STRATEGIC FRAMEWORK FOR THE FAMILY PLANNING PROGRAMME

2006-2010

NATIONAL FAMILY PLANNING BOARD

September 2006

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NATIONAL FAMILY PLANNING BOARD

STRATEGIC FRAMEWORK FOR FAMILY PLANNING

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STRATEGIC FRAMEWORK FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH 2006-2010

Objective : **Further decrease the number of unplanned pregnancies.**
Indicator: Total Fertility Rate (TFR) of 2.2 by 2010

Strategies:

1. Expand access to existing but underused family planning and RH options for women.
2. Improve access to Reproductive Health Information to Adolescent and Youth.
3. Expand access to reproductive health information and services to men.
4. Promote safe sexual behaviour, attitudes and practices to reduce the prevalence of STIs and HIV/AIDS.

Executive Summary

The International Conference on Population and Development (ICPD) held in Cairo in 1994 recognised that reproductive health is a critical part of an individual's well-being and is central and critical to human development. ICPD established a paradigm shift from family planning to a more comprehensive approach of reproductive health and rights, premised on the life cycle approach in which reproductive health concerns are not limited to women of reproductive age, but to men and youth. Jamaica is also committed to the achievement of the Millennium Development Goals (MDGs) including the goals to promote gender equality and empower women; improve maternal health; reduce child mortality; and combat HIV/AIDS and other diseases.

Global population trends are moving downwards supported by declining fertility rates and increased contraceptive usage among reproductive populations. Jamaica's population is currently estimated at 2.65m, of which women in the reproductive age group 15-49 represents approximately 707,600 or 26.7%. Of all the health challenges that countries face, those posed in relation to sexual and reproductive health are among the most daunting. *WHO estimates unsafe sex to be the second most important global risk factor to health.* Responsible sexual behaviour protects sexual health; and improves maternal and child health through planned pregnancies

The NFPB implemented the Family Planning component of the Strategic Framework for Reproductive Health 2000 – 2005 which aimed to decrease the number of unplanned pregnancies and reduce the Total Fertility Rate (TFR) to 2.5 by the year 2005. This was accomplished through strategies to improve contraceptive method mix, introduce emergency contraceptive protection (ECP), improve efficacy of contraceptive method use, and expand access to reproductive health information and services to adolescents and

men. Even as achievements were made, risky sexual and reproductive health behaviours among adolescents and men remained challenges to be addressed.

Other achievements and challenges included:

- Steady increases in contraceptive prevalence even as the change in the method mix that occurred was more appropriate for postponers and spacers rather than for limiters.
- Reduced unmet need for family planning, although the unmet need for limiting remains high.
- Increased knowledge of ECP among WRA, although use remains low.
- The age of sexual initiation remains virtually unchanged, but abstinence has increased among 15 – 17 year olds, and both genders.
- Reduction in incidence of forced sex among adolescent females although girls under age 15 remained at higher risk. ***Boyfriends or other steady partners were the main perpetrators of forced sex.***
- Transactional sex by adolescents under age 17, rural women, those with little education and from the lowest socio-economic stratum is also of concern.
- Increasing exposure to HFLE although there is room for improvement in specific messages and understanding.
- Declining user perception in the efficacy of condoms, pills and injectables in preventing pregnancy, and safety for women's health.
- Strong support among WRA for birth spacing of two years or more.
- Weakening support for the ideal two-child family.

An evaluation of the NFPB's Implementation of the 2000 – 2005 Strategic Framework found that the strategic framework has achieved its core quantitative targets of a reduced population growth rate and reduced fertility rate. The NFPB has also performed creditably in all the programmatic components except in the area of "Multi-sectoral linkages". It was recommended that NFPB continue with most of the existing strategies with emphasis on counselling, expanded training, research and evaluation, advocacy, and improved working conditions and incentives to performance.

A major challenge that has emerged from this evaluation was how to transform the family planning programme towards a framework advancing the reproductive health and rights agenda that has been accepted globally. In light of this challenge, and arising from the gaps identified, important actions for the next five years include:

- Reducing the unmet need among limiters.
- Increasing ECP knowledge and use among at-risk WRA.
- Enhancing adolescents' ability to protect their reproductive health through increased access to reproductive health information and services.
- Promoting responsible and safe sexual and contraceptive behaviours to reduce vulnerabilities to STIs and unplanned pregnancies.
- Supporting early exposure to HFLE.

- Strengthening positive attitudes among WRAs and men to the efficacy of contraceptive to RH and desired fertility outcomes.

Over the next five years, the NFPB will seek to effect further reduction in unplanned pregnancies by achieving a TFR of 2.2 through interventions that address fertility needs while reducing risks. The Board's mission over this period will be:

> *To enable individuals to achieve good reproductive health[1] (FP and RH outcomes) through the provision of high quality, voluntary family planning and HFLE services implemented efficiently and effectively.*

The following programme components, which are not mutually exclusive, remain relevant in addressing the reproductive health and family planning issues that have emerged:

- Advocacy & Policy Initiatives;
- Service Delivery;
- Training;
- Health promotion for behaviour change;
- Multi-sectoral linkages; and
- Research, evaluation, and management information systems (MIS).

In preparing the Strategic Framework for Reproductive Health 2006 – 2010, the NFPB identified the following over-arching themes or issues of particular importance to future success. These issues include:

1. The reality that high unmet need among limiters remains even as the method mix among women of higher parities consists predominantly of supply methods, would suggest the need for more targeting of contraceptive use by reproductive life stages.
2. Adolescents' sexual and reproductive health remains a priority in light of their patterns of contraceptive use / mis-use, and high risk behaviours.
3. The tendency of males to engage in behaviours detrimental to desirable reproductive health outcomes presents challenges and opportunities for gender equitable and holistic approaches in responding to their reproductive health needs.
4. Perceptions about the efficacy of modern methods in preventing pregnancy and safety for women's health, impacts negatively on birth spacing and other actions to prevent an unplanned pregnancy and protect against STIs. User perception about efficacy needs to be improved.
5. Weakening support for the two-child family ideal suggests a need for effective communication on the socio-economic benefits of small families.
6. The impact of societal and cultural factors on reproductive health decision making and behaviours and related strategies for behaviour change.

[1] The population programme recognises good reproductive health to be the ability to obtain medically accurate information about all aspects of reproduction in a timely manner for informed decision-making; enter into sexual relationship willingly without physical or economic coercion; avoid unintended pregnancies and births, and avoid STIs including HIV/AIDS.

7. Risk reduction through integrated messages for responsible reproductive health behaviour and STI/HIV/AIDS prevention.
8. Closer linkages with relevant stakeholders to achieve results (multi-sectoral linkages).

During the five year period 2006 – 2010, *focus will be on women who are at risk for unplanned pregnancies, WRA who do not desire any more children (limiters) but have an unmet need for contraception, and other underserved groups for example, men*

Critical strategies to be pursued by NFPB are:

1. Expand access to existing but underused family planning and RH options for women.
2. Improve access to Reproductive Health Information to Adolescent and Youth.
3. Expand access to reproductive health information and services to men.
4. Promote safe sexual behaviour, attitudes and practices to reduce the prevalence of STIs and HIV/AIDS.

The following are the key targets to be achieved over the next 5 years:

- Unplanned pregnancies among women 15 - 49 will be below 63%
- The percent of WRA in union using a contraceptive will be approximately 70%
- Unmet need for FP among fecund women 15 - 49 reduced from 8.7%
- Dual method use increased to approximately 25%

1.0. Introduction

Jamaica is one of many countries worldwide that has adopted the recommendations of the Programme of Action that was developed out of the International Conference on Population and Development (ICPD) held in Cairo in 1994. This conference recognized that Reproductive Health is a critical part of an individual's well-being and is central to human development. Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Inherent in this definition is the recognition of the individual's ability to reproduce, determine how many and at what interval to have children, and to practice and enjoy sexual relations.

The Government of Jamaica has also committed itself to the achievement of eight (8) Millennium Development Goals (MDGs) including the goal to promote gender equality and empower women; improve maternal health; reduce child mortality; and combat HIV/AIDS and other diseases.

The UNFPA in its 5-year review of its implementation of the MDGs recognised that the achievement of the MDGs cannot occur without addressing the population and reproductive health issues articulated in the Cairo Consensus. This requires stronger efforts to promote women's and young people's rights and greater investments in education and health, especially reproductive health, including gender equality, family planning, and HIV/AIDS prevention and care (*UNFPA 2005*). Based on this observation, Jamaica's way forward is to build on its achievements in sexual and reproductive health and address weaknesses through effective reproductive health and family planning programmes.

Jamaica's population is currently estimated at 2.65m, of which women in the reproductive age group 15-49 represents approximately 707,600 or 26.7%. The population growth rate has been declining steadily since 1995 and is currently at a rate of 0.5%. The annual population growth rate is however within targeted levels and is in keeping with the desired trend toward the goal of zero population growth[2]. Jamaica has been described as "…currently at an advanced stage of demographic transition reflected in the long-term pattern of decreasing trends in mortality and fertility rates" (ESSJ, 2004). Indeed, global population trends are moving downwards supported by declining fertility rates and increased contraceptive usage among reproductive populations.

Reproductive health is internationally recognized as the cornerstone of sustainable development. Improving reproductive health contributes not only to the health status of

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[2] Ultimate goal of zero population growth was indicated in the "*Statement of National Population Policy, Jamaica*" PIOJ, Revised 1995.

populations, but is central to the attainment of gender equity. With the growing pandemic of HIV/AIDS and sexually transmitted infections, the need for governments to fund and focus on reproductive health has never been greater. Of all the health challenges that countries face, those posed in relation to sexual and reproductive health are among the most daunting because they involve not only diseases but also normal components of life such as sexual maturation and pregnancy. *WHO estimates unsafe sex to be the second most important global risk factor to health.*

Effective programmes toward reducing risks inherent in unsafe sexual behaviors, enhancing fertility management and mitigating unplanned pregnancies, particularly among vulnerable and at-risk groups, will contribute to the achievement of the MDGs. Population policies and programme actions being implemented have shifted away from merely achieving demographic targets for reduced population growth toward improving the reproductive health of the population. In recognition of this, Jamaica has sought to ensure the rights-based and holistic reproductive health development of citizens thereby meeting the needs of individuals while seeking to accomplish demographic goals for macro-level development.

In 1999, the United Nations General Assembly convened a progress review towards meeting the ICPD goals. After reviewing the topics highlighted in the ICPD Programme of Action, the special session (known as ICPD+5) agreed on a new set of benchmarks in the following areas toward which the National Family Planning Board (NFPB) can contribute:

> **Access to reproductive and sexual health services including family planning.** Reproductive health care in the context of primary health care should , inter alia, include family planning counseling, information, education and services for pre-natal care, safe delivery and post natal care; prevention and appropriate treatment of infertility; prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counseling as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available as required.
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> **Reproductive health care and unmet need for contraception :** By 2015 all primary healthcare and family planning facilities are able to provide, directly or through referral the widest achievable range of safe and effective family planning and contraceptive methods *inter alia*. By 2005, 60 per cent of such facilities should be able to offer this range of services, and *by 2010, 80 per cent of them should be able to offer such services*. [para. 53]

> "Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, *75 per cent by 2010* and 100 per cent by 2050. ***In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients***." [para. 58]

> ***HIV/AIDS:*** "… by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counseling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent." [para. 70]

The National Family Planning Board (NFPB) is strategically placed to contribute toward meeting the ICPD+5 benchmarks in the above areas. The NFPB was established under the National Family Planning Act of 1970 with responsibility for preparing, implementing, coordinating and promoting family planning services. It is a statutory agency under the Ministry of Health (MOH). NFPB's **mission** over the next five years is

> *To enable individuals to achieve good reproductive health (FP and RH outcomes) through the provision of high quality, voluntary family planning and HFLE services implemented efficiently and effectively.*

The NFPB's organizational structure includes policy formulation, monitoring and evaluation. The Board continues to carry out core functions including the management and distribution of contraceptive supplies, promotion of family planning/reproductive health, development and dissemination of education and other related materials.

The Strategic Framework for Reproductive Health within the Family Health Programme 2000 – 2005, responded to the broader linkage between reproductive health and other factors within the individual's environment and placed reproductive health policy and service delivery firmly within the context of overall family health. The primary objective of the **Family Planning** Element of this Strategic Framework was to decrease the number of unplanned pregnancies and reduce the Total Fertility Rate (TFR) to 2.5 by the year 2005.

Strategies implemented to achieve that objective were:

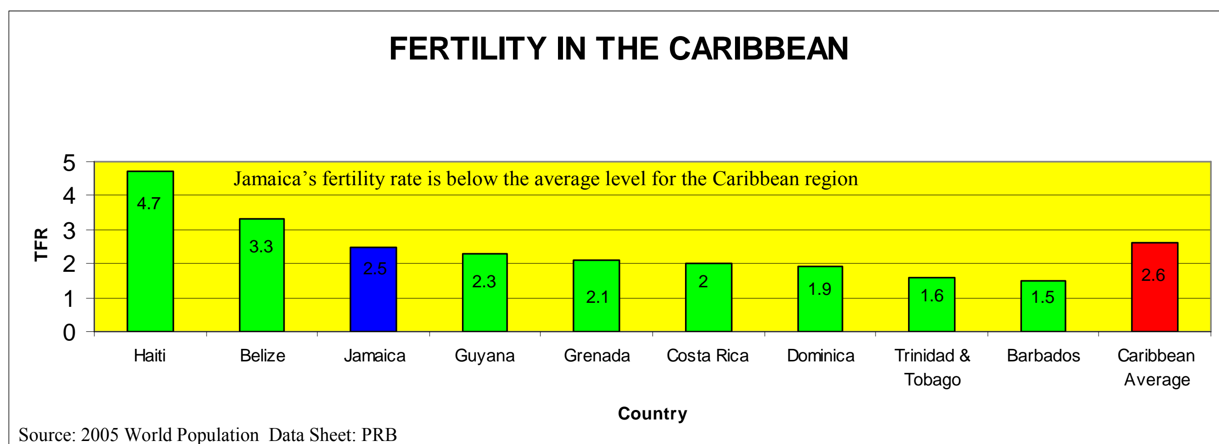
1. Improve contraceptive method mix

2. Introduce emergency contraceptive protection (ECP)
3. Improve efficacy of contraceptive method use
4. Expand access to reproductive health information and services to adolescents
5. Expand access to reproductive health information and services to men

1.1. Achievements and Challenges

The desired fertility outcome for the strategic planning period 2000 – 2005, that of a TFR of 2.5 by 2005 has been achieved. Jamaica's current TFR compares favourably with the Caribbean average of 2.7. Global and regional fertility have been falling over the past decade and most of the Caribbean territories, such as Dominica, Barbados, and Trinidad & Tobago, are already at or below replacement level fertility. The task for Jamaica, in light of its achievement, is to further reduce fertility to replacement level by 2010, or shortly thereafter.

Figure 1:



Source: 2005 World Population Data Sheet: PRB

Improvements in contraceptive prevalence, knowledge and use have contributed to the achievement of targeted fertility levels. Declines in age specific fertility were most noticeable among women in the 15 – 19 and 20 – 24 age groups. The age specific fertility rate (ASFR) for adolescents, measured in births per 1000 women aged 15 – 19, saw the most significant decline from 112 in 1997 to 79 in 2002. *This achievement however raises questions on the impact of voluntary termination of pregnancies, which studies show, can be easily accessed by this age cohort (Hope Enterprises, 2005).*

Despite the significant decline, Jamaica's adolescent fertility rate remains high when compared with global ASFR which is 60 births per 1000 women in this age group. Even as improvements have been seen, risky sexual and reproductive health behaviours among adolescents and men remain challenges to be addressed.

The contraceptive prevalence rate (CPR) among women in union (i.e. married, common law or visiting relationship) has increased steadily and is currently at 69.1%. Among

adolescents 15 – 19 in union, there was a significant increase in contraceptive prevalence from *58.6% to 69.8%*. The contraceptive method mix experienced an increase in the

contribution of condom which has become the most prevalent method used among women in union. This is followed by the pill, tubal ligation, and the injection. Dual method use (use of condoms along with a primary contraceptive method) also increased marginally during 1997 - 2002 from 11.2% to 12.8%.

The change in the method mix that occurred was however more appropriate for postponers and spacers rather than for limiters (the target group identified in 1997 as 58% of potential contraceptive users.) The contribution of Tubal Ligation to the method mix declined from 19% to 17% and continues the declining trend observed over the past three decades. The contribution of the IUD to the method mix remained at 2%.

Table 1: % Contribution of Contraceptive to Method Mix among Women in Union

Method	1997 RHS %	2002 RHS %
Condom	26	34
Pill	32	26
Tubal Ligation	19	17
Injection	17	17
IUD	2	2
Other	3	3

A contributory factor to the level of long-term method use among WRA is the strong preference among clients for short term methods (*Chambers, 2005*). This situation supports consumers' desire to keep their reproductive options open in light of the generally unstable nature of sexual relationships in Jamaica. Very few women, for example, were willing to accept the permanency of the tubal ligation, as in their perception, such a choice would adversely affect their "marriage prospects."

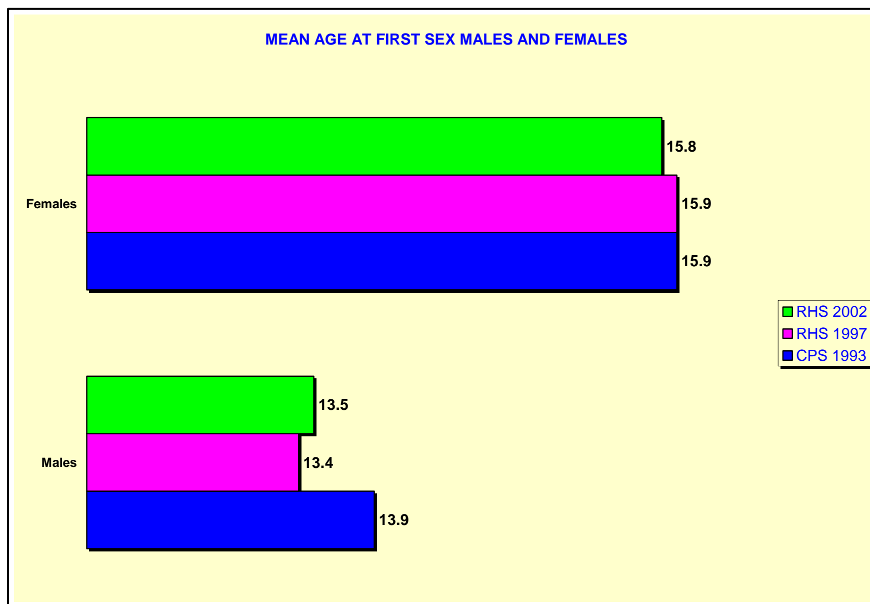
Even as the contraceptive prevalence rate has increased over the years, declines were observed in urban centres (Kingston and St. Andrew); among the 40-44 age cohort; and among users of tubal ligation (in particular, the 40-44 year olds). The age group 40-44 years was also reporting an increase in age specific fertility and the highest level of unmet need. Although unmet need for family planning has been reduced to 8.5%[3], there remained a high unmet need for limiting childbearing (5.5%). This finding indicates a further need to encourage limiters to graduate from short- term to more appropriate long(er) term methods.

[3] This refers to unmet need among women 15 – 44 years to allow for comparison with earlier surveys. When the age group 45 – 49 is taken into account, unmet need is 8.7%.

Emergency Contraceptive Protection (ECP) was introduced during the period as a post coital method to prevent an unplanned pregnancy. ***The current situation is that ECP acceptance is increasing and knowledge among WRA, though increasing is still not ideal.*** The emergency contraceptive pill is used by approximately 4% of women 15 – 49 who have ever used contraceptives and this finding indicates a growing acceptance of emergency contraception particularly among younger women. Knowledge of ECP among women in the reproductive age group is however relatively low (only 49% ever heard of it). Ever use of ECP is highest among younger women under the age of 30 years, particularly those with more years of schooling, but lowest among rural women (whose fertility is highest) and those from the lowest socio-economic stratum.

Despite interventions at various levels, sexual initiation continues to occur at an early age. The mean age at first sexual intercourse for young adult women 15 – 24 is virtually unchanged

Figure 2:



As has also been the observed trend, males typically enter their sexual debut at an earlier age compared to their female counterparts.

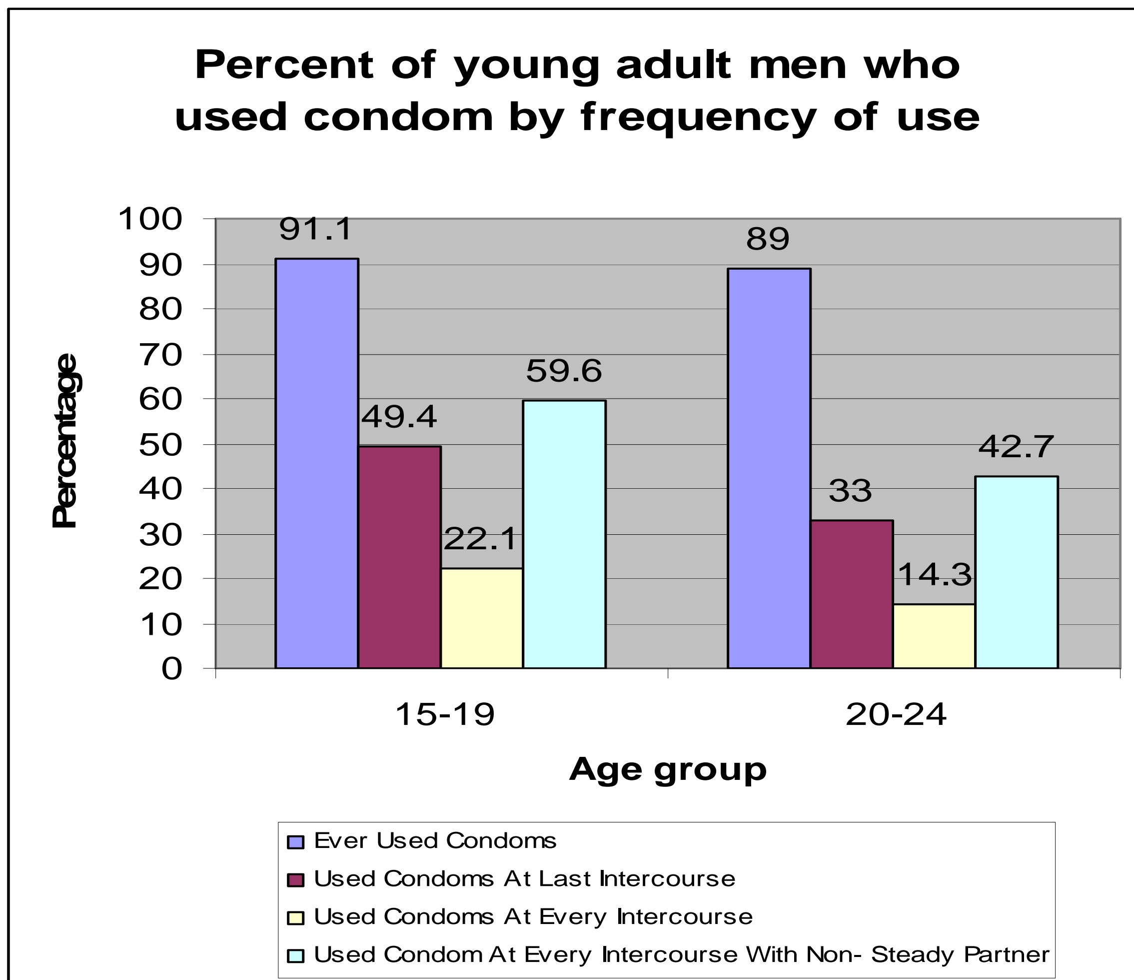
Findings from the RHS 2002 also indicate a greater propensity among males to engage in risky sexual and reproductive health behaviours. This leaves them vulnerable to adverse reproductive health impacts including exposure to STIs and HIV/AIDS. *For males aged 15 - 19, the proportion who used a contraceptive at first intercourse is 44.9%, which compared to contraceptive use at first intercourse among females, is relatively low. This situation is however due to the earlier age at which men typically enter sexual relationships, which also occurs before first exposure to HFLE for the majority*[4]. A key

[4] Only 30.7% of men had a class or course on sex education that included information on contraception before the age of 13 years. Mean age of sexual initiation for male adolescents is 12.5 (for 15 – 17 year olds) and 13.5 for older adolescents.

reason for contraceptive non-use among adolescent males is a lack of knowledge of methods (29.2%).

Condom use among young men is also inconsistent. While "ever use" among young males is high, few reported using a condom consistently at every intercourse (**Figure 3 below**).

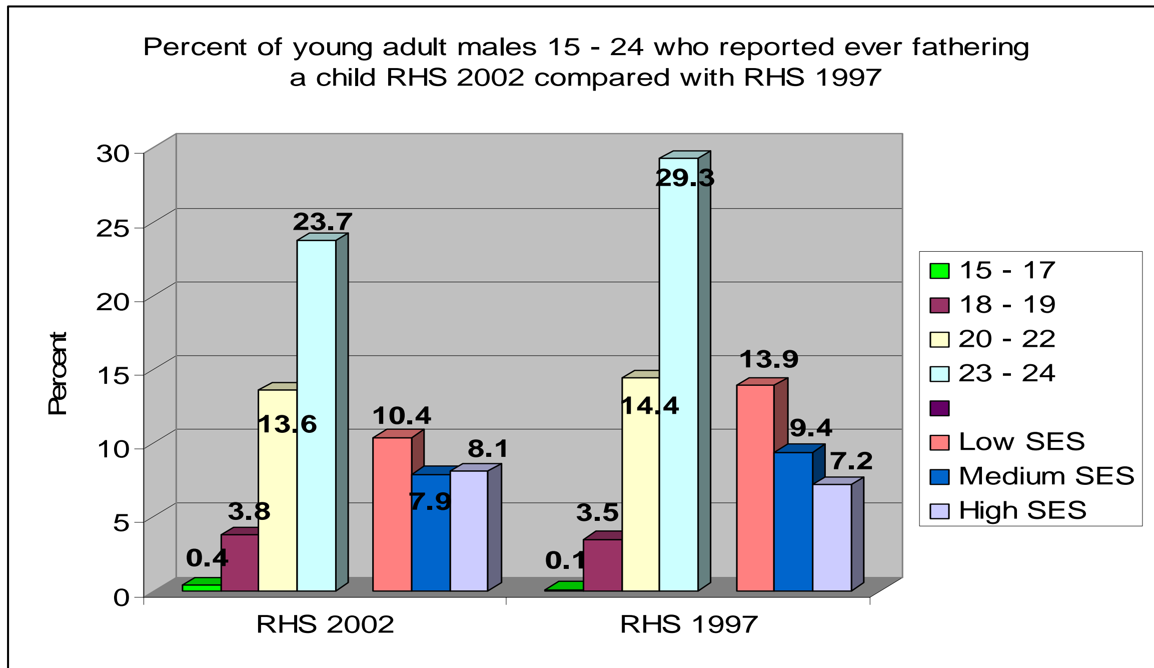
Figure 3:



Other research has found that male partners knew very little about female contraceptive practices and are therefore hardly / not involved in contraceptive decision-making (*Chambers, 2005*).

The proportion of young adult males who reported having two or more sexual partners during the three months prior to the Reproductive Health Survey **increased from 34.7% in 1997 to 44.4% in 2002.** The pattern for females has not changed with approximately 97% of women reporting having only one sexual partner during the same period. These

are worrying indicators of the high risk tendencies of young males and their vulnerability to adverse reproductive health impacts. More importantly, high risk behaviours among males also increase female vulnerability to adverse reproductive health outcomes.
Figure 4.



One consequence of this pattern of behaviour among males is that fatherhood by adolescent males 15 – 19 **increased** even as a decline was experienced among young adult males aged 15 – 24 (from 10.0% to 8.4%). The increase was more evident among males aged 15 – 17 (from 0.1% to 0.4%), and marginal among the 18 –19 age group from 3.5% to 3.8%). The number of young men reporting ever fathering a child is typically highest among males in the low socio-economic stratum.

Encouragingly, the proportion of adolescent females who are sexually experienced by age 19 years was reduced from 50.3% to 48.1%. This also indicates an increase in abstinence (never had sex) among this group which actually moved from 49.6% to 51.9%. The proportion of females who had a first birth by age 20 however remained relatively high (39.7%). For persons currently aged 20 years and under, this proportion was 15.8%[5]. The proportion of sexually experienced males 15 – 19 remained virtually unchanged at around 73%. Compared to females in the same age groups, more males are initiating sexual activity earlier.

Amidst the decline in the proportion of young adult women (15 – 24) who reported ever being pregnant (from 43.2% to 37.4%), was the increase in reported pregnancies among adolescents enrolled in secondary and post secondary institutions (from 42.2% to 48.3%

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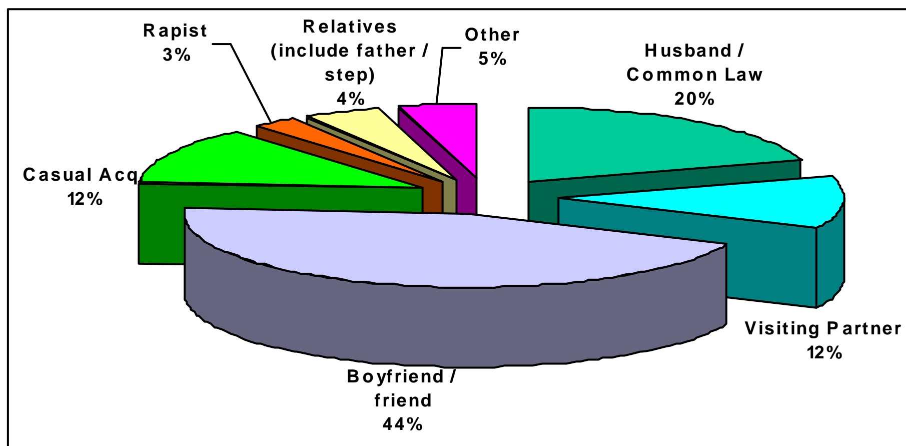
[5] No comparison can be made with the 1997 survey as the data were not disaggregated by age in the same way as in 2002.

and from 6.5% to 11.1% respectively). While the lowest incidence of pregnancy occurred among the age group 15 – 17 years (7.3% in 2002), the proportion of unplanned pregnancies among adolescents in this age cohort ***increased from 90.0% to 97.4%.***

Transactional sex remains a concern for effective action to protect the reproductive health rights of citizens. Approximately 3.8% of female adolescents in the 15 – 19 age group had exchanged sex for money or goods. Persons who are vulnerable to this are adolescents under age 17 (ranging from 4.0% among 17 year olds to 9.3% among 15 year olds), women in rural areas (3.3%) those from the lowest socio-economic stratum (4.2%) and who have little education (13.3%). Evidence from other studies suggest that transactional sex among adolescents is being done out of economic need and is also related to conditions of poverty (*Hope Enterprises, 2005*).

Forced sexual contact is also another impediment that violates the reproductive rights of the affected party and removes the ability to negotiate contraceptive use. While there was a reduction in the percentage of adolescent females who reported experiencing forced sexual intercourse (from 25.9% to 20.1%), the youngest age groups – 15 year-olds (21.3%), and 16 year-olds (25.8%) remained at higher risk to forced intercourse. ***Findings also show that boyfriends or other steady partners were the main perpetrators of forced sex.***

Figure 5: Perpetrators of forced sex



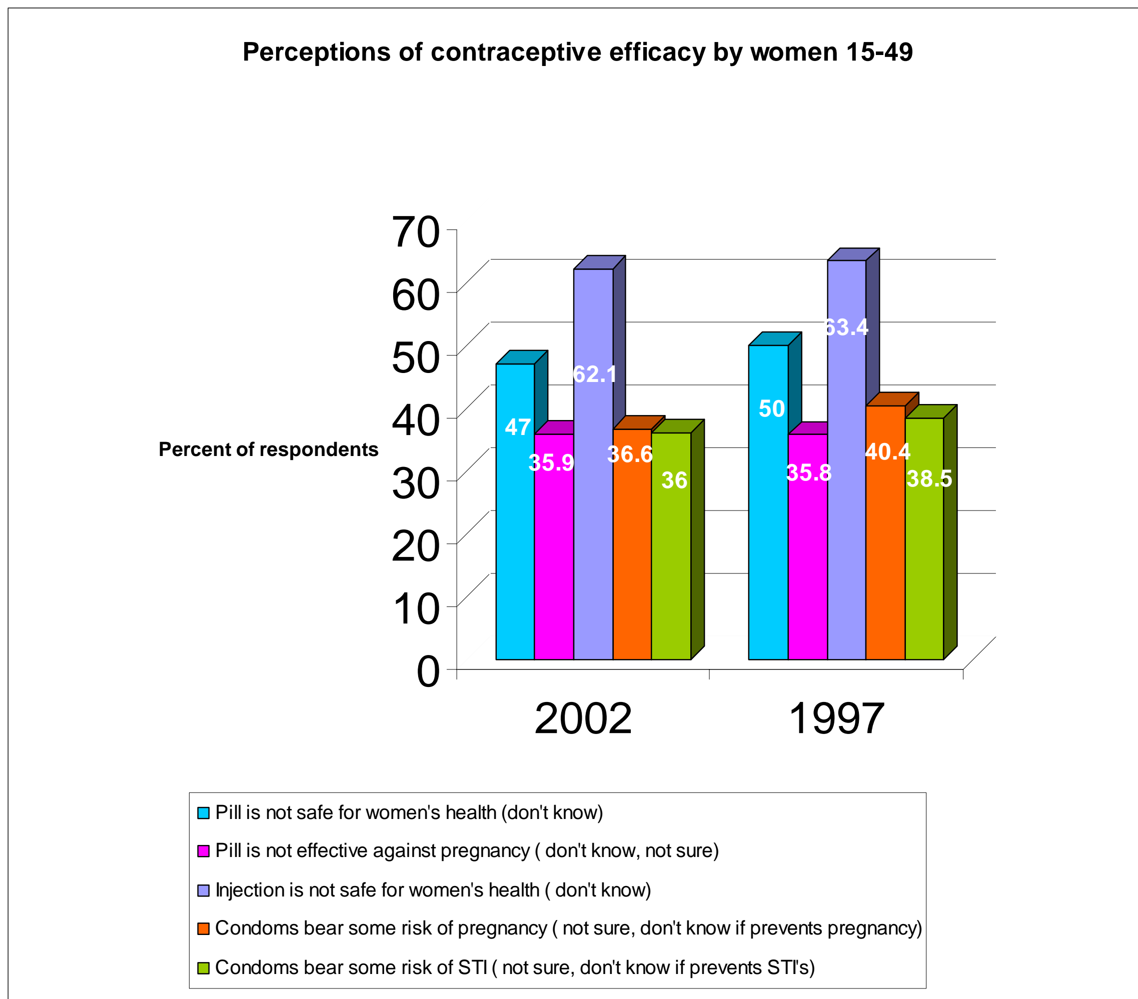
Other research has also highlighted the high incidence of coercive sex among adolescent that puts them at risk to unsafe abortion and its impacts (*Hope Enterprises 2005*).

Health and family life education is a critical component of health programmes aimed at promoting good reproductive health for adolescents. Participation in HFLE was associated with an increased likelihood of using contraceptives at first intercourse and for young men, at recent intercourse. While exposure to HFLE was high and data show that HFLE for adolescents aged 13 and younger is increasing, there was room for

improvement in specific messages and understanding. Knowledge of treatment and protection for sexually transmitted infections and methods to prevent unplanned pregnancies was inconsistent among young men and women.

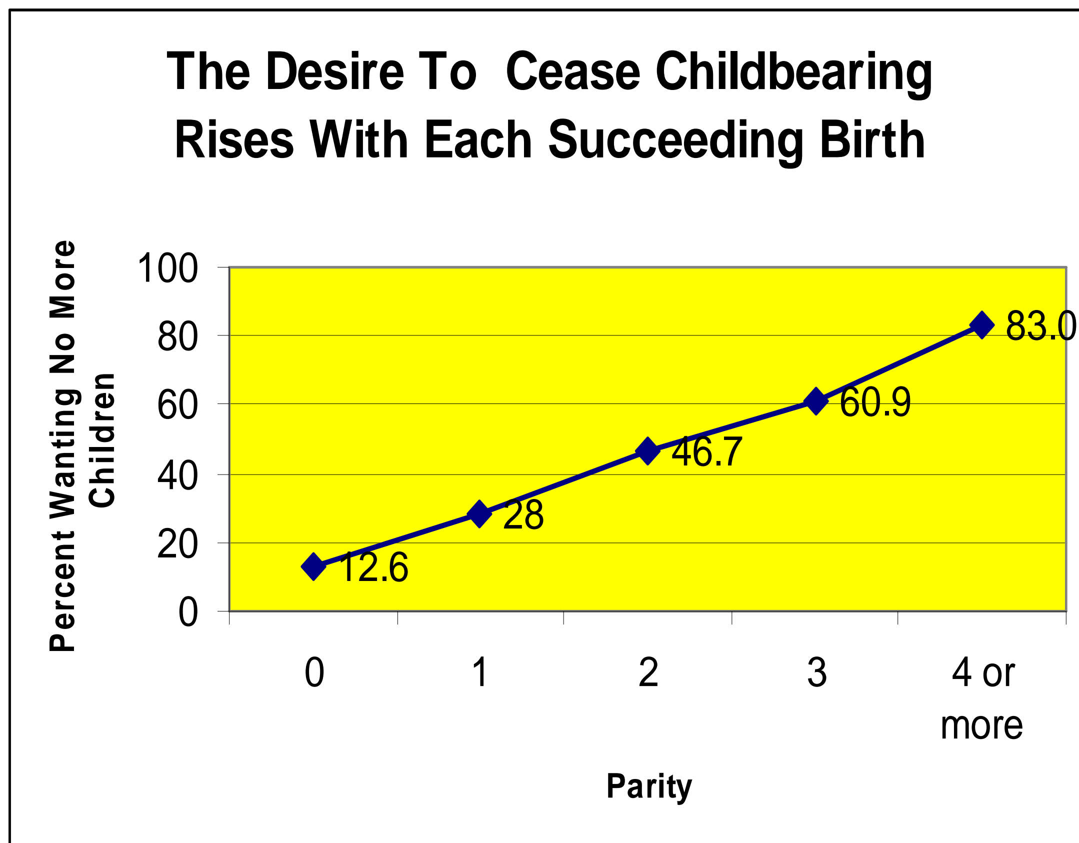
Negative perceptions about the efficacy of condoms, pills and injectables in preventing pregnancy, and safety for women's health, has changed little since the 1997 RHS. The weak acceptance of the efficacy of condoms for both pregnancy and sexually transmitted infection protection and for the efficacy of the oral contraceptive for pregnancy protection is fuelled by perceptions of or actual side effects associated with these options. Such loss of confidence in method efficacy, particularly among adolescents, is alarming in the context where knowledge about where to access treatment for STIs was low and represents a critical gap to be addressed.

Figure 6:



Young adult women (regardless of age), as well as men, continue to hold the view that a woman is responsible enough to have her first child between the ages of 20 – 24. Unlike their female counterparts, however, men were more in support of the view that younger women are responsible enough to begin childbearing. It is also disturbing to note that while the majority of women 15 – 24 supported the start of sex education before age 12 years, **a notable proportion (29.9%) preferred a later intervention.** There was also a reduction in the proportion of WRA who favoured longer breastfeeding durations beyond six months (actual breastfeeding duration was short). A reduced proportion of women continue to favour the limit of two children as ideal. ***In fact, approximately 51% of women who already had two children desired additional children.***

Figure 7:



Arising from the challenges highlighted, important actions for the next five years include:

- Reducing the unmet need among limiters.
- Increasing ECP knowledge and use among at-risk WRA.
- Enhancing adolescents' ability to protect their reproductive health through increased access to contraceptive information and services.

- Promoting responsible and safe sexual and contraceptive behaviours to reduce vulnerabilities to STIs and other impacts.
- Supporting early exposure to HFLE.
- Strengthening positive attitudes among WRAs and men to the efficacy of contraceptive to RH and desired fertility outcomes.

1.2. Evaluation of the 2000 – 2005 strategic framework

An evaluation of the NFPB's Implementation of the 2000 – 2005 Strategic Framework was conducted between May to September 2005. This evaluation found that the strategic framework has achieved its core quantitative targets of a reduced population growth rate and reduced fertility rate. The NFPB has also completed a significant portion of the programme activities and has generally performed creditably in all the programmatic components except in the area of "Multi-sectoral linkages". Indications are however that despite the quantitative success, the NFPB's implementation of the strategic plan could have achieved more and the outlook for sustainability more positive if the operating environment was more performance driven.

The evaluation found that the propensity for accelerating momentum and building on the initial success of the plan has been seriously undermined by five factors relating to sustainability including the unpredictable level of government disbursements. The evaluation recommended the implementation of mechanisms to improve the environment for performance. It also recommended two strategies to continue to improve efficiencies and effectiveness which will require the implementation of existing quality assurance mechanisms and collaboration with the Ministry of Health (MOH).

The final recommendation was to continue with most of the existing strategies in the succession plan (for 2006 – 2010) that emphasises counselling, expanded training, research and evaluation, advocacy, and improved working conditions and incentives to performance.

A major challenge that has emerged from this evaluation was how to transform the family planning programme towards a framework advancing the reproductive health and rights agenda that has been accepted globally.

2.0. APPROPRIATE PROGRAMME TOOLS

The following programme components therefore remain relevant for NFPB to address the reproductive health and family planning issues that have emerged:

- Advocacy & Policy Initiatives;
- Service Delivery;
- Training;
- Health promotion for behaviour change;
- Multi-sectoral linkages; and
- Research, evaluation, and management information systems (MIS).

Advocacy & Policy Initiatives should create and maintain a supportive environment for the delivery and use of reproductive health services. In the policy arena, formal laws and regulations affect the health technologies and methods available, eligible providers and users, and conditions for service provision. Policy tools can assess legal and regulatory barriers to services and can be used to develop revised national policy and operational guidelines for improving reproductive health. Improvements in the policy climate such as Cabinet approval of the Policy Guidelines for Access to information and services to persons under Age 16, in 2003, and the reclassification of Postinor 2 an ECP as a List 2 item also in 2003 will allow for the equitable delivery of reproductive health services to previously underserved target populations.

Service Delivery. NFPB's mandate for service delivery is to effectively expand access to contraceptive products and information to target populations. Service delivery is the mechanism through which Jamaicans receive information and contraceptive products in order to meet their full potential for reproductive health. The NFPB provides contraceptive products to end users (directly and indirectly), counselling through hotlines and the Marge Roper Service, and training to providers, and IEC materials.

Training ensures that all those who interact with reproductive healthcare clients have the knowledge and skills necessary to deliver information, products, and medical services safely, correctly, and acceptably and to support continuation of desired health behaviours among the client population. Provider training enhances the opportunity for informed choice by clients and thus increases the likelihood of continued healthy behaviour. Training remains necessary for the range of healthcare providers within the service delivery infrastructure: physicians, nurses, midwives, pharmacists, counsellors, and outreach workers as well as for informal "trainers" such as parents and peers.

Health promotion for behaviour change is the tool used to identify and influence the root causes of health behaviour choices, risk assessment, and the decision making among targeted groups of the population. Health promotion for behaviour change requires that the individual be viewed in a holistic manner and that the relationships between reproductive health choices and other influencing factors within the individual's environment are recognised and taken into account in promoting targeted reproductive health behaviours. For this 5-year period the task is to reach underserved target groups using innovative methods that can effectively respond to their needs. Health promotion for behaviour change strategies are supported by, but not limited to, communications campaigns that reach target populations through a variety of channels such as personal interaction, social norms, mass media, entertainment, and information, education and communication (IEC)/educational materials.

Multi-sectoral linkages are closely related to health promotion for behaviour change. Multi-sectoral linkages are in keeping with the NFPB's recognition that many factors in the overall environment have an impact on the reproductive health decisions and behaviours of individuals. These linkages also indicate an understanding that addressing

the challenges of behaviour change, fostering healthy reproductive behaviours as societal norms, and delivery of client-acceptable services requires the resources and expertise of both public and private entities across a broad range of sectors. The strategic approach is to broaden the linkages required to effectively reach target populations in "their own spaces". NFPB provides contraceptives and information to service providers in the public health system as well as some private / NGO providers in support of RH service delivery.

Research, evaluation, and management information systems (MIS) is the mechanism through which NFPB gather and analyze the information required to assess the reproductive health needs of the population. Well designed research and effective MIS will uncover clients' needs, desires, and acceptance of reproductive health services which in turn inform development and implementation of effective service delivery strategies.

Formative research allows programme planners to design, in response to demonstrated reproductive health needs, service delivery and other programmatic activities that are client-informed and therefore more likely to be used. Research that monitors programme implementation helps to ensure that quality of care standards are maintained, that service delivery and other activities are reaching their targeted audiences, and that necessary supplies are provided efficiently. Monitoring research allows the NFPB to make any needed "mid-course" corrections in programmatic strategies and direction thereby contributing to the long term success. Evaluative research demonstrates the level at which programme strategies are finally successful in achieving the overall reproductive health objectives.

3.0. IMPORTANT ISSUES

In preparing the Strategic Framework for Reproductive Health 2006 – 2010, the NFPB identified the following over-arching themes or issues of particular importance to future success. These issues include:

1. The fact that high unmet need among limiters remains even as the method mix among women of higher parities consists predominantly of supply methods, would suggest the need for more targeting by reproductive life stages.
2. Adolescents' sexual and reproductive health remains a priority in light of their patterns of contraceptive use / mis-use, and high risk behaviours.
3. The tendency of males to engage in behaviours detrimental to desirable reproductive health outcomes presents challenges and opportunities for gender equitable and holistic approaches in responding to their reproductive health needs.
4. Perceptions about the efficacy of modern methods in preventing pregnancy, and their safety for women's health impact negatively on birth spacing and other actions to prevent an unplanned pregnancy and protect against STIs. User perception about the methods need to be improved.
5. Weakening support for the two-child family ideal suggests a need for effective communication on the socio-economic benefits of small families.

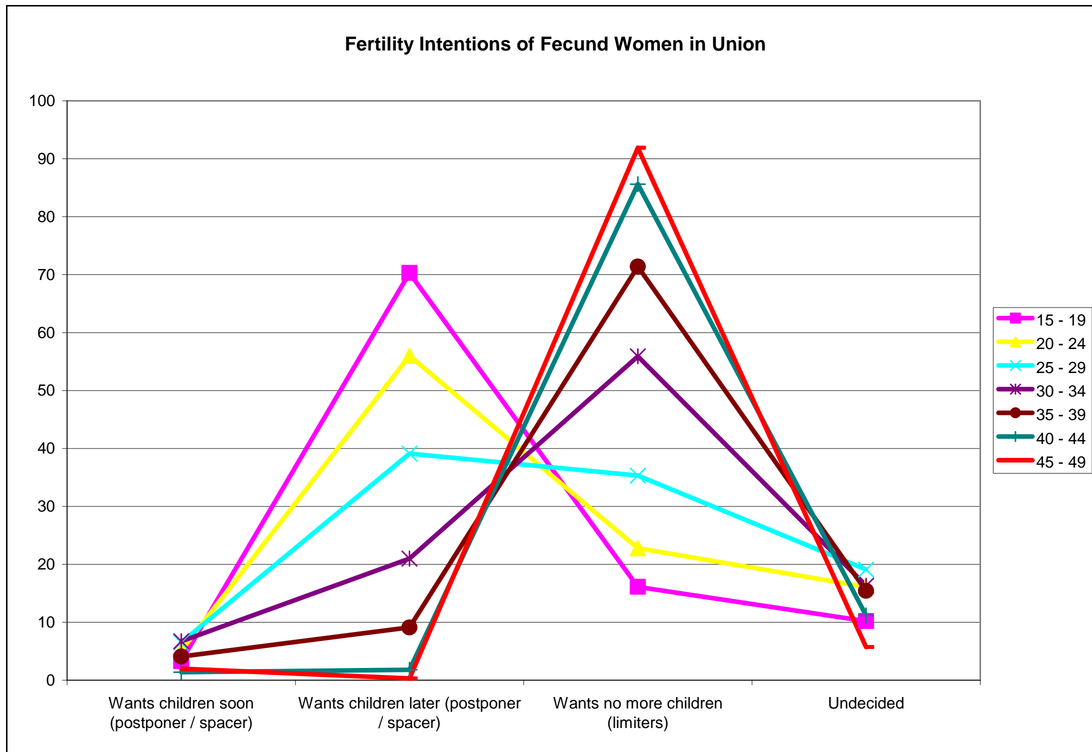
6. The impact of societal and cultural factors on reproductive health decision making and behaviours and related strategies for behaviour change.
7. Risk reduction through integrated messages for responsible reproductive health behaviour and STI/HIV/AIDS prevention.
8. Closer linkages with relevant stakeholders to achieve results (multi-sectoral linkages). This will enable effective response to the reproductive health needs of vulnerable and under served population groups.
9. Institutional capacity building through staff training and development, improved facilities and procedures, and support programmes.

Responding to RH in life stages (the life stage approach)

In order to successfully accomplish replacement level fertility in Jamaica, a more targeted approach in reproductive health communication and service delivery will be continued. Addressing the reproductive health needs of all individuals in accordance to their reproductive life-stage will ensure that as WRAs move through their reproductive life stages, appropriate service options will be accessed.

Emphasis therefore will be placed on client acceptance of appropriate options that will meet their actual fertility needs, counselling relative to life stage issues, and addressing unmet needs particularly for limiting child bearing. Indeed, as was the finding of the previous RHS (1997), limiters constituted the majority of potential contraceptive users as they represented approximately 52.6% of fecund women in union. It is also important that interventions also reach the approximately 14.5% of these fecund women in union who are ***undecided*** as to their future fertility intentions.

Figure 8:



Special attention will also need to be placed on women in the 40 – 44 age group who have experienced increased fertility. It is within this age cohort also that the highest unmet need for contraception is seen. Women in this age group are usually of high parity and are more likely to be interested in a longer term or permanent form of contraception such as Tubal Ligation. RHS 2002 findings, suggest that the fear of the operation and its perceived side effects have effectively prevented a significant proportion of women who do not want anymore children (approx. 40%) from accessing Tubal Ligation. Allaying such fears will require effective counselling for clients and training of service providers.

Enhanced counselling and expanded training of service providers has emerged as one of the critical issues that will impact on the achievement of desired fertility outcomes. Service providers are not all of the same understanding as it relates to the quality of service to be provided to clients. Personal biases and preferences often interfere with their optimal provision of service that meet the needs of the clients. Enhancing the quality of counselling and training to health providers will contribute to the ability of clients to make informed contraceptive choices.

Addressing adolescent RH needs:

Adolescent reproductive health remains a priority owing to their continued exposure to early sexual initiation, level of contraceptive use / mis-use, other high risk behaviour - transactional sex, inconsistent condom use, among other things, and their vulnerability to coercive sexual encounters, and negative impacts of unsafe abortions. Addressing their reproductive health needs through early interventions may result in the achievement of reduced adolescent fertility beyond 79 per 1000, as well as increased contraceptive

prevalence above 68.8%. Enabling policies and legislation will also make it possible to respond positively against sexual coercion of adolescents, as well as the provision of appropriate reproductive health services to this age group.

Responding to men's RH needs & risk reduction

Men continue to play a marginal role in reproductive health decision-making and behaviours. They also continue to engage in risky sexual and contraceptive use behaviours, much to the detriment of their own and their partner's reproductive health. Contraceptive choices and reproductive health behaviours are also often dictated by the nature of the relationship in which they are involved. By understanding and applying solutions to the dynamics presented by different relationship types, it is possible to encourage more men to actively participate in reproductive health decision-making and behaviours thereby protecting their own health. A challenge for effectively addressing the reproductive health needs of men however is to reach them in a variety of settings. This requires innovative approaches and less reliance on traditional modes of information and service delivery. A proposed approach is to address men's health in holistic terms zeroing in on maintaining health, emphasis on increased education and awareness and to employ multi-sectoral linkages to achieve goals. Gender sensitivity and equity will be guiding principles in responding to the reproductive health needs of men.

Restoring Confidence in Method Efficacy

The provision of a range of safe and effective family planning and contraceptive methods represents a critical ingredient to the successful achievement of the fertility goal for 2010. In light of this, it is imperative that users are satisfied with the efficacy of modern methods in meeting their fertility needs. Perceptions about the efficacy of modern methods in preventing pregnancy, and for safety for women's health, impacts negatively on birth spacing and other actions to prevent an unplanned pregnancy and protect against STIs. Such perceptions about the efficacy of available modern contraceptive products have not improved over the years; and may be influenced by side effects (perceived or actual) that users may experience. While WRAs recognise the utility of spacing births for between two to four years (or more), increasing distrust of the efficacy of condoms, pills and injectables in preventing pregnancy and the safety of hormonal contraceptives for women's health may contribute to prevailing levels of contraceptive use and reliance on less effective, traditional methods. Effective communication and counselling on the benefits and the nature of unexpected (side) effects will be required to allow for informed choice and to restore user confidence in method efficacy. Exploration of alternative products may also be required.

The two-child family

The NFPB has long been an advocate for the two-child family and fertility trends over the past three decades demonstrate public acceptance of this ideal. Attitudinal indicators however highlight a weakening support for the two-child family ideal among women in the reproductive age group. Of particular interest are those women who have begun

child-bearing and who already had two or more children. The fact that compared to the results of the 1997 RHS, there was a significant increase in the percentage of women already having two children[6] who desired additional children (53.3% compared to 37.4% in 1997) may be a signal of a prevailing desire, particularly among high parity women, for larger families. Other research also suggest that in communities where the loss of a child, such as by violence, is highly likely, the retention of the ability to bear another child is desirable (*Chambers, 2005*). Effective communication and counselling on the socio-economic benefits of small families may be required.

Accounting for societal and cultural impacts

Societal and cultural influences on reproductive health behaviours are important considerations for the successful implementation of strategies to reduce unplanned pregnancies in the WRA population. These influence the formation of relationships, contraceptive choices made, and acceptance or rejection of behaviour change communication messages. A notable proportion of WRA accept and retain values that emphasise high fertility, men are generally resistant to any threat to their own potency and ability to procreate, while the youth are heavily influenced by ever changing fads and trends that give emphasis to instant gratification and materialism. Reproductive health information and services should penetrate such influences to be successful.

Risk reduction via integrated messages

Continued promotion of responsible sexual and reproductive health behaviours and STI/HIV/AIDS prevention is considered an efficient vehicle for reaching currently underserved members of high-risk populations. Integrated messages remained a means of reaching targeted groups with needed reproductive health services. Men, for example do not typically access services from family planning outlets although they themselves have reproductive health needs to be addressed. Indeed, family planning services have typically been addressed to women and the facilities are therefore designed for this group. Men are however principal clients at STI treatment facilities. It is necessary to maintain collaboration and cohesion among STI / HIV/AIDS prevention, family planning and other reproductive health messages to reach men and other high risk groups.

Multi-sectoral linkages:

Close institutional collaboration within the various sectors responding to reproductive health issues remain a critical component to the successful implementation of the next five year strategic plan. It is however the one area in the evaluation of the NFPB's implementation of the strategic framework 2000 – 2005 that was rated as the weakest. It is clear that the successful implementation of the five-year strategic plan for 2006 – 2010 will require a more collaborative interplay of the various stakeholders who have an interest in the reproductive health outcomes for Jamaica. Such linkages also become

[6] Similar observations can be made for women of higher parity.

highly relevant as we seek to respond to the reproductive health needs of vulnerable and underserved groups such as persons with disabilities and their care givers.

As Jamaica faces reduced funding support for reproductive health, it becomes more critical for coordination among the public health, private and commercial sectors and the NGO communities to ensure the broadest possible coverage and reach as well as a minimisation of effort duplication. One of the important strategies inherent in this strategic framework is to further shift client dependence from the public sector family planning facilities into the private sector. Innovative ways to bring expertise and resources of private and other institutions into full partnership with the NFPB will be required in the design and implementation of programmatic response to identified reproductive health needs of the target populations.

Institutional capacity building

Institutional capacity building should be considered an important element in the implementation of the next five-year strategic plan. Continued research and evaluation, and advocacy have been recommended as critical in making advocacy for policy more effective. The following recommended areas for enhancing the effectiveness of the NFPB in executing the next five-year strategic plan can be achieved through institutional capacity building:

1. Implement mechanisms to improve the environment for performance. Namely:
    - Train the technical and administrative support staff especially in: records management, customer service, communication and operational processes and procedures.
    - Develop and implement a performance assessment system and instruments.
2. Implement interventions to ensure success:
    - Develop and implement a model for financing NFPB.
    - Reposition the NFPB through social marketing.
    - Increase the level of effort and resources into behavioural change management programs among school children (adolescents).
    - Develop and secure capital funding for capacities to undertake research for timely and sound decisions.

4.0. TARGETING WOMEN AT RISK

Under this strategic framework, 2006 – 2010, focus will be placed on limiters (women who desire no more children), those who are undecided about their fertility intentions, and on women who are at risk for unplanned pregnancies and STIs. Over the next five-

year period WRA, who are considered “at risk” by virtue of their classification based on a number of indicators, will be targeted for intervention by the NFPB[7].

Women at Risk

Risk Indicator	Needs / assumptions
Non-users who were ever users Women not currently using a method (for reasons other than pregnancy related, sub-fecund and sexual activity) **(6.5%)**	Accurate information, couple counselling, expanded contraceptive options, choices that resolve health concerns and side effects.
Women using traditional methods (**2.3%)**	Assumption: The majority do not intend to switch to modern methods. Could be targeted toward high parity women (where tendency for traditional method use is higher).
Women who never used condoms as (primary or secondary) methods[8] **(6.5%)** Includes adolescents who are non-condom users.	These women are also at risk of STI / HIV / AIDS infection. Encouragement via messages and promotions on the benefits of consistent condom use with any partner. Increased access to condoms through a variety of means, targeted education and counselling among persons in “non-steady

[7] Double counting is assumed in the case of women who non-users of contraceptive users and the other categories (except the category “users of traditional methods”). For the purpose of this strategic plan, the total number of non-users represents the universe under which the other categories (except users of traditional methods) are found. Each category is also treated as a discrete variable for easier targeting.

	relationships". Such interventions are critical given the higher proportion of "never users" with non-steady partners.
Women with an unmet need for family planning (8.5%) **–** i.e. limiting (5.5%) and spacing / postponing (3.0%)	Increased promotion of long term methods (Tubal Ligation, and IUD) for limiters. Other methods (Condom, oral contraceptive pill, injectable) for spacers / postponers.
Adolescent non-users of contraceptives (**17.6%**)	Target increased contraceptive prevalence above current levels.
Women who have had at least one abortion (**1.4%**)	Increased access to ECP to reduce incidence of abortions. Review current legal framework governing access. Guidelines for post abortion counselling for providers.

5.0 STRATEGIC FRAMEWORK

This section sets out the framework for the five-year overall strategy for reproductive health that the National Family Planning Board has developed after review of findings from research conducted during 2002 – 2005. It reviews strengths, weaknesses, threats and opportunities; presents a series of statements relating to NATIONAL FAMILY PLANNING BOARD's vision, mission, values and objectives; and sets out its proposed strategies and goals.

Strengths, Weaknesses, Threats & Opportunities

Strengths:

- Organisational structure is appropriate and the NFPB's management team is highly qualified.
- The NFPB operates from its own location and has a team of dedicated staff.
- The NFPB's image is highly recognizable.

Weaknesses / Challenges:

- Organisational mechanisms are not performance driven.
- The NFPB's image has lost visibility.
- Financing mechanism does not allow for predictable government subvention to support

[8] This category consists of 6.4% who never used with a non-steady partner and 0.08% who never used with a steady partner.

- Contraceptive distribution to Clinics and service delivery points is reliable.

programme activities.

- Financial model that is able to accurately predict cost recovery is not maintained.
- Adequate funding for research is not secured.
- Technology for timely data processing and dissemination to support sound decision-making is inadequate.

Threats:

- Increased desire for more children among women(compared with RHS 1997)
- Poor understanding of the gender dynamics influencing contraceptive use.
- Messages from popular culture celebrating sexual irresponsibility and promiscuity.
- Consumer's disposable income may not be prioritised to include contraceptive purchase.
- Budgetary priorities may not always be in favour of Family Planning initiatives.

Opportunities:

- Government commitment to the ICPD and MGDs (positive implications for RH and FP).
- Donor support for collaborative approaches in HIV/AIDS prevention and Safe Motherhood.
- Public support for healthy lifestyles.
- Enabling Government policies and legislation (e.g. Policy Guidelines for Access to RH by minors; Reclassification of Postinor 2 as a List 2 product, other revised legislations)
- Fertility is on the decline.
- More women are using contraceptives.

Vision

The vision of the National Family Planning Board in the next five years is:

To be the pre-eminent source of family planning and HFLE information and services in Jamaica.

Mission Statement

The mission of the NFPB is to enable individuals to achieve good reproductive health (FP and RH outcomes) through the provision of high quality, voluntary family planning and HFLE services implemented efficiently and effectively.

Core Values[9]

The core values governing the National Family Planning Board's implementation of the Strategic Framework for 2006 - 2010 will include the following:

- *Involving People:* People's views should be sought in order to respond to differing needs of different populations.
- *Respecting People:* Everyone is entitled to be treated in a non-judgmental manner
- *Respecting Confidentiality:* Everyone is entitled to have his or her confidentiality respected, within the legal framework in Jamaica.
- *Integrity* : Ensuring that staff and associates are not placing themselves under any financial or other obligation to individuals or organizations that might seek to encourage improper behaviour in the performance of official duties.
- *Objectivity*: Making choices on merit in carrying out mandates, including awarding contracts.
- *Building on success:* Future activities should, where possible, build on existing, evaluated, local, national or international good practice.
- *Accountability* : Being responsible for decisions and actions to the public and submit to whatever scrutiny is appropriate.
- *Equity*: Exercising fairness in treatment without discrimination.
- *Innovation*: Seeking to adopt and adapt to change using new approaches where outmoded approaches and practices are inappropriate.
- *Gender Sensitivity*: Respecting the needs of both genders and applying due regard to the differences in both.
- *Non-discrimination*: Recognising the rights of all, without prejudice.

Strategic Goals

Longer term strategic goals of National Family Planning Board are summarized as:

- Further reduce unplanned pregnancies by 25% by 2010.
- Achieve a Total Fertility Rate of 2.2 by 2010.

[9] Adapted from Ministry Paper No. 56 "Government at Your Service: Public Sector Modernisation Vision and Strategy 2002 – 2012", The Cabinet Office, Sept. 2002.

Key Strategies

The following critical strategies will be pursued by National Family Planning Board

1. Expand access to existing but underused family planning and RH options for women.
2. Improve access to Reproductive Health Information to Adolescent and Youth.
3. Expand access to reproductive health information and services to men.
4. Promote safe sexual behaviour, attitudes and practices to reduce the prevalence of STIs and HIV/AIDS.

Major Targets

The following key targets will be achieved by NATIONAL FAMILY PLANNING BOARD over the next 5 years:

- Unplanned pregnancies among women 15 - 49 will be below 63%.
- The percent of WRA in union using a contraceptive will be approximately 70%.
- Unmet need for FP among fecund women 15 - 49 reduced from 8.7%.
- Dual method use increased to approximately 25%.

Family Planning Strategies, Performance Indicators, Level of Implementation

Strategic Element	Performance Indicators	Level of Implementation
1. ***Expand access to existing but underused family planning and RH options for women.***		
Advocacy & Policy Initiatives		
o Assess and develop advocacy initiatives for expanded access to FP and RH by employed and working women.	o No. of workplace / worker-based service delivery points. Persons served.	National / NFPB
Service Delivery		
o Develop and implement strategies to integrate FP service for persons with disabilities and other underserved women in traditional FP settings. o Ensure timely availability of adequate contraceptive options at all public sector service outlets. o Explore more cost-effective approaches to IEC and counselling to ensure proper method use. o Expand access to services in non-clinical settings. o Introduce new contraceptive technology.	o No. of providers trained to deliver services. o No. of health centres provided with contraceptives / quarter. o Types of alternative materials provided to clients and providers. o No. of clients reached / type. o No. of users / new methods accepted.	National / NFPB National / NFPB National / NFPB Regional/ Parish Regional / Parish
Training		
o Strengthen counselling at point of service delivery to ensure informed choice and support for continuing correct use of contraceptives. o Expand capacity to supply clinical methods through training.	o No. training programmes held / type of participants trained. o No. of participants trained.	National / NFPB National / NFPB
Strategic Element	**Performance Indicator**	**Level of Implementation**
1. ***Expand access to existing but underused family planning and RH options for women.***		
Health Promotion for Behaviour Change		
o Implement media campaign to promote access and use of contraceptives by specifically defined segments of the population.	o Media campaign executed. o Impact of campaign on behaviour.	National / NFPB National / NFPB

o Design and implement comprehensive mass media programme promoting 2-child family. o Produce and distribute IEC materials. o Develop and implement a multi-channel IEC campaign to respond to myths and mis-information that inhibit acceptance and continuation of under-used methods. o Develop and implement a multi-channel communication campaign on the availability and accessibility of the ECP and supporting its use.	o No. of IEC materials produced and distributed. o No. of ECP users.	National / NFPB National / NFPB National / NFPB
Multi-Sectoral Linkages		
o Develop in collaboration with other agencies strategies for community based delivery of commodities. o Review and collaborate with training institutions the provision of specialised training in FP / RH issues.	o Commodities distributed / type of distribution. o No. training programmes / participants reached.	National / NFPB National / NFPB
Research, Evaluation, and MIS		
o Conduct a quality of care evaluation of training provided to different categories of health providers on under-used family planning options. o Ensure commodity logistics system is fully compatible with the other components of the computerised MIS. o Design and implement evaluative research that demonstrates success in improving access to FP. o Conduct research to better understand the social context in which individuals are making decisions about dual method protection. o Conduct study to explore ways to bridge ECP users to regular contraceptive use.	o Study conducted and disseminated via stakeholder reviews. o Compatibility with MIS achieved. o No. of users / method o Study conducted and disseminated.	National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB

Family Planning Strategies, Performance Indicators, Level of Implementation

Strategic Element	Performance Indicators	Level of Implementation
2. Improve access to Reproductive Health Information to Adolescent and Youth.		
Advocacy & Policy Initiatives		
o Continue advocacy initiatives on the Guidelines for access to contraceptives by	o No. of youth accessing services /	National / NFPB.

persons under 16. o Disseminate guidance on the re-integration of adolescent mothers into the formal school system after pregnancy[10]. o Implement advocacy initiatives to create and sustain a more favourable climate for the delivery of HFLE and family planning education in all schools from early ages. o Develop and implement advocacy initiatives targeting specific groups such as legislative system, youth clubs, faith-based groups, on issues related to sexual violence and exploitation of adolescents and youth. o Secure private sector support for mentoring programme for young men at risk.	setting. o % of pregnant adolescents who returned to school. o No. seminars / category of participants trained. o % age at first FLE class received. o No. events/ type and categories of participants o No. of workshops held / participants.	National / NFPB National / NFPB National / NFPB National / NFPB
Service Delivery		
o Develop and implement strategies for the use of alternative delivery mechanisms for provision of counselling and services to adolescents and youth at the community level. o Expand family planning counselling / family life education services to adolescents / youth. o Ensure the timely availability of contraceptive options for youth at all service delivery points. o Ensure the timely availability of IEC materials to all Youth Friendly Sites.	o No. of activities implemented / persons reached. o % exposed to HFLE / topics / CPR. o CPR 15 - 19. o # youth friendly sites receiving IEC materials, # IEC materials	National / NFPB Regional / Parish National / NFPB National / NFPB
Strategic Element	**Performance Indicators**	**Level of Implementation**
2. Improve access to Reproductive Health Information to Adolescents and Youth.		
Training		
o Conduct training for youth friendly counselling and contraceptive provision to different categories of providers. o Conduct sensitization seminars for targeted individuals on emerging ARH issues. o Expand FP/FLE to adolescents through training of parents and other influentials, eg. Guidance Counsellors. o Conduct training of providers to mainstream gender issues in ARH programmes.	o No. of training programmes / category of participants. o No. of persons trained/ category. o Impact of training on behaviour / practices.	National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB

[10] Section 31, paragraphs 2&3 of the Education Act & Regulations 1980 provides for re-integration of adolescent mothers into the formal school system.

o Train Community workers and community distribution outlets on community based distribution of commodities. o Conduct skills building workshops for male and female adolescents.	o No. of events / adolescents reached.	
Health Promotion for Behaviour Change		
o Promote abstinence as a viable option among adolescents as a first option and consistent condom use for those who are sexually active. o Promote responsible parenthood concepts among adolescents. o Implement a media campaign on targeted RH issues for adolescents and youth. o Improve access to medically accurate HFLE in school and out of school. o Develop, promote and support multi-channel IEC strategies to change sexual risk behaviour. o Produce and distribute new and / or revised IEC materials. o Implement special programmes / activities to promote youth participation.	o Media campaign developed and executed. o No. of adolescents who become pregnant. o Media campaign developed and executed. o No. of activities / type / persons reached. o No. of activities / type / persons reached. o No. of IEC materials produced / or revised and distributed. o No. reached / type of events.	National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB National / NFPB
Strategic Element	**Performance Indicators**	**Level of Implementation**
2. Improve access to Reproductive Health Information to Adolescents and Youth.		
Multi-Sectoral Linkages		
o Collaborate with other agencies to implement outreach FP/FLE/ IEC activities. o Develop collaborative relationships with outreach organisations for referrals among clients. o Collaborate with other agencies to develop an inventory of programme interventions for FLE activities for out-of-school youth and implement coordinating mechanisms. o Develop and implement collaborative strategies for condom distribution through multi-sectoral linkages.	o No. of collaborative Outreach activities implemented. o Linkages are in place. o Inventory in place, No. of meetings held. o No. of condom distribution outlets developed. Quantities of condoms distributed.	National / NFPB National / NFPB National / NFPB National / NFPB
Research, Evaluation, and MIS		

o Design and implement evaluative research that demonstrates success in improving Adolescent Reproductive Health.	o ASFR 15 – 19, % pregnant / birth, CPR.	National / NFPB

Family Planning Strategies, Performance Indicators, Level of Implementation

Strategic Element	Performance Indicators	Level of Implementation
3. ***Expand access to reproductive health information and services to men.***		
Advocacy & Policy Initiatives		
o Develop and implement advocacy strategies to engage media and popular culture in dialogue on gender norms. o Identify and showcase positive role models for men.	o No. events / type o No. of TV features developed and aired.	National / NFPB National / NFPB
Training		
o Expand access to information on RH and sexuality for fathers. o Ensure that provider training includes components to help men learn couple communication to help them support their female partners in decision making. o Conduct training seminars among service providers on the gender dynamics in relationships and contraceptive use. o Develop and implement a training programme for health providers on issues surrounding provision of male RH services.	o No. of training programmes conducted. /No. of persons trained.	National / NFPB
Health Promotion for Behaviour Change		
o Development and implement a communication/ behaviour change programme for men that improve behaviour and their support of partner's reproductive health and family planning	o Media campaigns developed and executed within timeframe.	National / NFPB

choices. o Transform gender relations between men and women in order to increase men's support for women's equity, rights and health. o Implement community-based reproductive health education for men. o Develop, promote and support multi-channel IEC strategies to change sexual risk behaviour in order to reduce STI's. o Produce and distribute IEC materials for men.	o No. of persons reached. o % men with more than one partner in three months. o No. of IEC materials developed and distributed.	
Strategic Element	**Performance Indicators**	**Level of Implementation**
3. ***Expand access to reproductive health information and services to men.***		
Multi-Sectoral Linkages		
o Collaborate with other agencies to develop an inventory of programme strategies for the conduct of sexual and reproductive health activities for men and implement coordinating mechanisms. o Collaborate with NGOs in providing counselling for partners of teen mothers. o Collaborate with community leaders such as sports coaches and faith-based organisations to effect changes in masculinity norms for young men.	o No. of meetings held, activities / No. beneficiaries. o No. of collaborating agencies involved.	National / NFPB
Research, Evaluation, and MIS		
o Conduct of an analysis of the situation of young men in the context of gender relations. o Design and implement evaluative research that demonstrates success in improving Reproductive Health for men.	o Study conducted and reports disseminated. o Indicators measured by RHS.	

Family Planning Strategies, Performance Indicators, Level of Implementation

Strategic Element	Performance Indicators	Level of Implementation
4. Promote safe sexual behaviour, attitudes and practices to reduce the prevalence of STIs and HIV/AIDS.		
Advocacy & Policy Initiatives		
o Develop and implement advocacy programme and information materials to promote safe sexual behaviours. o Develop and implement clearing house mechanism for family planning / RH information. o Sensitise community members through established social structures and enlist support for family planning.	o No. of advocacy activities (information packages, briefs, stakeholder consultations). o Library & Documentation Centre resources improved. Information materials accessed, procedures strengthened. o No. of events conducted / community organisations / persons reached	National / NFPB National / NFPB National / NFPB
Service Delivery		
o Ensure the timely and reliable supply of condoms to all clinics and community-based service delivery points. o Ensure the availability of IEC materials at all service delivery points.	o Condom delivery schedule, quantity of condoms supplied. o No. of IEC materials distributed to service points. Timing.	National / NFPB National / NFPB
Training		
o Provide training to health providers, counsellors and non-traditional providers on dual method use and related counselling techniques. o Coordinate family planning training with NGOs.	o No. of training programmes conducted /No. of participants trained. o No. of training / participants / NGOs.	National / NFPB National / NFPB

Strategic Element	**Performance Indicators**	**Level of Implementation**
4. Promote safe sexual behaviour, attitudes and practices to reduce the prevalence of STIs and HIV/AIDS.		
Health Promotion for Behaviour Change		
o Develop and implement a multi-channel IEC campaign on safe sexual values, attitudes and practices targeted at high-risk and vulnerable populations. o Organise events such as Family Planning Week and exhibits to promote and increase community involvement.	o No. of behaviour change activities conducted. o No. of target audiences reached / location.	National / NFPB National / NFPB
Multi-Sectoral Linkages		
o Support the MOH in condom distribution efforts against HIV/AIDS and STIs. o Strengthen relationships with print and radio journalists.	o No. of condoms distributed. o No. of articles / media collaboration activities conducted.	National / NFPB National / NFPB
Research, Evaluation, and MIS		
o Conduct secondary research on the common issues relating to reproductive health and sexual attitudes and their influence on STI and HIV/AIDS. o Design and implement evaluative research that demonstrates success in reducing risky sexual behaviours. o Evaluate NFPB's performance as necessary to assess consumer / client perspectives of service provision.	o Studies completed and results disseminated via stakeholder reviews.	National / NFPB National / NFPB National / NFPB

Appendix 1

Key findings and Recommendations from Evaluation of 2000 – 2005 Strategic Plan

Evaluation of NFPB's Implementation of the 2000 – 2005 Strategic Plan. Trevor Hamilton & Associates Center for Excellence. October 4, 2005.	
Key Findings	**Conclusions and Recommendations**
1. The plan has achieved its core quantitative targets : □ The population growth rate has reduced to 0.5%. □ Total fertility rate has reduced to 2.5. □ The retention rate at family planning clinics has increased to 63%. 2. The plan has achieved the desired core results primarily because it has been very relevant, and efficiently and effectively managed. 3. Despite the quantitative success of the plan, it could have achieved much more, and the outlook for sustainability could have been more positive if the operating environment were more performance driven, and the propensity to sustain momentum were more favourable. For example: □ The environment for performance could be greatly enhanced if: - More managers at NFPB were able to relate their operating activities with the strategic imperatives of the Plan. - A regime of effective organizational mechanisms were in operation to monitor and drive client service quality assurance. - The office environment and technology were improved to enhance increased productivity. - Frontline and administrative support personnel are trained in some critical competencies. - Performance based pay were practiced. - Job descriptions and the performance appraisal system were designed to stimulate accountability for performance. 4. The propensity for accelerating momentum and building on the initial success of the plan has been seriously undermined by the following factors relating to sustainability. □ The level of government's disbursements has been very unpredictable. □ The image of the organization is not soundly positioned. It needs to be positioned as a reproductive health care organization instead of its current positioning as a family planning one. □ The financial indicators such as: administrative and overhead cost as percentage of government grants, and trend in operating balances are all deteriorating.	***The Challenges Ahead*** □ **The challenges for enhancing performance comprise:** - Increasing the level of effort in service quality/customer service assessment. - Creating a productivity oriented office. - Training support personnel to acquire the necessary competencies to perform more effectively. - Reducing the personal security risk of working at the office. - Designing and introducing job descriptions and performance appraisal framework to promote performance. □ **The challenges for enhancing efficiency and effectiveness comprise:** - Causing the required collaborative arrangements between NFPB and the MOH to work effectively. - Getting the quality assurance mechanisms to be taken to the implementation stage. □ **The challenges for enhancing sustainability comprise:** - Developing and introducing a financing model for NFPB that makes government's subvention predictable and reliable. - Increasing the propensity to retain staff. - Repositioning the organization from being a Family Planning institution to a holistic reproductive health facility. - Turning around the negative trend in net operating revenue. - Reducing overheads/administration as a percentage of government grants. - Securing the necessary legislative support especially relating to abortion. - Developing and maintaining a financing model that is able to accurately predict cost-recovery. - Increasing the level of behavioural programs among schoolers, since they represent the highest propensity for behavioural change in reproductive and sexual responsibility. - Maintaining adequate capacity for research and data analyses to improve the environment for rationalizing the use of resources and timely management decisions.

□ The level of behavioural reinforcements among schoolers (adolescents) where the highest propensity for behavioural change in reproductive and sexual responsibility prevails, has been very minimal. □ The level of capacity for research and data analyses to support sound and timely decision making as well as rationalized allocation has been extremely low. 5. There are some key lessons to be learnt from the implementation experience. □ Performance can be realized even with dwindling public sector resources in social services if there are innovative strategies to broaden the participation of stakeholders and complimentary service providers. □ Investment in training beyond the public sector can empower the wider community to effectively share responsibility for social interventions such as family planning services. □ The inadequate effort into research and evaluation has been a major driving force behind the relatively ineffective policy promotion work at NFPB. □ Counseling is a high impact activity especially in mobilizing and sustaining the demand for family planning services. □ The inadequate or slow policy and legislative interventions all have adverse effects on the responsiveness of high priority population segments especially youngsters. □ The multidimensional design and implementation of the program has been a critical success factor with those areas receiving the greatest level of support of effort being the most effective. □ The visibility and effectiveness of the leadership, management competencies, and high staff moral have been invaluable assets to the Plan.	***<u>The Recommendations</u>*** NFPB could sustain and build on its achievements in the 200-2005 Strategic Plan as follows: 2. Implement four mechanisms to improve the environment for performance. Namely: 3. Create a productivity oriented office through improved air-conditioning, lighting, seating, and office technology. 4. Train the technical and administrative support staff especially in: records management, customer service, communication and operational processes and procedures. 5. Improve the security at the office: at the point of entry, and internally, and through training and equipping of the security personnel. 6. Develop and implement a performance assessment system and instruments, staff development plan, and compensation structure. 7. Implement two strategies to continue to improve efficiencies and effectiveness. □ Implement the existing quality assurance mechanisms more rigorously. □ Meet with the MOH to establish mechanisms to ensure that the arrangements for collaboration especially on policy and STI related matters are effectively executed. 8. Implement at least six interventions to ensure the success of the 2000-2005 plan: □ Develop and implement a model for financing NFPB. □ Increase the propensity to retain staff . □ Reposition the NFPB through social marketing . □ Advocate for the completion of the legislative work to support the work of NFPB. □ Increase the level of effort and resources into behavioural change management programs among school children (adolescents). □ Develop and secure capital funding for capacities to undertake research for timely and sound decisions. 9. Continue with most of the existing strategies in the succession plan. □ Counseling should continue to be significant. □ Expand training. □ Expend more in research and evaluation to make advocacy for policy and legislative work more effective. □ Continue to retain and improve the working conditions and incentives for the leadership, management, and staff.

Appendix 2:
Summary Status of Family Planning Strategic Elements

Strategic Element	Achievement vs Target	Challenges / gaps / concerns
Improve Contraceptive method mix.	♦ ***Target***: increase TL above 19% & IUD above 2% ♦ ***Achievement***: TL declined to 17%, IUD remains the same at 2% (Condom has become the most prevalent contraceptive followed by the pill, TL, and injection. Significant increase in condom use among adolescents.)	♦ The method mix has always been predominantly supply methods. ♦ Unmet need for contraceptives is 8.7% - the greatest unmet need being among limiters at 6.0% - individuals need to identified and targeted for use of long(er) term methods
Introduce ECP	♦ ***Target:*** None ♦ ***Achievement***: Postinor 2 reclassified List 2, making the product more readily accessible	♦ Awareness and knowledge needs to be increased. ♦ Trained professionals in the public sector should be allowed to administer the product ♦ Usage lowest among rural women (where fertility is currently highest.)
Improve efficacy of contraceptive method use	♦ ***Target***: reduce contraceptive discontinuation rate (below 31% for pills and 42% for condoms). ♦ ***Achievement***: Not measured by RHS 2002 but annual statistical reports continue to show high discontinuation for pills and condoms.	♦ Discontinuation rates in public sector for condoms (48%), pills (50%) and injections (30%) still high (*NFPB Annual FP Statistical report 2004*). ♦ Inconsistent condom use particularly among young men (*RHS 2002*). ♦ Male resistance toward consistent condom use particularly with steady partners (Q*ualitative findings from Social Marketing Evaluation, 2004*)

Strategic Element	Achievement vs target	Challenges / gaps / concerns
Expand access to RH information and services to adolescents	♦ ***Target:*** Increased access to HFLE before age 13 -above 35% for females, 30% for males. ♦ ***Achievement***: 37% females and 31.4% men reported accessing first school-based course on HFLE before age 13. ♦ Cabinet approval of policy guidelines toward access to contraceptives to persons <16. ♦ Reduced adolescent fertility rate (79 per 1000). ♦ Increased CPR among adolescent females (from 58.6% to 69.8%) ♦ Reduced % of unplanned pregnancies. ♦ Increased condom use.	♦ Little change in the mean age of first sexual encounter for both males and females. ♦ % of young adult females who became pregnant upper and post secondary school, increasing ♦ Younger adolescents vulnerable to intimate partner coerced sex ♦ 9 % of pregnancies among girls 15 – 17 yrs is reported as planned ♦ Induced abortions are readily accessible to adolescents (*Hope Enterprises 2005)* ♦ Increased risky behaviour / multiple partnering by young males. ♦ Marge Roper service was helpful to less than 50% of adolescents who sought information from this source.

Expand access to RH information and services to men	♦ ***Target***: none. ♦ ***Achievement***: Increased condom use at first and last sex.	♦ More improvement needed in dual method ♦ Multi-partnering – an accepted norm among males (S*ocial Marketing Evaluation, 2005*) ♦ Decline in % of young adult males who knew where to go for RH information & STI treatment. ♦ Male partners knew little about female's contraceptive practices and are hardly/ not involved in contraceptive decision making (*Chambers 2005)*

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NATIONAL FAMILY PLANNING BOARD
Meeting Reproductive Health Targets 2006 - 2010

1. Goal and Priorities

1.1. Goal

To reduce the number of unwanted pregnancies and achieve a Total Fertility Rate (TFR) of 2.2 by year 2010

1.2. Priorities:

1. Improved access to contraceptive options by Adolescents and Youth.
2. Increased acceptance of long-term methods within the public sector Reproductive Health / Family Planning programme.

1.3. Targeting Matrix for Strategic Framework

Characteristics	Target					Comments (expected outcome / potential risks.)
Method Mix	% prevalence					
	2006	2007	2008	2009	2010	
Condom	23.34	23.33	23.25	23.16	23.15	
Pill	15.81	15.83	15.85	15.86	15.88	
Injectable	11.20	11.25	11.38	11.51	11.57	
TL	14.23	14.64	15	15.37	15.81	
Other	2.9	2.78	2.65	2.53	2.40	
Total	69.06	69.43	69.81	70.18	70.57	

Proximate Determinants	- Unplanned pregnancies among women 15-49 will be below 63% - The percent of WRA in union using a contraceptive will be approximately 71%. - Unmet need for FP among fecund woman 15-49 reduced from 8.7%. - Dual method use increased to approximately 25% (from 15%).	
Source Mix o ***Public*** ➢ ***Private***	Public Private Condom 10% 90% TL 90% 10% Injectable 90% 10% Pills 20% 80% IUD 60% 40%	

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