Chapter

Pioneers against Stigma: Access to Family Planning in the Caribbean

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Abstract

In the English-speaking Caribbean, internationally-funded local NGOs pioneered the introduction of family planning, a game-changer in women's empowerment, ensuring access to women who cannot afford private physicians. These NGOs faced social controversy and cleared the space for governments to introduce the service in primary care clinics. As governments have cautiously stepped into this space, Family Planning Associations have lost clientele and not benefitted from significant government contributions. After 50 years, they remain fragile and dependent on foreign funds. They have been buffeted by the winds of the US Gag Rule, the COVID-19 pandemic, and the drive from IPPF to provide more comprehensive services, including abortion. Small size and stigma are obstacles to attracting high quality board members, and grant reductions make staff salaries unattractive to skilled professionals. The purpose of the paper is to explore the history, growth, gender bias, and the struggles for sustainability among family planning associations across the Caribbean region.

Keywords: NGOs, pioneers, stigma, family planning, sustainability, Caribbean

1. Introduction

The story of family planning in the Caribbean is a fascinating one of several faces and phases. What started as independent, indigenous activism is more than 50 years later a charity industry still mired in dependency on international funding. In our colonial period, members of the middle- and upper-classes pioneered the drive for social service and social change by attacking stigma. Today the charity industry has matured. In the era of national independence, the new leaders no longer challenge the status quo. They are the status quo. They have become so conservative that they sometimes resist advances of inclusion, equity, and service. In some instances, they have become the captive of religious forces hostile to their core mission, while others ride on Boards to extract social status. Across the region, the exceptions to this pitiful tale can be counted on one hand.

2. Women step forward

In Jamaica—as early as 1937—two Jamaican women, May Farquharson, a social worker and Amy Bailey, a social worker, educator and women's rights activist, started working to improve women's and children's lives. They created the Save the Children Fund, Mother's Welfare Clinic, and in 1939 established the Jamaica Birth Control League (JBCL). The goal of the JBCL was to advance women's social and economic welfare through birth control and to win government's support for their programme. Farquharson, who had studied in the UK and the US developed strong links with activists on both sides of the Atlantic: Vera Houghton in the United Kingdom (UK) and Margaret Sanger in the United States (US), both of whom were associated with the eugenics movement. It was no surprise then, that the JBCL ran into strong opposition from the Catholic Church, Marcus Garvey's Universal Negro Improvement Association and, expediently, the Jamaica Labour Party. Bailey pushed back forcefully against the notion that birth control was a plan to kill or limit Black people and argued instead that birth control would advance their social and economic wellbeing [1].

Two other Jamaicans, Lenworth Jacobs, a physician and his wife, Beth Jacobs, also saw the rapid birth rate and the need for women to have the means to control their childbearing, reach broader audiences, and more community integration. This led to the opening of the Beth Jacobs Clinic from 1939 to 1967 in St. Ann's [1]. So once again, the focus on population control was at least equal to the concern for women's control. By 1957, the JBCL and the Beth Jacobs' clinic merged, forming the Jamaica Family Planning Association, becoming the eighth member of IPPF. Believing that family planning should not be the sole province of a charitable organization, they promoted family planning as integral to the government's services. This led to a series of efforts at integration with and separation from primary care over various political regimes [1].

In Grenada, Helen Saftel, an expatriate from the United States of America and a member of a birth control organization in Boston recognized that birth control was a problem in Grenada. In an interview with a former Executive Director of the Grenada Planned Parenthood Association (GPPA), it was reported that "Saftel influenced a diverse group of professionals and privileged lay people to develop an NGO to support birth control for women." Helen Saftel convinced retired Chief Justice of the Windward and Leeward Islands to help organize a committee and chair the Association. Together, in 1964, they formed the Grenada Planned Parenthood Association (GPPA). They sought help to prepare committee members for their first meeting from those connected to family planning in Barbados, such as Lady Grace Thorne Adams, Sir Aubrey Gordon Leacock, known as 'Jack', and Mr. Clyde Gollop [2]. In April of that same year, on their way to the Western Hemisphere Conference on Planned Parenthood, Helen and her husband met Sir Colville Deverell, former Governor of World Planned Parenthood who provided US $2000.00 to the GPPA. In February 1964 Grenada became a member affiliate of IPPF [2]. At that time, family planning services were not being offered by the Government of Grenada, but most of the community health nurses referred women to the GPPA for family planning services. In an interview with first author, TF, a senior nurse at the time recalled (Best S 2023, personal communication, Jan 22), there was no real objection from the Ministry of Health, but some doctors and nurses objected or at least objected to the use of methods such as the intrauterine contraceptive device (IUCD) and Depo-Provera [3]. The main opposition came from the religious sector, specifically the Catholic Church on grounds of morality. She described the government's support for family planning as being driven by the need to promote child health. The focus was pediatric - on the child rather than the mother. There was less concern with

poor women and more interest in providing for the nutritional and educational needs of their children in an effort to address high infant mortality [3].

In 1966, all on her own, Theresa Louisy, a registered nurse in St. Lucia saw the high birth rate and malnutrition in her rural community, Bexon. She contacted the Chief Medical Officer, John Gibling and together, they started family planning in St. Lucia. In 1967, they commenced information and education programs, and individual counseling in rural areas. With her husband Raymond Louisy, they engaged in public education called *Market Steps* to reach new communities. In 1968, St. Lucia Planned Parenthood Association (SLPPA) sought Associate Membership in IPPF. Although Mrs. Louisy led the SLPPA, it was Raymond Louisy, her husband, who became the Executive Director at that time. Almost 30 years later, in 1996, the first woman, Mrs. Audrey George became Executive Director of SLPPA [4]. SLPPA remains the only non-governmental organization offering SRH services on the island.

The story was similar in Guyana. Olga Byrne, a Trinidadian by birth who migrated to Guyana, was a teacher who organized her colleagues, expanding access to education, adult suffrage, and family planning. Byrne was a pioneer in breaking the glass ceiling by becoming the first female President of the Guyana Teachers Union in 1961; she also led the Women's League of Social Services and the International Alliance of Women (IAW). While her focus was on women, she appreciated the need to develop boys, hence the youth centre in her name for training in joinery, masonry, and welding. She contended that there was little point in women having the right to vote if they could not control their own bodies. Again, a woman of privilege using her status to help the poor. Her work leading the Women's League of Social Services gave birth to the Guyana Responsible Parenthood Association (GRPA) in 1973. The GRPA was rooted in concern with, "fostering better family life and not with contraception" [5]. The Association received funding from IPPF in 1974 and through membership in the Caribbean Family Planning Affiliation (CFPA) became a member affiliate of IPPF [6].

Essentially, across the Caribbean, the initial thrust for family planning and women's reproductive health advocacy and services was home-grown. It was largely the work of privileged middle and upper-class women who leveraged their social status and social connections to advocate for services primarily for the poorer members of their societies. In doing so, they were venturing into an arena of controversy scarred by religious dogma (St. Lucia, Guyana, Jamaica, Barbados, Grenada), disfigured by racial tension (Jamaica, Guyana), and torn by partisan opportunism (Jamaica, Antigua). It was an area spurned by private business primarily because of the controversy. Any profitability was certainly not worth the noise. With few exceptions, Caribbean businesses were still largely family owned. So, they were more sensitive to community pressure. Family planning associations (FPAs) were in a field that was at best unpopular and unprofitable. While private businesses avoided the area, governments were even more circumspect. They either stayed away or offered arms-length support. They outsourced a fundamental health service to NGOs. It is into this void that courageous women stepped and stood ever so boldly. We agree with Bourbonnais' that despite their pivotal role in the international birth control movement in the 1950s, FPAs in the Caribbean, such as Barbados, Trinidad, and Jamaica, are yet to receive due recognition [7].

3. From passion to professionalism

Passion and professionalism are not incompatible. In the best circumstances they make wonderful companions and yield great benefits. But this is not always the

case. As FPAs bodies joined the IPPF, there was a gradual shift from the passionate volunteerism through which clinical services were made available in the early days to more settled operations based on paid employees. Inevitably and entirely understandably, with funding from IPPF, there came an ever-increasing need for accountability—reports and performance standards. How well these standards were adjusted to small island developing states (SIDS) is an important issue, but not one within the scope of this chapter. One example will suffice. The cost of an external audit is considerable and in some cases in small countries could amount to a third of the budget. That is onerous. Another major challenge is that volunteerism remains the mechanism through which governance of FPAs occurs, even today. In small societies with very small professional classes, the pool from which one can attract volunteers is quite limited. From our observation, this has had a tremendous negative impact on the growth and operation of associations in small poor countries, like those in the Caribbean.

Even greater than the remarkable contribution to the dramatic decline in birth rates, we contend that the real and lasting success of the associations in the Caribbean is that they persisted. They did not bend to the noise of the church, politicians, or quite commonly, the sensationalism of the media. For example, in 1977 the news that there was a plan to train a few doctors in Antigua in vasectomies resulted in quite a brouhaha [8]. In Trinidad and Tobago, many Roman Catholic officials mounted opposition to Dr. Eric Williams' People's National Movement (PNM) at the 1956 general election, on the grounds that the party supported birth control. This forced the PNM's denial of the party's official position in lieu of the statement that "birth control was a private matter for private decision rather than government policy" ([9] p. 5). According to Bourbonnais [7], Sir Grantley Adams, at the time, the Premier of Barbados and an ardent advocate for family planning and Barbados' global leadership in family planning was under attack by the politicians at home and across the region, led by the Roman Catholic Church, as illustrated below:

> *'our embryo Prime Minister would begin his Federal term without the blessing of the Christian church. What a sickening thought?' (Secretary of Bustamatne's JLP [Jamaica Labor Party] p. 272]*
>
> *'Birth control is for the white man, not for the black man.' (Premier of Antigua Vere Bird) [p. 272]*

The fact is that there was a great demand from women wanting to control their fertility, even before the rise of the family planning movement in some countries. Bourbonnais quotes a 38 year old domestic worker in 1956 Trinidad who stated, "We, the several young women of the community, have been practicing birth control in Trinidad long before Little Eric came on the scene." ([7], p. 272). Historically, the English-speaking Caribbean countries did not experience very high fertility levels as measured by crude birth rates, however, between 1950 and 1960 crude birth rates increased, somewhat representing a baby boom. Nonetheless, between 1960 and 1965 the rates remained fairly stable with a downward trend [10]. Except for a brief period at the outset, when the passion was still there, most FPAs assumed a quite passive posture. They waited for clients to arrive at their doors. Charismatic advocates like Raymond Louisy in St. Lucia, Beth and Lenworth Jacobs in Jamaica, and Clyde Gollop in Barbados, who walked the streets and played dominoes in police stations, soon

vanished and were replaced by largely office-bound technicians. Those larger-than-life entrepreneurs were usually replaced by timid administrators.[1]

Still the associations stayed the course, local advocates applied constant pressure on officials and in doing so, normalized reproductive health services amidst the changing social and political dynamic of the region [7]. They made contraception such a routine component of women's health that the very governments that were hands-off in the 1950s would later begin to provide family planning services in their primary care clinics. Herbert Eldemire, a physician, was Jamaica's first Minister of Health after independence in 1962. After years of pressure from JFPA, he threatened to demit office unless his Ministry was allowed to announce its support of family planning. His coercion worked and he created birth control clinics at hospitals and primary health care facilities. The Ministry also created a Family Planning Unit within the Ministry in 1966, and the National Family Planning Board (NFPB) in 1968 [1]. This is undoubtedly the major accomplishment of the pioneers: they vanquished the stigma of contraception sufficient to win strong partnerships in government.

Of course, this very success would haunt the associations. Potential clients could obtain services for free at public health clinics. While this was good news for the society, it inevitably signaled a measure of competition for the associations whose market was depleted. The ultimate goal of associations was ensuring women's access to family planning services, and so they found ways to adapt to this changing context. In Jamaica, for example, JFPA continued to work alongside and with the government in promoting birth control, and Dr. Lenworth Jacobs of the Beth Jacobs Clinic and the JFPA became the first Director of the NFPB [1]. With very few exceptions, Caribbean governments did not readily see the value of contributing to the livelihood of the associations. In Barbados, due to vehement political opposition internal and external to his party (Barbados Labour Party), Sir Grantley Adams, in 1955 refused initiating a government-run wide-scale birth control program, but instead provided a government grant of 5000 Barbados dollars to the BFPA and allowed operations out of maternity hospitals and government health centers, increasing it to $12,000 in 1956 and to $20,000 by 1959. Governments of Jamaica (1966) and Trinidad (1967) later provided financial support [7].

The idea of integrated reproductive health services is attractive. Although there are different approaches to integration [11], it was generally viewed as providing a more convenient one-stop service for clients. But this form of integration often proved difficult at the clinic level. Working together in a single clinic there were significant differences in salaries of nurses with the same qualifications, one working with the association the other with the government. Typically the public employees were better paid, with more security and benefits. Pharmacists would struggle to fill prescriptions depending on whether drugs were available from one channel or another. Some felt that integration was the best way to serve the client, others contended that integration depleted family planning. Jamaica went back and forth—swinging between, integrating, separating and back again [1]. In some countries the commitment to integration was frustrated by funding. Governments were unable

[1] A stark example of this passivity is evident in an unpublished analysis by Fred Nunes, Yvette Delph, Dane Abbott, and Sheila Roseau of new acceptors in one FPA from Jan- Dec 2006. As many as 80% of the new acceptors joined after their first pregnancy. They were joining to delay their next pregnancy and for many to end childbearing rather than to plan it. Even more indicative of the Associations passivity is the fact that no client joined because of outreach from the association. Some 75% were influenced by their social network; only 15% reported being influenced by a health worker and less than 5% by a doctor.

to provide the budget for contraceptives. So, the service gradually reverted to the associations by default; one example of this is Dominica.

But there was more to be done. The hostility to unwed pregnancy persisted. Unwed mothers lost their jobs. High adolescent birth rates (ABR) persisted, declining at a much slower rate than other age groups [10], and pregnant teenagers were expelled from school. All the while the men involved in these pregnancies remained untouched and invisible. Lacking data, associations persist in a focus on teenagers to reduce teenage pregnancy. That is a focus on the vulnerable. Some 77% of teenage pregnancies result from relationships with men 20 years and older and 56% with men 20–24 [12]. The focus should be on young men. But FPAs have been generally timid about outreach to men. They have lived within the mistaken notion that Caribbean men have a cultural resistance to vasectomy when their own evidence shows no basis for that view [13].

In the broader society, the Caribbean has experienced a major shift in religious affiliation. In the 1960s the 'established' churches typically formed the Council of Churches, Anglican, Methodist, and Roman Catholic, who were routinely consulted by governments. By the 1980s, Associations of Evangelical Churches had emerged with at least equal voice—Baptist, Pentecostal, Seventh Day Adventist, Independent—and far more energy. In an interview with the fourth author, FN, in December 2020, one observer stated, "In the early 70s as a student at UWI [Jamaica], the Intervarsity Christian Fellowship (IVCF) was little more than a handful; by 2000 it was the dominant group." Some of these evangelical groups have benefited from substantial funding from their counterparts in the US. The growth of this religious right would represent a major challenge to associations in the face of IPPF policies.

Within the associations two challenges emerged as they matured. First, the passion of volunteerism was gradually replaced by employed professional staff. Second, once contraceptive service had become a widely accepted norm, associations became status conferring organizations rather than pioneers fighting stigma. The first transition for staff meant that a more contractual relationship replaced volunteerism. Services were delivered from paid staff. The alignment with the mission was no longer the primary driving force. For some of the staff it was economic; employment was mere livelihood. There was the problem of staff retention as the salary packages and recruitment policies were often inadequate to attract and retain suitable staff. In more than a few cases, staff members successfully sued the associations for considerable sums. The fact that the associations were successfully sued also exposed real deficiencies in governance. This takes us to the second transition, voluntarism at the Board level. In far too many cases, board members were no longer attracted to serve a mission that involved taking risks and lending their status and influence in a battle for social justice. Quite the opposite: Some members were climbing on to an established, recognized, reputable charity to extract status and enrich their résumés. Sadly some board members were focused on status and extraction—what's in it for me (WIIFM). It is not surprising that the boards were suboptimal if not downright dysfunctional in their governance and oversight mandate, and their ability to collaborate with management for the sustainability of the associations. Over the years, this has resulted in an absence of accountability, poor performance and closure of some FPAs, as resulted in Grenada between 2019 and 2021 [14].

4. International push and pull

Being a small island developing state is one thing. Being a small region in the shadow of a dominant world power is another, which makes the old adage

fitting—"when the US sneezes, the Caribbean gets pneumonia." Of course, US foreign policy on family planning, known as the Mexico City Policy (MCP) and referred to as the Global Gag Rule (GGR) is like a windscreen wiper. It flips from one extreme to another with each change of political regime resulting in consequences for the Caribbean and globally [15, 16].

In the 2020s, it will be interesting to see how the wave of White, male supremacy in the US manifests itself in our predominantly Black region. Only a few days after the leak of Justice Alito's draft US Supreme Court decision that would vanquish 50 years of women's right-to-choice, the Rev. Dr. Hensworth Jonas, Presiding Elder of the Eastern Caribbean Baptist Mission, was gloating in the media. In a television interview, he made the most bizarre statement in saying why abortion should not be allowed in any circumstance whatsoever, not even for rape: "If women want to be pro-choice, they should choose well about their sexuality. Don't choose abortion to cover up your sin. Basically, a woman's choice should be not to conceive children" [17]. This was his bizarre, uncompromising statement in a region where a substantial proportion of women's first sexual experiences are coerced—not of their choosing. For example, studies on the prevalence of partner and not-intimate partner violence among women in the Caribbean show that among respondents 25% of women in Grenada, 30% of women in Guyana, and 32.3% of women in Jamaica reported being coerced, going along or forced to have sex at sexual debut. Sexual debut in the Caribbean is reported to start early, with 10.9% in Grenada and 13.7% in Jamaica of respondents reporting sexual debut before age 15. In Jamaica 7.7% and 10% of women, and in Grenada 9.5% and 10% of women had in their lifetime, experienced sexual violence by their male partner and a non-partner, respectively [18–20].

The tiny Caribbean basin is home to every shade of abortion law in the world—all six stages from total prohibition to fulsome choice. Half of the 10 countries in the world that have total abortion bans are in the Caribbean basin [21]. What is even more ironic is the colonial contradiction of The Netherlands Antilles which holds fast to a total ban as against The Netherlands which provides with complete access. Frankly pathetic.

The Kissinger Report (1974) is a clear example of the relationship between US political power and population policy [22]. The report, which was confidential until the 1990s, aimed to protect US, military and business interests by controlling population growth in poor countries. Known as National Security Study Memorandum (NSSM) 200, the policy proposed to constrain political power in poor countries so US business could more easily extract resources. The report reasoned that by restricting population growth, the risk of restless, anti-establishment youth, hostile to America and prone to communism would be minimized. The Study Memorandum became a Decision Memorandum under President Richard Nixon. The policy rested on four ugly pillars: [22].

1. Population growth in poor countries threatens US political power

2. The US needs poor countries to remain poor so it can extract resources

3. High birth rates yield younger populations more likely to be anti-establishment

4. American business will be threatened by governments that need to provide for growing populations

In practice, the policy was driven through the United States Agency for International Aid (USAID), by funding United Nations (UN) programmes, and by

influence on national leaders. It is little wonder that even in the 1970s, persons seeing the strong USAID support for family planning across the Caribbean—although it was not listed in the 13 target countries mentioned in the Kissinger Report—were ambivalent about this new-found US interest.

Of course, Vatican II, had concluded only a few years earlier in 1966, and 2 years later in July. Pope Paul VI issued his encyclical, Humanae Vitae, declaring the church's opposition to artificial birth control and its absolute condemnation of abortion and sterilization, for the promotion of natural family planning (NFP) [23]. The stage was set for a conflict between the US National Bishops Conference and the US population policy.

Stephen Mumford has documented how rapidly the Catholic Bishops responded to the US Supreme Court's decision in 1973 (Roe v Wade) making abortion legal and NSSM 200 [22]. By 1975 the bishops had issued a Pastoral Plan for Pro-life Activities. It was a remarkably strategic document that in great detail set out how the church would finance, organize, lobby and infiltrate every level of political activity. And they did. They were persistent and relentless and, finally, in 2022, they had gained such control over the US Supreme court, that they won.

Perhaps no US policy has more directly and immediately affected the conduct of reproductive health services in the world than the Mexico City Policy, also known as the "Global Gag Rule" [24]. At first, this policy merely applied to US funds and required any NGOs receiving funds from the US to declare that they were not actively promoting or providing abortion services using US Government funding. In nearly 40 years since President Ronald Reagan introduced it in 1984, it has been enforced for 21 years [24]. But the most aggressive use was under Republican President Donald Trump from 2017 to 2021. His administration expanded it to apply to NGOs receiving funds from any source, including non-US funds and their own funds—not just US funds. Even worse, Trump extended this to programmes with no link to family planning, such as malaria and nutrition [15, 24]. Basically saying to the international community: You want my money? Then you swallow my values. Not the values of the American people, but the values of the Republican Party. An ironic anecdote exposes the unique features of the Caribbean. The late Dr. Ivor Heath of Antigua, recounted how, under the hammer of the Gag Rule, a colleague in the USVI called him, "We know you can't do them over there, just send them to us". Predictably, as history has shown, Democratic President Joe Biden reversed the Gag Rule as one of his first acts [24].

The 1990s was a period of intense international meetings of population and reproductive health and rights. In addition to several rounds of preparatory UN meetings there was the International Conference on Population and Development and Programme of Action in Cairo in 1994, the 1995 Beijing Declaration and Platform for Action, and of course Cairo+5 and Beijing+5 [25]. These meetings provided platforms for government and non-government representatives and organizations to explore the leading edge of provisions to ensure women's equality. They equally offered space for conservative groups to block those negotiations. A distinct minority of conservative states and their NGOs sought to thwart the negotiations at every turn. They were invariably assisted by the US which recorded reservations on several matters [25]. When it became clear that a small group might impede progressive positions from reaching the Group of 77 (G-77), a group of Some Latin American Countries (SLAC) emerged. They faced intense pressure from the Vatican. Soon, 14 Caribbean CARICOM countries joined this group which then became SLACC. The group worked with India, and countries in East and West Africa to advance a progressive women's rights agenda.

The Montevideo Consensus on Population and Development in the Caribbean and the preparatory meetings that preceded it, were yet another round of government and non-governmental meetings [26]. They were designed to assess the region's accomplishments since Cairo, set new targets and confirm commitment to the wide scope of social goals. Governments adopted more than 100 "priority areas" on a very broad range of topics – sexual and reproductive health, comprehensive, rights-based sexuality education for young people, provision of SRH services including contraceptive methods for adolescents, gender equality, population planning, aging, indigenous peoples, and so on [26]. The Caribbean is known for ratifying conventions and then walking away from those obligations. There are good reasons why this happens so easily.

These platforms were spaces in which Caribbean advocates displayed their passion, intellect, negotiating skill, discipline, and commitment to the mission of women's human rights. In these international meetings, they were calm, forthright and unambivalent. Yet, once back at home in their small countries, most of these very same vociferous advocates were seldom visible. The international platforms were a safe space, free of the risks and costs of speaking up. For example, in 2000, the fourth author, FN, attempted to recruit an advocate in Trinidad to join Advocates for Safe Parenthood: Improving Reproductive Equity (ASPIRE), one advocate explained, "My child goes to an excellent Catholic school. This is no time for me to jeopardize my child's education" [27].

Democracy is a good deal more than ceremonial signing of documents. Those documents have little or no meaning without a culture of accountability, which requires constant vigilance by civil society [28]. Based on our observations, in the Caribbean, there is precious little sustained noise from non-governmental organizations to hold the government accountable. Governments are not under any real public scrutiny. NGO's typically lack the resources [29] for research, so they seldom have the data essential for meaningful dialog. Therefore, in practice then, "sovereignty" becomes one party's five or so years to do as they please. Then it's either more time or another party's turn. Democracy in form, but not in substance. While small scale offers the advantage of familiarity, small scale also means easy visibility and little opportunity for the social distance that anonymity provides in larger societies. Therefore, making it hard to find allies and harder for individuals to speak up, especially so in respect of controversial and stigmatized issues.

Two major global health phenomena also left their footprint on FPAs—HIV/and AIDS, and COVID-19. The first recorded HIV/AIDS case in the Caribbean was in Haiti in 1979 [30]. Initially the disease spread among homosexual contact with bisexual males, but by the early 80s the spread was mostly by heterosexual males. This was evident throughout the region, and gradually more women became infected than men. HIV/AIDS became the leading cause of death among adults 15–44. Today the Caribbean still has the second highest prevalence of HIV/AIDS in the world; only Sub-Saharan Africa is higher [31, 32]. By the mid-1980s the disease was spread more widely among heterosexuals and, gradually in the Caribbean, more women became infected than men. HIV/AIDS became the leading cause of death among adults 15–44.

During this crisis of stigma, poverty, and sex tourism, it was the Medical Association that took the lead in Barbados. Through leadership from Professor Errol "Mikey" Walrond, Barbados became only the second country in the world to start testing blood donations for HIV. The US poured funds into the region and supported condom use. The Pan Caribbean Partnership Against HIV and AIDS (PANCAP) was established by a Declaration of CARICOM Heads of Government to support the

region's response to the threat of HIV [33]. In Jamaica, there was a massive increase in condom use, largely as a result of government promotion. The same was true in Barbados. In fact, the barbados family planning association (BFPA) was not happy with the focus on condoms because it had invested heavily in more reliable methods—injections and IUDs—and saw the condom drive as undermining its hard work. Preservation of gains took precedence over the opportunity to meet a new social need.

The impact of COVID-19 was quite different. It was indirect and economic. Caribbean economies rely on tourism, with between one third and half of the gross domestic product (GDP) of The Bahamas, Barbados and Jamaica being derived from tourism [34]. When travel shrinks by 75% the impact is devastating. And when the only available approach for month after month is strict masking or staying at home or both, similar to other businesses [34], FPAs shuddered under the shrinkage of demand for services. In an interview with the Caribbean Family Planning Affiliation (CFPA) in January 2023, it was stated that "the shrinkage in service demand due to fear of COVID-19 meant a sharp drop in revenue for FPAs. Notwithstanding, supply chain challenges resulted in low contraceptive supply to meet the already low demand. Notably, in some countries family planning and SRH services were not deemed as part of the essential health services, and family planning health care providers were reassigned as part of the COVID-19 response teams." Anecdotal evidence from some FPAs indicated that during the pandemic, some women were engaging in self-harm practices to end unwanted pregnancies due to lack of access to contraceptives. Recognizing the negative impact of the COVD-19 pandemic on SRHR, CFPA together with international donor agencies, such as the United Nations Population Fund (UNFPA) [35] advocated for governments in the region to include SRH care and family planning as essential health services.

Stresses are seldom isolated. Along with the COVID-19 pandemic came the tumultuous internal conflict in IPPF [36, 37]. Allegations of fraud in London resulted in friction between London and WHR New York. That friction resulted in Caribbean countries being faced with a choice—London or New York. Typical of the region, we could not find a common position and so some chose to stay with WHR and others went with IPPF (London). IPPF then created the Americas and Caribbean Regional Office (ACRO) to work in the region and a separate office of ACRO in Trinidad to focus on the Caribbean.

Finally, the Russian invasion of Ukraine and European support for Ukraine seemed to signal a sudden and major shift of resources away from family planning and away from the Caribbean. The alarm clanged when IPPF shared the likelihood of this prospect. This time it was not simply the colossus to our north whose sneeze would cause our pneumonia. This time it threatened to be global. The Caribbean was utterly unprepared. There were anxious moments of concern for finding other sources of funds, especially at the level of national and regional governments. But as the threat subsided and the normal flow of funds resumed, the feverish interest in the initiative to be more self-reliant faded away.

5. Impact

Notwithstanding the wretched problems of governance that have plagued many FPAs in the region, their pioneering action created the space for making contraception and more broadly sexual and reproductive health acceptable. Nonetheless, the journey for sexual rights remains. The net result is that while some associations

suffered debilitating problems of governance, several governments, private medical practitioners and private pharmacies provided contraceptive services. The real impact of the FPAs cannot be measured merely in the number of services or the number of advocacy events they conducted. Their far greater value was creating the social space for other actors, including non-governmental organizations (NGOs), government and private sector. They established family planning as a central and acceptable component of health care. Using fertility data from The World Bank Databank [38], **Figure 1** shows the fertility rates at 10 year intervals from 1950 to 2020 in select countries in the Caribbean region. The decline in fertility rates, starting in the 1960s, are inseparable from the path-breaking work of the FPAs. Indeed, such is the normalization of family planning that it is not easy to recall the measure of hostility and opposition the pioneers faced.

This success was so dramatic that in some cases it turned against the service. In Jamaica, a former Senior Medical Officer at Victoria Jubilee Hospital (VJH), recounted that when he started there in 1972, "We were doing 16,000 plus deliveries per year. By 2000, we were barely doing 7000. So, by the time I took over, we were no longer focused on family planning. Instead, I concentrated on modernizing obstetric and gynecological services. In fact we closed the family planning service at VJH and converted that room into a dental clinic."

Although the name had changed from birth control to family planning, the appreciation of reproductive health had not yet taken root. Even in sophisticated medical circles, family planning was still linked to population control. The HIV pandemic was a catalyst in the shift from family planning to sexual and reproductive health, and the International Conference on Population and Development (ICPD, 1994) in Cairo reiterated the expansion of family planning beyond mere contraceptive services to sexual and reproductive health—education, prevention and treatment of HIV, other

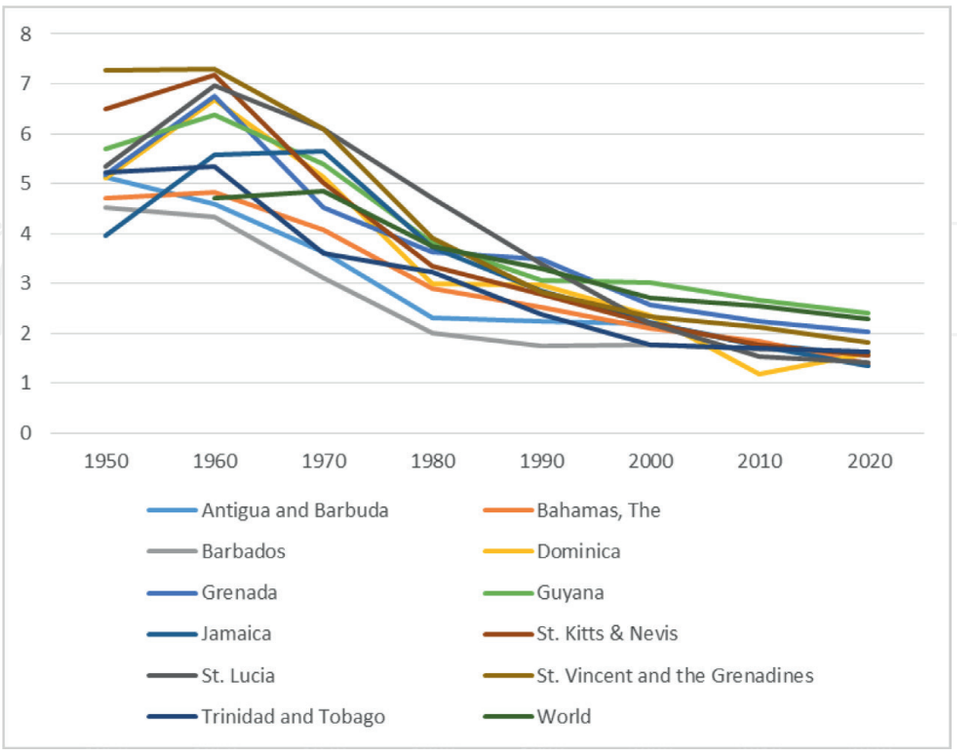

Figure 1.
Fertility rates in select Caribbean countries for 1950–2020.

STIs, and reproductive cancers, gender equity, intimate partner violence, safe pregnancy, and safe abortion in a right-based environment free of coercion, discrimination and violence [39].

5.1 Abortion law reform and services

In 1980, Belize modified its Offenses Against the Person Act to provide for a wide range of exceptions, including the expansion of legal access to abortion [40]. The changes not only codified Bourne [41], making provisions for protection of the woman's physical and mental health, but they also allowed abortion where the child was likely to be born with severe mental and physical abnormalities. Further, in assessing the impact on the woman's health, it allowed consideration of her actual and foreseeable social and economic circumstances [40]. We had expected that this remarkable advance, 3 years before the Medical Termination of Pregnancy Act in Barbados (1983), was the result of women's activism and pressure from the Belize Family Life Association (BFLA). Not so. In fact, there was no public discussion whatsoever.

On the verge of independence, 1981, with the threat of invasion from Guatemala, British Harrier jets flying overhead and an intense political campaign for general elections in December, the Criminal Code was revised without a whisper. The Attorney General, Said Musa, contracted Professor Nicholas Liverpool in the Faculty of Law at the University of the West Indies in Cave Hill, to review the Criminal Code. He did. It is his revisions that appear in the law. The Code was passed without discussion along with 10 other bills presented to the House in November 1980 [42]. This significant advance in women's health occurred without so much as a murmur. In 1980, Belize was 62% Roman Catholic. Given that process, it is little wonder that in 2023 there is almost no public knowledge of this level of legal access to abortion in Belize.

We should pause to describe the landmark Bourne UK case [40] since it also bears witness to courage and a focus on women's health, but not on women's rights. Aleck Bourne was a distinguished Harley Street surgeon. Parents asked him to perform an abortion on their 14-year-old girl who had been raped by five officers of the Royal Horse Guards. He examined her and satisfied himself that she was sufficiently well developed to bear the child. He nevertheless, performed the abortion. He then called the Chief Constable, reported his action and was promptly arrested. At the Old Bailey, his defense was that he could not distinguish between a woman's life and her health and that if the child had been forced to carry the pregnancy, it would have made her a "mental wreck." Justice Macnaghten advised the jury that life includes physical and mental health. Bourne was acquited [41]. This decision has been upheld in every Commonwealth jurisdiction in which it has been tested—Canada, Australia, and so on. While it has not been tested in any Caribbean country, Attorneys General in several Caribbean countries felt it would be upheld [43]. Bourne was not what we would call pro-choice. In fact, he opposed the 1967 Abortion Act in the UK which he considered too liberal. He favored doctors making decisions on therapeutic grounds, not women exercising their choice.

The process of law reform in Barbados was almost an exercise in stealth. Billie Miller, Minister of Health and the first woman to serve in the Cabinet of Barbados, quietly met with religious leaders and shared the facts of the harm of unsafe abortions with them. Meeting with them one-on-one, she explained the social reality and the damage poor women faced because of a law that did not in any way restrict others from obtaining safe abortions, whether from local doctors or by travel abroad. She defused the religious opposition [44]. Once again, it is not clear that the Barbados Family

Planning Association was at the forefront of this major advance in reproductive health, even though Miller had been a member of the Board and President of WHR.

In 2013, under new leadership, GRPA showed itself as an exception to this trend of withdrawal. Although Guyana's 1995 abortion law made provision for mid-level providers to perform early non-surgical abortions, no action had been taken to put this in practice. GRPA organized a workshop for midlevel providers and invited Women on Waves and Family Planning Association of Guyana (FPAG) to conduct the training. The Chief Medical Officer and the Attorney General claimed that the workshop was illegal. FPAG went to court to seek its interpretation of the clause and GRPA was an equal partner in that action. In 2016, the court ruled unequivocally in favor of the associations [45]. Allowing mid-level health professionals to provide medication abortion is important generally. It eliminates the sole reliance on doctors, removes the focus on hospitals, and radically shifts the gender of providers to women. In a large country like Guyana, with 20 percent of the population sparsely spread over a vast hinterland with very few doctors, provision of abortion services by mid-level health professions makes a world of difference for access.

Twenty years earlier, in the early 1970s, there was also a moment of real excitement in Jamaica. Kenneth McNeil, as Minister of Health was a former medical officer at VJH. He had seen at first hand the horrible conditions in which poor women arrived on the "abortion ward" or "slip and fall ward". These women could not afford doctors, but had nevertheless sought help to end their unplanned and unwanted pregnancies. The Minister for Health attempted to persuade the Cabinet to change the law [46]. When that failed, he worked with other doctors in his Ministry, notably Dr. Wynante Patterson, and Dr. Deanna Ashley to establish the Glen Vincent Clinic (GVC), a clinic that would provide abortion services. The guidelines for the GCV were carefully sculpted by Gloria Cumper—a barrister and social reformer, and Dr. Ashley. They were carefully constructed and included rape, statutory rape, referrals from the Family Court, and failed contraception (supported by her clinic record). There were provisions for Tubal Ligations (TL) following counseling [47]. Of course, once the clinic opened, the guidelines were employed with sensible elasticity. They are still used today almost 50 years later by private physicians referring patients to providers "in order to give them some legal cover." The GVC operated from 1976 to 96. It is unclear why it stopped providing abortions. Certainly, one difficulty was recruiting a doctor to replace the one who had functioned there for two decades, performing services and teaching colleagues.

The GVC's impact is only known through anecdotes. In an interview with the fourth author, FN, in 1993, the late Professor Hugh Wynter wryly remarked that the establishment of the clinic "created problems for me. Before '76 I had all the septic cases I could want. Once the clinic was established, I had problems. How could I teach my students to manage septic cases when there were none?" [48] Professor Wynter, who had recommended the physician who served there for almost its entire existence, was pleased at the service of the GVC. Wynter's experience at the University Hospital of the West Indies was fully corroborated by Dr. Douglas McDonald, former Senior Medical Officer at VJH in an interview with FN in 2022. According to McDonald, "almost immediately after GVC opened, the incidence of septic cases at VJH fell. In the early 70's women would arrive almost at the point of death, in truly horrible conditions. There is no question that GVC definitely had a huge impact in reducing the number of cases we encountered" [49].

Unfortunately, in spite of our best efforts, we have been unable to recover records for those years—not from GVC, or UHWI or VJH. Paper records take up a great deal of space. It appears that in all of the locations, dockets have been culled. Based on the anecdotal evidence provided by Wynter and MacDonald, the authors hypothesize

that if records were recovered from 1965 to 2020 (x-axis) they would yield a stark picture of the number of abortion (y-axis) demonstrating the public value of creating safe access to abortion (**Figure 2**).

Our purpose for the note on the GVC is to show first how rapidly the associations had normalized family planning so that the government could easily enter that space. But also, to show that the spirit of entrepreneurship had slipped away from the 'established' associations. The government was exercising more leadership and taking bigger risks.

5.2 Lack of accountability

So much for the positive aspects. What about those associations who have performed so poorly that they have been suspended or defunded? In almost every instance this has been the consequence of poor governance, other words, Boards that did not function and Executive Directors who went off on a course of their own. One obvious metric of Board operations is attendance at meetings. Several associations struggle to get members to attend meetings, and are seldom engaged between meetings. Meaningful volunteerism has become a rare phenomenon. Nor, in several instances, is it clear that Board members truly understand their role.

The composition of Boards is critical. Let us be clear, in small, poor societies it is not easy to attract people with the competencies required. Constructing a strong Board of individuals with skills in law, finance, research, strategy, fundraising is never an easy task. Few Boards have managed to attract persons with business experience, specifically in areas of finance and strategy. This is difficult even in resource rich environments. It must be exponentially more challenging in small, poor societies. Some Boards have been rich with conservative religious leaders comprehensively misaligned with the FPA's mission. And by default, in more than a few cases, the Executive Directors essentially fill the Board with persons from their own social network. This is a recipe for non-accountability. When IPPF sets criteria for gender, age and the inclusion of

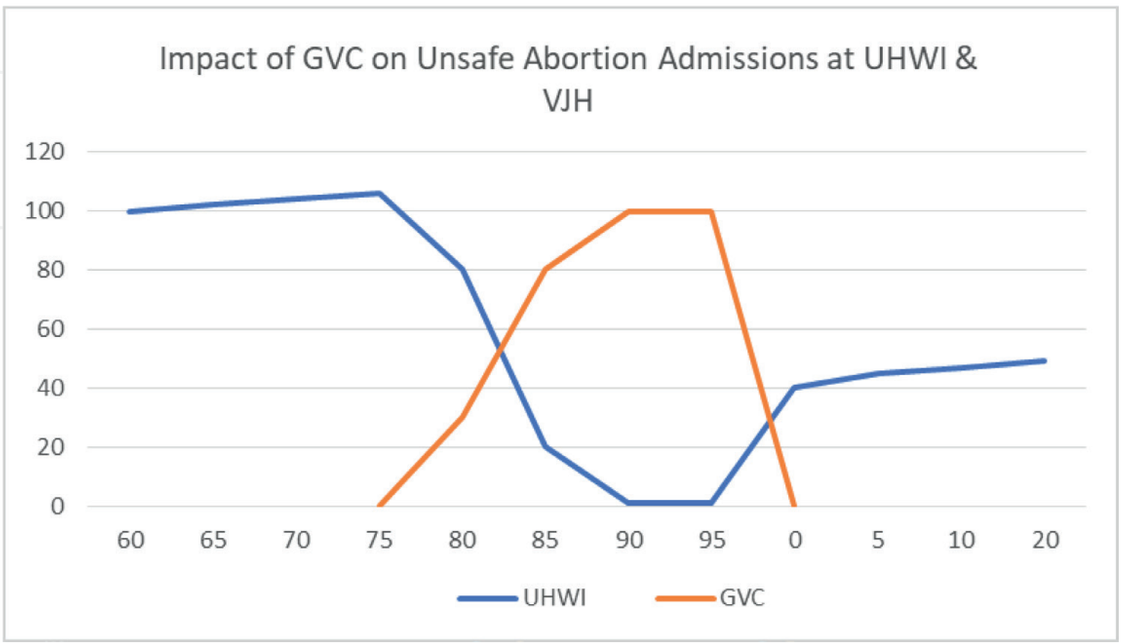

Figure 2.
Anecdotal impact of safe abortion services at GVC on unsafe abortion admissions at UHWI & VJH.

marginalized groups, the task becomes nearly impossible. It is not surprising that governance remains one of the major challenges, perhaps the major challenge of FPAs.

6. Caribbean family planning association (CFPA): colonial legacy or regional strength

The Caribbean Family Planning Association (CFPA) was created in 1971 with a clear mission: To advocate for sexual and reproductive health and rights (SRHR) through information and services including family planning, gender equality and freedom for physical and psychological, and institutional abuse. But this is exactly the mandate of the national organizations, so what was the added value of CFPA? Two decades before, Barbados, Jamaica and Trinidad had already become members of IPPF. During the 1960s the family planning movement had found roots in organizations in several other Caribbean countries—St Kitts, Grenada, St. Vincent, St. Lucia, Suriname, among others. Each of these national bodies wanted membership and so a seat on IPPF-WHR's Regional Council. Such an arrangement would have been consistent with UN-style democratic relationships.

However, the decision makers felt that the Caribbean would then have voting rights out of proportion to its population. In order to contain the voting power of the Caribbean, the CFPA was created as an umbrella for the nine affiliates. The decision did not affect the three 'larger' countries—Barbados, Jamaica and Trinidad—that had enjoyed membership since the 1950s. Subsequently, in the 1990s, Belize, Guyana and Suriname became a part of the group that had gained IPPF membership.

This arrangement through CFPA would prove problematic. First, it served to reinforce the divisive big island-small island politics of the Caribbean which had led to the downfall of the West Indies Federation in 1962—a political union of 10 Caribbean territories. Second, the decision was not aligned with established practice among international organizations. The arrangement had all the trappings of a colonial incubus.

The question then remained, what was the value proposition of the CFPA? What could it do that would make it attractive and an asset to the countries—small and large alike? The CFPA would have to deliver where the national associations could not perform. For example (i) raise funds, (ii) provide technical assistance to staff and Board alike, (iii) conduct research to nurture evidence-based approaches to reproductive health (iv) engineer deals with suppliers for the region as a whole that would yield economies no one member could command (v) foster a sharing of best practices—including any in the larger countries (vi) raise the profile of SRHR across the Caribbean, and (vii) be a voice for members in regional and international meetings.

The strength of the CFPA and its capacity to deliver added value cannot reside in the CFPA alone. Any secretariat, any collective body, is only as strong as the vibrancy of its members. That collective commitment must be a dominant characteristic. The real strength of any federal body lies in the willingness of members to work together in pursuit of a shared mission. Given the weaknesses at Board level, this is no easy task. Those weaknesses are also real in the so-called larger countries. Small countries do not have a monopoly on absenteeism, indiscipline, and unaccountability.

When the CFPA has been properly resourced, it has delivered on its value proposition—conducting research, raising the profile of sexual and reproductive health, and successfully raising millions of dollars for its members. When staff resources shrink from 16 to 2, it is absurd for anyone to expect the same level of output. Further, we do not believe that even the most insightful observer could have anticipated the spread of governance

issues that have emerged in recent years. Improving governance is not a technical fix. It is an adaptive challenge that needs behavioral change. It takes and drains time.

The CFPA has not recently enjoyed the cohesion among its members that it needs to flourish. As too often happens in the Caribbean, we have broken into little pockets of comfort and division. We seem to lack the maturity for forthright dialog. We do not seem to have the appetite for high quality discussion and resolution of disagreement, without which we cannot forge the level of commitment to tackle our mission.

With IPPF's new willingness to give a vote to each country that meets certain criteria, several countries are exercising that option. That is entirely progressive. In this regard, several countries have already graduated from CFPA. They now have direct membership in IPPF. That is wonderful. Like physical fitness, graduation is not a permanent condition. Anyone who thinks otherwise is living an illusion. Several Caribbean countries are reliant on tourism, a very fickle industry. Beaches and hotels can be destroyed in a hurricane. Some countries are disrupted by volcanoes. In many ways our economies are fragile. Membership in a larger group is one way to manage the risks each country faces.

The invitation of separateness, of graduation to IPPF membership and individual votes is entirely parallel to the process that set the gears for the dissolution of the West Indian Federation. When the islands thought that their only path to separation from the UK was a federation, they hung together. As soon as they learned that the UK was only too happy to cut them loose one at a time, the fissure started to appear. We could be walking that same path again. Our short-sighted parochialism could be blinding us to the bigger picture of collectivism. Graduation does not mean abandoning a broader engagement. After all, the independent nation states in Europe saw the wisdom of forming a union in the face of global economic strength and political self-interest. Sovereignty does not imply isolation. Graduation can lead to a stronger CFPA.

The question for us is simple: Do we have the courage and the skill to convert a damnosa hereditas into a magnificent asset? Or do we prefer to see the CFPA wither away?

7. Culture of mendicancy

The first steps at birth control were driven largely by Caribbean nationals of status, privilege and means, based entirely on the realities in their immediate communities—frequent pregnancies and poverty. They were locally initiated and locally nurtured. We did what we could with what we had. The drive was rooted in empiricism, passion and good faith. The pioneers soon realized that the magnitude of the problem they faced required far more than mere good faith. So, they tried to attract support first from their governments. The toil of these pioneers was not isolated. It has to be seen as part of a broader national struggle. Across the Caribbean, the labour unrests of the 1930s had forced the creation of the Moyne Commission which addressed the problems of poverty and made recommendations for social and political reforms. The emergence of family planning was part of a nationalist, anti-colonial movement. But precisely because birth control was so controversial, even with the force of the Moyne Commission [50], Caribbean governments were largely hesitant to support the fledgling bodies. The pioneers, in some cases led by middle class women who had been educated in the UK and the USA, then turned to foreign sources for funds. Although the pioneers were women, and the mission was women's health, once the funds started to flow, it was men who occupied the posts.

Relatively easy access to funds changed the game. Self-reliance was quenched. During the severely constrained colonial period, while the colonialists extracted

wealth, the national population lived by the ethic of living within your means. Incurring debt was to be avoided. That message was neatly conveyed by Charles Dickens in David Copperfield:

> *'Annual income 20 pounds, annual expenditure 19, 19 and 6, result Happiness.*
>
> *Annual income 20 pounds, annual expenditure 20 ought and six, result Misery'.*

However, that sentiment of self-sufficiency was sharply inverted upon Independence. Borrowing, seeking credit, which was once shameful, became a hallmark of accomplishment. The more one could borrow, the greater the signal of one's worth. Indeed, one of the attractions to political independence was precisely that—direct access to more channels of international funding. We celebrated our independence by significantly expanding our dependence on international borrowing. In a sense, if the World Bank, United Nations Development Programme (UNDP), Inter-American Development Bank (IDB), Pan American Health Organization (PAHO), and others would lend us money, "we had arrived". This was mendicancy on a national scale. This became the norm in our associations. Writing proposals became the important skill. Whether directly or indirectly through CFPA, IPPF became the steady source of funding for Caribbean FPAs. Naturally, with that dependence came IPPF's priorities, standards, and reporting requirements. This relationship became its own reinforcing cycle. FPAs had found a comfort zone in which we needed IPPF for our financial survival and IPPF needed us for their fundraising.

One unfortunate consequence of this relationship is that our associations were required to keep certain records of service and finance. Unfortunately, for the most part, those records were used to satisfy the reporting requirements for IPPF. They were seldom used to inform strategic planning or to guide management decisions about programme outreach or service delivery. The associations learned how to use data to placate donors but lost the capacity to turn those data to serve the mission. It is hardly surprising then that after more than 50 years of ties to IPPF, for the most part, the associations remain as dependent as ever. We have become victims of a culture of mendicancy. We no longer seem to seek to become self-sufficient.

8. Conclusions: creeping toward self-sufficiency

FPAs in the Caribbean region must try to move toward a measure of self-sufficiency and sustainability. Some Caribbean associations have shown the way, notably Barbados. We should learn from each other. There is a need to attract individuals with professional skills in finance, fund raising, and strategic planning to our Boards. The widespread Caribbean diaspora is an untapped reservoir that should be mobilized to endow our work. The associations have not tapped into the working-class and corporate organizations whose members have benefitted from their services for decades. The associations have not yet made a sufficiently strong, evidence-based case to national governments. Even if the associations cannot each become entirely self-sufficient, surely, they can set themselves the target of a sliding scale of becoming less dependent, less reliant, and less vulnerable to the shocks and whims of our international partners. If the alarm generated by the threatened decapitation of funding because of the threatened redirection of European resources following the Russian invasion of Ukraine was not a sufficient wake-up call, perhaps no alarm will be loud enough.

For most associations, ground zero is governance. This challenge must be faced and tackled head-on. Without this, there is no prospect of establishing a clear shared vision of the associations' role in 10 or more years. Without vision there can be no meaningful strategic planning or rigorous discipline of accountability. Proper governance is pivotal. There is no easy fix. Probably 90% of the work in organizations is technical, routine and managed by rules and standard procedures. That is the day-to-day busyness of the business. The other 10% requires facing uncertainty and ambiguity. That is the realm of adaptive leadership. Success in this area involves fostering disagreement, challenging the status quo, risk-taking, failure and innovation. This involves reflection—the antithesis of busyness [51]. Resolving the challenge of governance requires adaptive leadership. It will be a struggle of discovery and will require painstaking search for persons with the skills the associations need and whose values are aligned with their mission. It means building Boards of members with an appetite for constructive disagreement. This will be difficult in all countries but even more so in the smaller ones. Leaders in associations need to think outside the box. The Caribbean has lost a huge chunk of its technical skill. The fact that people have emigrated from their home country is not a statement of disinterest. In an internet connected world it is entirely possible to attract some of these persons to function as Board members. In terms of sheer numbers, there may be a pool of at least equal size in Canada, the UK, and the US. We believe this resource pool should be explored for the strength it could add to our governance.

Further, they could be a source of both direct and indirect financial support. Finance is arguably the associations' second weakest leg. By linking national expertise with their overseas cousins, literal and metaphorical, it is possible to begin to address the chronic financial challenges. No one should underestimate the willingness of Caribbean people living abroad to contribute to the region from their pockets and through their skills. There are Caribbean nationals at the leading edge of digital technology, finance, law, health care, and social justice movements who can be reached for support. The diaspora is potentially a rich source for unrestricted donations—the funds most sought by charities, because they can be used at their discretion, free of specific reporting. Attracting unrestricted funds is a function of reputation. Given their 50-year-old reputation, the associations should be well placed to explore this trove in the diaspora.

Between governance and finance is the generation of a shared vision. This is not an esoteric, pie-in-the-sky exercise. Too often it is given short shrift. Get the vision wrong and the result can be catastrophic. Railroads in the US were a phenomenally wealthy and powerful group. But they defined their business by what they did, running trains, rather than the purpose they served, moving goods and people. So, in the 1950s as then President Eisenhower built highways, they campaigned against large container trucks and missed a huge opportunity. They were in transportation, not railroads. This story has been repeated so often—Parker pen and ballpoint pens; Kodak and digital photography, and so on. IBM showed both phases—success in mainframe computing, missed out entirely on laptops and has rebounded with digital technology. FPAs need to address the far wider range of factors affecting reproductive health and justice—gender-based violence, male reproductive health, the stigma of abortion, homophobia, LGBTQ inclusion, etc. The associations need to apply their reputation for high quality and confidential services they have acquired over the years to advance justice on these frontiers. Then beyond that, what next? In some countries, FPAs were among the first charities established. They should be setting about to lead reform in other areas of social justice.

Internally, we need to learn from our mistakes. We need to invest in the diagnosis of the collapse of associations and study the dynamics of their recovery. We seem to prefer to dismiss these events rather than to document them and school ourselves in the lessons we can extract. Or worse, we imagine we are immune from a similar experience. We do not construct serious after-action reviews. This is a serious weakness and bleeds into thin 'strategic' planning. Similarly, we should learn from those associations that have soared. Sharing best practices is a neat way of building relationships and sparing under-resourced organizations from having to re-invent the wheel. But to do this sincerely, we need to care about each other. And caring about each other means vaulting over our parochialism.

One of the crushing day-to-day burdens associations face is the struggle to provide reports to a range of different donors, each with its own format and priorities. This is a paradox: it's the price we pay for our success in attracting funds from a variety of donors. No one country by itself can push against this tide that both feeds and then drains us. This surely is an area in which acting together, the region can propose some standard approach or template that makes economic sense to the associations and yet satisfies the donors. We have no doubt that this has been tried, we do not know whether it has been pushed as a collective, Caribbean wide initiative. We think reducing this burden is well worth a further effort. In some countries FPA staff are paid lower salaries than government staff. This situation exacerbates opportunities for collaboration. This is yet another area in which associations could, with real advantage, act collectively.

The way forward rests in purpose-driven, united, inclusive, collective action. "Going it alone" was a non-starter for Caribbean nations nearly 70 years ago. The word is far more connected today. Any national association that believes it can manage on its own with little or no regard for its neighbors, is simply delusional. Each national body needs to see the strong added value of a regional organization, whether CFPA or another, and work together to strengthen it. The national bodies must work together to define and create the "CFPA" that the region needs—one that has a voice because all the associations in the region are solidly aligned and speak with one voice. A regional body that can help with negotiations with individual governments precisely because it can leverage information of advances in government relations in one country with others in the region. A secretariat that is empowered because of the support it enjoys from all Caribbean countries regardless of size or status, whether affiliates, recent graduates, or long-existing postgraduates.

Advocacy rests on facts and values. Without empirical research we are stuck with our blindness and our beliefs. The lack of research, whether conducted by the associations or inspired by them in liaison with tertiary institutions, is one of the significant, persistent deficiencies of the FPAs. This lack of evidence depletes advocacy, diminishes professionalism, and erodes relevance, and leaves them blind to oncoming threats and opportunities alike. This is an easy area for the associations to quickly earn short term wins.

No one imagines any of this will be easy. If that were the case, it would have almost certainly happened long ago. But the leadership of FPAs must bend their efforts to make a clear turn in the road, so the next 15 years is distinctly unlike the last 50.

Acknowledgment

The Caribbean has not yet developed a grand tradition of record keeping. Further, as with any drive for social change, actors are far more focused on forward movement

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Conflict of interest

The authors declare no conflict of interest.

Notes/thanks/other declarations

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