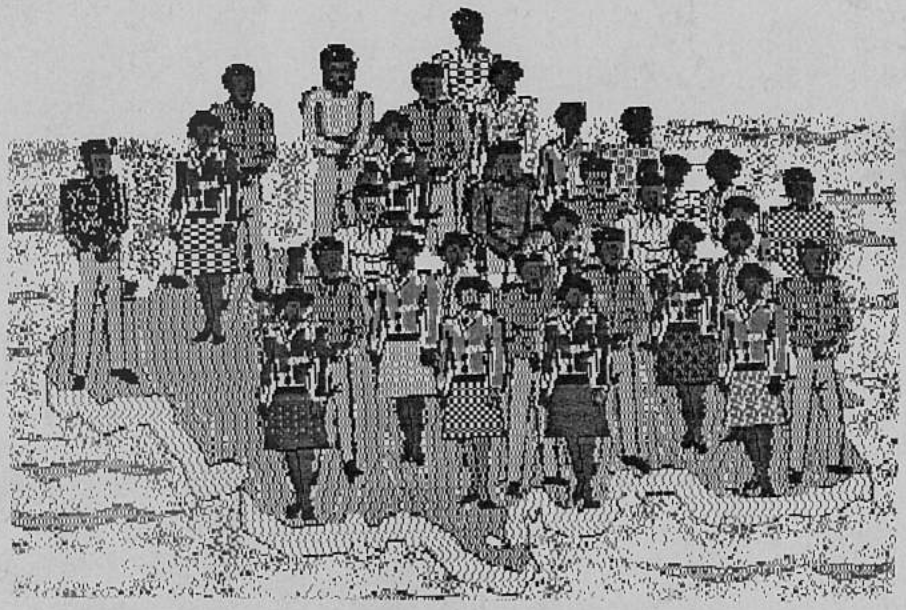
Analysis of the Legal and Regulatory Environment for Family Planning in Jamaica

Final Report



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Ref Only

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List of Abbreviations

NFPB	National Family Planning Board
GOJ	Government of Jamaica
USAID	United States Agency for International Development
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
MOH	Ministry of Health
JCPS	Jamaica Contraceptive Prevalence Survey
CPR	Contraceptive Prevalence Rate
CDC	Commercial Distribution of Contraceptives
GPs	General Practitioners
PHC SVCs	Primary Health Care Services
PIOJ	Planning Institute of Jamaica
GCT	General Consumption Tax
NGOs	Non-Governmental Organizations
FMU	Fertility Management Unit
MAJ	Medical Association of Jamaica
IEC	Information, Education, Communication
FLE	Family Life Education
OB/GYN	Obstetricians/Gynecologists
WRA	Women of Reproductive Age

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SECTION I.

BACKGROUND, PURPOSE, AND METHODOLOGY

I.A. Background

Since the 1930s, when the first family planning activities were launched in Jamaica through private voluntary efforts, family planning has evolved as a valuable contributor to Jamaica's social and economic development. The Jamaican family planning program is characterized as mature since the country has attained a contraceptive prevalence level of 62 percent. For the most part, the gains achieved by the family planning program are a result of collaboration between the public sector, active private voluntary groups, and commercial companies.

The population of Jamaica is estimated at 2.4 million, with an average growth rate of 0.9 percent from 1989-1993. Migration, a release valve for population growth, has been a major component of population change in Jamaica since the early 1970s. Migration patterns over the last decade, however, indicate a trend toward lower out-migration.

According to the 1993 JCPS, overall contraceptive prevalence is approximately 62 percent, and the total fertility rate remains three. Table 1 indicates trends in overall contraceptive use, as well as shifts in method mix that have occurred over the last 15 years in Jamaica.

Table 1
Trends in Contraceptive Use: 1975-1993

METHOD	1975-76	1983	1989	1993
Pill	11.9	19.3	19.5	21
Female Sterilization	8.1	10.9	13.6	12
Condom	6.6	7.6	8.6	17
Injection	6.2	7.6	7.6	6
IUD/Vaginals	3.5	3.0	1.6	1
Withdrawal	1.4	1.9	2.4	3
Rhythm	0.3	1.1	1.0	1
Other	0.0	0.0	0.3	1
Not Using	62.0	48.6	45.4	38
TOTAL PREVALENCE	38.0	51.4	54.6	62

Trends indicate a limited shift in the method mix of the program. There was a slight increase in the use of female sterilization and the pill from 1983 to 1989. Between 1989 and 1993, the percentage of women of reproductive age in union and using sterilization declined. International experience indicates that generally, as contraceptive prevalence increases and people become more accepting of family planning, the use of longer-term and permanent methods increases. This shift, however, has not occurred in Jamaica.

Contraceptive prevalence increased from 38 percent to 51.4 percent in 1983; however, the increase during 1983-1989 was less dramatic, with contraceptive prevalence moving from 51.4 percent to 54.6 percent. This slowing down in growth of the CPR is expected as it becomes more difficult to reach new acceptors. While the 1993 JCPS indicates that the GOJ goal of 62 percent contraceptive prevalence has already been achieved, it is disconcerting to learn in the same survey that women report approximately 75 percent of all last births to have been mistimed (54.0%) or unwanted (21.95%). Also, virtually the entire increase in contraceptive prevalence reported by the 1993 JCPS is attributed to an increase in the use of condoms only.

The current CPR of approximately 62 percent of women of reproductive age in union can, perhaps, be better thought of in terms of an absolute number of users -- estimated at approximately 250,000 women[1]. This absolute number will increase even in the absence of any change in contraceptive prevalence due to the youth-weighted age structure of the population and the consequent in-built momentum of population growth. For example, by the year 2000 the absolute number of WRA will have increased by approximately 17 percent to 720,000.

The 1993 Jamaica Contraceptive Prevalence Survey (JCPS) reports current unmet need for family planning to be 14 percent of WRA, or approximately 88,000 women. (Unmet need is defined as sexually-active women of reproductive age wanting no more children or no more children now and who are not currently using a contraceptive.) Of the approximately 630,000 women of reproductive age in Jamaica, 77.7 percent have been or are currently sexually active, and 69.3 percent are currently in a consensual union (as defined by the 1993 JCPS). Among WRA in union (therefore exposed to pregnancy), over 85 percent indicated that they do not want to become pregnant now. Only 62 percent of these women, however, are currently using contraception.

Non-users of family planning fall into two categories: 1) those who have never used contraception, and 2) those who have used a method and have discontinued its use for some reason. The largest group of women who have never used a method is those in the 15-19 year age group. Yet, survey data indicate that this group is at risk of becoming pregnant. Of the women aged 15-19, 58.9 percent stated that they have had sexual intercourse; Yet, the overall mean age of first use of contraception is just under 20 years. In addition, knowledge levels regarding the specific methods of family planning are lower for the 15-19 year age group. Approximately 25 percent of all births annually in Jamaica are now attributable to mothers under the age of 19 [JCPS 1993].

Recent focus group research ["Consumer Attitudes and Behaviors Regarding Contraceptive Methods in Jamaica -- A Focus Group Exploration," PSEARCH Associates, January 1994] has revealed that one of the biggest barriers to increasing and sustaining contraceptive prevalence is the high rate of discontinuation due to health concerns, side effects and misinformation.

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[1] Demproj Model projection based on GOJ census.

Similarly, many clients do not use contraceptives properly, leading to unplanned pregnancies and other problems. Awareness of methods is universal, but widespread misunderstanding of contraceptives persists -- among both users and service providers -- regarding proper use, effects on the human body and the ways in which the various methods function. ["Family Planning Service Delivery Practices of Private Physicians in Jamaica: Final Report," Bailey et al, 1994 and "Lay Concepts Affecting Utilization of Family Planning Services in Jamaica," C.P. MacCormack, 1985].

I.B. Purpose

With the passage of the National Family Planning Act [Appendix I, p.46] in 1970, the Government of Jamaica (GOJ) committed itself to the promotion of family planning as an integral part of its population policy. Since then, the 25-year history of the national family planning program, under the aegis of the National Family Planning Board (NFPB), has experienced remarkable accomplishments: achievement of a 62 percent contraceptive prevalence rate, reduction of the total fertility rate to 2.9, and a population growth rate of 1.4 percent. A number of international agencies -- USAID, the World Bank, the UNFPA, UNICEF, and other donors -- provided considerable support for this effort.

The national family planning program is now, however, at a crossroads. On the one hand, there are ambitious national goals for increased contraceptive prevalence and fertility reduction. On the other hand, donor resources are declining and the GOJ is facing serious fiscal constraints. To keep up with current demand and achieve national population goals, the national family planning program must serve an estimated 322,300 users by the year 2001, a 40.5 percent increase over current levels. Additionally, increasing contraceptive prevalence and further reducing fertility will require that new family planning users be recruited from more difficult-to-reach, harder-to-persuade segments of the population, particularly from among young Jamaicans.

Continued success of the national family planning program, within this new and complex environment, will necessitate the elimination of as many barriers and constraints to expanded acceptability and accessibility of family planning products/services as possible. This study, therefore, examines the legal and regulatory environment within which family planning services are provided in Jamaica. It provides an overall assessment of the laws, regulations and service guidelines that impede or favor the ability of the public, non-profit, and commercial sectors to deliver the best quality family planning products and/or services to the largest number of Jamaicans in need of them. Aspects of the legal and regulatory environment that may constrain the availability or acceptability of contraceptives and family planning service delivery will be identified and recommendations for their modification or elimination will be made. Finally, this analysis will provide information to support the NFPB's development of a strategic plan for family planning advocacy and policy reform.

I.C. Methodology

This study examines a broadly-defined legal and regulatory environment, covering a range of

factors or circumstances that can regulate or influence the availability and acceptability of contraceptives and family planning service delivery. These factors are not limited to formal laws and regulations, but can also include the following:

- formal regulations of government, decrees, and enacted legislation;
- perceptions or interpretations of those regulations and laws;
- promulgated standards of practice or professional guidelines;
- bureaucratic procedures; and
- social, cultural, and religious norms.

It is understood that only those practices articulated in the laws, decrees and regulations of a country are legally "enforceable" and "protected" in their strictest definition, and that only these "rights" given are legally-defined and enforceable rights. It is also understood, however, that the other factors listed above do, in practice, have considerable force in regulating contraceptive availability and family planning service delivery.

This study is based upon information derived from several sources:

1. Briefing books and papers prepared by the OPTIONS II Project for the USAID/Kingston National Family Planning Initiatives Project and for the development of a strategic plan for the National Family Planning Board; the 1989 and 1993 Contraceptive Prevalence Surveys; the completed NFPB Strategic Plan 1993 - 1998; written materials provided by the National Family Planning Board; and consumer research reports and papers from other family planning/population related sources. Most of these materials were originally developed for use by the NFPB. They provide information on the development of family planning services in Jamaica, profiles of users of these services, contraceptive methods available, and the attitudes of both acceptors and providers of family planning services. Some materials provide information on the population policy of the GOJ.

2. The acts and regulations that govern all aspects of family planning service delivery in Jamaica; standards of practice developed by the NFPB for family planning service delivery; and the codes of ethics of relevant professional associations and councils. A list of the relevant acts and regulations appears in Appendix I.

3. Interviews with officials and staff of the NFPB and of the Ministry of Health (MOH), commercial pharmaceutical importers and distributors, pharmacists, private practice physicians, and those professionals responsible for the theoretical and clinical training of providers of family services. Appendix II is a list of individuals who were interviewed for this study.

SECTION II.

LEGAL AND REGULATORY FRAMEWORK - FAMILY PLANNING AREAS AFFECTED

A. INTRODUCTION

II.A. Introduction

The main acts and regulations of the GOJ have all been passed since Jamaica declared independence, and have facilitated a shift of responsibility from the technical heads of departments, such as the Chief Medical Officer in the Ministry of Health, to the Minister of Government, under whose portfolio the subject matter falls. So far as family planning is concerned, the Food and Drugs Act [Appendix I, p.46] and the Pharmacy Act [Appendix I, p.46] regulate much of the delivery of these services. Both were put in place to replace the old Drugs and Poisons Law, giving the responsibility for protecting the safety and standard of drugs to the Minister of Health and giving the training and registration of pharmacy students, pharmacists, the registration of pharmacies and pharmacy owners to a Pharmacy Council, which also had the duty of classifying drugs and determining how they should be handled in sales to the public.

Although not contemplated in the legislation, neither of these acts could become operative without detailed and comprehensive regulations being put in place. In each case, it took about 10 years for that to happen. In the meantime, ad hoc practices evolved that blurred the lines of responsibility between the acts. As a result, the Pharmaceutical Services Division was established to exercise some of the responsibility legally assigned to the Pharmacy Council.

The present laws governing the training, registration and practice of doctors, nurses and midwives also date from the same period. It was a time when family planning was not on the national agenda as it now appears. Consequently, the regulations governing the training and practice of the major providers of family planning in the public sector make no mention of family planning, though it now forms a part of their basic training and has done so for several years.

In Jamaica, acts of Parliament and their accompanying regulations provide the legal and regulatory framework that govern every aspect of life. Such legislation is one way of ascertaining a country's policy. For example, passage of the National Family Planning Act in 1970 made clear the GOJ's commitment to family planning as an important aspect of its population policy. Another and sometimes more important way of ascertaining policy is looking at whether other laws and regulations as well as bureaucratic policies and procedures do or do not support the implementation of such a declared objective.

The nature of official regulations is specific. Regulations can only be made to support specific subjects spelled out in an act. If there is any attempt to include matters not specified in the relevant act, those regulations would be ultra vires, and unenforceable. In the area of the delivery of heath care, the various acts only become operative when regulations detailing how their functions should be carried out are put in place.

In the public sector there is another way in which conduct can be regulated -- by standing orders. Where no laws exist, or where changes in the function of public servants seem necessary, standing orders can be used to regulate their practice. These, however, are without effect in the private sector.

Attempts to influence standards of practice in both the public and private sector are sometimes pursued through the preparation and issuance of guidelines. The authority of these guidelines depends on what agency or under the aegis of which official they are issued. For instance, more weight is given to those issued by a Ministry of Government, even though it is recognized that the guidelines are not legally binding. In the field of family planning considerable effort has gone into the preparation of practice guidelines to ensure quality of care standards in the public sector. It must be recognized, however, that compliance with guidelines is not legally obligatory unless they are incorporated in regulations under an act of Parliament or made the subject of standing orders, which affect only the public sector.

The overall environment for family planning in Jamaica is quite positive. The first Population Policy was developed for the Conference in Mexico City in 1982 and was distributed in 1984. Still today, the Prime Minister, Honorable P.J. Patterson (MP) speaks of the importance of family planning service delivery to achievement of national development goals and the GOJ, through its Ministry of Health, makes family planning services available to a significant portion of the population.

In general, there are very few legal and regulatory constraints on the delivery of family planning services in Jamaica. A broad range of modern contraceptive methods is legally available in the country; service delivery points are widespread throughout the population; the commercial pharmaceutical and medical sectors operate freely; and knowledge of family planning and modern contraceptive methods is very high among the general population. There are, however, some areas in which laws, regulations, and operational policies may constrain the ability of the national family planning program to sustain and increase contraceptive prevalence in order to meet fertility-related national population goals. These areas of constraint assume increasing importance as the task of recruiting new contraceptive users becomes more difficult and as the long-term sustainability of the national family planning program becomes increasingly important.

This analysis will examine the legal and regulatory environment within which the national family planning program operates; identify those aspects of the environment that constrain family planning service delivery from operating optimally; and make recommendations related to resolution of constraints and to possible policy reform. This study analyzes the legal and regulatory environment in relation to five major family planning program areas:

- products/methods;
- service delivery points;
- clients;
- information; and
- program sustainability.

B. PRODUCTS/METHODS AVAILABLE

II.B. Products/Methods Available

Many legal and regulatory factors can have impact on the number and range of contraceptive methods available for potential delivery to family planning consumers in any country setting, such as:

- requirements for registration of products prior to importation and distribution;
- availability of foreign exchange necessary for production, purchase, and importation;
- import quotas;
- pricing policies that make production or importation financially attractive to suppliers;
- duties, tariffs and other taxes that may affect the product/method's profitability for importers and distributors; and
- laws or regulations that actually prohibit the availability of a product/method within the country.

This section discusses those areas of the legal and regulatory environment that relate to the current availability of contraceptive methods within Jamaica.

B.1. Legal Methods

Within the broad range of legally available contraceptives in the Jamaican marketplace, several brands and formulations of oral contraceptives; IUDs; Depo-Provera; and Norplant® are registered for distribution and use. Tubal ligations are available through the public sector's hospitals and through physicians' private practices. Condoms are also widely sold, but do not require registration by a governmental agency prior to import and sale.

Table 2 provides a list of contraceptive products/methods available in Jamaica (July 1994) along with the current retail price of each.

Table 2
Contraceptive Products available in Jamaica and Prices

ORAL CONTRACEPTIVES	PRICE	CONDOMS	PRICE	IUDs	PRICE
Gynera	J$220.00/cycle*	Preventor	J$21.00/3*	NovaT	J$716.00
Logynon ED	155.00	Sultan	5.00	(to MDs)	579.00
Logynon	135.50	Gossamer	26.00	GynaeT (to MDs)	466.00
Neogynon	140.50	DurexGold	33.00		
Microgynon 30 ED	130.00	Durex Extra Safe	32.00		
Microgynon 30	100.00	Spiral	34.00		
Anteovin	49.00	Spiral	12.00		
Tri-regol	55.00	WetnWild	27.00		
Minulet	280.00	Bareback	27.00		
Trinordial	85.00	Exotica	27.00		
Nordette	80.00	KissofMint	27.00		
Ovral Ortho-Novum 1/50	165.00	Erotica	27.00		
Ortho 7/7/7	95.20	PowerPlay	27.00		
Ortho 1/35	127.00	Sultan	17.00		

* per cycle or per box of three except where indicated different
J$ 33 = US$ 1

It should be noted that Sultan condoms, a public sector product, were found for sale in some commercial pharmacies [B.B. Ravenholt, pharmacy shelf review at selected Kingston pharmacies, July 1994].

Conclusions and Recommendations

The legality of contraceptive methods in Jamaica is favorable for family planning. No policy is recommended at this time.

B.2. Product Registration

Worldwide, virtually all countries have a registration system for pharmaceutical products.

Such systems are necessary to protect public health and are not, in themselves, an undue barrier to provision of pharmaceutical products. No pharmaceutical product that requires registration, however, can be made available within a country without successfully completing the registration process.

In Jamaica, The Food and Drugs Act of 1964 [Appendix I, p.46] requires that all pharmaceutical preparations intended for distribution and sale be regulated by the Pharmaceutical Services Division. All ethical drugs require registration under the Act, and this requirement includes hormonal contraceptives such as oral contraceptives and injectables. Topical contraceptives such as foaming tablets, creams, and jellies must also be registered. Products classified as devices, such as IUDs, do not require registration; nor do condoms. All products are regulated, however, in that under the Act no person is allowed to sell any device that when used according to the stated directions can cause injury to the health of the user.

The registration process, according to the Food and Drugs Act of 1964, is initiated by the local representative of the manufacturer who submits to the Pharmaceutical Services Division an application for registration. This application includes the internationally customary requirements for chemical analysis, reports of clinical trials, and attestation of legal use within the country of manufacturing origin, and must be accompanied by an application fee of J$ 5,000 [as of July 1994]. According to representatives of the local pharmaceutical sector, the process of registration often requires nine to 15 months for completion. There is no limit on the number of brands within any pharmaceutical product category that may be registered for distribution and sale within Jamaica.

Once registered, products are classified. List 4 classification, which includes, among other categories, all preparations for systemic use, such as oral contraceptives, injectables, and implants, requires a prescription for provision to the consumer ["Regulations on Contraceptive Registration and Marketing," speech by Mrs. Princess Osbourne, Scientific Officer, Pharm. Serv. Div./MOH, 18 April 1994]. Other contraceptive products such as foaming tablets, creams, and jellies are classified as over-the-counter preparations, and do not require prescription for distribution to the consumer [Osbourne, as above].

In the case of oral contraceptives, the requirement for a physician's prescription prior to dispensing to consumers is commonly ignored by pharmacists. Precedent was set in the mid-1970s when the MOH exempted Perle, a USAID-subsidized brand provided at low cost to consumers under the aegis of the NFPB's Commercial Distribution of Contraceptives (CDC) project, from the prescription requirement. (The NFPB's CDC was privatized in 1993.) The subject of moving all oral contraceptives from List 4 to over-the-counter status is currently under consideration by the Pharmaceutical Services Division, but no decision has yet been made.

Regulation under the Food and Drugs Act also extends to the packaging and labeling of pharmaceutical products. Sanctions are applicable if the regulations are violated.

Conclusions and Recommendations

Current practice in the registration of pharmaceutical products in Jamaica does not appear to constrain unduly the availability of contraceptive methods and/or brands to the consumer. Family planning program managers should be mindful, however, of the time and information required for any future registration and introduction of new contraceptive products to the Jamaican marketplace. No policy reform appears to be needed at this time.

B.3. Pricing

The cost to the consumer (retail price) of a contraceptive product is based on many factors:

- the cost of product manufacture;
- cost of shipment if imported;
- duties, fees and tariffs associated with importation;
- profit to the manufacturer and importer;
- cost of distribution, including wholesale and retail markups; and
- sales taxes.

If the retail price does not adequately cover the costs and the profitability expectations of the manufacturer/importer/retailer, then the product is not likely to be available in the marketplace. On the other hand, if the retail price is beyond the financial means of targeted consumers, demand for the product is likely to be limited. In either case, prices and pricing policies can affect the availability of contraceptive products.

In countries where a free market economy is not in operation, wholesale and retail markup rates are controlled by the government and, in some cases, retail prices are set by the government at the time of product registration. In recent years, there has been significant pricing policy reform in Jamaica; consequently, there is now no governmental control of pharmaceutical prices and/or margins. The pharmaceutical sector operates freely in response to the pressures of supply and demand and the competitive environment.

In the case of IUDs, which must be inserted, tubal ligations, which must be performed, and injectable contraceptives, which must be given, the real price of the method in the private sector must also include the fee of the provider who delivers it. Depending on the type of provider, the required fee may add considerably to the total price.

Provider fees vary according to the type of provider. OB/GYN specialists, for example, are likely to charge more for their services than general practitioners. Private practice physicians, especially general practitioners, are also very likely to set their fees according to their perception of the ability of potential clients to pay. Physicians whose offices are located in lower income, urban neighborhoods or rural areas and whose clients come from those areas are likely to charge less than physicians serving higher income areas. Private practice physicians understand the importance of not pricing themselves out of the reach of their target market.

It is also reported by some private practice physicians that they do not charge as much for the follow-up visits necessary for quarterly or monthly contraceptive injections as they do for example, for the initial "prescribing" visit [B.B. Ravenholt, interview with Dr. Olivia McDonald, Medical Director, NFPB]. Reported prices for visits to private practice physicians in 1994 range from J$ 300-350 for rural general practitioners to J$ 350-500 for urban GPs, and from J$ 450-500 for rural ob/gyn specialists to J$ 750-1000 for urban OB/GYNS. There is no attempt in Jamaica to control the fees of private practice physicians through laws and regulations. The Fair Competition Act of 1993 [Appendix I, p.46] prohibits price controls in the private sector.

The pricing policy for public sector health services is currently in transition. Two years ago, the MOH decided to ask patients to make a cash contribution in exchange for services received. Within the secondary (hospital) care system, there is a formal policy for fee collection. These fees are collected by the Administrator at each hospital. A formal policy for primary care pricing (fees for services) is being researched. The contributions suggested for primary care are, on the whole, modest. They are neither intended to recover the full cost of the service nor to deny service to those who cannot pay. These contributions usually take the form of "registration fees" that are paid for selected client services such as a visit with the physician or immunization. Collection of these fees is uneven because the nurses responsible for fee collection are anxious about the lack of security within the primary care clinics and fear robbery attacks. It is reported that in numerous instances fees are simply not collected to avoid the accumulation of money at the clinic site.

As with other PHC services, family planning services are not yet formally included in the MOH primary care pricing plan. Therefore, collection of fees from MOH family planning clients is inconsistent. Some MOH clinics charge registration fees for family planning clients; others do not. Some clinics charge for contraceptive products distributed, but no family planning client is supposed to leave a Ministry clinic without contraceptives because of the client's inability to pay. In 1992, all clinics began charging a proportion of clients for Depo-Provera because the MOH/NFPB had to purchase its supplies of this product commercially. The NFPB currently recommends a price of J$50 for each injection of Depo-Provera at a MOH clinic. Prices actually charged range from J$ 50-150. (The increase over the suggested price is reportedly a result of the need to cover the cost of necessary syringes, swabs, etc., which were formerly available from donors free to the MOH.) Prices charged for a cycle of oral contraceptives range from J$ 5-10. Money for oral contraceptives collected from clients by MOH clinics is not returned to the NFPB, but rather to the MOH.

Conclusions and Recommendations

With the phasing out of free supplies of condoms, oral contraceptives, and IUDs from USAID and injectable contraceptives from the UNFPA, cost of method provision in the public sector is becoming a very important consideration for the GOJ and specifically for the MOH and the NFPB, which are held responsible for contraceptive procurement and distribution.

There is considerable ambiguity in Jamaica concerning the equity of distribution of subsidized public sector services. It may be that some people who can afford to pay for the services they receive are receiving services provided free or at less than cost, while some potential family planning consumers may not be receiving all the services they require.

The MOH's evolving policy of requesting "contributions" from its clients who can afford to pay some portion of the cost of product/service provision may be resulting in an increased number of family planning consumers going to private doctors. (Private practitioners report noticing an increased number of clients coming to them for family planning services.) These former public sector clients see no advantage in enduring the long waits and uncertainties of supplies at the public sector clinics when the cost of the service is perceived as not particularly different from the cost of a visit to a neighboring general practitioner. Additionally, a 1989 survey of current users of public sector health facilities indicated that 40 percent of clients interviewed stated that they could afford to purchase contraceptives and, in fact, were paying private practice physicians for other, non-family planning related health care services.

It is commonly believed among MOH service providers that a second group of potential family planning consumers affected by public sector pricing policies is those who are unable to meet the public sector request for contributions, but who are unwilling to expose themselves to the embarrassment of admitting this. Thus, they make no attempt to secure the services that would be given to them free as a matter of policy. Perhaps the less than private atmosphere in which public sector services are commonly delivered contributes to this. The experience of managers at the Family Planning Clinic of the Fertility Management Unit at the University Hospital also seems to confirm this behavior. Approximately 60 percent of those public sector clients interviewed in the 1989 survey indicated they would not be able to or would find it difficult to contribute to the cost (through user fees) of health services.

While relevant MOH staff passed draft pricing/fee-for-service proposals to the NFPB for review during the policy development period, the NFPB has no authority over the Ministry's implementation of its pricing policy for family planning services. In fact, under current practice, fees collected by the MOH from clients for contraceptives dispensed to them are not returned to the NFPB, which is responsible for procurement of "replacement" contraceptives.

There are no legal and regulatory constraints on the prices that may be charged by local pharmaceutical distributors for contraceptives or on the fees that private practitioners may charge for the delivery of family planning services. There are, consequently, no apparent constraints on the availability of contraceptive methods of all kinds in the local, private sector market.

Based on these conclusions, the following recommendations are proposed:

1) To ensure the most effective use of finite government, donor and consumer resources for family planning, a plan for the rational segmentation of the family planning market among the three service delivery sectors should be developed. This segmentation strategy should ensure that the efforts of each sector are focused in the areas of its

strengths and among consumers who are its most appropriate financial targets.

- **Public Sector** - It is recommended that the public sector develop a pricing policy that would facilitate target resources to the safety net population and would facilitate shifting those consumers who are able and can afford to pay for the services they want and need to the private sector.

- **Private Sector** - The public sector clearly cannot meet the needs of all Jamaicans for family planning goods and services. Consequently, it is further recommended that the national family planning program promote the use -- among those consumers who can afford to pay -- of private practice physicians, retail pharmacies and non-profit private sector providers for family planning services. Such promotion could be implemented through the mass media as well as through public relations campaigns and GOJ policy statements.

Furthermore, the NFPB should promote among the three service delivery sectors, public and private (both commercial and NGO), a clear understanding of the roles of each so that a false sense of competition among the sectors does not constrain the ability of each to serve its appropriate target audience.

2) A clear policy regarding revenues from family planning fees should be developed between the MOH and the NFPB. This policy should take into account the fact that fees collected for contraceptives dispensed to clients should be returned to the NFPB for the specific purpose of procurement of "replacement" contraceptives. Practical guidelines for the implementation of this fee schedule should be developed and disseminated and the infrastructure necessary for fee collection should be in place prior to implementation of the policy. Inconsistencies in operation confuse consumers and may make them distrustful of the system; they may also create opportunities for inappropriate personal gain among providers and clients.

B.4. Duties, Fees, Taxes, Import Quotas and Foreign Exchange

When any pharmaceutical-related product (including all contraceptives) is imported into Jamaica, an import permit must be acquired from the Pharmaceutical Services Division and presented to Customs staff. The fee for issuance of the import permit is J$200 and a permit must be acquired each time the product is imported. The purpose of the permit is to provide customs staff with MOH assurances that the product being imported is legal and acceptable for distribution and sale within Jamaica.

Ethical pharmaceutical products imported into Jamaica are subject to a 15 percent duty. Currently, however, no import tariffs are assessed on oral contraceptives, injectables and condoms. Over-the-counter pharmaceutical products are also subject to a 15 percent import tariff, but OTC contraceptive products are exempted. No General Consumption Tax (GCT) is charged on the distribution and sale of contraceptive supplies of any kind. The GCT rate

for other goods and services is currently 12 1/2 percent. There are no import quotas of any kind on pharmaceutical products in Jamaica. The availability of necessary foreign exchange is limited only by the pressures of supply and demand within the freely operating market.

Conclusions and Recommendations

Duties, fees, taxes, import quotas and foreign exchange do not currently constitute barriers to the availability of contraceptives in Jamaica. It should be remembered that the tax and fee regime can easily be changed and close attention ought to be paid by the NFPB to any movements in this area.

C. SOURCES OF SUPPLY

II.C. Sources of Supply

Sources of contraceptive supply or service delivery points are essential to the implementation of a family planning program. Service delivery points are defined in this study as places where contraceptives are dispensed/distributed or where methods are applied, e.g. IUD insertions, Depo-Provera injections and surgical contraception procedures.

Family planning services in Jamaica are delivered through the public sector, private voluntary sector and commercial sector. Public sector sources for service delivery include 324 MOH health clinics, 16 public hospitals and three NFPB clinics. Private voluntary sources include two FAMPLAN (formerly Jamaica Family Planning Association) clinics and their employment-based outreach programs, Operation Friendship, the Women's Centre and FISH ["Mapping Study and Private Physicians' Survey," Bailey et al, 1994, p.24]. Commercial sector sources for family planning service delivery include the practices of 367 private physicians: general practitioners, family practitioners, obstetrician/gynecologists and urologists; seven private hospitals and approximately 230 commercial pharmacies. According to the 1993 JCPS, commercial sector pharmacies are the source of supply for almost 50 percent of oral contraceptive users while pharmacies and retail shops together supply approximately 60 percent of all condoms. Historically, private medical providers have played a passive and minor role in service delivery. Table 3 indicates the sources of family planning services for both clinical and supply methods.

Table 3
Source of Contraceptive Supplies - 1993 JCPS

METHOD	PUBLIC	PRIVATE	UNKNOWN	TOTAL
Pill	46.0 %	51.1 %	2.8 %	100 %
Injection	89.7 %	6.5 %	3.7 %	100 %
Condom	28.8 %	61.3 %	10.0 %	100 %
VSC	88.7 %	7.3 %	4.0 %	100 %

Many factors in the legal and regulatory environment can have impact, both positive and negative, on the availability and acceptability of sources of family planning services. These factors include the following:

- regulations concerning certification of providers and clinics;
- restrictions on establishment of private medical practice;
- limitations on the kinds of services that can be provided by certain types of health care providers;
- policies that affect availability of service delivery points and service providers at those points; and
- regulations regarding the training of potential providers.

This section will examine those factors in the legal and regulatory environment of Jamaica that significantly influence the availability and acceptability of sources of family planning services in the public, private-voluntary, and commercial sectors, and those factors that affect the types of health care providers who can provide family planning services within these three sectors.

C.1. Public Sector

The change in the availability of donated contraceptive supplies to the public health service has recently brought into sharp focus both the Government's policy and the implementation of that policy for family planning. The delivery of family planning services has been perceived, mainly, as the responsibility of the public sector's primary health care clinics. Heavily-subsidized supplies of Panther and other condoms, and Perle and other oral contraceptives, provided in the past by USAID, and of Depo-Provera, currently provided by the UNFPA, have fostered the view that family planning is the responsibility of the government.

All family planning services and contraceptive methods legal in Jamaica are available in the public sector with the exception of Norplant®, which is being considered for introduction. Because of the type of health care personnel working in the various types of public sector outlets, however, all methods are not available in all outlets.

Midwives are the primary providers of family planning services in the public sector. They staff Type One primary care centers (165 of the 324 total public sector health care outlets are Type One facilities), where they provide client counseling, condoms, oral contraceptives and contraceptive injections. At the time of the NFPB's 1993 Mapping Survey, family planning counseling was found to be available in all 324 of the MOH clinics, condoms in 316, oral contraceptives in 321, injectable contraceptives in 283, IUD insertions in 19, and tubal ligations in two. Fifteen of 16 MOH hospitals were providing tubal ligations at the time of the survey. A referral network among types of public sector outlets is in place to try to ensure that family planning clients receive the contraceptive services they want and need.

MOH clinics operate between the hours of 8:30 a.m. and 4:30 p.m. Six MOH clinics now stay open until 8 p.m. two evenings per week. In busy or short-staffed clinics, there is a tendency to limit special services to certain days of the week. For example, family planning services might be offered on Wednesdays. This concentration of family planning clients within a constrained period of time often means that the wait for service is quite long for each woman. It is almost universally accepted that geographic access to public sector outlets for family planning services is not a constraint on service availability, except in a few deeply rural areas.

Conclusions and Recommendations

Actual availability of contraceptive methods in the public sector is sometimes limited by operational policies, product shortages, and the absence of qualified health care personnel to provide them. The current public sector system creates a situation in which longer-term or permanent contraceptive methods are not so readily available as oral contraceptives and

condoms. This operational system works directly against the national family planning program goal of increasing the share of longer-term contraceptives within the overall contraceptive method mix.

The policy that limits operating hours of primary health care centers to weekdays between the hours of 8:30 a.m. and 4:30 p.m. constrains the ability of most women who work to receive family planning services without missing time on the job. It may be, however, that many women who work are able to pay for their family planning needs within the private sector and are not, therefore, appropriate public sector clients.

Occasional product shortages within the public sector may be exacerbated as the GOJ begins, to procure for itself an increasing percentage of total contraceptive needs. While the interest of commercial sector suppliers has been stirred by the prospect of opening up a new market area through large-scale sales of contraceptives to the MOH, there is reportedly some question as to how available to the MOH these products will be. The MOH has a poor record for paying promptly for the supplies and services it orders from commercial firms. This is likely to influence the willingness of importers and distributors to provide contraceptive supplies to the Ministry for its clinics.

Based on these conclusions:

1) The NFPB should work with the MOH to develop and implement a service availability plan that ensures that the current service delivery bias toward supply methods is minimized. Using the recent Mapping Survey, NFPB staff in conjunction with appropriate MOH personnel should prepare recommendations for the redistribution of service personnel to ensure easier availability of all contraceptive methods -- especially longer-term methods -- to women throughout the country. Promotion of longer-term methods through personal counseling, mass media messages, and continuing education for providers should be undertaken to support the service availability plan.

2) In accordance with the segmentation strategy discussed in the section "Pricing," above, the service delivery focus of the public sector may increasingly be on serving only those "safety net" consumers who cannot afford to pay any or much for the products and services they receive. Attributes of service delivery, such as hours of operation and fees, should be tailored to meet the specific needs and ability to pay of the public sector's target clients.

3) The NFPB should aggressively advocate within the GOJ for the necessary funds for contraceptive purchases and continued support for the entire family planning program as donor funds are withdrawn. It should be recognized within the GOJ that commitment of funds necessary to support family planning service delivery is a stronger indication of political commitment than policy statements.

C.2. Non-Government Sector

In Jamaica, there is no parliamentary act that regulates the establishment and/or operation of Non-Governmental Organizations (NGOs). Consequently, there is no governmental body to which NGOs must report. NGOs may choose to register themselves with the Registrar of Companies, but they are not required to do so. Those that do receive certain benefits, such as the ability to offer tax deductible status for contributions made by donors [B.B. Ravenholt, interview with Ms. Janet Cupidon, Executive Director, Council for Voluntary Social Services].

There are four umbrella organizations to which individual NGOs may belong. One of the better known organizations is the Council for Voluntary Social Services. Membership to any of the umbrella organizations is not mandatory. These umbrella organizations offer lobbying, fund-raising, and technical support to their members. There are no legal or regulatory constraints on the ability of PVOs to charge fees for the services offered to clients. To maintain their non-profit tax status, however, NGOs must be able to demonstrate that any profitability produced by their activities has been reinvested into the provision of social services. The GOJ/Ministry of Finance Revenue Department has the authority to regulate this financial aspect of NGO operations. However, it is generally believed that the Revenue Department, in practice, does not monitor this area. There has been no apparent abuse by NGOs of their non-profit status.

There are a number of NGOs that offer limited medical services to the public, a few of which include family planning. These few NGOs that provide family planning services are FAMPLAN with two clinics (one in downtown Kingston, the other in St. Ann's Bay), an employment-based outreach service in the commercial areas around Kingston and the northern resorts, and a rural outreach program in St. Ann and Trelawny; Operation Friendship working in western Kingston; FISH working in northeastern St. Andrew; and the Women's Centre in Kingston.

FAMPLAN clinics offer a full range of contraceptive services. Other NGO outlets provide supply methods (oral contraceptives and condoms) only. FAMPLAN, an affiliate of the International Planned Parenthood Federation, receives contraceptive supplies as part of its budget allocation from that organization. Other Jamaican NGOs rely on the NFPB for the contraceptives that they distribute. To that extent, their family planning service delivery is public sector funded.

The only requirement for a NGO to provide medical, dental, and related services to its clients is that these services be delivered by a registered physician, dentist, nurse and/or midwife competent to perform them.

Conclusions and Recommendations

NGOs offer the possibility of additional outlets for family planning information, products and services affordable to low income consumers and accessible to potentially hard-to-reach

segments of the population. NGOs that have already established outreach networks may be able to add family planning to their portfolio of services delivered in relatively cost-efficient ways.

Based on these conclusions:

1) The NFPB should assess the ability of NGOs not currently providing family planning services to provide such services, identify potential new providers among them, and support their addition of family planning services through local technical assistance and public-relations campaigns.

2) NGOs, with their grass roots service delivery experience, should be included in the overall family planning service delivery segmentation strategy. To the extent that NGOs provide low-cost services through subsidies from the private voluntary sector, they represent an alternative to the current high level of public sector responsibility for family planning service delivery and the relatively higher cost to the consumer of private for-profit services delivery.

C.3. Commercial Sector

The present severe constraints on Government resources show no sign of easing in the foreseeable future. The result has been a new emphasis on the contribution that the commercial sector -- whether as importers and distributors of pharmaceutical products or as medical practitioners -- can make to keep family planning service delivery functioning at the required level. This section of the study will examine the legal and regulatory requirements for the operation of pharmacies and the provision of medical care within the commercial sector.

Pharmacies - The Pharmacy Act states that in order to operate a pharmacy in the commercial sector, the potential owner of the pharmacy must register him/herself with the Pharmacy Council as a pharmacy owner, register the shop premises as a pharmacy and, in so doing, attest that no business "so far as it relates to the compounding, dispensing, storing for sale or retailing of drugs" will be carried on except under "the immediate control, management, and supervision of a registered pharmacist." A registered pharmacist is required to be on the premises of the pharmacy during all hours of operation. A fee is required both for the registration of the individual as owner of the pharmacy and for the registration of the premises as a pharmacy. Currently, the fee to register a pharmacy is J$ 6,000 -- recently increased from J$ 500. Pharmacy premises must have their registrations renewed annually, and a registration fee is charged on each occasion.

The Pharmacy Council has staff inspectors authorized to visit any registered pharmacy at any reasonable time for the purpose of ensuring that the premises are suitable for the purposes of a pharmacy (i.e., that they offer no unsafe or unsanitary conditions) and to ensure compliance with all provisions of the Pharmacy Act.

Private Practice by Nurses and Midwives - According to representatives of the Nursing Council, Jamaican law does not address the ability or inability of nurses and midwives to operate private practices (for example, antenatal clinics, well baby clinics, immunization clinics, or family planning clinics); and this issue has not previously been raised. Some registered nurse/midwives, however, operate centers for birth training and charge privately for such sessions. A few registered midwives currently provide home deliveries and charge privately for these services. Fees are reported to be quite low.

Private Practice by Physicians - The Medical Act (1 November 1976) [Appendix I, p.46] states that every medical practitioner who has successfully registered (A registration fee of J$ 60 is required) with the Medical Council is entitled to practice medicine in Jamaica and "to demand and recover any reasonable charges for services rendered by him as a medical practitioner and for all drugs, medicines and appliances supplied by him." The law does not appear to prescribe any minimum standards necessary for the site of or equipment available to a physician's practice.

GOJ policy currently prohibits any physician employed by the public sector as a Grade 1, 2, or 3 medical practitioner from practicing medicine in the private sector during the regular working day of the public sector system. Physicians who are employed by the public sector as higher-grade medical practitioners (which includes "consultants") are permitted to operate private medical practices during the regular work day of the public sector. Physicians employed at some public sector health facilities are allowed to use those same facilities for the treatment of their private clients. Many public sector physicians -- across all grades -- are reported to be leaving their public sector posts during working hours to operate private medical practices. Such practice is considered to be the norm, and there is no apparent attempt by public sector supervising personnel to correct this situation.

Conclusions and Recommendations

There are no undue constraints on the establishment and operation of commercial pharmacies or on the private practice of medicine by physicians in Jamaica.

With the drying up of free supplies of family planning products that have kept the public clinics functioning successfully over the years, the expectation now is that the commercial sector, through private physicians and retail pharmacies, will play a much greater role in delivering family planning services.

The legal status of nurses and midwives in private practice is not clearly stated and has not been tested. While nurses and midwives could represent a new, low-cost and wide-spread group of private providers of family planning services in Jamaica, there does not appear to be a shortage of private practice physicians that needs to be remedied.

Based on these conclusions:

1) The NFPB should explore with the Nurses Council and with the MOH ways in which

the ability of nurse/midwives and midwives to provide services in the private sector can be acceptably expanded and the impact on service availability that this expansion might have. This effort will undoubtedly require considerable lobbying and negotiating with the Medical Association of Jamaica.

2) While the majority of nurse/midwives and midwives are currently employed in the public sector, it may be possible that, like Jamaican physicians employed in the public sector, they can offer private services outside the public sector work day. Such private services related to family planning could include the operation of private family planning clinics that offer family planning counseling, referrals to affiliated physicians for tubal ligations, contraceptive injections, prescription of oral contraceptives including mini-pills to lactating new mothers, pap smears, insertions of IUDs, and the like. Nurse practitioners and physician assistants in other countries currently provide such services in the private sector under the aegis of a supervising physician.

C.4. Service Providers

Family planning service delivery can be affected not only by the range of sites at which services are available, but also by the types of providers allowed to deliver them and the training those providers have received. This section of the analysis examines the laws, regulations and policies that affect the ability of Jamaican health care providers to deliver high quality family planning services.

Nurses and Midwives - The Nurses and Midwives Act of 1966 [Appendix I, p.46] states that all practicing nurses and midwives must have successfully completed a prescribed course of training at an "approved training institution" and must have their names entered in either the Register of Nurses or the Register of Midwives. The Nursing Council is given authority to approve training institutions, maintain the Registers, approve curricula and examinations, regulate the functions of nurses and midwives, and govern the professional conduct of registered nurses and midwives through the relevant Code of Ethics. Nurse/midwives are not mentioned as a separate category within the Act.

The Nurses Association and the Midwives Association are professional associations that do not operate with the force of law. These associations offer various benefits, such as continuing education opportunities, to their members but serve primarily as negotiating agents (like a trade union) for the group with the GOJ for renewal of public sector employment contracts.

The detailed regulations governing the training and practice of nurses and midwives do not reflect the changes that have taken place since 1966, when family planning was not a part of public sector healthcare service delivery. For example, The Nurses and Midwives Act does not include family planning as a topic on its list of subjects required for approved training courses for either nurses or midwives. The syllabus of subjects for examination for the certificate of midwifery published by the Nursing Council in 1989, however, contains (pp. 17 & 18) a unit on "Planning the Family." This unit contains a section on family life education, as well as a section that covers the delivery of family planning services in public sector

facilities with some emphasis on counseling and on adolescent fertility. Procedures like the insertion of IUDs and the giving of injectable contraceptives are not covered in this basic course -- due at least in part to the limited opportunities for clinical practice in these procedures. Basic and post-basic courses are available at the Fertility Management Unit at the University Hospital of the West Indies and, from time to time, at Victoria Jubilee and Cornwell Regional Hospitals.

Additionally, The Nurses and Midwives Act does not list the provision of family planning services as a function of either nurses or midwives. In fact, no specific functions of nurses are listed in the Act or its accompanying Regulations and no subsequent additions to the law address their functions. Functions of midwives are laid out in some detail in the Act, but do not include any family planning-related activity.

In current practice, general nursing students receive approximately 12 hours of theoretical training in family planning plus four weeks of clinical experience. Midwifery students receive at least 36 hours of clinical experience in family planning plus a two-year training program. Nurse/midwives must complete the three-year nurses' training, in addition to a one-year midwifery course. All public health nurses are nurse/midwives who have completed an additional one-year public health course.

The public sector employs general nurses, midwives, nurse/midwives and public health nurses. It is primarily midwives and nurse/midwives who are the providers of family planning services in the public sector. According to the 1993 Private Physicians Survey undertaken by the NFPB, physicians providing family planning services as part of their private practices, in most cases, provide the services themselves. Nurses working for these physicians typically assist in the provision of counseling (10.6%) and the contraceptive injectable (20.6%) but rarely in the delivery of other family planning services. Nurses, therefore, do not currently play a significant part in the delivery of family planning services in the private sector ["Mapping Study and Private Physicians' Survey," Bailey et al, 1994, p.39].

There is a considerable shortage of nurses in Jamaica. This shortage, of course, has a negative impact on the availability, quality and convenience of family planning service delivery in the public sector. It is widely reported that the primary reason for the shortage of nurses is the MOH salary schedule for health care providers. Jamaican nurses are well trained and are frequently recruited for work in the United States, Canada and even Great Britain. In these countries, they are able to earn many times the salary that they are paid by the MOH.

Conclusions and Recommendations

Nurse/midwives and midwives are critically important to the quantity and quality of family planning services in Jamaica. While these health care providers carry the primary responsibility for family planning service delivery in the public sector, they appear to be under-utilized in the private sector.

Nurse/midwives and midwives are reasonably well trained in family planning topics during

their professional education, yet the opportunity for clinical practice, especially in such procedures as IUD insertion, is limited. This lack of opportunity for clinical practice is generally ascribed to low case rates at training sites.

Based on these conclusions:

1) The NFPB should periodically examine the professional training curricula for nurse/midwives and midwives to ensure that their education in family planning is adequate for the role they play in service provision. Relevant NFPB staff should maintain a continuing dialogue on the importance of family planning topics in the general training curricula with those groups/institutions responsible for the training of nurses and midwives.

2) In conjunction with the Nursing Council and the Nurses and Midwives Associations, the NFPB should develop continuing education requirements for all registered nurses and midwives that include regular refresher courses in contraceptive technology and counseling techniques. Standards of practice should be kept up-to-date with scientific knowledge and should be disseminated to nurses and midwives as well as to physicians.

3) The MOH should be encouraged to strengthen opportunities for education in relevant family planning clinical techniques for nurses and midwives.

4) The NFPB should explore and promote possibilities for greater use of nurses and midwives for family planning service delivery within the private sector wherever such activities would increase the availability of family planning services or make the provision of services more cost affordable to clients.

Physicians - The Medical Act of 1976 states that all medical practitioners registered in Jamaica must have satisfactorily completed the course of study at an approved medical school, one year of internship, and comprehensive examinations. Required curriculum areas are not, however, described within the Act, as is the case for nurses and midwives. Since the establishment of the Fertility Management Unit at the University Hospital of the West Indies, medical students have received training in the management of hormonal contraceptive methods during the obstetric and gynecology rotation. Clinical practice in IUD insertion is limited by the FMU case load; consequently, many medical graduates may have only observed provision of this method. Medical students are required to attend clinics at the FMU twice per week over a four-week period. Further training in other contraceptive methods is available at the FMU for those with a special interest in family planning. Training in family planning counseling techniques, however, is not offered to student physicians or to practicing physicians through the FMU.

Obstetrics/Gynecology specialists complete four years of training beyond the basic medical course -- three years of theoretical and clinical training in obstetrics and gynecology plus one year of training in an additional specialty.

Of the approximate 367 private practice physicians providing family planning services in Jamaica, 51 percent are general practitioners, 18 percent are OB/GYN specialists, 14 percent are family medicine practitioners, and 17 percent are other specialists ["Family Planning Service Delivery Practices of Private Physicians in Jamaica" report]. Eighty-eight percent of these physicians indicated that they had received training in the provision of a variety of family planning services and techniques either during or after medical school.

Many doctors still in private practice graduated before training in family planning methods and procedures became a part of the regular medical school curriculum. In addition to post-graduate courses offered by the Fertility Management Unit of the University Hospital of the West Indies, professional associations, such as the Medical Association of Jamaica and the General Practitioners Association, are now becoming involved in offering family planning training to their members through continuing education programs.

There are no laws or regulations that prohibit general and family practitioners from offering such services as IUD insertion, vasectomies or tubal ligations to their clients. However, any procedures that require the use of hospital facilities necessitate the accreditation of the provider's technical competence by a hospital board of referees.

Conclusions and Recommendations

There are no particular constraints on the ability of physicians to provide a range of contraceptive services to clients beyond the physician's interest in doing so. Current medical education includes basic training in the theoretical aspects of contraceptive methods and case management. Opportunities for clinical practice relevant to longer-term methods among non-specialist medical students, however, are constrained. Local opportunities for continuing education in family planning related topics are currently being developed.

Based on these conclusions:

1) The NFPB and MOH should facilitate and/or participate in periodic reviews of the university curriculum for medical students to ensure that their education in family planning is adequate for national quality of care standards. Relevant NFPB/MOH staff should maintain a continuing dialogue on the importance of family planning topics in the curriculum with those responsible for physician training. The NFPB/MOH should promote particular emphasis in physician education on longer-term contraceptive methods and client counseling techniques in line with the national family planning program's goals and objectives.

2) In conjunction with the Medical Council and the Medical Association of Jamaica, the NFPB should develop continuing education requirements for all registered physicians that include refresher courses in contraceptive technology and counseling techniques. Standards of family planning practice should be disseminated to all relevant physicians in both the public and private sectors.

Pharmacists - The Pharmacy Act requires that all registered pharmacists must have successfully completed a course of study at a college or institution approved for pharmacist training by the Pharmacy Council, passed the final examination, and undergone vocational training. The primary function of the pharmacist, according to the Pharmacy Act, is "dispensing", which is defined as supplying a drug "in accordance with a prescription given by a registered medical practitioner or a registered dentist or a registered veterinary surgeon or veterinary practitioner." The regulations of the Pharmacy Act do not contain any details of the curriculum required for pharmacist training. It is reported that there is presently no family planning or contraceptive-specific unit within the curriculum [CAST]. Pharmacies, however, are the source of supply for almost 50 percent of all oral contraceptive users in Jamaica and half the condom users. IUDs and injectable contraceptives are also sold in some pharmacies [1993 JCPS].

Conclusions and Recommendations

If a shift in family planning clientele from the public to the private sector occurs, pharmacists are likely to be the source of supply for more contraceptive products and receive more requests from consumers for family planning information and advice.

Proposals that pharmacists be permitted to play a greater role in delivering family planning services may require a change in the regulations. Training in family planning topics, however, would require only a change in the curriculum of study accepted by the Pharmacy Council which could be achieved without regulatory change.

Based on these conclusions:

1) The NFPB should advocate the inclusion of a unit on family planning/contraceptive topics in the required curriculum for all pharmacy students. This unit should also include instruction in techniques which allow pharmacists to communicate effectively and correctly with clients who ask for contraceptive information and advice. The NFPB should work with the Pharmacy Council and Pharmacists Association to develop and implement regular continuing education opportunities for pharmacists in contraceptive technology updates and client counseling.

2) The NFPB should liaise between the MAJ and the Pharmacists Association to encourage them to establish or to strengthen existing informal referral networks between pharmacists and neighboring physicians for the benefit of family planning clients.

3) The NFPB should explore the contribution to expanded availability and affordability of injectable contraceptives which pharmacists' provision of injection services might provide. If the results of such an assessment are positive, the NFPB should move to achieve the changes in the law required to allow this service delivery by pharmacists.

D. WHO CAN RECEIVE SERVICES AND UNDER WHAT CIRCUMSTANCES

II.D. Who Can Receive Services and Under What Circumstances

The delivery of family planning services which are available within a country may be constrained by limitations on those potential users who are allowed to receive them. Some of these limitations may be necessary to protect the health and safety of contraceptive users with special medical needs. Other limitations may, however, unduly restrict access to effective contraceptives for women who need protection from pregnancy. Restrictions on who can receive family planning services and under what circumstances can take the form of the following:

- age restrictions;
- requirements for spousal or other consent;
- prescription requirements;
- promulgated standards of practice; and
- generally held beliefs of service providers.

D.1. Age Requirements

As discussed previously, it is well known that the sexual practices and fertility of the segment of the Jamaican population between the ages of 15 and 19 years have a significant demographic impact on the overall population growth of the country. There are differing opinions on how girls under the age of sixteen requesting contraceptives should be treated. The public sector's Family Planning Service Delivery Manual states (p.35) that "The sexually active adolescent has a right to contraceptive services"; Yet, no such right exists in law. The Law Reform (Age of Majority) Act [Appendix I, p.46] sets the age of sixteen years as the age at which a person, not yet an adult of 18 years, may give consent to medical, surgical and dental treatment. Below this age the responsibility for getting and consenting to medical aid for their children is the responsibility of parents and legal guardians. Under the Juveniles Act [Appendix I, p.46], failure by them to provide medical aid, if they are able to do so, is one of the aspects of neglect punishable as a misdemeanor.

The law makes it clear that girls under the age of sixteen are not legally competent to give consent to sexual intercourse, and any such act is an offense committed by her partner for which he is punishable. There have been few prosecutions under this law and it is generally ignored. (It is important to note that service providers working with pregnant young girls report that the children's fathers are not usually boys of similar age to the mothers, but older men.) Some family planning service providers, however, have qualms about giving contraceptives to these minor females, particularly without the knowledge of their parents or at least a competent adult. This situation appears to mean that the law, and its selective enforcement, albeit selective, give females under the age of sixteen no systematic protection from pregnancy.

Anecdotally, it is reported that some nurses in public health centers discourage, through disapproving or judgmental comments, "students" or "school girls" from receiving contraceptive information and/or products. The lack of privacy at public health centers is also reported to

discourage young women who do not want to be known as sexually active from seeking family planning services. The costs of using the more private services of a general practitioner or specialist are thought to be well beyond the financial means of such young people.

One effect of the sixteen year old age of consent to medical treatment is that women under this age who have children cannot legally consent to their offspring's medical care. This matter appears never to have been tested in court. It is not known whether this is because young mothers can usually get the support of an older person when problems arise, or whether the law is simply ignored. In any event, the irony of this current legal situation is striking.

Conclusions and Recommendations

A demographically important segment of the Jamaican population is denied easy access to contraceptive services by current law. Yet, the lack of direct access to contraceptives has not lead to decreased sexual activity among Jamaican youth. Current law only increases the likelihood of unprotected sexual activity among that segment of the population least able to care adequately for any offspring produced and reinforces the cycle of uncompleted -- and therefore inadequate -- education of many Jamaican women. Early and repeated childbearing can have enormous negative impact on achievement of national development goals.

Based on these conclusions:

1) Family planning service providers should not have more to fear from the law for providing contraceptives to sexually active minor females in order to protect them from adolescent pregnancy than do the adult males who are having sexual intercourse with those minor females.

2) The NFPB should undertake, as a priority action, the promotion of changes in the current law to allow direct access to contraceptive services for any sexually active female in Jamaica, regardless of age.

3) Further study of fertility and contraceptive usage patterns among women 15 to 19 years of age should be undertaken due to the early age of sexual activity and the reported high levels of adolescent fertility.

4) There is a need to enhance the role of the MOEC regarding family life education in schools. The NFPB should pursue policy dialogue with the MOEC to take action to implement sex education for the school-age population.

D.2. Spousal Consent

There have never been any legal requirements for spousal consent to the use of family planning methods up to and including sterilization. It appears, however, that some service providers, perhaps unaware of the absence of any such legal requirement, require spousal consent for sterilization procedures.

Conclusions and Recommendations

Provider misconceptions, rather than the law itself, constrain the ready availability of contraceptive methods -- especially female sterilization -- to some Jamaican women.

The NFPB should oppose any future effort to change the law so as to require spousal consent for use of family planning methods. Additionally, the NFPB should ensure the dissemination of correct information to physicians regarding current legal requirements for method provision so that providers do not themselves create an unnecessary constraint on method availability.

D.3. Informed Consent

Consent to medical treatment must be given by a competent person able to understand what they are agreeing to. A person who is unconscious, drugged or senile is incompetent. There does not appear to be a generally accepted standard of competence. One example is the case in which a parent or guardian seeks sterilization for a mentally handicapped woman for her own protection. There is no legislative provision in Jamaica that the consent given to medical treatment need be informed and there are no traceable cases on the subject. There is, however, a growing number of related cases in England that would be recognized in the courts of law here, as well as cases from all over the United States that might be regarded as persuasive.

Informed consent is also thought by family planning program managers to play an important practical role in increasing the continued and correct use of contraceptives by family planning acceptors. Women who understand clearly the contraceptive options open to them, the correct use of their selected method, and the physiological effects of the use of that contraceptive are most likely to be satisfied, effective contraceptive users over time. Continued, correct use of contraceptives is especially important in an environment where 75 percent of last births were reported to be either mistimed or unwanted [JCPS 1994].

Conclusions and Recommendations

Medical service providers not only explain the likely outcomes of the procedures they recommend but also offer alternatives so that clients may make a responsible and informed choice. It is generally agreed that this is an obvious and necessary part of the counseling process. Acknowledgment of this fact can be seen in the informed consent form included in the Standards for Female Voluntary Surgical Contraception.

The need to counsel family planning clients so that they can give informed consent to method selection should be included in all standards of practice developed and disseminated to both public and private sector service providers. Training in appropriate counseling techniques should be included in all university and professional curricula for physicians, nurses and midwives. Continuing education in family planning topics for physicians, nurses and midwives should also contain training relevant to informed consent. Also, the NFPB should foster

increased service for voluntary sterilization.

D.4. Prescription Requirements

All pharmaceutical preparations for systemic use including oral, injectable and implantable contraceptives are classified under the Food and Drug Act as List 4 products and require a physician's prescription for provision to the consumer.

An exception to the List 4 prescription requirement was made in the 1970s for the low-cost Perle oral contraceptive brand because it was introduced to the market as an NFPB-sponsored contraceptive social marketing brand. In practice, most pharmacies in Jamaica do not require a physician's prescription prior to dispensing any brand of oral contraceptives. The MOH/Pharmaceutical Services Division is now considering official removal of oral contraceptives from List 4, partly because of this widespread de facto liberalization.

Injectable and implantable contraceptives, also List 4 preparations, are currently dispensed directly to the consumer by the physician. (Pharmacists are not allowed to give injections, and implants are a minor surgical procedure.) Prescription requirements for these contraceptive products, therefore, do not constitute any additional barrier to their availability.

Conclusions and Recommendations

Prescription requirements do not themselves constitute an important barrier to easy access to contraceptive products in Jamaica. The inclusion of oral contraceptives on List 4 serves, however, to prevent brand-specific advertising of these contraceptives.

The NFPB should continue to promote the removal of oral contraceptives from List 4 to ensure their continued easy availability to consumers and to allow effective use of mass media channels for brand-specific promotion of oral contraceptive products.

D.5. Standards of Practice

Written standards of practice and other such guidelines commonly describe:

- The types of family planning consumers for whom each contraceptive method is or is not appropriate;
- The risks and benefits of method use;
- The correct clinical procedures for providing each method;
- The instructions for method use; and
- The appropriate follow-up care.

The information given in this guidance, as well as the provider's interpretation of the information, can have significant impact on a client's access to any given contraceptive method as well as on the quality of care which a client receives from the provider. Common medical practice based on an informal consensus among providers, previous training of the provider

or accepted social/cultural norms can often operate with as much authority as the written guidelines and standards described above.

A recent study by the NFPB, "Family Planning Service Delivery Practices of Private Physicians in Jamaica," indicates that current, common medical practice **may inappropriately constrain** the availability and acceptability of contraceptive methods to potential users in the following instances:

- "Rest" periods during contraceptive use, especially for pills and IUDs, are often recommended. These periods of "rest" leave clients unprotected from pregnancy and are unnecessary.
- Providers have inappropriate fears concerning the safety of Depo-Provera as a contraceptive.
- Sickle cell is seen as a contraindication for use of Depo-Provera.
- Providers do not screen potential IUD users for STDs and under-utilize this method in appropriate circumstances.

A few years ago, the MOH in conjunction with the NFPB developed a written standards of practice manual for family planning service providers in Jamaica. While distributed to many public sector personnel, the manual was not made available to private sector providers. A recent informal and unofficial review of the manual indicates that its usefulness in ensuring correct practice by providers could be strengthened in several areas:

- The level of informational detail given should be consistent from method to method.
- More guidance in correct provision of each method should be given in order to ensure adequate quality of care. The manual should serve as a treatment guideline for each method.
- Use of Depo-Provera should not be limited to parous women.
- Follow-up care recommended for oral contraceptive users is unduly intense, while no follow-up care for IUD users is described.

Conclusions and Recommendations

There is appropriate recognition of the importance and usefulness of written standards of practice for the provision of high quality family planning services among MOH and NFPB program managers. Additionally, considerable knowledge now exists concerning common medical practice among physicians who provide family planning services in the private sector. The current standards of practice manual can be strengthened to better meet the needs for information and guidance for all service providers.

The preparation and dissemination of practice protocols may do much to remove misconceptions about contraceptive methods and improve not only the quality of patient care but the satisfaction of clients with the care they receive.

Based on the following conclusions:

1) The NFPB should provide the impetus for a revision of the current written standards of practice for family planning service delivery. Copies of the revised manual should be disseminated to all relevant physicians in both the public and private sectors and to nurse/midwives and midwives working in the public sector. The NFPB should work in collaboration with the MAJ and other appropriate professional associations to provide fora in which the guidelines are discussed and explained to both public and private sector service providers. The MOH should be encouraged to develop quality of care standards based on the revised standards of practice manual.

2) Close collaboration between the agencies providing these guidelines is essential to ensure consistency of service provided to consumers and this should be coordinated by the NFPB.

E. AVAILABILITY OF INFORMATION

II.E. Availability of Information

Availability of family planning-related information has a significant impact on overall use of contraceptive services. Information campaigns can communicate benefits of family planning to potential users, attributes of contraceptive methods, locations at which services are available, correct use of contraceptives, brand benefits and costs of products and services. Information can also allay fears connected with contraceptive use and promote use of contraceptives among selected segments of the population. Constraints on the availability of such information can seriously diminish effective demand for family planning services.

There are three categories into which family planning-related information can be grouped: 1) information, education, communication (IEC) programs; 2) "sex education," as mentioned in the Family Planning Act; and 3) advertising for both products and service providers.

Family planning-related information can be delivered through a number of channels. These channels include the following:

- Print materials such as booklets, leaflets, posters and fliers;
- Personal counseling;
- Mass media such as newspapers, billboards, radio and television;
- Family life education in NGO and government sectors; and
- Public relations activities such as speeches and events.

This section of the study examines the legal and regulatory environment that surrounds the delivery of family planning-related information to the Jamaican public.

The Family Planning Act of 1970 states that, among other functions, the NFPB may "disseminate information, in relation to family and population planning," "provide for sex education and encourage the development thereof," and "collaborate . . . in the preparation and carrying out of family life programmes."

For the most part, the NFPB has taken responsibility for IEC activities through its Communications Unit, with financial support from the World Bank through a combination of matching grant and loan assistance. The NFPB's efforts have been hampered by difficulties in accessing funds from the World Bank vis-a-vis the MOH. IEC activities are focused on providing educational materials for the mass audience and, to some extent, special target groups. With the exception of a small-scale maintenance campaign that used previously developed advertising messages, no mass media activity has taken place in the last few years and no method-specific IEC messages have ever been aired. There is no apparent regulation in Jamaican law that prohibits the provision of method-specific information through the mass media.

The primary source of family planning information for Jamaican consumers currently appears to be the personal counseling available in MOH primary care clinics and in the offices of physicians who offer family planning services [JCPS 1994]. In both cases, it is reported that

provider biases sometimes constrain provision of such information to adolescents.

During the past twenty years, the NFPB has attempted to fulfill its mandate to provide sex education by encouraging the development and implementation of a Family Life Education (FLE) component for the public schools' curriculum. To date, the MOEC has introduced FLE into some grades at some schools; however, there is ongoing debate regarding what should be the definition and curriculum content, as well as whether FLE should be taught as a separate examinable subject. Although linkages between the NFPB and the MOEC have been weak, recent joint initiatives to develop a new FLE policy bode well for progress. By law, the NFPB has no line of authority over the MOEC; hence, the NFPB is limited to powers of persuasion to influence the MOEC. The implementation of a successful FLE program in the public schools (all age, primary, and secondary) is critically important to the overall national family planning goals.

The advertising of ethical pharmaceuticals, which includes all contraceptives on List 4, is controlled by the Pharmaceutical Services Division. Present regulations stipulate that "A person shall not advertise any List 4 Drugs to the general public." This means that no *brand name* advertising of oral, injectable, or implantable contraceptives to consumers may occur.

Condoms are already advertised in the mass media in Jamaica, with a new print and radio campaign recently initiated by a commercial distributor of these products. IUDs are considered by the Pharmaceutical Services Division to be "devices," and are not, therefore, subject to the restrictions on List 4 preparations. It is not clear, however, whether brand-specific advertising of IUDs to the general public would actually be allowed. The regulations state only that "A person shall not label, package, treat, process, sell or advertise any device in a manner that is false, misleading or deceptive or is likely to create an erroneous impression regarding its character, value composition, merit or safety."

The ability of physicians to advertise their services has been controlled by the Medical Council under the regulations of the Medical Act. Doctors have been allowed to advertise only to announce the opening of a practice or a change in the location of a practice. Medical Council regulation of these ads extended even to the size of type which could be used for each portion of the message. With the passage of The Fair Competition Act [Appendix I, p.46] in 1993, however, the authority of the Medical Council to regulate and control the business aspects of medical practice -- including advertising by providers -- has been called into question. The Medical Council is currently considering new guidelines, and the topic is hotly debated within the medical community. Entities within other "professions," such as the accounting firm Price Waterhouse, have recently begun to advertise their services to the public on the basis of The Fair Competition Act.

Conclusions and Recommendations

Teenagers, a demographically important segment of the Jamaican population, are constrained from receiving information necessary to prevent unwanted pregnancy partially due to the MOEC's reluctance to implement comprehensive and effective FLE program in the public

schools, which expressly addresses sexuality, family planning, and reproductive health. The NFPB does not have the authority under the law to ensure that its mandate to provide sex education is fulfilled.

There appear to be no regulations which prohibit communication of contraceptive method-specific messages through the mass media. Such messages are important to promote method use, allay fears of use, and ensure correct use. The national family planning program has not taken adequate advantage of this opportunity to make vital information available to the Jamaican public.

The ability to advertise oral contraceptives and physician services to the general public is currently in transition. Liberalization of current restrictive regulations may occur in the near future.

Based on these conclusions:

1) The NFPB should seek support from the highest levels within the GOJ for its efforts to have implemented an effective FLE course in the public schools. This course should contain contraceptive method-specific information. The demographic importance and impact on development of adolescent fertility should be a main point in the NFPB's overall public education campaigns so that public resistance to providing services to adolescents may be lessened.

2) The opportunities for family life and family planning education and counseling that exist in the primary care clinics of the MOH should be continued and strengthened. Provider biases against provision of information and services to adolescents or other segments of the population should be eliminated.

3) Method-specific advertising campaigns that seek to eliminate user fears and misconceptions and that support correct and effective use of contraceptives should be a major priority of the national family planning program.

4) The NFPB should monitor evolving trends in regulations regarding the advertising of contraceptives and private service providers and should promote liberalization of these regulations to ensure the availability of necessary information to all Jamaican family planning consumers.

F. SUSTAINABILITY OF SERVICE DELIVERY

II.F. Sustainability of Service Delivery

The long-term sustainability of Jamaica's national family planning program depends not only on the commitment of financial resources necessary to pay the costs of services delivery, but also on the ability of the NFPB to operate within the bureaucratic environment to ensure the implementation of necessary family planning services. This portion of the analysis will examine the broadly defined legal and regulatory environment that affects the allocation of resources on the national level for family planning services and the ability of the NFPB to implement its mandate under the Family Planning Act.

An important change taking place in Jamaica today is the transformation of the role and structure of the government. Changes in the size and responsibility of the public sector are taking place as the GOJ attempts to reduce the cost of public administration and at the same time withdraw from production and commercial activities. Three main strategies are in operation:

- reduction in the scope of operations of the public sector;
- divestment of state enterprises; and
- privatization of activities.

In particular, NFPB recognizes that statutory boards such as it is, which are funded from the central government, are being reviewed and that these boards are subject to wage restraint and possible reduction in budgetary allocation. For the present, the health sector has received special protection from austerity cuts. Nevertheless, the MOH is itself engaged in a process of rationalization and performance improvement that may affect the NFPB. Specifically, the MOH is undertaking the following institutional strengthening schemes:

- rationalization of the service delivery network;
- improved cost recovery through user fees;
- co-payment collection, reduction in the granting of waivers;
- privatizing some hospital services;
- decentralization of hospital budgets;
- strengthening procurement, storage, distribution and inventory controls;
- improving the management of the health system; and
- program budgeting and corporate planning.

The NFPB has been only peripherally involved in this program, mainly because it is not closely networked with the management structure and processes of the MOH.

The policy on fees for services in the public sector and the priority to be given to family planning within the national health program appears to rest within the MOH. The Minister, the Permanent Secretary and the Chief Medical Officer (in post as of Fall 1994) all affirm their commitment to keeping a vigorous program of family planning going. While acknowledging the importance of the family planning program, other sections of the MOH, however, have questions about the level of priority it should have. For example, the

Pharmaceutical Services Division reported that the need for contraceptives should be considered alongside the need for drugs for chronic illnesses such as diabetes and hypertension. The Maternal and Child Health section is sure that the highly successful immunization program should continue to be the top priority for health services delivery. Shortages of personnel to deliver services in primary health care will undoubtedly add to the problem of continuing the family planning program in the public sector.

The Ministry of Finance allocated J$ 13,175,000 to the NFPB for GOJ fiscal year 1994 in recognition that the NFPB performs several important activities in support of the national family planning program -- principally commodity support, IEC, planning and monitoring, and expanding service delivery through the private sector. In all centrally funded agencies, GOJ allocations have been declining in real terms over the last four years; the NFPB is no exception.

"An Act to Provide for a Board to be known as the National Family Planning Board" (No. 122-1970, 13 August 1970) mandates the NFPB to carry out and promote population and family planning programs in Jamaica. This act authorizes NFPB to carry out research and disseminate information in relation to family planning and population planning, to provide for sex education, and to operate and collaborate with other agencies in operating clinics concerned with family and population planning. The NFPB's work of co-ordination and direction of agencies and other governmental offices working in this field, however, has no effective powers of enforcement and must rely heavily on cooperation and persuasion to achieve its ends.

The ambiguity between the NFPB's responsibility versus its authority under the law is obvious in its relationships with Ministries of Government. In the case of sex education, the NFPB is given responsibility for seeing that such education occurs, but the MOEC controls the ability of the NFPB to implement that mandate. Additionally, the NFPB was established under the Minister as a statutory body with its own Board of Directors to provide it with policy guidance and oversight. The NFPB's relationship with the MOH, however, is unclear since the NFPB is responsible under the law for the success of a service delivery program over which it has no direct line of authority. There is even confusion within the MOH as to whether or not the NFPB must report to and seek operational approvals from the Ministry.

Since the establishment of the NFPB, the GOJ has also created the Planning Institute of Jamaica with responsibility for setting population goals and advocating broad population issues. There appears to be no clarification within the law on how the NFPB and the PIOJ are to share these responsibilities.

Conclusions and Recommendations

The current economic climate of Jamaica, characterized by a struggling economy and drastic decreases in real purchasing power, is recognized as an impediment to family planning program sustainability. The economic plight that Jamaicans currently face may, however, in and of itself, provide motivation for personal fertility regulation. Getting priority status for

family planning among the many programs of the MOH at this time may not be easy. Policy statements, after all, mean something only if they are implemented. Relationships between the NFPB and the MOH have to be substantially improved if what the Ministry says is its policy on the importance of the family planning program is to be realized. The mandate of the NFPB to promote and implement the national family planning program is not supported in law by the authority and/or enforcement powers necessary to achieve program goals.

The roles of the various governmental agencies working in areas related to population and family planning are not sufficiently clearly delineated to ensure greatest effectiveness.

The role of advocacy in promoting family planning in terms of garnering policy-maker support has been virtually ignored over the last five years. Day-to-day operations seem to have overshadowed the undertaking of an advocacy role. The situation calls for aggressive actions to increase advocacy measures which are critical for GOJ support.

Based on these conclusions:

1) The NFPB should undertake a very active advocacy campaign within the GOJ, itself, to try to ensure the commitment of financial and personnel resources necessary to maintain the effective delivery of family planning services.

2) The NFPB should work to strengthen its perceived standing within the government so that its power to leverage cooperation from other governmental agencies is increased.

3) The NFPB should work to clarify and strengthen its relationship with the MOH so that the gap between NFPB program policy and direction and MOH service delivery is diminished.

4) The GOJ should act to ensure that the NFPB has the authority to ensure implementation of program areas for which it has been given responsibility under the Family Planning Act.

SECTION III.

POLICY AGENDA SUGGESTED BY ANALYSIS

The overall environment for family planning in Jamaica is quite positive. In general, there are very few legal and regulatory constraints on the delivery of family planning services. A broad range of modern contraceptive methods is legally available within the country; service delivery points are widespread throughout the population; the commercial pharmaceutical and medical sectors operate freely; and knowledge of family planning and modern contraceptive methods is very high among the general population.

There are, however, some areas in which laws, regulations, and operational policies may constrain the ability of the national family planning program to achieve the contraceptive prevalence necessary to meet the national population goals. Equally important, these constraints impede the accessibility and acceptability of contraceptive services to some of those Jamaicans who want and need them.

The policy reform agenda of the NFPB offers an excellent opportunity to address and ameliorate wherever possible the constraints identified by this study.

Perhaps the most demographically important constraints on family planning service delivery within the Jamaican context are those which impede the access of sexually active adolescents to contraceptive services and family planning information. These constraints include:

- age of consent for medical treatment;
- providers' personal biases against provision of family planning services to adolescents; and
- unwillingness of the MOEC to develop and implement a truly effective FLE course in the public school curriculum.

The ability of service providers to deliver the quality of care necessary to support continued, correct use of contraceptives among family planning consumers is constrained to the extent that some providers lack complete and/or up-to-date knowledge of contraceptive technology, delivery and counseling techniques. This constraint can be lessened in the following ways:

- revise and distribute widely within both the public and private sectors of family planning service delivery guidelines;
- develop and implement updated technological information reinforcing counseling for service providers regarding continuing education; and
- include, within the pharmacist pre-service training curriculum, a unit on family planning, contraception and client communications.

To ensure that long term sustainability of family planning services remain available in Jamaica, the NFPB should lead dialogue with the MOH and non-governmental sector to develop a rational market segmentation policy and strategy for the family planning market. This should be driven by the MOH and NFPB's new cost recovery and pricing strategy that would enable the public sector to serve the safety net population and would "signal" consumers with the ability to pay to access resources in the private sector.

The level of effectiveness of current contraceptive prevalence is constrained by MOH operational policies that appear to make longer-term contraceptive methods less easily available than supply methods and by under-utilization of IUDs among appropriate potential acceptors. Limited, if any, promotion of tubal ligation as a contraceptive method also constrains the effectiveness of current prevalence.

Overall availability of contraceptive methods is somewhat constrained by limitations on the types of health care personnel who can provide them. Some advances in contraceptive availability might be made with changes.

Effective use of contraceptives by family planning consumers is constrained by misinformation, rumors and inappropriate health and side effect fears. This constraint could be greatly reduced by exploitation of the apparent absence of any laws which prohibit use of the mass media for contraceptive method-specific promotion.

Long-term sustainability of the national family planning program for which the NFPB has been given responsibility is constrained in the following ways:

- NFPB has little if any authority under the law to ensure the implementation of program areas for which it has been given overall responsibility;
- There is considerable competition for financial and personnel support among central government-funded agencies and within areas of the MOH;
- The perceived standing of the NFPB within the government is not strong enough to provide the NFPB the ability to leverage full cooperation from other governmental agencies; and
- The linkages between the NFPB and the MOH are not sufficiently clear and strong to prevent a gap between NFPB program policy and direction and MOH services delivery.

Appendix I

Legislation

1. Food and Drugs Act, Act 46 of 1964 as amended by Act 54 of 1974.

2. Food and Drugs Regulations 1974.

3. The Pharmacy Act, Act 5 of 1966 implemented 4th August 1975.

4. The Pharmacy Regulations 1975. Publication of Lists 1, 2, and 3 under Pharmacy Act, Section 17 (1) (a), October 20, 1977.

5. National Family Planning Act, No. 22, 1970.

6. The Customs Act, Cap. 89.

7. The Fair Competition Act No. 9, 1993.

8. General Consumption Tax Act, No. 15 of 1991 as amended by No. 21, 1991. General Consumption Tax Regulation 1991.

9. Medical Act No. 22 of 1972. The Medical (Registration and Disciplinary Proceedings) Regulations 1976.

10. The Nurses and Midwives Act No.35 of 1964. Implemented September 8, 1966.

11. The Nurses and Midwives Regulations, October 3, 1966.

12. Juvenile Act Cap. 189 as amended up to 1975. Section 9 (2) (a) meaning of "neglect"includes failure to provide medical care to minors under 17.

13. Law Reform (Age of Majority) Act No. __ of 1972. Section 7 (Consent by persons over 16 to surgical, medical and dental treatment).

Appendix II

Legal and Regulatory Analysis: Interviews

1. Mrs. Beryl Chevannes, Executive Director, National Family Planning Board (overview of relevant issues).

2. Dr. Olivia McDonald, Medical Director, National Family Planning Board (medical barriers, general issues).

3. Mrs. Grace Allen Young, Director, Pharmacy Services, Ministry of Health (promotion and registration of pharmaceuticals, tariffs).

4. Dr. Margaret Green, President, Medical Association of Jamaica (standards of practice, licensing, requirements for private practice).

5. Dr. Morris Guy, President, General Practitioners' Association (private practice, constraints on general practitioners, standards of practice).

6. Dr. David Thwaites, obstetrician/gynecologist (private practice, standards of practice, medical barriers).

7. Dr.Mary Sloper, general practitioner (private practice, standards of practice, medical barriers, constraints on general practitioners).

8. Mrs. Ellen Grizzle, President, Pharmacists' Association (tariffs and taxes on pharmaceuticals, methods available, prescription requirements, constraints on service delivery by pharmacists, family planning content of pharmacists' university curriculum, medical barriers, licensing, requirements for practice).

9. Mrs. Pam Beckford, Mrs. Joy Phillips, and/or Mr. Dick Kincaid, pharmacists (as in Number 8, above).

10. Dr.Barry Wint, Chief Medical Officer of Health, Ministry of Health (laws and regulations concerning medical practices and standards, methods available in public sector, formal and/or informal standards of practice, requirements for spousal and/or parental consent, constraints in supply, constraints on provision of methods, public sector pricing policies, informed consent, availability of physicians and nurses within public sector system for family planning service delivery).

11. Dr. Hugh Wynter, University of West Indies (standards of practice,informed consent, constraints on provision of methods, family planning content of basic medical education).

12. Dr. Tony Mullings, Chief, Obstetrics/Gynecology, UWI (family planning content in medical curricula, standards of practice, requirements for private practice).

13. Mr. Tony MacGregor,distributor for Wyeth (tariffs and taxes, currency and foreign exchange regulations and constraints, importation requirements, product registration process, pricing, patent and trademark protection, constraints caused by black market and informal importation of competitive products, methods and/or product types available).

14. Central Trading Company, distributor for Ansell condoms (as in Number 13, above).

15. Mr. Brown, Hopwood, distributor for Upjohn (as in Number 13, above).

16. Ortho representative, Hopwood, distributor for IUDS (as in Number 13, above).

17. Mr. Basil Wright, Medimpex, importer of contraceptives (as in Number 13, above).

18. McKann Erickson and/or Mr. Greg McClure, Dunlop Corbin, advertising agencies (restrictions on contraceptive advertising, promotion of methods, promotion of private practices, mass media mention of products and/or methods by name, censorship, campaign approvals for "sensitive topics").

19. Dr. Bernard, Victoria Jubilee Hospital (long-term methods, constraints on service availability, standards of practice, restrictions on who can receive methods, pricing of long-term methods, accessibility of supplies and equipment required, other medical barriers).

20. Dr. Diane Ashley, Secondary Care, MOH (same as in Number 19, above).

21. Dr. Eva Lewis-Fuller, Primary Care, MOH (methods available in public sector medical barriers, standards of practice, screening practices, access to services, pricing, access to providers).

22. Dr. Beryl Irons, Maternal and Child Health, MOH (same as in Number 21, above).

23. Revenue Board, Ministry of Finance (tariffs, taxes).

24. Mr. Paulwell and/or Mrs. Playfair, Fair Trade Commission (ability of practitioners to promote their services and to advertise, pricing).

25. Director, Nursing Council (constraints on practice, licensing, supervision requirements, services which can be provided, family planning content in nursing curricula).

26. Mr. Richard Ashenhein, attorney, Medical Defense Union (laws and regulations affecting doctors' practice, informed consent, constraints on practice).

27. Staff, MOH Health Center, St. Thomas Parish (medial barriers, methods available, access to providers, informed consent, screening barriers, standards of practice, constraints on hours or conditions of operation).

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