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ABSTRACT

A profile of Trinidad and Tobago is sketched in this paper. Although they are now unified into one national whole, their histories and socioeconomic and demographic developments have differed somewhat. Thus, these aspects of the two islands are treated separately where circumstances warrant. Emphasis is placed on the nature, scope, and accomplishments of population activities in the islands. Topics and sub-topics include: location and description of the islands; population--size, growth patterns, migration, age/sex structure, rural/urban distribution, ethnic and religious composition, literacy, economic status, future trends; population growth and socio-economic development--relationships to national income, size of the labor force, agriculture, social welfare expenditures; history of population concerns; population policies; national family planning program--objectives, organization, type, operations; research and evaluation; and private efforts and foreign assistance for family planning activities. Summary statements indicate that the presence of a climate favorable to acceptance of family planning has facilitated the achievements and progress of the national family planning program. However, two areas needing intensified and further study are: (1) community motivation and education, and (2) research and evaluation. A map of the islands is drawn and statistical data, tables, and charts are given. (BL)

Country Profiles

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TRINIDAD and TOBAGO

THIS PROFILE was compiled from material furnished in 1970 by Maxwell P. Awon, M.D., the Minister of Health of Trinidad and Tobago at that time. It was prepared by Dr. Sumedha Khanna in her capacity as advisor to the Government of Trinidad and Tobago from the Pan American Health Organization. Dr. Khanna is currently FAHO/WHO representative in Guyana.

Although Trinidad and Tobago are now unified into one national whole, their histories and socioeconomic and demographic developments have differed somewhat. Thus, for the purposes of this Profile, these aspects of the two islands will be treated separately where circumstances warrant.

Location and Description

The state of Trinidad and Tobago is located in the southern Caribbean. Formerly a British colony, the two islands gained independence in 1962. They have a total area of 1,980 square miles. Trinidad is seven miles from the Venezuelan coast. As the second largest island of the group formerly known as the West Indian Islands, it is about 65 miles long and 48 miles wide, with a total land area of 1,863 square miles. Tobago lies 19 miles northeast of Trinidad. It is about 32 miles long and 11 miles wide, with an area of 116 square miles. Trinidad is mostly flat with some swampland, especially in the coastal areas. There are two narrow belts of highlands in the center of the island. The topography of Tobago is broken by an 18 mile ridge extending southwest to northeast, reaching the height of 1,800 feet. The islands have a tropical climate with average temperatures of 84 degrees Fahrenheit by day and 74 degrees Fahrenheit by night. The dry season, which produces severe droughts, especially in southern Trinidad, lasts from January to May, and the wet season lasts from June to December.

The islands were discovered by Columbus in 1498. Trinidad was claimed by Spain and a Spanish governor was appointed in 1532. Tobago was claimed and occupied by the Dutch in 1632. Both islands, because of their strategic positions in the Caribbean, were involved in the expansionist activities of various European powers. During the seventeenth century, the islands were seized at different times by Great Britain, France, Spain, and the Netherlands. Trinidad was finally ceded to Great Britain by the Treaty of Amiens in 1802 and Tobago fell under British control through a later agreement in 1814.

The islands remained under British colonial rule until 1956 when they were granted limited self-government. In 1958 they jointly entered The Federation of the West Indies. Full self-government came into effect in June 1961 and, shortly after the dissolution of the West Indies Federation in May 1962, Trinidad and Tobago became an independent nation and a member of the British Commonwealth.

The economy relies heavily on the petroleum industry located in the southwestern region of Trinidad. Farming constitutes another important element in the state economy. Sugar cane, the main agricultural staple, is grown primarily in the west coastal region of Trinidad. The area around the capital, Port-of-Spain, is intensely developed. It is the only heavily industrialized area and, as a result, is the most densely populated region. In Tobago, agriculture, often at subsistence levels, is the main occupation. Industrial development on the island is limited to handicraft, cottage industry, and small plants producing a limited range of goods mostly for local consumption.

Population

Size

Total population. In 1861 the population of Trinidad and Tobago was 99,800. By 1901 the population had increased to 275,900. During the twentieth century, population growth has been rapid, and in 1960, the most recent Census year, the population was 831,000. The mid-year population estimate for 1968 was 1,021,000, of whom slightly over 50,000 were inhabitants of Tobago.

Total number and average size of households. At the time of the 1960 Census there were an estimated 180,846 households in the country, with an average of 4.6 persons per household.

Total number of women of reproductive age. In 1967 there were 208,700 women in the age group 15–44 out of a total female population of 505,750.

Union status of women of reproductive age. The most recent data on union status of women aged 15–44 are those of the 1960 Census. Of a total of 170,812 women in this age group in 1960, 71,277 were married; 27,993 in

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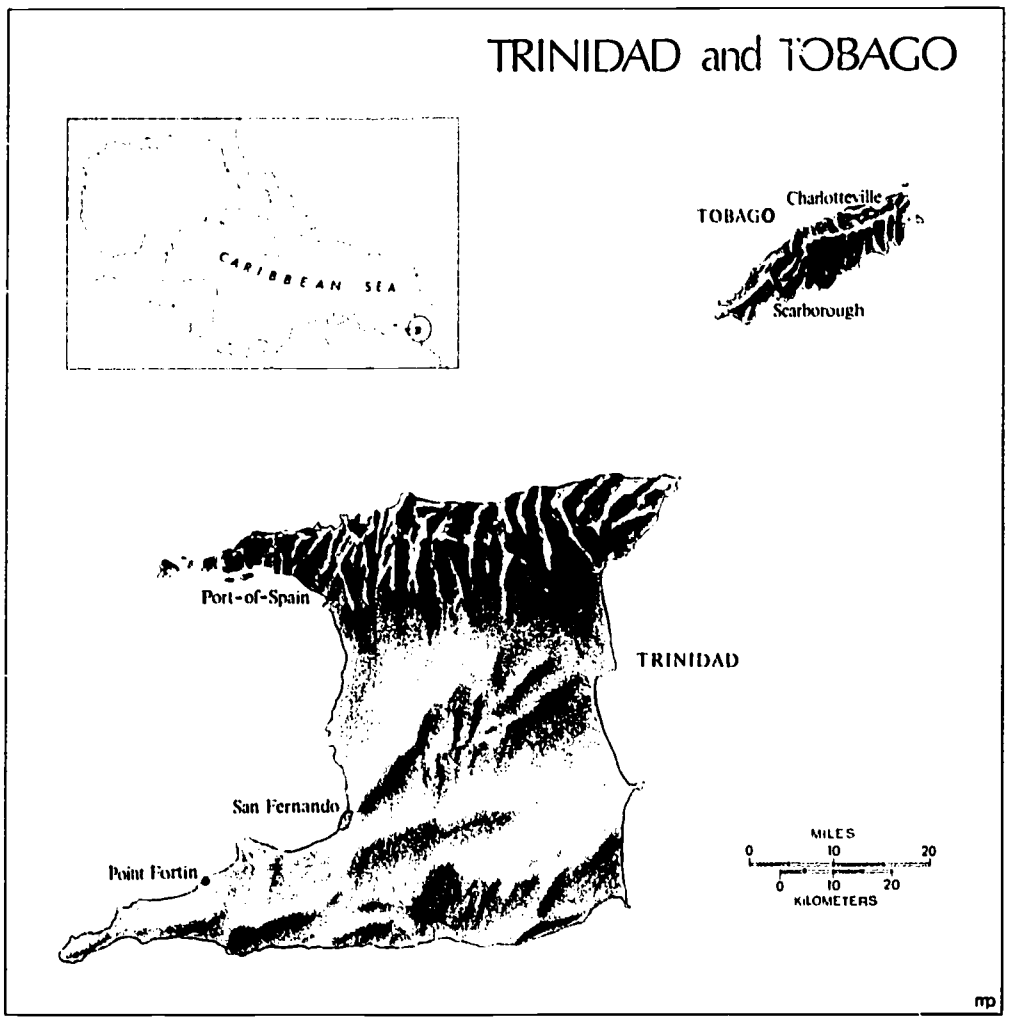

common law unions; 4,045 in visiting unions; and the remainder single or unstated.

Growth Patterns

Between 1861 and 1960, the total population of Trinidad and Tobago increased by eight and a quarter times, from 99,848 to 827,957. Table 1 shows the total population and annual rates of growth between censuses for each of the census years from 1861–1960. It is evident that this growth was not uniform: instead it fell into roughly three stages: 1) a rising rate of growth to a record 3 percent per annum for the years 1871–1881 followed by: 2) a decline to a growth rate of less than 1 percent during 1911–1921; and finally, a steady rise in the growth rate, increasing after 1931, and, by 1960, approaching the earlier maximum. This recent increase is more noteworthy demographically than the earlier increase because it can be attributed almost solely to rising natural increase; while the earlier increase may be largely attributed to large-scale migration.

For the twentieth century, Jack Harewood in an article published by the Central Statistical Office outlines three phases of population growth in Trinidad and Tobago, as follows:

1. During the first decade, 1901 to 1911, rates of birth, death, and net immigration were very high, resulting in a high rate of total population growth.

2. During the next two decades, 1911 to 1921 and 1921 to 1931, birth and death rates fell steadily but almost equally so that the annual natural increase changed little. In this period, there was a considerable fall in net immigration, leading to a big drop in the annual rates of overall growth.

3. From 1931 on births rose, slowly at first, and dramatically in the period 1946–1960, and deaths continued to decline, again dramatically in the period 1946–1960, so that natural increase rose rapidly. Net immigration rose significantly in the period 1931–1946 and fell somewhat again in the period after 1946, but its influence on total population growth was on the whole less marked than in the first phase.

Were the rate of 2.87 recorded from 1946 to 1960 to continue, it would lead to a doubling of the population in 22 years, and a total population of two and a half million by the end of the present century. But there is evidence that the present rate of population growth in Trinidad and Tobago is decreasing. Although in the first half of the 1960s the annual rate of population growth in the islands was 2.9 percent, in 1967 the rate of natural increase declined to 2.17, and in 1968 to 2.0 percent.

During the period 1960–1965 the total number of live births ranged from 32,858 to 34,107 per annum. In 1966 the number of live births declined to 30,079, and further declines occurred in 1967 to 28,462 and in 1968 to 28,017. The crude birth rate declined from 39 per thousand in 1960 to

TABLE 1. *Growth of Population for Census Periods: Trinidad and Tobago, 1851–1960*

Inter-censal Period	No. of Years in Interval	Total Population at End of Interval	Total Growth	Annual Rate of Growth (per cent)
1851–1861	10	99,848	16,870	1.87
1861–1871	10	126,692	26,844	2.41
1871–1881	10	171,179	44,487	3.06
1881–1891	10	218,381	47,202	2.46
1891–1901	10	273,899	55,518	2.29
1901–1911	10	333,552	59,653	1.99
1911–1921	10	365,913	32,361	0.92
1921–1931	10	412,783	46,870	1.21
1931–1946	15	557,970	145,187	2.03
1946–1960	14	827,957	269,987	2.87

Source: Jack Harewood, "Population Growth of Trinidad and Tobago in the Twentieth Century," Research Papers, Number 4, 1967, Central Statistical Office, Trinidad.

27.5 per thousand in 1968, a decrease of 32 percent.

There has been a significant decline in the crude death rate from 11 per thousand in 1951–1955 to 6.7 per thousand in 1967. This decline was due largely to the reduction in infant mortality rates from 73 per thousand live births in 1951–1955 to 37 per thousand live births in 1968. There has also been a marked decline in the death rate among children under age five over the last eight years. The declines in mortality are the result of a number of medical and public health measures as well as improvement in economic and social conditions.

Migration

Until recently, migration was almost as important a factor in population growth as the rate of natural increase. Between 1901 and 1911 net immigration to Trinidad and Tobago accounted for over 43 percent of the total population growth of that period. Between 1911 and 1921 migration to the islands was slight. However, in the inter-censal period 1931–1946, net immigration again increased, becoming a significant factor in population growth. The increased levels of immigration in that period were largely due to the increased employment opportunities on the islands arising from the location of a United States military base on Trinidad and from the expansion of the petroleum industry. During 1941–1942 alone, the total number of immigrants was 20,000. As World War II came to a close, migration ceased to contribute significantly to population growth. By 1964 the net migration pattern had changed from positive to negative. Between 1964 and 1968 there was a net emigration of 30,586 persons.

Age/Sex Structure

The population of Trinidad and Tobago is characterized by a young age structure: over 42 percent of the total population is under age 15. Mid-1967 estimates give the age distribution as follows: 15 percent, 4 and under; 27 percent, 5 to 14 years; 41 percent, 15 to 44 years; 13 percent, 45 to 64 years; and 4 percent, 65 and over. Out of the total population of 1,010,100 in 1967, 504,350 were male and 505,750 female.

TABLE 2. *Estimated Midyear Populations with Percentage Distributions by Age Groups: Trinidad and Tobago, Specified Years*

	1970		1975		1980	
Age Group	Number in thousands	Percent	Number in thousands	Percent	Number in thousands	Percent
Total	1,041.5	100	1,134.0	100	1,261.7	100
Under 1 year	27.4	3	30.0	3	34.8	3
1– 4 years	111.9	11	112.0	10	128.5	10
5–14 years	294.5	28	293.8	26	279.1	22
15–24 years	203.6	20	245.9	22	290.8	23
25–34 years	129.1	12	153.5	14	194.9	15
35–44 years	95.2	9	102.2	9	119.5	9
45–54 years	82.4	8	83.5	7	86.5	7
55–64 years	58.3	6	66.9	6	71.9	6
65–74 years	27.5	3	33.8	3	42.4	3
75 years and over	11.6	1	12.4	1	13.3	1

Source: Prepared by PAHO/WHO Country Office, in consultation with Central Statistical Office, Trinidad and Tobago, as an updating of previous published and unpublished projections. The table is based on provisional 1968 population estimates, provisional 1969 birth, and migration figures, and the assumptions: (a) fertility rate declining from 135 in 1968 to 120 in 1980; (b) emigration (age-selective according to pattern of 1966-68) declining linearly from 10,000 in 1969-70 to 0 in 1975.

Table 2 gives the estimated populations for 1970, 1975, and 1980 together with the expected age distributions. Figure 1 shows the population age group structure, broken down by sex, in 1960 and as estimated for 1980. The table and figure are based on slightly different assumptions. The table includes allowance for migration and, hence, is somewhat more realistic.

Rural/Urban Distribution

The capital, Port-of-Spain, had a population of 93,954 in 1960; its population is currently estimated at about 100,000. It dominates an urban region with a total population of some 400,000. The other two principal towns in Trinidad are San Fernando (1960 population 39,830) and Arima (1960 population 10,982). Scarborough, the chief town of Tobago, had a 1960 population of 2,500. Tobago comprises a number of village settlement areas, each containing populations of over 300 persons. Of these village areas, only 14 had populations in excess of 1,000 persons in 1960.

Ethnic and Religious Composition

The islands have a multiracial society with Negroes and East Indians the predominant ethnic groups. At the time of the 1960 Census, the population was 43 percent Negro; 3.6 percent East Indian; 2 percent white; 1 percent Chinese; 16 percent mixed; and less than 1 percent other or unstated.

At the time of the 1960 Census, 30 percent of the population were Protestant; 38 percent Roman Catholic; 23 percent Hindu; 8 percent Muslim; and 4 percent other or not stated.

Literacy

In 1960 the literacy level of the total population of Trinidad and Tobago was 89 percent. During 1967–1968 out of a total of 274,700 population aged 5 to 14, 244,772 or 89 percent were in primary schools; and out of a total of 103,200 persons 15 to 19 years of age, 28,949 or 28 percent were in secondary and technical schools.

Economic Status

The average per capita Gross National Product (GNP) in 1968 was US$755.00. Of the economically active population, 21 percent were employed in the primary sector (agriculture, forestry, hunting, fishing, mining, and quarrying), 31 percent in the secondary (manufacturing and construction), and 48 percent in the tertiary (commerce, transport, storage, communication, electricity, gas, water, and services).

Future Trends

For purposes of comparison, two projections of future population trends are presented. Under Assumption A there is no migration; mortality declines in accordance with the rates of decline during 1921–1960; and fertility declines from the gross reproduction rate of 2.98 in 1959–1961 to 2.00

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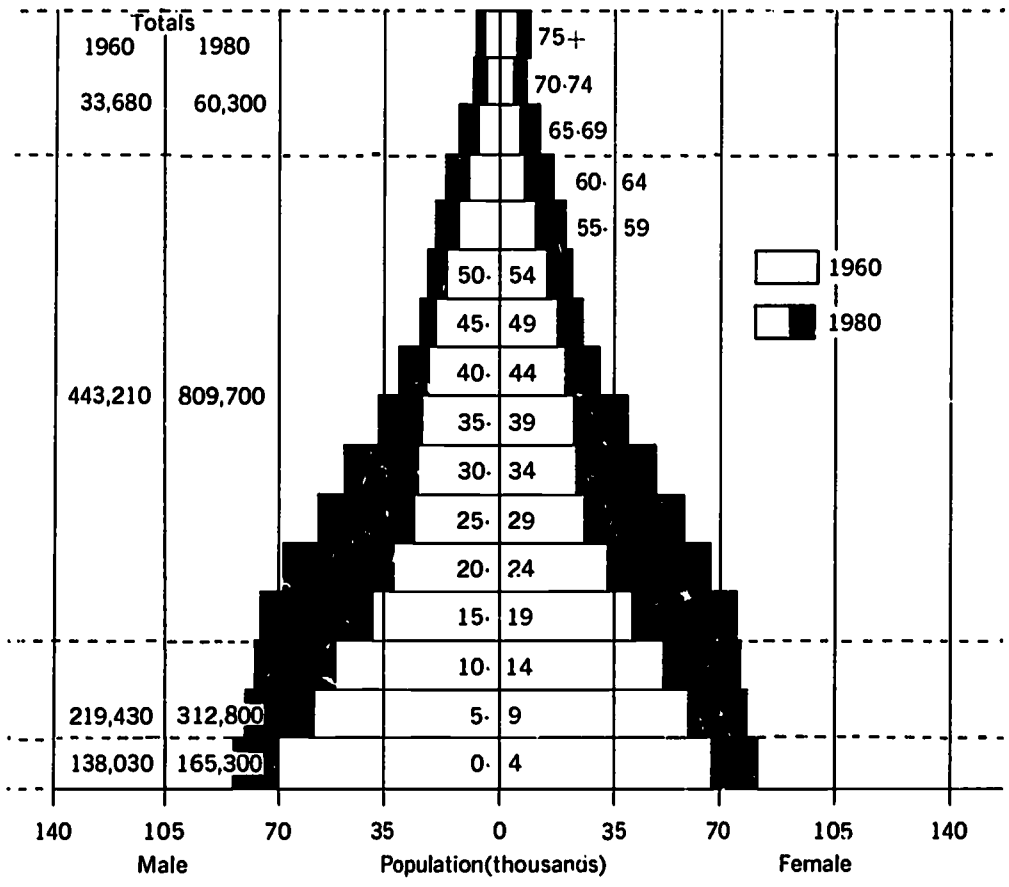
FIGURE 1. *Population Age Group Structure: Trinidad and Tobago, 1960–1980*



Source: This figure is derived from Table 22 from the Digest–1969, a publication of the Central Statistical Office of Trinidad and Tobago.
The table is based on the 1960 Census (adjusted figures) and the assumptions: (a) no migration; (b) mortality decline in accordance with rates of decline from 1921–1960; and (c) fertility declining from joint gross reproduction rates of 2.98 in 1959 to 1.66 in 1980.

in 1980. Under Assumption B there is no migration; mortality declines in accordance with rates during 1921–1960; and fertility declines from the gross reproduction rate of 2.98 in 1959–1961 to 1.66 in 1980.

Assumption	*1960*	*1965*	*1970*	*1975*	*1980*
A	834,400	964,700	1,100,500	1,250,200	1,413,000
B	834,400	961,100	1,090,500	1,215,200	1,348,100

Population Growth and Socio-Economic Development

Relationship to National Income

After independence in 1962, the responsibility for economic development depended more than ever before on the country's own efforts—with greater reliance being placed on utilization of its own resources. Between 1962 and 1965, the Gross Domestic Product (GDP) grew at 5.5 percent per annum in current prices. With a population growth rate of 2.7 percent per annum and price increases of about 2 percent per annum, the annual average rate of growth of real GDP was negligible. In the years 1966–1968, with increased production of petroleum, the GDP in constant prices is estimated to have grown an average of 6 to 7 percent.

Out of a total Gross Domestic Product of TT $1,543,200,000[1] in 1968, 33 percent comes from the primary sector; 21 percent from the secondary sector; and 46 percent from the tertiary sector.

Relationship to Size of the Labor Force

In Trinidad and Tobago all persons 15 years and over engaged in or willing and able to be engaged in the production of economic works and services are classified as being in the labor force. As of June 1968 there were 364,000 persons in the labor force, or 54 percent of the total population. The dependency ratio for that year was 84.

Between 1960 and 1968, the labor force grew from 289,000 to 368,000, a growth of 3 percent per annum. Had it not been for a net emigration of 26,000 persons during this period, the labor force would have grown by about 3.5 percent per annum. The estimated labor force participation rate in 1968 is 86 percent for men and 36 percent for women. Due to an increase in the female participation in the labor force there was an increase in the overall participation rates from 60 percent to 62 percent between 1960 and 1968.

The dilemma facing Trinidad and Tobago is that the labor force is growing more rapidly than the employment opportunities. Fertility rates have been declining over the last six years, but even if the decline continues, it will have little effect on the supply of labor for the next nine years, since annual increase in the labor force is determined by the number of births 15 years ago. After nine years, the labor force should grow less rapidly.

Relationship to Agriculture

Agriculture provides employment for some 22 percent of the labor force. It accounts for only 8 percent of the total value of goods and services produced in the economy. In recent years, the agricultural GDP has declined as a percentage of the total GDP. In 1956, its percentage contribution to GDP stood at 15 percent; in 1964, at 9 percent; and in 1968, at 8 percent. Sugar continues to be the principal crop, occupying 90,000 acres of land and contributing about one-quarter of agriculture's share of GDP. Other crops include cocoa, coffee, and citrus.

Relationship to Social Welfare Expenditures

Public education. In 1967 the government agreed that a long-range draft education plan should be introduced. The Draft Education Plan covering the 15-year period, 1969 to 1983, sought to reorient educational philosophy in Trinidad and Tobago to

[1] TT $1 (One Trinidad and Tobago dollar) = U.S. $0.50.

make it consistent with the goal of full national independence and identity.

The plan provides for a three-tier system of education—primary level, junior secondary level, and senior secondary level. It proposes to provide places for approximately 109,000 students in new primary schools and increase enrollment in existing schools by 91,000. The Junior Secondary School will offer secondary education on the basis of a three-year course for the age group 12–14. At the senior secondary level, the plan proposes a comprehensive program of education, encompassing both academic and technical courses.

For the first five years of the plan (1969–1973), places for approximately 7,000 students will be created in new primary schools; and for approximately 37,000 in 16 new junior secondary schools on a double shift system. The latter will make it possible for approximately 60 percent of the 12–14 year age group to attend junior secondary school as compared with 22 percent in 1968. At the senior level, 5,000 additional places will be provided in this period. The plan also envisages expansion of teachers' training programs.

Public health. In the Ten-Year National Health Plan (1967–1976), specific objectives include reduction of the incidence of communicable diseases and improvement of environmental sanitation and diagnostic and curative care.

In 1969, there were 410 physicians in the country, giving a ratio of 3.98 per ten thousand population and 1,440 registered nurses, giving a ratio of 13.98 per ten thousand population. There are 5,318 hospital beds and a total of 117 health facilities, including hospitals, health centers, health posts, and dispensaries.

History of Population Concerns

The family planning movement began in Trinidad in 1956 when a general practitioner attached to an oil company hospital opened a family planning clinic in Point Fortin. It operated under the auspices of a privately organized Family Planning Association. The aim of the clinic was to provide easy access to medically approved methods of family planning and to subsidize the cost of contraceptives for those who could not afford them. In 1959 a second major clinic was opened in Port-of-Spain. Subsequently clinics were opened in other areas, but several were forced to close, and the efforts of the Association were severely handicapped by a number of factors: lack of community support for clinics; opposition from the Roman Catholic Church; administrative and funding problems; the need for a largely volunteer corps of medical professionals; and the lack of government backing.

Despite the major setbacks to the Association and largely because of the perseverance and dedication of a group of medical professionals, the movement was successful in winning popular support and ultimately, in 1967, the backing of the government.

In 1961 the Trinidad and Tobago Family Planning Association was formed and became an affiliate of the International Planned Parenthood Federation (IPPF). By 1965, three urban and two rural clinics were in operation, each with two salaried midwives and one salaried field worker working full-time, and a volunteer staff of physicians and nurses. The continued absence of government support at that time was a major liability in that it made contributions even from foreign agencies less possible.

Population Policies

The Government's Draft Second Five-Year Plan (1964–1968), recognizing the relationship between economic development and population increase, called for a "better balance between birth rates and death rates." However, rather than recommend any program for family planning, the plan concluded that "if the historical and contemporary experience of other countries is any guide, the high and rising standards of living as well as the further spread of education and sophistication should bring about in the future a better balance between birth rates and death rates."

At this time, polls of local leaders showed a favorable response to the proposal of introducing family planning. In 1965, encouraged by this open show of support, the People's National Movement (PNM), the political party then in office, appointed a committee from its General Council to consider and report on what the party's policy toward family planning should be. The report, completed in March 1965 and published in 1967, recommended that the PNM accept family planning as necessary to the social and economic progress of the country. The Special Convention of the PNM on 22 April 1967 requested the Government of Trinidad and Tobago "to institute a national program of education in family planning and to introduce a Family Planning Program on a national scale to cater for the needs and desires of all."

A Population Council was appointed in June 1967 by the Cabinet to advise the Minister of Health on the organization of a national program that would coordinate all the family planning activities in the country. During 1967 the national family planning program commenced, with the Population Council as its primary executive body.

National Family Planning Program

Objectives

The goal of the national program is to reduce the birth rate to the vicinity of 20 per thousand by 1977, the end of the tenth year of program activity. The program aims emphasize the health and economic benefits of family planning to the individual, to the family, and to the nation as a whole. Thus, major goals are: reduction of pregnancy wastage arising from premature births, foetal and neonatal deaths, and induced and spontaneous abortions; avoidance of hazards to maternal health resulting from excessive and frequent childbearing; reduction of mortality and morbidity rates of infants and young children; and improvement of the socioeconomic status of individual families and national economic development.

The program operates on a nationwide basis to ensure the ready availability of family planning services to all who wish to make use of them. No coercion or pressure will be exerted; and the choice of family planning services and methods will be left to the individual.

The National Family Planning Program is a collaborative effort of the government sector and the two voluntary organizations—the Family Plan-

ning Association and the Catholic Marriage Advisory Council.

Specifically, the short-term objectives of the program include:

(1) Establishment of an administrative organization at central and peripheral levels, for formulation and effective implementation of the program.

(2) Establishment of family planning clinics through a phased program, making services easily available to all who wish to make use of them.

(3) Recruitment and training of medical, paramedical, and nonmedical personnel for the total program.

(4) Implementation of a program for community education and motivation.

(5) Establishment of a system of research and evaluation for periodic assessment and adjustment of the program.

Organization

The National Family Planning Program operates under the auspices of the Ministry of Health and was developed concurrently with the reorganization of that Ministry under the National Health Plan, 1967–1976. The internal structure of the program provides for three levels of responsibility and authority: policy decision; program formulation and evaluation; and program execution.

Policy decision level. The Population Council of Trinidad and Tobago has been established within the Ministry of Health at the policy decision level. It functions as an advisory body to the Minister of Health. It has been entrusted with the coordination of overall development, implementation, evaluation, and readjustment of the National Family Planning Program. The Population Council is appointed by the Cabinet to serve for a two-year period. The Council completed its first two years on 30 June 1969 and was reappointed on 1 July 1969.

The Council is headed by a Chairman and a Deputy Chairman, both appointed by the Cabinet. The director of the National Family Planning Program serves as the Secretary of the Council. Members of the Council include senior representatives from related government departments such as Health, Statistics, Public Relations, and Planning Development; community leaders; representatives from the private associations; specialists in obstetrics and gynecology; and a medical officer. Presently there are 15 members on the Council.

Program formulation and evaluation. Program formulation and evaluation are carried out by five committees concerned with different aspects of the program. (1) The Community Education and Publicity Committee, chaired by the Director of the National Family Planning Program, is responsible for the development of a comprehensive community education program, including publicity campaigns, audiovisual aids, and training programs for health and community educators. (2) The Maternal and Child Health Committee is chaired by the Principal Medical Officer of Integrated Health Services. The major functions of this committee that are related to the family planning program are: to set family planning clinic targets; to advise regional health staff in implementation of these targets; to advise the medical officer of the family planning program in formulating and implementing training programs for medical and paramedical personnel; and to establish norms and procedures for the clinic services. (3) The Research and Evaluation Committee is chaired by the Director of the Central Statistical Office. The major functions of this committee are to quantify national family planning program goals and objectives and set targets; to develop recording and reporting procedures; to develop a scheme for total program evaluation; and to formulate proposals for such research studies as are desirable for program evaluation. (4) The Medical Committee, comprising the senior obstetrician and gynecologist and representatives of the Medical Association of Trinidad and Tobago, deals with medical and technical aspects of the program, including clinical research. (5) The Finance Committee deals mainly with financial aspects of the program, including determination of needs for external assistance.

Program execution level. At the central level of program execution, a Family Planning Unit has been established in the Ministry of Health under the Principal Medical Officer in charge of the Integrated Health Division. The staff assigned to the unit include a director, a medical officer, a nursing officer, a health education officer, a statistical officer, and supporting staff. This unit functions as a team and coordinates the implementation of different components of the program. The unit staff form the liaison between the program formulation level and regional program execution levels. The unit staff collaborates with the staff in the health services; supports and complements them in implementation of the total program; and also collaborates with such other government sectors as education and community development and with the private sector. Program execution at the regional level is the responsibility of the Regional Directors of Health. All medical and paramedical staff collaborate in the implementation. The Family Planning Association and the Catholic Marriage Advisory Council also operate at the regional level in national program execution.

Type

Family planning clinics provide contraceptive supplies and counseling on contraceptive techniques and practices. Health education is an integral component of all these activities. A full-time health staff of doctors, nurses, midwives, and nonmedical staff, supported wherever necessary by part-time staff, conduct family planning activities within the established health facilities. Contraceptive supplies are provided free of charge to the public.

In 1968 a National Maternal and Child Health Program Formulation Committee was established by the Minister of Health to review existing maternal and child health services; to formulate a comprehensive maternal and child health program integrated with family planning activities; and to establish norms, procedures, and targets for maternal and child health services. The broad structure for such a program has been formulated.

Operations

Character of Program. The Five-Year National Family Planning Program (1968–1972) projected the estab-

lishment of clinic services throughout Trinidad and Tobago according to a phased plan. The ultimate goal is to provide family planning services in all of the country's approximately one-hundred health facilities.

During 1967, clinic services were offered through two regional hospitals and five Family Planning Association clinics. By mid-1970, there were 36 clinics, including 26 government, 8 Family Planning Association, and 2 Catholic Marriage Advisory Council (CMAC) clinics. The major urban clinics function daily or two to three times weekly; the other clinics function as often as needed, the need being assessed by means of clinic utilization figures. A minimum of two new government clinics a year is planned until all the health facilities have been covered.

The clinic locations are determined by population density, prevalent fertility, availability of health staff, suitability of physical structure of the health facility, and accessibility. All strategic areas in the country have already been provided with clinic services. The current emphasis is on expansion of clinic services to remote areas.

As a general rule, a government clinic is staffed by a medical practitioner, two nurses, and a clerk. Where possible, a full-time health service staff is in charge of the clinics. Because of staff shortages in a number of areas, however, extra staff have to be recruited and paid predetermined sessional fees. The government policy has emphasized that family planning is to be considered an integral part of the functions of the government health personnel, and hence no extra allowances are paid for family planning work performed during normal duty hours. Manuals of clinic procedures have been developed to assist and guide the clinic staff in the operation of clinics. These have been made available to all clinics.

While encouraging all sectors of the community to participate, the program's special targets include women of high parity; women who have recently completed a pregnancy; women who have special health problems that are likely to be aggravated by repeated childbearing; industrial employees; armed forces; and young people in the early reproductive period.

Information and education. The 1968–1972 Five-Year Program recognizes the importance of a vigorous and effective effort for community education and motivation. Because of the many years of work of the Family Planning Association of Trinidad and Tobago, a climate now exists for the acceptance of family planning. Recruitment of 15 percent of the women aged 15–44 to the family planning clinics in the first two years of the national program without an intensive publicity or motivation drive is evidence of the widespread acceptance of family planning.

It is recognized, however, that for the success of the program, sustained motivation is necessary and greater efforts are required to bring the ambivalent and unmotivated groups into the clinics. The national program is now reaching the second phase when extension of field programs for community education is envisaged.

Among the community education and motivation efforts, many types of approach have been utilized:

1. Mass Media. Through the use of radio, television and newspapers, the public is kept informed about the location of services, the progress, and the achievements of the program. Series of weekly radio broadcasts on family planning and related topics were developed and used during 1969 to create public awareness of the population problem and to promote public participation. Since the beginning of 1970, a bi-weekly feature on family planning has been presented on television.

2. Group Education. Film shows, lectures, and discussions have been held throughout the country. The Health Education Division of the Ministry of Health has collaborated in these efforts. Shows are held at prenatal clinics, child welfare clinics, and family planning clinics as well as in community gatherings such as the village councils and in some schools.

3. Personal Approach. The Postpartum Education/Referral Program is the main program using a person-to-person approach in family planning education. Since July 1969, an education/referral program has been effective in the maternity and abortion wards of the three regional hospitals, and the program now being extended to the maternity wards of other hospitals. Eight nurse-midwives have been appointed on a sessional basis to make daily ward rounds and approach each mother individually, explain contraceptive methods, and give referral cards for family planning clinics. Approximately 6,000 women were contacted through this program in 1969. The evaluation of the program is in progress. During 1970, the education/referral program was extended to the maternity wards of the district and county hospitals. Since 61 percent of the total deliveries in the country take place in government institutions, this program, when in full phase is expected to reach 15,000 women in maternity wards and about 4,000 women in abortion wards. The nurses conducting this program were trained locally under the direction of hospital senior medical and nursing personnel.

4. Other Media. Leaflets and posters have been printed locally for distribution in clinics and other health facilities and at public and group meetings. A flip chart and a teaching kit have been devised locally and are used by all clinic nurses and nurses in the education program in postpartum wards. Eight family planning exhibitions were mounted during 1969, five by the Family Planning Association and three by the Ministry of Health. Cinema slides have also been produced and are to be pretested before full use in the program.

During 1970, the program plans included two pilot projects in person-to-person contact through home visits. The first utilized the collaborative effort of hospital and district nurse-midwives in Tobago. All newly delivered mothers in a selected area were to be paid a home visit for family planning referral. This project could not be implemented on a systematic basis due to a shortage of nursing personnel. In the other project non-professional field workers who have been trained in education and communication techniques contact individuals at homes in selected areas in Trinidad for the purpose of referring them to family planning clinics. The impact and cost effectiveness of these projects will be carefully evaluated prior to further expansion.

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5. Family Life Education. A conference in "Family Life Education" was held in 1969 to consider the need for a family life education program for young people and education of the men in parental responsibility and family planning. Eighty representatives from professional and community organizations met to discuss the subject. Subsequently, a Technical Subcommittee of the Community Education and Publicity Committee of the Population Council was formed to examine the current status of education in family life in the country and to draw up a comprehensive program for use in schools and for youth groups. Members of this committee are drawn from the Ministries of Health, Education, Community Development, and Youth Affairs, teachers' training colleges, religious groups of major denominations, the University of the West Indies, the Family Planning Association, the Parent-Teachers' Association, the Probation Office, and others.

Because of the current interest at several teachers' training colleges and some schools in holding lectures on family life education, ad hoc programs have been conducted by the Family Planning Association, World Council of Churches, Catholic Marriage Advisory Council, and staff of the Family Planning Unit.

Methods. All family planning clinics offer a wide variety of contraceptive methods including orals, IUDs, diaphragms, foam, and condoms. The choice of method is left to the individual. Advice on the rhythm method is also available through the specially trained staff of the Catholic Marriage Advisory Council.

Since 1967, there has been a trend among acceptors toward oral contraceptives. During 1968 and 1969, 77 percent and 73 percent, respectively, of the total new acceptors selected orals. Only 6 to 7 percent of the new acceptors chose the IUD; the rest chose other methods.

During the earlier years of the Family Planning Association Program, before the free availability of the oral contraceptives, the IUD was accepted more widely. While many factors may have contributed to the shift in the choice of method, perhaps the major ones are free and easy availability of the orals and fear of adverse effects of the IUD among the public and the professional staff.

Contraceptive continuation rates appear to be high. For the year 1969, the crude estimates give a total discontinuation rate of 27 percent for all methods: 26.7 percent for oral contraceptives; 8 percent for IUD; and 29.7 percent for all other methods. A follow-up study is planned to get more accurate estimates.

Clinical trials of injectable contraceptive methods have been conducted by the Family Planning Association.

Tubal ligation is offered to women on request, mainly at the two regional hospitals, particularly if indicated on medical grounds. During 1968 and 1969, approximately 220 tubal ligations were performed at the two hospitals.

Personnel and training. Training programs for different categories of workers—medical, paramedical, and nonmedical—have been devised and conducted. The emphasis during 1968 and 1969 was on short in-service training courses including lectures on pertinent topics and practice sessions. The target groups for this training were medical and nursing staff in the maternal and child health services, key community educators, and clerical staff of the clinics.

Arrangements were made at both Regional Hospitals to provide facilities for training in family planning techniques for doctors and nurses. The family planning clinics located in the maternity departments serve as training centers in clinical techniques and in organization procedures. They offer two sessions monthly for this purpose.

For doctors, seminars at regional and national levels have been conducted through the Trinidad and Tobago Medical Association. At the inception of each clinic a doctor is appointed to head the staff and is instructed in clinical techniques when necessary.

Training of nurses and midwives has been undertaken through two types of programs: short in-service courses; and lectures on family planning as part of the pre-service curricula. By December 1969 all nurses working at the district level had attended in-service courses on the nature of the National Family Planning Program and the technical and educational aspects of family planning. Hospital nursing personnel, mainly graduate nurse-midwives or those about to graduate, were given a similar course. Nursing educators and instructors and nursing administrative staff have been given in-service training.

Family planning and related subjects were first introduced in nursing curricula during 1969. Curriculum content for all nursing education programs, including basic nursing, midwifery, public health nursing, and assistant nurse training, has been revised to include lectures on such topics as demographic and sociological consequences of population growth, family planning—rationale, techniques, education, and communication, government plans, and policies. The course content also allows for practical training in clinics. Nursing educators are now taking the leading role in these training programs. Clerical staff for the clinics are trained in clinic recording and reporting procedures through quarterly short work groups as well as through individual contacts. Seminars have been held for the Health Education Officers and for the Community Development Officers, to highlight important aspects of the family planning program and the role of community educators in motivation of the community.

Opportunities for training overseas in special subjects—medical, administrative, educational, statistical, etc.,—for selected staff of the Family Planning Program and other Public Health and Ministry of Education staff have been provided largely through fellowships awarded by the Pan American Health Organization/World Health Organization (PAHO/WHO).

Budget. The program budget is met by allocations from Government Development Funds. The allocations are voted on yearly. The Government Development Program has promised an allocation of TT$200,000 per year for the first five years of the program, mainly for purchase of supplies.

In 1968, $200,000 was allocated under the Development Program and $100,000 under recurrent expenditure of the Ministry of Health. This provision was adequate to meet the estimated cost of all supplies, clinic and office equipment, staff salaries, subventions, and expenses involved in

training and education. Because of substantial aid from foreign sources and a delay in the appointment of full-time staff, only TT$78,370 of the allocated funds was spent during the year.

In 1969, TT$417,050 was allocated to the program, of which TT$205,020 was released. However, expenditure came to TT$160,669. Again expenditure fell below allocation because of substantial aid received from foreign sources toward equipment and supplies and overseas training.

The government gave subventions to both voluntary organizations for 1969. The Family Planning Association received TT$50,000, and the Catholic Marriage Advisory Council TT$10,000. These amounts were increased to TT$60,000 and TT$12,000, respectively, for 1970.

Research and Evaluation

Procedure

During 1968, the government program adopted the record forms and procedures in effect at the Family Planning Association clinics. Efforts were started to outline a comprehensive evaluation scheme. Three principles were kept in view: that the system be kept simple; that the compilation of data be decentralized, i.e., at the clinic level; and that both government and private sectors use the same procedures to maintain uniformity in data collection. During 1969, the following procedures were adopted:

Clinic level. A Family Planning clinic case card was designed and adopted in January 1969 by all clinics. Under this procedure, a card is made out for each person attending a clinic for the first time and kept at the clinic. A clinic card for appointment or referral is given to each client and is to be brought by the client to each revisit. This procedure facilitates location of the clinic case card from the clinic files. A system of transfers of records and patients from one clinic to another has been organized through the use of transfer slips.

Since December, 1969, a Statistical Card has been used for each new acceptor. This new card contains information on age, address, number of living children, and contraceptive method prescribed. The card is completed at initial interview and all cards from all clinics are forwarded to the central office at the end of each month for monthly analysis.

At the clinic level, daily and follow-up records are also kept. Pertinent information is extracted and forwarded to the central office for compilation. A daily summary is compiled from the record of daily attendances and provides information on clinic caseloads, new cases by choice of contraceptive method, old cases and revisits, and amount of contraceptive supplies distributed. A system of recording follow-up visits attempts to provide a continuous record for each individual case for a period of three years and a gross estimate of discontinuers for each clinic.

A monthly report form is completed by each clinic, giving pertinent information on clinic performance for the month. This is basically a compilation of daily summaries.

Central level. A monthly report is compiled by the central office of the Family Planning Unit. This is derived from the clinic monthly reports, and gives statistical information on program performance. It is supported by a narrative program report which incorporates pertinent information for each program component. This report is then studied by the Population Council of Trinidad and Tobago at its monthly meetings. Promptness is encouraged and so far there have been no lag periods.

Throughout 1969, the system was closely monitored and weaknesses were identified. The procedures were revised as necessary, and the system is still subject to constant review and adjustment.

A manual of instructions was prepared for service statistics, and all program staff and clinic clerks were instructed on its use. A manual is provided for each clinic.

Operational evaluation. Evaluation of the program is largely carried out by the Family Planning Unit Staff through a team approach. The program has established annual targets for each program component, including administration, personnel, training, clinic services, community education, and research and evaluation. Through a system of monthly reports, the program achievements are critically reviewed by the Family Planning Unit staff and the Population Council of Trinidad and Tobago. Currently there are plans to set quarterly and monthly targets for each program component.

Evaluation of training courses has been undertaken mostly through administration of questionnaires. Certain aspects of community education programs, particularly of the postpartum/postabortion education programs are being evaluated.

Research

In 1968, about 20,000 clinic case cards of the Family Planning Association used prior to 1968 were analyzed.

Research targets for 1969–1970 included: (1) a study of continuation rates for various contraceptives and reasons for discontinuation; (2) a field survey for assessment of knowledge, attitudes, prevalence of contraceptive practice and fertility performance; (3) design of an abortion survey; and (4) a study of characteristics of new acceptors.

Research projects undertaken include: analysis of a sample of clinic case cards; a pilot project to study discontinuation of contraceptive practice; and study of some variables affecting fertility decline in the country.

A research study of IUD contraception Lippe's Loop D has been directed by the Family Planning Association over a period of four years in their two major urban clinics. The study indicates that the incidence of pregnancy, expulsion, and removal tends to occur in the first 12 months of use. With regard to the effectiveness of the IUD as a contraceptive method, pregnancy rates of 1 percent to 4.2 percent have been recorded over the four years. The active cases indicate that out of every ten loop users, at the end of one, two, and three years, six, five, and four persons, respectively, are still on the method and possibly two or three at the end of the four-year period.

A comparative study of the loop and the oral contraceptive for a four-year period was also undertaken by indicated higher acceptance levels for the latter. For the oral contraceptive, the percentages on the method at the end of one, two, three and four years were 91, 78, 58, and 34, respectively; for the IUD, they were 55, 47, 31 and 14, respectively.

New acceptors. In the initial years (1968–1972), the National Family

Planning Program aims to recruit about 10 percent of the women in 15–44 year age group to the clinics each year. The annual targets of new acceptors for 1968 and 1969 were set at 20,000. The program aims to reach a total of about 100,000 women by the fifth year.

According to estimates of the Family Planning Association 20,000 women attended FPA clinics from the outset of the program until the end of 1967. During 1968, the national program recruited about 13,000 new acceptors and during 1969, 16,000. Presently the extent of the efforts of the private sectors—the private practitioners and pharmacies and drug stores—is not clearly known. It is known, however, that most private practitioners offer family planning services and that contraceptive supplies can be purchased at most drugstores. A survey undertaken in 1969 to estimate the sale of contraceptives through the private sector is not yet complete.

Private Efforts

As has been mentioned previously, the National Family Planning Program is a collaborative effort of the government sector and the two private organizations—the Family Planning Association of Trinidad and Tobago and the Catholic Marriage Advisory Council.

Family Planning Association. The Family Planning Association of Trinidad and Tobago was first organized by a concerned private practitioner supported by some private citizens in 1956. The Association became the thirty-second member of the International Planned Parenthood Federation (IPPF) in 1961. By 1963, the Family Planning Association participated in acceptability trials for contraceptive foaming tablets sponsored by the IPPF and for the IUD sponsored by the Population Council of New York. By 1968, the tenth year of operation of the Association, some 20,000 women had registered with its clinics.

The Association now runs eight clinics in Trinidad, including two clinics located in urban centers that hold daily clinic services. The services at all clinics include counseling on all contraceptive methods, supplies, pregnancy tests, and cancer screening through cervical cytology. Full-time and part-time medical, nursing, and nonmedical staff assist in the clinics and the educational program of the Association.

The Family Planning Association collaborates with the government program in all activities. It provides field education through film shows and lectures given at clinics, in community groups, in schools, and at exhibitions. The Association's medical staff has also actively participated in clinical research studies on acceptance of various contraceptive methods.

The Association receives financial support from IPPF and the Government of Trinidad and Tobago. The latter provides free contraceptives, clinic supplies, and an annual subvention of TT$60,000.

Catholic Marriage Advisory Council (CMAC). The Catholic Marriage Advisory Council was founded by a Catholic priest in 1962, and was initially supported by voluntary services of medical practitioners and Catholic priests. The Council now functions through an office in Port-of-Spain and has the services of a full-time nurse and voluntary services of five to six medical practitioners and two Catholic priests. CMAC operates daily rhythm clinics at the main center and at an extension clinic in the Port-of-Spain general hospital. Plans are under way to extend services to other areas. The staff also provides education/instruction courses for engaged and married couples. Financial support for the work of the Council comes mainly from a government subvention that goes toward staff salaries and supplies.

Foreign Assistance

The National Family Planning Program has received technical and material assistance from many external sources.

The Pan American Health Organization/World Health Organization (PAHO/WHO) has been a major source of both material support and short-term and long-term technical advisors. Technical assistance through short- and long-term consultants has been provided for program planning; local training of medical, nursing, and nonmedical personnel; planning of community education; and program evaluation procedures. Short-term and long-term fellowships for overseas training have been provided for key people in the program.

A grant obtained from the United States Agency for International Development (AID) in 1969–1970 was applied toward clinical and educational supplies and equipment for the program.

The Swedish International Development Authority (SIDA) has been a major source of material assistance to the program and has provided contraceptive supplies including oral contraceptives and condoms, as well as equipment for family planning clinics for the first three years of the program.

The British Ministry of Overseas Development has provided technical assistance in the establishment of clinics and contributed the services of a full-time medical officer for a period of two years.

Assistance has also come from the Population Council, New York, which provided IUDs and library and reference materials; from the Ford Foundation, which provided travel grants to the director of the program; and from the International Institute for the Study of Human Reproduction, Columbia University, New York, which gave technical assistance toward program evaluation.

A World Bank Mission visited the country in 1970, in response to a request from the government for assistance in the health service programs.

Summary

The presence of a climate favorable to acceptance of family planning in the country has facilitated the achievements and progress of the National Family Planning Program of Trinidad and Tobago. The voluntary agencies are to a large degree responsible for mobilizing community support and resources. The national program has also been greatly facilitated through generous support, both technical and material, from several international agencies.

The program as envisaged during its inception is now entering the second phase. During this period two areas will need to be intensified; community motivation and education, mainly through person-to-person ap-

proach; and research and evaluation. Among the many areas for research, of particular concern are: male attitudes; attitudes of the community toward implementation of a program of sex education in schools; prevalence and continuation of contraceptive practice; incidence of abortion; and the impact of family planning on fertility.

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