibility for FP. They indicate as well that the respondents have overcome traditional beliefs about male sex habits.

Family Planning Habits: 69 per cent of our responding counsellors practise FP as can be seen in Table A.8.

The 26.7 per cent who do not practise FP or only sometimes, have good reasons for it. Either they want to get pregnant or they have no

union at the moment or they are above child-bearing age. So there is actually no counsellor in our sample who does not practise FP without a good reason. Those who do not want any more children at the moment are using FP methods.

The care with which the respondents plan their families is shown in Table A.9 where it is to be seen that 46.9 per cent of the respondents who practise FP started to use FP methods before they had their first child. 12.2 per cent started FP as late as after the third child. Together with our finding that some of the counsellors in our sample hesitate to encourage their own children to practise FP but do not hesitate to explain it, we can assume that the counsellors are currently more able to teach and pass on knowledge of FP but will be less effective in influencing and really stimulating the school children to practise FP.

This is only inferred from their personal habits and attitudes. Whether the counsellors have enough knowledge to teach FP will be discussed later.

Table A.10 relates to the use of various FP methods and shows a relatively high percentage of female sterilizations which might indicate knowledge about the side effects of the pill and the injection and a very strong wish for a FP method which is 100 per cent safe. The relatively high percentage of condom, IUD and diaphram users in comparison to a relatively low percentage of pill and injection users may again be due to knowledge of side effects of the pill and the injection, in combination with the wish for safety and fear of the final solution like sterilization.

A comparison of Table A.11 with Table A.10 shows the difference between actual use of various methods and the methods considered as ideal.

The relatively low use of the pill (19.7 per cent) as compared to the relatively higher percentage of respondents who consider it as an ideal method (29.6 per cent) may support our above supposition that the users primarily make their decision in relation to health, taking into account side effects, whereas the judgement about an ideal method is primarily oriented at the level of safety. This can be seen in the fact that 68 per cent of the respondents give safety as a reason for their judgement about the methods. The fact that some of the respondents regard abstinence as ideal may be explained by religious factors.

Our findings suggest knowledge of FP methods and side effects, reasonable attitude towards FP and reflected personal usage. However, the fact that the respondents seem to have different frames of reference for the opinion about the ideal message (which is safety) and for their own usage (which is health), may introduce problems in an actual teaching situation. The use of various frames of reference might confuse the students. It therefore seems necessary to offer more training for guidance counsellors which will enable them to make a consistent decision for their own use and for teaching purposes.

(d) Knowledge of FP and FLE

Knowledge of FP: Four persons or 9.3 per cent of the counsellors in our sample did not answer the question "What contraceptive methods do you know?" (See Table A.12). It is not clear whether this indicates lack of knowledge of methods or of the word "contraceptive" (which was indicated in one case).

Most of our respondents know about the pill, the condom, IUD and diaphram. Only 62 per cent of our respondents mention creams and jellies, and 49.3 per cent the Rhythm method. There is considerably more knowledge of female sterilization than of male sterilization, with 42.3 per cent mentioning female sterilization as against 28.2 per cent mentioning male sterilization. Injection is considerably less mentioned (38 per cent) than the pill (84.5 per cent). Injection, male sterilization, withdrawal and abstinence are the methods mentioned by less than 40 per cent of our respondents. However, this does not necessarily mean that these methods are not known. It could simply be that they are not considered as being very important. Interestingly enough, male sterilization is almost at the bottom of the listings although we do find above a clear demand for more male use of contraceptive methods. Perhaps the desire is for a greater use of the condom only. This might reflect the fact that male sterilization is not really practised to any significant degree in Jamaica, and that it is not considered to be very important, probably due to social values which relate manhood to a large number of children.

However, our findings clearly indicate that even in our selected sample four family planning methods are not mentioned at all by more than 60 per cent of the respondents. It can therefore be assumed that there is still a considerable lack of active knowledge of FP methods among the guidance counsellors.

The fact that only four respondents or 5.6 per cent mentioned all existing FP methods supports our assumption. Lectures on FP during counsellors' seminars and workshops seem therefore necessary to enable the counsellors to give comprehensive instruction in FP.

The respondents' knowledge about the pros and cons of various FP methods supports our domand for upgraded training. (See Table A.13.) Since only four of the respondents mentioned all existing FP methods and they did not know all the pros and cons for them, it means that no guidance counsellor in our sample knows all pros and cons about all existing family planning methods. Only 26.7 per cent of our respondents know all or nearly all pros and cons of the methods they themselves mention. 73.3 per cent know only a few or no pros and cons at all. In reality there might even be a greater lack of knowledge on these questions.

The answers to the next question further indicate a need for more training. More than 50 per cent of the respondents could not correctly or not at all explain why the chances of a woman becoming pregnant are not the same each day of a month (see Table A.14).

Our demand for more training is strongly supported by the guidance counsellors themselves. Of our selected sample, 71.8 per cent feel that they would need more information and training about FP before they could do a good job in teaching it.

However, only 26.8 per cent of our respondents would like to have a FP agent taking over his/her responsibility in FP, and this only to intensify the work, make it more efficient, distribute contraceptives - not because they feel incompetent.

To the question whether they like to talk about FP, 26.8 per cent of our respondents answer: yes, very much, 59.2 per cent do not mind talking about FP. This means that 8.6 per cent - do not object to talking about FP.

It has to be mentioned that 7 per cent of our respondents sometimes feel embarrassed when having to talk about FP. This group might be bigger in reality, so the training courses should include enough knowledge and teaching methods to make counsellors feel more confident and avoid embarrassment. Since this kind of embarrassment can easily be transferred to the students, instruction by a guidance counsellor who himself feels embarrassed can be more damaging than fruitful.

Table A.15 gives an overview of the fields the respondents feel able to handle fully and lecture about. It can be seen that the variety of fields in FP which counsellors feel able to handle is not very high. Most counsellors mentioned only one field. 8.5 per cent admit incompetence and 9.9 per cent mix FP contents with FLE. FP methods was the most mentioned field but with only 28.2 per cent of our respondents thinking they could handle it.

Surprisingly, 28.2 per cent of the counsellors feel that they could speak knowledgeably about FP methods, whereas we saw above that knowledge in this field is limited. Because they are not aware of their lack of knowledge it seems that the respondents tend to overestimate their ability to lecture about FP methods. Although 88.7 per cent of our respondents mentioned at least one field in FP or FL that they feel able to handle this does not say anything about the objective situation and the quality of such instruction.

Knowledge of FLE: Table A.16 shows that only 55 persons responded to the question - "Please name some fields in FLE which you are able to handle and lecture about," meaning that 27.5 per cent of our sample preferred

not to answer the question. Of the ones that answered, 7 per cent mixed FLE with clear FP subjects. However, 36.6 per cent of the respondents mentioned several fields in FLE which they felt they would be able to handle. 4.2 per cent feel incompetent.

The felt need for training in FLE seems to be a little lower than the felt need for training in FP. But this is a subjective feeling and should not really affect the planning of the training courses for FP and FLE. Both fields should be equally covered.

Our findings concerning the knowledge of guidance counsellors in FP and FLE topics strongly suggest the demand for more training courses for counsellors in the related fields.

(c) Attitudes to Counselling

We asked three questions about the work of guidance counsellors in counselling about FP and FLE. The questions and answers are shown in Tables A.17-19. A majority of 87.3 per cent are trying to counsel in a responsible way, in the case of a school girl's pregnancy. 18.3 per cent do not want to consult personally in FP. They might not feel able to explain FP methods. This might however be the best they can do. To advise abstinence or only one FP method as 12.7 per cent of the respondents would do, does not seem to be very responsible. A majority of 64.8 per cent of our counsellors try to counsel in a reasonable way. Table A.19 shows that 78.9 per cent of our respondents react in a responsible way when confronted with personal FL problems of their students. 45.1 per cent seem to take their job very seriously since they not only support the girl's opinion but also try to reach the source of the problem.

21.1 per cent of our selected sample of counsellors however, react very superficially.

In general we found that most of the respondents react in a responsible way. However about 20 per cent of our respondents were either too superficial or wished to pass the job on to others. More profound training might augment responsible attitudes and practice.

(f) Instruction of FP and FLE

All respondents think that their work in FP and FLE is important for Jamaica. But since the counsellors' classes of FP and FLE are not integrated into the general curricula, not all counsellors teach regularly in these fields. Table A.20 indicates how many of our respondents actually teach FP and FLE classes. Only 28.2 per cent of our respondents teach FP regularly, as against 52.1 per cent teaching FL regularly.[2] 9.9 per cent do not teach FP at all but all respondents teach FL.

It has to be pointed out that only about half of our guidance counsellors teach FP and/or FL topics regularly in their schools although FP and FLE are mentioned by the Ministry as among the main topics that guidance counsellors should deal with.

Table A.21 shows the number of classes taught in FP and FL. The average number of teaching hours per week is 2.9 hours in FP and 3.6 hours in FL. Since the guidance counsellors are not supposed to have more than 12 classes per week in their schedule, this means that FL is relatively more stressed by most of our respondents than the other fields

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[2] The discrepancy between the percentage related to FP and FLE might be explained by the fact that the counsellors tend to include FP in FLE.

counsellors are supposed to teach (e.g. health, career education etd.). FP seems to be less emphasized.

In general the teaching schedule of our counsellors seems to vary quite a bit in relation to FP, less so to FL. Some counsellors hold classes irregularly, others regularly, 1, 2, 3 or 4 times per week. That means that the provision of FP and FL classes is not consistent in the various secondary and high schools throughout the country. While some schools offer 4 classes of FP per week others do not offer any FP classes at all.

(g) Target Grpups

Table A.22 gives an overview of the main target groups of guidance counsellors.

It can be clearly seen that new secondary school students in Grade 7-11 are the main target groups of our respondents for FP and FLE. Whereas FP seems to be taught more in the upper grades from Grade 9 onward, there seems to be a tendency to teach FLE in the lower grades starting with Grade 7. This suggests that the need for early FLE is felt by the counsellors, but not so much the need for early instruction about FP.

It is surprising that 9.9 per cent of our counsellors mention parents as their main target group for FP. This shows the need for the instruction of parents in FP. The same need is evident for FLE. The inclusion of FP and FLE classes for parents into each counsellor's schedule should therefore be considered.

(h) Use of Experts as Resource Persons

With respect to the use of experts and outside staff for FLE and FP classes, we see in Table A.23 that counsellors cooperate mainly with nurses and health officers and less so with other experts. The experts serve as resource persons and cooperate mainly through lectures, film shows and demonstrations, which might indicate a certain need for material (e.g. films, slides, flip-charts).

The high degree of cooperation with nurses can be explained by the fact that most high schools have a nurse seconded to their schools. So they will necessarily cooperate in a field where the nurse might have more knowledge and confidence through her special training, than the counsellor.

Some counsellors cooperate with more than one resource person, others do not use outside experts like doctors or FP staff or health officers. However for more effective FP and FL education it seems such cooperation with outside experts is necessary at least as long as the counsellors are not yet fully prepared for training in FP and FLE.

(i) TV Support through EBS

18.9 per cent of our respondents state that they use radio programmes produced by EBS for FP and FLE although currently there are no FP or FLE radio programmes produced and transmitted by EBS. That means that these counsellors either use programmes from other sources of services or that even the ones who say they use the programmes use them only very infrequently and refer to EBS radio programmes that were transmitted some time ago. We cannot therefore be too sure whether all those who say that they use EBS TV programmes to support their FP and FLE classes are really referring to the programmes produced by EBS and

whether the ones who state that they use the programmes do use them regularly. We therefore assume that even the low percentage of 16.9 per cent guidance counsellors who say they use the EBS TV programmes is still higher than in reality.

Reasons for the low use of EBS TV programmes are that the transmission times are not convenient (23.9 per cent) or that the TV set is not functioning (11.3 per cent), or that there is no TV set at the school (15.5 per cent). One person mentioned that the TV programme was being watched by other teachers and two said that there was only one set for the school, which was seldom available. The main reason is the inconvenience of the time. Since each counsellor, however, has a different time schedule, it needs to be established which time is most convenient for an optimal reception.

It seems that the times of EBS programmes and frequency of transmission need to be reviewed and maintenance services improved. If these programmes are only watched by a small number of school children the usefulness of the service is questionable.

The views held by the guidance counsellors as to the usefulness of mass media support for FP and FLE classes can be seen in Table A.25. Only 7 per cent of our respondents consider radio support to be not very necessary as against 36.6 per cent who think that it is extremely necessary. The findings are similar for attitudes towards the TV. 35.2 per cent of the respondents believe that TV support is extremely necessary.

In generaly we can see that more than 70 per cent of our respondents think that radio and TV support for their FL and FP classes is

necessary. This indicates clearly that the reason for the low level of programme use is by no means due to the disinterest of the guidance counsellors but to the situational facts mentioned above.

Since it can be seen that radio is as much appreciated for support as is TV, and since maintenance and production are less difficult for radio than for TV, it seems that greater emphasis needs to be placed on educational radio programmes for FP and FLE than has been the case in the past.

(j) Use of Printed material and Teaching Aids

81.7 per cent of our respondents use printed material for FP and FLE classes. But 76.1 per cent of our counsellors still feel the need for more material. This means that they do not have enough supportive material available. Table A.26 indicates the kinds of teaching aids needed.

Printed material for distribution seems to be needed most. Films and flipcharts are also mentioned fairly frequently. We recommend therefore the establishment of an organized system for providing all guidance counsellors regularly with the necessary printed material for distribution and with flipcharts and posters as teaching aids. The material can be ordered mainly from the BOHE and the NFPB, both of which are now the two main sources of material for the guidance counsellors.

(k) Distribution of Contraceptives

None of our respondents distribute contraceptives. Considering the high rate of teenage pregnancies even among school children, it seems that each counsellor should at least have some contraceptives available (e.g. condom and jellies).

(1) Problems

Table A.27 shows that most of the guidance counsellors who answered our questionnaire claim not to have any problem at all. 30 per cent mention problems mainly with parents. Asked to describe their problems in more detail, the respondents first mentioned that they do not have enough material; secondly, that they do not feel themselves knowledgeable enough, and finally, that they have problems with parents.

Another set of problems having to do with the cooperation of nurses in the high schools does not seem as important as anticipated. 66 per cent of the counsellors who have a nurse at their school say that they are responsible for a bigger part of FP and FLE classes. Nevertheless, as many as 34 per cent leave the bigger part of FP and FLE to the nurse. Only 9.9 per cent of our respondents say that they have problems in collaborating with the nurse. But only three respondents describe the problem. Two of them stated that the nurse is against FP, and one that the nurse interferes too much. It seems that clear job descriptions for school nurses and guidance counsellors need to be worked out, and that their responsibilities in FP and FL instruction be clarified.

TABLE A.1 Total Number of Respondents by Age

RESPONDENTS		AGE								
	Total	No answer	Under 20	21 to 25	26 to 30	31 to 35	36 to 40	41 to 45	46 to 50	51+	Average age of respondents
No.	71	3	0	5	12	11	13	7	8	12	33.3 years
%	100	4.2	0	7.0	16.9	15.5	18,3	9.9	11.3	16.9	

TABLE A.2 Marital Status of Respondents

	Total	Single	Married	Visiting union	Separated or Divorced
No	71	14	53	2	2
%	100	19.7	74.6	2.8	2.8

TABLE A.3 Answers to Question: "When do you Think it is Most Convenient to Explain to your Daughter About FP for the First Time?"

	Before the age of puberty	When she has her first period	When she has her first boyfriend	After marriage	After the second child	When she asks for it	No Answer Don't know	Total
No.	31	16	8	1	1	9	5	71
%	43.7	22.5	11.3	1.4	1.4	12.7	7	100

TABLE A.4 Answers to Question: "When Would you Encourage Your Daughter to Practise Family Planning?"

	Before age of puberty	When she has her first period	When she has her first boyfriend	After the first child	After the third child	After marriage	Not at all	No Answer Don't know	Total
No.	13	5	20	4	2	9	7	11	71
%	18.3	7.0	28.5	5.6	2.8	12.7	7.9	15.5	100

TABLE A.5 Answers to Question: "When Would you Encourage Your Son to Practise Family Planning?"

	As soon as he has his first girl-friend	After first child	After second child	After fourth child	After marriage	When he asks	Not at all	Do not know no answer	Total
No.	40	6	2	2	6	4	7	4	71
%	56.3	8.5	2.8	2.8	8.5	5.6	9.9	5.6	100

TABLE A.6 Answer to Question: "What Would you Tell Your Partner if He/She Tells you After the Second Child that He/She Wants to Practise FP"

	Don't you think we could afford another child?	Go ahead Practising FP	We will go to an FP agent for consultation	Other argument for FP	No answer	Total
No.	7	13	42	3	6	71
%	9.9	18.3	59.2	4.2	8.4	100

TABLE A.7 Answers to the Question: "What do you Think of Contraceptive Methods for Males?"

	Should be regularly used by all couples who want to practise FP	Should be more used than currently done in Jamaica	Should only be used if a woman is not able to practise FP		No Answer	Total
No.	28	29	4	3	7	71
%	39.4	40.8	5.6	4.2	9.9	100

TABLE A.8 Answer to the Question: "Do You Practise FP?"

	Yes	Sometimes	No	No answer	Total
No.	49	4	15	3	71
%	69	5.6	21.1	4.2	100

TABLE A.9 Answer to Question: "Since When Have you Practised FP?"

	Before the first child	After the first child	After the second child	After the third child	No answer	Total
No.	23	10	3	6	7	49
%	46.9	20.4	6.1	12.2	14.3	100

TABLE A.10 FP Methods Being Used

	Pill	Injection	IUD/ Diaphram	Withdrawal	Creams/ Jellies	Rhythm	Condom	F.Sterilization	M.Sterilization	Abstinence	No answer	Total
No.	14	1	12	1	3	4	10	10	0	0	16	71
%	19.7	1.4	16.9	1.4	4.2	5.6	14.1	14.1	0	0	22.5	100

TABLE A.11 Answer to Question: "What Contraceptive Method do you Think is Best?"

	Pill	Injection	IUD/ Diaphram	Withdrawal	Creams/ Jellies	Rhythm	Condom	F.Sterilization	M.Sterilization	Abstinence	No answer	Total
No.	21	1	10	1	1	0	14	6	2	4	11	71
%	29.6	1.4	14.1	1.4	1.4	0	19.7	8.5	2.8	5.6	15.5	100

TABLE A.12 Answer to Question: "What Contraceptive Methods do you Know? Please State Everything you Know"

	Pill	Condom	IUD/ Diaphram	Creams/ Jellies	Rhythm	F.Sterilization	Injection	M.Sterilization	Withdrawal	Abstinence	Respondents in Total
No.	60	61	58	44	35	30	27	20	15	14	71
%	84.5	85.9	81.7	62	49.3	42.3	38	28.2	21.1	19.7	100

TABLE A.13 Answers to the Questions: "What Pros and Cons of each Contraceptive Method do you Know?"

	Knows all pros and cons	Knows nearly all pros and cons	Knows only a few pros and cons	Mentions wrong pros and cons	Does not know/mention any pros and cons	No answer	Total
No.	3	16	25	0	10	17	71
%	4.2	22.5	35.2	0	14.1	23.9	100

TABLE A.14 Answers to the Questions: "Would You Please Explain Why the Chances of a Woman Becoming Pregnant are not the Same Each Day in a Month?"

	Correct, explained in detail	Correct explained in a few words	Not correctly explained	Does not know, no answer	Total
No.	12	21	18	20	71
%	16.9	29.6	25.3	28.2	100

TABLE A.15 Answers to the Question: "Please Name Some Fields in FP Which you are Able to Handle Fully and Lecture About"

	FP methods pros and cons	Human reproduction	Reason/ need for FP	Fields of FLE	Feel incompetent	Several fields	No Answer	Total
No.	20	12	16	7	6	8	2	71
%	20.2	16.9	22.5	9.9	8.5	11.3	2.8	100

TABLE A.16 Answers to the Question: Please Name Some Fields in FLE which You are Able to Handle and Lecture About

	Mainly FP fields	Mainly human reproduction and development	Only one or two fields of FLE	Several fields of FLE	Does not know, feel incompetent	No answer	Total
No.	5	9	12	26	3	16	71
%	7.0	12.7	16.9	36.6	4.2	22.5	100

TABLE A.17 Answers to the Question: "Imagine that a Schoolgirl of Fourteen Comes to You Telling you that she is Pregnant and Hoping for Some Help. What would you do?"

	Encourage adoption	Encourage giving the baby to other member of family	Arrange discussion with parents and baby's father	Encourage responsibility for baby	Encourage that father be asked to take responsibility	Encourage abortion	Other advice	No answer	Total
No.	0	1	62	2	3	1		2	71
%	0	1.4	87.3	2.8	4.2	1.4		2.8	100

TABLE A.18 Answers to the Question: "Imagine that a School Girl of Thirteen Asks You for Advice in FP, What Would You do?"

	Tell her to practise abstinence	Tell her one FP method	Explain all FP methods and the pros & cons	Ask her to bring boy-friend along for explanation	Tell her to wait for next lesson in FP	Send her to next FP clinic or midwife	No answer	Total
No.	9	1	33	13	0	13	2	71
%	12.7	1.4	46.5	18.3	0	18.3	2.8	100

TABLE A.19 Answers to Questions: "Imagine that a Schoolgirl Asks Advice Because Her Boyfriend is About to Leave her Since she does not Want to Become Pregnant. What Would you Tell Her?"

	Let him go He is not worth your friendship	Look for another boyfriend who under-stands	You are wise in not wanting a child before being prepared	Bring your boyfriend here, I will try to explain to him	Give in and stop objecting to having a child	Total
No.	8	7	24	32	0	71
%	11.3	9.9	33.8	45.1	0	100

TABLE A.20 Answers to the Question: "Do You Hold Classes in FP and FLE?"

		Regularly	Sometimes	Seldom	Never	No Answer	Total
FP	No.	20	32	7	7	5	71
	%	28.2	45.1	9.9	9.9	7.0	100
FLE	No.	37	26	4	0	4	71
	%	52.1	36.6	5.6	0	5.6	100

TABLE A.21 Amount of FP and FLE Classes Taught per Week

			CLASSES PER WEEK						
		Varies	1 class/ week	2 classes	3 classes	4 classes	No class	No answer	Total
FP	No.	13	6	4	2	13	9	24	71
	%	18.3	8.5	5.6	2.8	18.3	12.7	33.8	100
FLE	No.	7	3	4	3	35	1	18	71
	%	9.9	4.2	5.6	4.2	49.3	1.4	25.4	100

TABLE A.22 Answer to the Question: "Which are your Main Target Groups for FP? Please name Grade of Student and Qualify Other Groups"*

		Gr. 7-11 New -Sec.	Gr. 9-11 School	Form 1-3 High School	Form 2-3 High School	College Students	Parents	No answer	Total
FP	No.	22	27	4	2	4	7	5	71
	%	31	38	5.6	2.8	5.6	9.9	7	100
FLE	No.	36	11	4	1	2	6	11	71
	%	50.7	15.1	5.6	1.4	2.8	8.5	15.5	100

*The categories within this Table are not clearly separated from each other due to the fact that we asked an open question. We used the categories the counsellors gave us to give at least some idea of their target groups.

TABLE A.23 Cooperation with Other Experts in FP and FLE

	Private doctor	Education officer	Health officer	FP staff	Nurse	Total
No.	2	11	21	11	27	71
%	2.8	15.5	29.6	15.5	38	100

TABLE A.24 Answers to Question: "Do you Use the TV or Radio Programmes by EBS to Support Classroom Teaching in FP and FLE?"

		Yes	No	Sometimes	No answer	Total
Radio	No.	13	35	6	17	71
	%	18.3	49.1	8.1	23.9	100
TV	No.	12	31	5	23	71
	%	16.9	43.7	7	32.4	100

TABLE A.25 Answers to Question: "Do you Think That Radio and TV Support for FP and FLE Classes are Necessary?"

		Extremely necessary	Necessary	Not very necessary	Not necessary at all	No answer	Total
Radio	No.	26	27	5	0	13	71
	%	36.6	38	7	0	18.3	100
TV	No.	25	26	2	2	16	71
	%	35.2	36.6	2.8	2.8	22.5	100

TABLE A.26 Teaching Aids Needed by Guidance Counsellors

	Every-thing	Films	Slides	Flip charts, posters	Booklets leaflets to dis-tribute	Hard-ware	Nothing	No answer	Total
No.	4	20	4	16	26	2	0	0	71
%	5.6	28.2	5.6	22.5	36.6	2.8	0	0	100

TABLE A.27 Problems Related to Work in FP and FLE

	No problems	With students	With super-visors Ministry	Parents & other	Handling the topic	Other prob-lems	No answer	Total
No.	31	3	3	9	7	5	13	71
%	43.7	4.2	4.2	12.7	9.9	7	18.3	100

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