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CONSULTANT'S REPORT ON
THE NATIONAL CONFERENCE ON FERTILITY
AND THE ADOLESCENT

A Report Prepared By:
VERA RUBIN, PH.D
JOYCE JUSTUS, PH.D
BETTY J. DUDLEY, MPH

During The Period:
JANUARY 4-JANUARY 11, 1980

Under The Auspices Of The:
AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
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PREFACE

A National Conference on Fertility and the Adolescent in Jamaica was sponsored by the National Family Planning Board with the cooperation of the Department of Sociology, University of the West Indies and the United States Agency for International Development.

The consultants, Dr. Vera Rubin, Director of the Research Institute for the Study of Man, and Dr. Joyce B. Justus, Professor of Anthropology, University of California, San Diego, have been integrally involved in the initiation, development and completion of the AID-sponsored research project on "Occupational Structures, Educational Opportunities and Fertility" in Jamaica. Dr. Justus was the international consultant to the University of the West Indies Research Institute for the Study of Man project, and Dr. Rubin served as Principal Investigator. Major findings were presented at the Conference. Ms. Betty Dudley, M.P.H., was invited as a conference presenter because of her outstanding adolescent fertility services and accomplishments at the Mt. Sinai Hospital Family Planning and Teen Services Program, where she is the Director.

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Teen Services Program

INTRODUCTION

Dr. Vera Rubin of the Research Institute for the Study of Man, New York; Dr. Joyce Justus of the Department of Anthropology, University of California, San Diego, and Ms. Betty Dudley, Director, Mt. Sinai Hospital Family Planning and New Services Program, Chicago, Illinois participated in a five-day national conference on Fertility and the Adolescent sponsored by the National Family Planning Board along with the cooperation of the Department of Sociology and the United States Agency for International Development held January 7 through January 11, 1980 at the Jamaica Pegasus Hotel. Members of the Department of Sociology, U.W.I., coordinated this conference.

The conference was designed to heighten public awareness of adolescent fertility and to bring together additional resources to impact upon the problems of high levels of adolescent fertility in Jamaica.

The objectives of the conference were:

1. To make available current research findings in the field of adolescent fertility for groups discussion by policy members and program leaders in the field.
2. To stimulate exchange of information on current action programs for adolescents and to encourage coordination between programs.
3. To stimulate the development of an ongoing national interest group of those concerned with the welfare of adolescents.

The National Conference on Fertility and the Adolescent represents a landmark. The excellent organization, broad participation and focused discussion and enthusiasm, is a milestone in the series of family planning conferences that have been held in Jamaica over the past decade. The program planning by the Conference Committee encompassed the broadest range of issues, to date, relative to adolescent fertility; and involved the largest group of participating agencies and individuals ever invited to a conference on family planning in Jamaica. The meetings were unusually well attended throughout the five days with very high levels of discussion and active participation.

Presentations of data on health, education, social and economic condition of Jamaican adolescents, both male and female, and their fertility behaviors were presented. A wide range of contributors discussed their particular area of expertise as it related to adolescent fertility.

The University of the West Indies (UWI) Research Institute for the Study of Man staff and Drs. Rubin and Justus presented a major paper. This was a report of a research project entitled, "Occupational Structure, Educational Opportunities, and Fertility." The primary responsibility for conduct of the study and of analyzing the data was held by Dorian Powell and Hermione McKenzie of UWI. Drs. Rubin and Justus assisted in the design and acted as technical consultants to the project.

Presentations were made by Jamaican agencies on their current and proposed programs for adolescents with special emphasis on fertility behavior.

Workshops and discussions on the issue of adolescent fertility which led to the establishment of policy guidelines for future services for adolescents were conducted.

The workshop topics consisted of the following:

1. Attitudes among clients in the use of contraceptives
2. Family Life Education Programs
3. Parent Group Programs
4. Quality of General Education Programs
5. Training or preparing personnel working with teenagers
6. Legal Issues

The conference involved approximately 150 participants along with a wide range of policymakers such as Mr. Donald Miller, Permanent Secretary, Ministry of Health, and Chairman of the National Family Planning Board. Rev. Webster Edwards, Mr. A. Z. Preston, Vice-Chancellor, University of the West Indies, Dr. Winston Davidson, Parliamentary Secretary, Ministry of Health, His Excellency The Honorable Loren E. Lawrence, United States Ambassador to Jamaica, Mr. Terry Tiffany, Population Officer, Agency for International Development and Dr. Phillis M. Russell, Ministry of Education.

The conference also involved representatives of both government and non-governmental organizations working with adolescents and fertility, churches, youth groups and regional and international family planning agencies. (See Appendix A for conference agenda presented and list of participants.)

II. ISSUES PRESENTED

There was high enthusiasm for discussing the issues and trying to work out solutions, despite the critical economic situation.

The formal papers presented included discussion of economic, educational, medical, psychological, sociocultural, and socioeconomic factors related to adolescent fertility, as well as legal issues concerning teenage pregnancies; employment prospects for youth, and the needs of training for relevant skills.

During the week, the conference organizers also arranged several presentations of existing youth programs, with the participation of teenage boys and girls in the discussion. A particularly interesting program of skits prepared and executed by young people, giving their version of problems of adolescent fertility, was presented. The skits touched on several of the issues that had been presented during the conference: negative parental/school attitudes to teenage fertility; abrupt, non-informative methods of professionals in counseling youth about contraceptives; and lack of communication, generally, with adults about sex education and adolescent concerns. The young people indicated, in response to questions from the floor, that peer counseling and peer support (as practiced in the Haile Selassie School they attend) were the most effective methods of dealing with sex education.

There was also a continuous film program as well as displays of posters and charts and considerable literature available for the participants which contributed to the interest and informative value of the conference.

IV. DISCUSSIONS

The formal papers stimulated considerable discussion from the floor. The discussions covered a wide range of issues: economic problems impinging on adolescents and their families; lack of educational/occupational opportunities; sociocultural problems related to prevalent types of conjugal union; absence of father as household head; internal and external migration of parents or parent surrogates; dependence of mother on plural relationships with men in effort to establish economic and psychological security; lack of privacy due to poor housing; young girls' search for stable heterosexual relationships; and cultural values related to childbearing as an indice of female sexual and social maturity. Rural-urban differences and urban ghetto difficulties were also considered.

Technical problems for teenagers who lack actual knowledge about effective use of contraceptives were stressed throughout the meetings. Emphasis was also placed on the limited ability of most individuals (family, school, clinic) with whom teenagers come in contact to supply adequate medical, technical and psychological support. The discussions also focused on teenage problems of going to family planning clinics, being rudely received by clinic personnel; lack of confidentiality and privacy; and a general lack of communication about possible side effects of contraceptive use, all of which are conducive to dropout from the program. It was also pointed out that, although over-the-counter availability of the pill might be more convenient (and anonymous) for teenage girls, the lack of counseling was generally counter-productive for contraceptive use, and further, failed to provide the context of family life and sex education essential to lowering fertility.

Considerable attention was given to the question of who should assume responsibility for sex education and the age at which sex education should commence. Generally, it was felt that socialization for sex and family life education should start early. It was variously suggested that parents, schools, and peers and/or clinic personnel assume responsibility as communicators. No consensus was reached as to which group could be most effective. There was discussion of the pronounced difficulty most parents have in communicating with children; however, clinic personnel (including doctors and nurses) were not perceived as having accurate knowledge or appropriate attitudes for counseling teenagers.

At various points, particularly after the presentation of the skits, young people were thought to be better communicators. The tenth and eleventh grade students who presented the skits reported that they counsel seventh and eighth graders at their schools. The urgency of having effective cross-generational communication included the need for "rap sessions" of parents with their young children. More effective use of the mass media for family life educational programs and the need to reach out to school children in rural and ghetto areas was also emphasized.

Although the question of sexual relations was hedged somewhat, it was recognized that sexual relations in the country may start at pre-teenage levels, consequently, contraceptive usage should commence early, both to circumscribe pregnancy and prevent venereal disease. No embarrassment was evident about the

use of technical or colloquial terms about the human body and sex. The straightforward discussions represent a shift from traditional and straitlaced attitudes of the past. In general, the aim of lowered adolescent fertility and population control was taken for granted -- only one or two persons at any time brought up fundamentalist religious doctrines concerning fertility and procreation. Two of the panelists emphasized that economic and social development would be instrumental factors in lowering fertility, apparently drawing on demographic transition theory.

In the context of family life education, considerable discussion was devoted to the need for two parents, both man and woman, to raise their children and provide appropriate role models of interpersonal responsibility of parents and children, children to each other, and each to the society as a whole. It was recognized that economic factors have historically limited the possibilities for stable family unions during their early formation and the periods of high fertility for many women. The ideal of stable two-parent unions, at all socioeconomic levels, was seen as a salient factor in limiting family size.

Major emphasis was placed on the lack of educational opportunity and training for the present adolescent cohort, as one-third of the population was born in the high fertility years of the '50s and '60s and the educational system has not expanded rapidly enough. The need to rationalize the educational system was also stressed: to include programs in all schools, both academic and vocational, that are relevant to Jamaican society and economy with parallel preparation of boys and girls in agricultural and technical skills that are needed in the society at this time and can provide steady incomes and a sense of accomplishment. The dichotomy of academic and technical programs in the present system and the tyranny of the examination system which straitjackets young people into divergent academic and occupational tracts, without regard to their innate abilities, reflect an older socially stratified value system.

Considerable attention was paid to the reorganization and rationalization of secondary schools curricula programs to provide across-the-board relevant training, regardless of social class and gender, in order to insure that the range of varied student skills are developed and utilized for their own self-realization as well as for the development of the society.

It was pointed out that migration has created gaps in needed skills and services which could be filled by well-trained young people. Emphasis was also placed on informal training programs (such as the youth corps and 4H) which could be integrated into the regular school system and that schools could become centers of learning for out-of-school youth as well as for regular students which would result in better utilization of capital investment programs. Considerable emphasis was placed on the need for socially and economically disadvantaged youth to develop a healthy self-image, particularly since these young persons could become national leaders in due course.

Such educational programs could also limit the frequently mentioned problem that young girls seek economic and psychological security in relationships with older men. These "transitory and illusory relations" compound the problems of

young women as they multiply. It was seen as essential to bring youth into the mainstream of social and economic life so that they would be neither disadvantaged or alienated from their society.

Expansion and development of existing academic programs emerged as a leading solution for the economic problems of the present, with comprehensive educational and technical training as a productive investment for the future. Such training would increase the economic self-sufficiency of young women in self-account activities, reduce the perceived socioeconomic pressure to increase their fertility, and enhance their ability to make individual decisions about childbearing.

While need for improved contraceptive counseling and services was accentuated, the expansion of family planning programs per se was not seen as the ultimate solution to the problem of adolescent cultural and social as well as economic and educational factors. Despite the complex issues and the real problems of the society which were raised, there was a notable lack of pessimism about possibilities for their solution and rather a strong sense that the participants believed solutions could be found with concerted efforts, both in the short term as well as the long run.

The conference was principally devoted to problems of female adolescents, stemming from the research report which initiated the discussions. The role of the male, necessarily, was continuously brought into question. A good deal of anecdotal material about the role of young (and older) men in initiating sexual relations arose during the discussions. Several of the young men who were present indicated that young (and older) women were often initiators and generally equally active participants in sexual relations; they seemed reluctant to accept responsibility for any resultant issue. There was considerable feeling about the need for research data on the attitudes and behavior of men with regard to fertility and family life.

The conference coordinators were able to persuade Professor Herman McKenzie of the UWI, who had undertaken a study of 60 males, to present his initial findings before the computer analysis had been completed. The findings reveal a sociocultural gap between ideals and actual behavior of the men in the study. The subjects, who are representative of urban working-class men, indicate they believe in the two-parent family, support for women and children and small family size, although they were ambivalent about contraceptive use. The main factors involved in the gap between beliefs and behavior were economic issues and the difficulties of settling down to stable family life under the circumstances; economic difficulty was also cited as a principal factor in small family size preference. It is, therefore, important to note that these values do exist for men as well as women; that the problem for Jamaica is to provide the possibility to close the gap between values and actual behavior.

An interesting psychocultural point was raised about the symbolic meaning of fertility for the adolescent girl as a rite-de-passage -- a mode of communication to adults that the adolescent female was reaching independence and the dependency of adolescence had been terminated. Increased educational and occupational opportunities could provide new symbols of independent status for the adolescent. It

was also suggested, in this context, that given the lowered age of menarche and cultural expectations of early sex, that contraceptive use be presented as a means of enhancing sexual pleasure, aside from limiting fertility. The concern was also voiced that parental emphasis on constraint of heterosexual relations might result in recourse to both male and female homosexuality. A question was raised as to whether government should restrict family size to two children. It was generally agreed that family size would be conditioned by the interaction of educational, occupational, socioeconomic and cultural factors, including the availability of adequate contraceptive knowledge.

Throughout the discussions there was a search for both long-term and short-term solutions and an awareness that the socialization of children about sex and about family life education should start at an early age.

It was emphasized that frank and open dialogue was necessary to help adolescents create new family life values and enhance their own development as well as the development of the society.

The Ministers and Ministry representatives who participated in the conference indicated that plans were underway for the development of new educational and social service policies; they registered the strong concern of the government for broader education and development of youth, and support for all-embracing programs in addition to family planning services. The conference provided an opportunity for airing and discussing such policies and programs as well as the exchange of information among agencies and individual participants.

The group luncheons and coffee breaks provided the opportunity for informal, personal exchanges among all the participants.

V. WORKSHOPS

The workshops were held on the final afternoon of the conference. The results were striking; they produced significant observations and practical recommendations.

Dr. Phyllis McPherson-Russell of the Ministry of Education had worked out guidelines to structure uniform discussions and reporting, which made it possible for the workshop participants to address the central issues of the conference. The ten workshops produced combined reports on the five topics selected as general topics of the conference. Full copies of the reports are to be forwarded to the funding agencies as well as to relevant ministries and agencies and the participants.

The workshop reports reflect and highlight the salient points that were raised in the four preceding days of presentation and discussion and indicate the serious and concerned deliberations that prevailed during the entire conference. There was a minimum of anecdote and a maximum of attention given to substantive programs. The reports dealt with the shortcomings of the current situation and proposed solutions to be implemented in the short term and the long term.

There was an interesting intergenerational exchange between persons who have long been involved in family planning programs and relative newcomers. While there was difference in style there was recognition across age groups of the work that needs to be done. The workshop reports provide far-reaching plans for national policies for the development of youth as well as for lowered fertility.

One of the workshop presentations provoking interest was that presented by Ms. Betty Dudley on the services of Mount Sinai Hospital Family Planning and Teen Services Program, Chicago, Illinois. (A copy of paper is attached in Appendix B). Along with the paper, two 45-minute video tapes on the different components of the program, entitled "Parent and Teen Rap Group - A Demonstration of what a typical visit to Teen Services Program is Like" and "Overview Continuing Education Seminar" for professionals and paraprofessionals working in the field of adolescent sexuality were presented.

VI. CONFERENCE COORDINATING COMMITTEE

The final workshop report proposed a mechanism for continuing and maintaining the momentum engendered by the conference.

A special workshop was arranged to discuss possibilities for future coordination. The group proposed that the Conference Coordinating Committee serve on an expanded ad hoc committee to continue the seminal work that had been started and formulate plans to coordinate and facilitate a national program on issues concerning adolescent fertility. It was proposed that such a program should serve as a clearinghouse and retrieval center for available research on the variables involved in adolescent fertility; serve as a clearinghouse for available information and resources on sex education, family planning agencies and family life education; facilitate the training of counselors in family life education; facilitate communication among clients, counselors and community through "rap sessions," use of media and preparation of culturally relevant resource materials; facilitate the development of youth-based family life programs; and encourage the involvement of young people in policymaking for programs relevant to their own development as well as the development of the society.

The Conference Coordinating Committee proposal was accepted by the conference as a whole. The full text will be presented in the report of the conference committee.

It was subsequently noted that such a center could also serve as a much-needed clearinghouse for the collection and analysis of epidemiological medical data and records on maternal and child health. Nutritional deficiency is a major public health problem affecting young children in Jamaica. Considerable data is available on infant malnutrition at the University Hospital and records of the pediatric wards can provide data on age as well as socioeconomic status of the mother. Data available on childhood deafness, resulting from Rubella, and on other childhood handicaps could also provide correlations of age of mother and infant and child health status.

VII. REPORTS

The comprehensive report on the conference, including papers presented, workshop reports and recommendations and an abstract of the proceedings, will be prepared by the Conference Coordinators.

VIII. RECOMMENDATIONS

We wish to underscore the exceptionally high level of performance throughout the conference; the well-conceived program organization which made it possible to focus on significant issues without sidetracking into subjective anecdotal diversions, and the interaction of professional stimulation and felt needs that made it possible to maintain high interest among almost 200 participants over a five-day period. We strongly urge that the momentum engendered by this unique experience should be maintained in the development of a National Coordinating Center that can bring together the resources of available knowledge and highly competent personnel to work toward implementation in the near future of policy concerning adolescent fertility.

A P P E N D I X A

Observers/Participants

NATIONAL CONFERENCE
ON
FERTILITY AND THE ADOLESCENT

January 7-11, 1980

JAMAICA PEGASUS HOTEL

A Conference sponsored by the National Family Planning Board
with the co-operation of the Department of Sociology, U.W.I.,
and the United States Agency for International Development.

P R O G R A M M E

Monday 7th January.

OPENING SESSION

Chairperson: Mr. Donald Miller
Permanent Secretary,
Ministry of Health and
Chairman, National Family Planning Board,

8.00 - 9.00

Registration

9.00 - 9.10

Prayers by Rev. Webster Edwards

9.10 - 9.20

Welcome and Introductions

9.20 - 9.35

Formal Opening of Conference by Mr. A.Z. Preston,
Vice-Chancellor,
University of the
West Indies.

9.35 - 10.00

Greetings

10.00 - 10.30

Keynote Address by Dr Winston Davidson,
Parliamentary Secretary,-
Ministry of Health.

10.30 - 11.00

Overview of Conference by Conference Co-ordinators.

11.00 - 11.45

.....
Coffee break

11.45 - 12.30

.....
Chairperson: Dr. Vera Rubin, Director, Research
Institute for the Study
of Man.

12.30 - 2.00

.....
Lunch Break

2.00 - 3.30

.....
Chairperson: Professor Laurie Reid, School of Education
U.W.I.

3.30 - 3.45

.....
Findings from U.W.I. Department of Sociology Study of
Adolescent Fertility by Research Team (continued).

3.45 - 4.30

.....
Tea Break

7.00 - 8.30

.....
Chairperson: Dr. Patricia Anderson
Co-ordinator, Social Planning,
National Planning Agency.

Discussions and resolutions on Education and Fertility.

.....
Cocktails.

Tuesday 8th January

9.00 - 10.30

Chairperson: Mr. Sam Cheddar,
Executive Director,
National Family Planning Board.
Address: Mrs. Carmen McGregor, Member of
Parliament.
Paper: A Profile of Problems of the Adolescent
Mother.
Presenter: Dr. Carmen Bowen-Wright

.....

10.30 - 10.45

Coffee break

.....

10.45 - 12.30

Chairperson: Dr. Lenworth Jacobs
Paper: Social and Psychological Aspects of
Adolescent Fertility.
Presenters: Mrs. Inez Morrison
Dr. Freddie Hickling
Dr. R.G. Lampart

.....

12.30 - 2.00

Lunch Break

.....

2.00 - 3.30

Chairperson: Mrs. Trixie Somerville,
Sub-Regional Co-ordinator,
Caribbean Conference of Churches.
Paper: Educational Aspects of Adolescent
Fertility.
Presenter: Miss Jean Tulloch-Reid.

.....

3.30 - 3.45

Tea Break

.....

3.45 - 5.00

Chairperson: Miss Daisy Goldson
Youth Programme Showcase No.1.

Friday 11th January

8.30 - 10.30

Chairperson: Mrs. Edna McLaran,
Department of Psychiatry,
University Hospital.

Conference Evaluation and Recommendations by
Conference Co-ordinators and Co-opted Committee.

10.30 - 10.45

Coffee Break

10.45 - 12.30

Chairperson: Mrs. Dorian Powell,
Lecturer, Department of Sociology, U.W.I.

Conference Highlights and formation of ongoing
interest groups.

12.30 - 2.00

Lunch and Closing Exercise in "Talk of the Town".

Vote of Thanks - Mrs. P.L. Lewis,
Conference Co-ordinator.

Researchers

Mrs. Dorian Powell, Lecturer, Dept. of Sociology, U.W.I.
 Mrs. Hermione McKenzie, Lecturer, Dept. of Sociology, U.W.I.
 Dr. Joyce Justus, University of California, San Diego.

Organizing Committee.

Mrs. Ruth Brown - Operation Friendship.
 Mrs. Pam McNeil - Women's Centre.
 Mrs. Aileen Frazer - Social Development Commission
 Dr. Thelma Stewart - Ministry of Education
 Miss Elaine Rainford - Y.W.C.A.
 Mrs. Hyacinth Bulgin - Ministry of Health
 Mrs. Beryl Chevannes - Ministry of Health
 Dr. Carmen Bowen-Wright - K.S.A.C. Health Dept.
 Miss Thelma Thomas - National Family Planning Board
 Mrs. S. Bailey - National Family Planning Board
 Mrs. Alma Smith - Mico Teachers' College
 Mr. Oscar Grant - Roseneath Hotel
 Mrs. Jean Jackson - Assistant Co-ordinator
 Mrs. Pet Lewis - Co-ordinator

NATIONAL CONFERENCE ON
FERTILITY AND THE ADOLESCENT

JAMAICA PEGASUS HOTEL

JANUARY 7, 1980 AT

9.00 - 11.00 A.M.

CHAIRPERSONS

MONDAY

Mr. Donald Miller,
Permanent Secretary, Ministry of Health and
Chairman, National Family Planning Board.

Dr. Vera Rubin.

Dr. Patricia Anderson,
Co-ordinator, Social Planning,
National Planning Agency.

TUESDAY

Mr. Sam Cheddar,
Executive Director, National Family Planning Board.

Dr. Lenworth Jacobs.

Mrs. Trixie Somerville,
Sub-Regional Co-ordinator,
Caribbean Conference of Churches.

Miss Daisy Goldson,
Director, Bureau of Health Education,
Ministry of Health.

WEDNESDAY

Mrs. Sybil Francis,
Director, Social Welfare Centre, U.W.I.

Miss Elsie Sayle,
Executive Director, C.V.S.S.

Mrs. Hyacinth Bulgin,
Ministry of Health.

THURSDAY

Mrs. Hazel Blake-Nelson,
Director, Women's Bureau.

Professor Aubrey Phillips,
Dean, School of Education, U.W.I.

Mrs. N. Chambers,
Director of Children's Services.

Miss Marjorie Lamont,
National Planning Agency.

FRIDAY

Mrs. Edna McLaren,
Dept. of Psychiatry, University Hospital.

Mrs. Dorian Powell,
Lecturer,
Department of Sociology, U.W.I.

NATIONAL CONFERENCE ON
FERTILITY AND THE ADOLESCENT

JAMAICA PEGASUS HOTEL

JANUARY 7, 1980 AT

9.00 - 11.00 A.M.

RESOURCE PERSONS

Susan Olds

Dr. Vera Rubin, Director, Research Institute For The Study
of Man.

Dr. Betty Dudley

Dr. Joyce Justus, Lecturer, University of California, San Diego.

Hermione McKenzie, Lecturer, Dept. of Sociology, U.W.I.

Dorian Powell, M.A., Dept. of Sociology, U.W.I.

Miss E. Ramesar, Senior Education Officer,
Guidance & Counselling Section, Ministry of
Education.

Dr. Thelma Stewart, Assistant Chief Education Officer,
Ministry of Education.

Miss Jean Tulloch-Reid, Tutor, Family Life Education,
Social Welfare Centre, U.W.I.

Mrs. Aileen Frazer, Community & Family Life Education Officer,
Social Development Commission.

Dorothy Allsop, Women and Development Unit, Barbados.

Daisy Goldson, Director of Bureau of Health Education,
Ministry of Health.

Beryl Chevannes, Nursing Consultant, Ministry of Health.

Dr. Carman Bowan-Wright, Senior Medical Officer, K.S.A.C. Health
Dept.

Carman Stewart, Chairman, Ministry of Health Task Force on
Family Planning.

NATIONAL CONFERENCE ON
FERTILITY AND THE ADOLESCENT

JAMAICA PEGASUS HOTEL

JANUARY 7, 1980 AT

9.00 - 11.00 A.M.

RAPPORTEURS

Hyacinth Ellis
Elsie Hines
Wilma Bailey
Ruth Hall
Ivy White
Trixie Somerville
Edna McLaren
Barry Chevannes
Enid Whyte
Novelet Jones
Alma Smith
Beryl Chevannes
Leith Brown
Pearl Gammon
Vinetta Brown
Pat Anderson
Elizabeth Ranesar
Mr. Victor Barrett
Elsie Sayle
Hyacinth Bulgin
Elaine Brooks
O. Dixon

NATIONAL CONFERENCE ON
FERTILITY AND THE ADOLESCENT

JAMAICA PEGASUS HOTEL

JANUARY 7-11, 1980

OBSERVERS/PARTICIPANTS

NAME	AGENCY	WORKSHOP
ASHBOURNE, Vivian	Mental Health	
BAILEY, Olive	Ministry of Health - Commun. Health Nurse	
AARONS, Derrick	Min. of Health - Medical Officer	
BOWEN, Sadie	S.D.C.	
BOWEN, Sonia	EXED Community College	
CAMPBELL, Shelly	EXED Community College	
CARPENTER, Herma	Harbour View Health Centre	
CARSON-JONES, Doriel	Public Health	
CASTRICIA, Angela	University Student	
CHEVANNES, Vivienne	EXED	
CLARKE, Ms. M.	EXED	
CLARKE, Rayol	Child Welfare Service	
CLAY, Coleen A.	Lecturer, School of Education, U.W.I.	
CROOKS, Sonia	National Planning Agency	
DAVIS, Angela	Nat. Family Planning Board	
DAVIS, Edmund	Jamaica Council of Churches	
DAVIS, Julia A.	Operation Peace - Wesley Methodist Church	
DAVIS, Martha	Pediatrics, U.H.W.I.	
DAVIS, Sophia M.	Women's Centre	
EDWARDS, Ionie	Comprehensive Health Clinic	
ELLIS, Barbara E.	Nat. Family Planning Board	
EVANS, Aston	Nat. Family Planning Board	
FERGUSON, Mavis M.	Dept. of Correctional Service	
FORBES, Clive W.	Min. of National Security (Police Youth Clubs)	
GAJRAJ, Dr. K.	Glen Vincent Poly Clinic	
GAYLE, K.E.	EXED	

NAME	AGENCY	WORKSHOP
GOLDSON, Daisy E.	Bureau of Health Education (Min. of Social Security)	
GORDON, Junis	Social Work Dept. (U.W.I.)	
GREEN, Maureen	EXED	
GREEN, D. Edson	Dept. of Psychiatry	
HAMILTON, Pansy	Ministry of Health	
HARRIS, Irene	Women's Centre	
HOLDING-COBHAM, Marjorie	K.S.A.C. Health Dept. (Ministry of Health)	
JACKSON, Elaine	EXED	
ELLIS, Joyce	Ministry of Health	
LESLIE, A.A.	Canadian International Devel. Agency	
LLEWELLYN, D.	K.S.A.C. School of Health	
MARSH, Jennifer	Dunlop, Corbin Compton Assoc.	
MCCASKIE-WINT, Grace	Social & Preventive Medicine	
MCLEOD, Beverly	Dept. of Psychiatry (U.W.I.)	
MILLS, Carlton	Social Work (U.W.I.) - Student	
MILLS, Inez	Child Care	
MORRIS, Prudence	EXED	
MOYSTON, David	Social Work Dept. (U.W.I.) - Student	
MUNRCE, Dawn	P.S.O.J.	
MURPHY, Patricia	EXED	
OSBURN, Monica Y.	Child Care & Protection	
PANTON, Barbara	K.S.A.C. Public Health Dept.	
PURO, Pamela	Paediatrics, U.H.W.I.	
REID-GORDON, T.L.	Min. of Health (Spanish Twn.)	
REID, Mrs. Norma	Wolmers Girls' School	
PITGRAVE, Jacqueline	Trench Town Comprehensive	
REID, Wylet	Dunlop Corbin Compton Assoc.	
REYNOLDS, Barbara	EXED	
ROBINSON, Francis	Trench Town Comprehensive	
ROBINSON, Sybil A.	St. Andrew High School	
ROSS, Ms. Hedy	Women's Bureau	
SHIRLEY, Beverly	Women's Bureau	

NAME	AGENCY	WORKSHOP
HWAPP, Norma	Comprehensive Health Centre	
ITH, Mrs. Carolyn	Church Teachers College	
GENIE-SMITH, Jenny R.	Women's Bureau	
EWART-WILLIAMSON, Hyacinth	Jamaica Constabulary Force - Counselling Officer	
ANFORD, Veronica	Mona Secondary School - Guidance Counsellor	
ESIGER, Grace	Educational Broadcasting Service	
OMAS, Thelma	EXED	
ORPE, Valencia	EXED	
MLINSON, Miss D.	EXED	
MLINSON, P.O.	Nat. Family Planning Board	
BOUGHT, Marlene G.	Harbour View Health Centre	
LLACE, Charmaine	EXED	
ODDERBURN, Maurette	Norman Manley Secondary School	
LLIAMS, Ruth M.	K.S.A.C. Public Health Dept.	
LLIAMS, Vinola	Public Health	
ENTER, Astrid	International Educational Devel. (Student).	

NATIONAL CONFERENCE ON
FERTILITY AND THE ADOLESCENT

JAMAICA PEGASUS HOTEL

JANUARY 7-11, 1980

PARTICIPANTS

NAME	AGENCY	WORKSHOP
ALLEYNE, Sylvan	Dept. of Sociology, U.W.I.	
ANDERSON, Dr. P.	National planning Agency	
AARONS, Derick		
ASHLEY, Dr. Doanna	Ministry of Health	
ALLEN, Dr. Tony		
BAILEY, Wilma	U.W.I.	
BAILEY, Mrs. L.	N.F.P.A.	
BARRETT, Victor I.A.	Brotherhood of St. Andrew, J.A.	
BEACHER, Mabel	Jamal Foundation	
BECKFORD		
BELLE-TAYLOR, H.	Ministry of Agriculture	
BERNARD, Dr. G.W.	Ministry of Health	
BERNARD, Jaunita	Girls' Brigade	
BLAKE-NELSON, Hazel	Women's Bureau	
BOLAND, Barbara		
BOWEN, Annette	Family Planning Centre, St. Thomas	
BOWEN, S.		
BOWEN, Norma P.	Community Health Aide	
BOWEN-WRIGHT, Dr. C.	Ministry of Health	
BRAGG, Lola		
BRITTON, Ms. Martia	Grenada Planned Parenthood Assn.	
BROOKS, Elaine	Census Research Programme, U.W.I.	
BROWN, Dahlia E.	C.A.S.T., U.W.T. Health Centre.	
BROWN, Leith L.	Caribbean Conference of Churches	
BROWN, Ruth		
BROWN, Veronica M.	Social Devel. Commission	

NAME	AGENCY	WORKSHOP
CAMPBELL, Mrs. Enid	Ministry of Health	
CAMPBELL, Olive	K.S.A.C. School Health	
CARTER, Ethlyn	Women's Bureau	
CHEVANNES, Barry	Dept. of Social and preventative Medicine, U.W.I.	
CHEVANNES, Geryl	Ministry of Health	
CHEVANNES, Enid (Mrs.)	Jamal Foundation	
COMRE, Miss N.L.	Sociology Dept.	
COOKE, Mrs. Estina V.		
CUNNINGHAM, Mrs. M.	Norman Manley Community Skill Centre, S.D.C.	
CUMMINGHAM, M.		
DALEY, Edwina E.	National Family Planning Bld.	
DAVIDSON, Barry S.	Jamaica Youth For Christ	
DAVIDSON, Dr. Winston	Ministry of Health & Social Security	
DAVIS, Martha	Podiatrics, U.H.W.I.	
DELPRAATT, Audith	Min. of Health & Environmental Control	
DIXON, Ivel	Correctional Services	
DOLLY-BESSON, June	U.W.I.	
DOUGLAS, Colin L.	Boys Town School	
DRUMMOND, Cynthia	Bureau of Health Education	
DUDLEY		
ELLIS, Barbara		
ELLIS, Hyacinth M.	U.W.I.	
EMBOEN, Carol		
EVANS, Rhoda May	Min. of Agriculture	
FENTON, Mrs. Lois	Dept. of Obstetrics & Gynaecology, U.W.I.	
FERGUSON, Mrs. Joyce	Operation Friendship	
FINLAYSON, Mrs. G.V.	Daughters of the King	
FORBES, Derrick U.	S.D.C.	
FRANCIS, Mrs. C.O.	School of Nursing, U.H.W.I.	
FRANCIS, Sybil E.	U.W.I.	
GALLUP, Clyde		
GARMON, Pearl A.	Nat. Planning Agency	

NAME	AGENCY	WORKSHOP
COLOUB, Almbre	Norman-Manley Soc. School	
GOLDSON, Modesta		
GRAHAM, Viola		
GRANT, Oscar H.	Independent Rossmouth Hotel	
GRANT, Patricia	Churches' Advisory Bureau	
GRANT, Sheila	Ministry of Housing	
GRIFFITHS, William	Ja. Family Planning Assn.	
HALL, Mrs. Ruth	Dept. of Social & Preventative Medicine, U.W.I.	
HAMILTON, Carman	K.T.H. School	
HAMILTON, Linda E.	Ja. Federation of Women	
HAYNES, Mrs. M.	St. Annos Secondary School	
HEADLEY, Rolano F.	Police Youth Clubs	
HICKLING, Frederick	Bollvue Hospital	
HINES, Elsie	S.D.C.	
HOWELL, Jacqueline	Family Court	
HUNT, Irvine	Y's Mens Club, Y.M.C.A.	
HUNTER-SCOTT, L.V.	Ministry of Health	
ISAACS, Dudley	N.F.P.B.	
JACKSON, Lynette	Ministry of Health	
JACOBS, Mrs. B.	Ja. Family Planning Assn.	
JACOBS, Dr. Lenworth M.	Ja. Family Planning Assn.	
JAMES, Hyacinth	St. Catherine Health Dept.	
JAMES, June	Churches Advisory Bureau	
JOHNSON, Cynthia	Ministry of Education	
JONES, Novlet C.	Min. of Agriculture, P.U.	
JOSEPH, Lilath A.	Parade Gardens Y.C.T.C.	
JULEYE, Gloria O.	Jamal Foundation	
JUSTUS, Joyce B.	University of California	
KELLY, Daphne	Ministry of Health	
KENSINGTON, Mrs. E.		
LAMPART, Dr. Ronald	Princess Margaret Hos.	
LEVY, Don	Junloo Corbin Cemetery Assn.	
LLEWELLYN, Dorothy	K.S.M.C.	
LLOYD, Sharon	ECC Community Center	

NAME	AGENCY	WORKSHOP
LUKE, Glenroy	Social Develop. Comm. (J.Y.C.)	
LYTTLE, Catherine	Bureau of Health Education, Ministry of Health	
McCASKIE-WINT, Graco A.	Social & Preventative Medicine, U.W.I.	
McCAW, Sybil	Operation Friendship, Public Health	
McFARQUHAR, Dudley	Jamaica 4-H Clubs	
McFARQUHAR, E.L.	Ministry of Health	
McGREGOR, Carmon	Member of Parliament	
McKENZIE, Elaine	Glen Vincent Poly Clinic	
McLAREN, Edna F.	Faculty of Medicine, U.W.I.	
McLAREN, Morley	Min. of Health & Env. Control	
McLAUGHLIN, G.I.	Ministry of Health	
McPHERSON-RUSSEL, Dr. P.	Ministry of Education	
MASON, Yvette	Jamaica 4-H Clubs	
MAXWELL, Joan P.	St. Hugh's Girls	
MEGGOE, Gordall R.	Campdown High School	
MILLER, Donald E.	Nat. Family Planning Board	
MONTEITH, Dorothy	Mothers Union	
MOODY, Christine	Ministry of Health	
MOORE, Joyce	Girls' Town	
MORRISON, Donna	Dept. of Correctional Services	
MORRISON, Inez	Family Court	
MOULT, E.	Ministry of Housing	
MOWATT, Nella	Ministry of Health	
MURPHY, Patsy E.	Woman's Centre	
NEUMAN, Basil	Child Care & Protection	
NICHOLSON, Sheila	Vol. Organization for the Upliftment of Children	
OLUSEGUN, Abatundo	Swallowfield Youth Club	
OWEN, Spencer, G.	Jamaica Midwives' Assn.	
O'SULLIVAN, Lucy	Health Dept. Health and Environmental Control	
PERKINS, Sydney		
PETGRAVE, Jacqueline	Trench Town Comprehensive High School	

NAME	AGENCY	WORKSHOP
PHILLIPS, A.S.	School of Education, U.W.I.	
PITTER, Lorna	Woman's Centre	
PITTER, Louise	Ministry of Health	
POLLARD, Velma	School of Education, U.W.I.	
POWELL, Dorian	U.W.I.	
PURKISS, L.	Victoria Jubilee Hospital	
RANKING, Maria	Bureau of Health Education	
REID, I.H.E.	U.W.I.	
REID, Norma	Walmers Girls' School	
ROBINSON, Francis	Trench Town Comp H.S.	
TOONEY, Lorna E.	Church Teachers College	
ROWE, Audrey	Ardenne High School	
RAINFORD, Elaine	Y.W.C.A.	
SADLER, Dolores	Pomeroke Hall Secondary Sch.	
SAMUELS, Mrs. Freda	Shortwood College	
SAMUELS, Mrs. Justina	Ja. Federation of Women	
SAYLE, Elsie	Council of Voluntary Social Services	
SERVICE, Marie M.	Social Welfare Training Centre, 2 Beaton Cres.	
SMITH, Mrs. J.L.	Michael Manley Clinic	
SMITH, Nooline May	Vauxhall Secondary School	
SEMPERVILLE, Trixie	Caribbean Conf. of Churches	
SPENCE, Evelyn	J.F.P.A.	
STERLING, Louis N.	EYED Community College	
STEWART, Barbara	Holy Trinity Sec. School	
STEWART, Mavis Mrs.	Victoria Jubilee Hospital	
STEWART, Thelma	Ministry of Education	
TALBOT, Everton	Correctional Services	
THOMAS, Calvert	Dept. of Mass Communication, U.W.I.	
THOMAS, Thelma E.	J.F.P.B.	
TUMMINGS, Marjorie	VOUCH	
WALKER, Valrie	Jamal	
WALLACE, Valrie V.	Glan Vincent Fertility Control Unit	

NAME	AGENCY	WORKSHOP
WALTERS, Gordon	Youth & Community Development Public Bldgs., Barbados.	
WHITE, Ivy	Family Planning Sub-Committee	
WHITEMAN, Leila	Family Court	
WILHEL, Laurance	Ministry of Agriculture	
WILLIAMS, Angela		
WILLIAMS, Lillith	Excelsior High School	
WILLIAMS, Norma	Bureau of Health Education	
WILLIAMS, V.	Social Work Dept., Calverue Hos.	
WILSON-IVEY, Dr. Veon	K.S.A.C. Health Dept.	
WYNTER, Prof. H.	U.W.I.	
WINT-BAUER, V.		

A P P E N D I X B

Mt. Sinai Hospital Family Planning and Teen Services Program

The Family Planning Program of Mount Sinai Hospital is located on the West Side of Chicago which encompasses communities whose residents are predominantly poor and black. Health problems in general are prevalent in these communities and reproductive health problems are no exception. Birth and fertility rates are among the highest in Chicago, including the rates for adolescents, and the infant mortality rate is also alarmingly high. In addition, close to one-third of the reported cases of venereal disease each year come from the West Side. The social problems which often accompany these medical ones are also prevalent in our service area, including single parent households, disrupted education, and welfare dependency.

The Family Planning Program has had a special program for adolescents since 1973. The program has significantly grown and changed since its inception, and I would like to trace for you the experiences which have contributed to this growth and change.

In 1973 when the Family Planning Program first contemplated providing services to adolescents, the goal was to help fill the gap in the availability and accessibility of medical care for this population group. It was clear that adolescent sexual activity was increasing with no corresponding increase in the use of effective contraception. As health care providers, we felt that a clinic setting in which educational, social and medical services were geared toward the particular level and needs of adolescents would be an effective intervention strategy.

The clinical setting for teenagers was designed to stress education and counseling. This emphasis stemmed from the belief that teenagers are just beginning to exercise the ability to critically analyze information and make well-reasoned choices. While this is true in many areas of their lives, sexuality in particular raises new and unfamiliar concerns. Therefore, the objective was that each clinic visit should include in-depth information in all areas of reproductive health as well as the opportunity, through group discussion and individual counseling, to explore thoughts and feelings and receive helpful feedback from professional staff and from peers.

As time went on, we realized that those teenagers attending clinic sessions represented a self-selected group which did not include all of the sexually active teenagers in the community and certainly did not include all of those teenagers who were "at risk" of being sexually active in the near future. We decided that educational services must not be confined to the clinical setting alone, but must be taken out into the community. In this way, we hoped to broaden the clinic population by reaching out to teens who for one reason or another were not motivated to become family planning patients.

Efforts to do community outreach were at first slow and tentative; making contacts in schools and community organizations, talking with parent groups, conducting short presentations wherever and whenever we were asked. Gradually, as we became known in our community, we were able to develop a more structured, well planned program. By 1977, we had developed a six session curriculum in reproductive health which we were able to schedule on a regular basis through the physical education programs of ten high schools in our area. This program now provides services to 5,000 teenagers annually.

Parallel to the development of the school program, we designed the Community Sex Education Program which was directed toward upgrading the skills of professionals and paraprofessionals already working with adolescents in some capacity. The objective was to add the dimension of reproductive health to their ongoing programs so that at the very least they would act as referral sources to clinical services, and at best they would initiate their own sex education programs for teens. We felt that this program was a necessary complement to the school program since our staff would never be able to reach all teenagers in the community. We believed (and still do believe) that in order to have an impact, as many of the service agencies as possible must participate in a unified effort to address the problems associated with adolescent sexuality.

As it stands now, then, the Family Planning Program has three major components: the Clinical Services Program and the two outreach programs which aim at recruiting teens to the clinic setting. The school program provides services directly to teenagers while the Community Sex Education Program provides services to adults in the community who can then provide direct services to still other teenagers.

Because our program encompasses these various approaches, we have built in several evaluation mechanisms which provide us with information on the effectiveness of the programs and compare and contrast the particular ways in which each program works.

In the high schools, students are asked to complete a pre- and post-test which contains questions that correspond to the topic areas in the curriculum. The test measures the effectiveness of the Health Education Team in teaching the course as well as portraying the pattern of student knowledge and knowledge change. Based on test results, the curriculum is modified to better meet the needs of the students. The test also includes an upgraded section which asks for some descriptive information to help characterize the students and their understanding of human reproduction. (Table 1). Similarly, pre- and post-testing is conducted in the Community Sex Education Program to measure the impact of its curriculum on the participants.

An integral part of both the high school curriculum and the Community Sex Education Program curriculum is a discussion of the services offered at the Teen Clinic. In the schools this involves a description of medical procedures and an open invitation to come and participate in rap group. For the participants in the Community Sex Education Program, the discussion of clinic services includes information regarding the importance of preventive health care and encouragement to actively refer teenagers to family planning services.

At the Teen Clinic there are two sign-in sheets, one for rap group and one for medical services, which elicit information that allows us to assess the effectiveness of the education programs in recruiting teens to family planning services. The sign-in sheets ask the teenagers where they heard about the clinic and whether they have ever been to the clinic before. With this information we can compare the utilization pattern of teens who have come through the Community Sex Education Program and also with those who did not come due to either of the outreach programs. (Figure 1).

Finally, using the clinic registration sheet, we draw a sample of patients and conduct a chart review process which looks at contraceptive, pregnancy, and visit history as well as presenting problem and attrition rates. The sample is drawn using the date of the initial medical visit and source of referral.

Taken together, the pre- and post-tests, the clinic sign-in sheets and the chart review process give us a picture of the effectiveness of the education programs in recruiting teens to a family planning clinic and in promoting better use of services.

For a moment I would like to focus on some of the results of the pre- and post-testing in the high schools. As Table 2 indicates, in general students showed marked improvement from the pre- to the post-test. However, it is those questions they answered incorrectly which we feel have important implications for family planning providers.

The questions pertaining to conception and the menstrual cycle appear to cover information which is the least well understood by the students and which is also the hardest for them to learn. The question asking for the definition of conception was answered correctly by only 30 percent of the students on the pretest and still by only 34.5 percent on the post-test. (Table 3). And while there was quite a large change of 11 percentage points from the pre- to the post-test on the question regarding the time when a woman is most fertile, even on the post-test fewer than 40 percent knew that "during ovulation" was the correct answer. (Table 4).

Two questions on the tests pertained to medical services. On the question concerning how a woman knows for sure if she is pregnant, slightly more than half of the students on both the pre- and the post-test knew that a positive pregnancy test and medical exam are necessary, with "if she misses her period" remaining the second most popular answer. When asked who family planning services are available to, 41 percent on the pretest and 46 percent on the post-test knew that both males and females whether or not they have ever had intercourse are welcome to use clinic services. Incorrect responses revealed either the belief that family planning services are only available to women or that they are available to both sexes but that having had intercourse is a prerequisite for being accepted as a patient. (Table 5).

While the teenagers answered many of the other test questions correctly after participating in the six session course, their incorrect answers reveal the fragmented nature of their knowledge which we feel acts as one barrier to the effective use of family planning services.

For instance, although 81 percent of the students are aware that it is possible to get pregnant at first intercourse, fewer than half are aware that a family planning clinic offers services to individuals who are not sexually active. Many teens, therefore, may have unprotected first intercourse not because they erroneously believe that they are safe from pregnancy but because they are unaware that there are services available to them.

Another example of this kind of fragmented knowledge is seen in responses to the question on conception in conjunction with responses about contraceptive methods. If as many as 26 percent of the students think that conception is the hard penis, how can we expect these same teenagers to understand instructions given at Teen Clinic for use of foam or even the pill? Similarly, if 31 percent of the teenagers believe that women are most fertile during menstruation, how meaningful is it that they answered correctly that the birth control pill works by preventing the ovary from releasing an egg?

It is the reality of the teenagers' fragmented knowledge which makes recruitment to Teen Clinic even of teens who are not yet sexually active such an important component of the education programs. At Teen Clinic we can take the time to give in-depth information and reinforce again and again the information given in the schools and in the community.

Figure 1 shows the impact of the educational programs in recruiting teenagers to family planning services; in addition it shows the different recruiting patterns depending on the type of outreach program. Looking at the teenagers who were not referred through either of the outreach programs, it can be seen that they are almost equally divided between those whose first encounter at the clinic was for medical services and those whose first encounter was for rap group only. This equal distribution does not exist among those teenagers who came through the school program where 83 percent of their first encounters were medical visits. And on the other hand, 92 percent of the first encounters of teenagers who were referred through the Community Sex Education Program were for rap group only. This difference is probably due to the differing amounts of information given to the teenagers before they come for their first clinic visit: the health educators in the schools provide an entire six session course, while the Community Sex Education Program participants may only be providing minimal information with a lot of encouragement to attend a clinic session.

Perhaps the most exciting result of our outreach and education program is shown in Figure 2. It appears that those patients who participated in the school program are different from other patients at Teen Clinic. An overwhelming 80 percent of these patients came to clinic requesting contraceptive services, and 67 percent were requesting contraceptives for the first time ever. Only 20 percent of these patients came to clinic already in crisis, that is, with a suspected pregnancy, infection or other medical problem. This is quite different from the pattern of presenting problems seen in the other groups of patients sampled where at least 42 percent of the patients came in crisis or in need of treatment, and where no more than 40 percent were first time ever contraceptive users. We feel this is important evidence that an extensive outreach and education program can motivate teenagers to utilize family planning services preventively.

I would like to leave you with the following three recommendations which sum up the experiences of the Family Planning Program over the past seven years:

1. Know your limitations -- provide what services you have the capability of providing and then build relationships with other service providers, encouraging the development of cooperative programs that address the problems associated with adolescent sexual activity.

2. Do not rely solely on one approach, but design programs which utilize a variety of methods, whether it be provision of medical services, development of an educational curriculum, parent programs, media campaigns, community events, multi-service centers and so on. The problem of adolescent sexual activity is not one dimensional, and, therefore, neither is the solution.
3. Become involved in the social and political mainstream of your community. Stress the broadness of the issue of adolescent sexuality -- that it is not simply a medical concern, but an economic, social and psychological one as well which impacts on the quality of life for the community as a whole.

Table 1

Percent Distribution of Students Who Completed the Pre / Post Test
by Five Descriptive Variables

	Pre Test	Post Test
1. <u>Age</u>		
Under 14	5.0%	4.3%
14 - 15	79.9	80.7
16 - 17	12.2	12.1
18 +	2.9	2.8
Total	100.0	99.9
2. <u>Sex</u>		
Male	51.0%	52.1%
Female	49.0	47.9
Total	100.0	100.0
3. <u>Proper Age to Begin Intercourse</u>		
14 or Under	6.0%	7.2%
15 or 16	28.0	24.0
17 or 18	19.6	17.1
19 or over	11.7	9.8
Only if Married	10.4	9.0
No Specific Age	24.2	32.9
Total	99.9	100.0
4. <u>Have Children</u>		
yes	2.9%	3.4%
no	97.1	96.6
Total	100.0	100.0
5. <u>Been to Family Planning Clinic</u>		
yes	19.6%	21.4%
no	80.3	78.6
Total	99.9	100.0

Table 2
 Change in Mean Scores on the Sex Education Pre and Post Test
 for Students in Five Chicago High Schools

		Number of Students	Mean Scores*	Significant at .001 level
School 1	Pre Test	302	16.67	+
	Post Test	256	21.60	
School 2	Pre Test	360	16.74	+
	Post Test	327	20.62	
School 3	Pre Test	60	22.25	+
	Post Test	48	26.94	
School 4	Pre Test	73	15.77	+
	Post Test	108	19.12	
School 5	Pre Test	410	16.89	+
	Post Test	236	20.58	

* A perfect score = 34.

Table 3
Distribution of Responses on Test Question No. 10 on the
Definition of Conception

	Pre Test % (n)	Post Test % (n)
Conception is:		
1. The hard penis put into a woman's vagina	22.7 (273)	18.6 (181)
2. The sperm entering the uterus or womb	22.7 (273)	18.5 (180)
3. The sperm fertilizing the egg	30.0 (362)	34.5 (336)
4. The penis getting hard	21.5 (259)	26.1 (254)
Not answered	3.2 (38)	2.5 (24)
Total	100.1 (1205)	100.2 (975)

Table 4
 Distribution of Responses on Test Question No. 14 on
 Female Fertility

	Pre Test		Post Test	
	%	(n)	%	(n)
When is it easiest for a woman to get pregnant (when is she most fertile)?				
1. During menstruation	42.2	(509)	31.4	(306)
2. Every 14 days	14.0	(169)	20.1	(196)
3. During Ovulation	25.8	(311)	36.8	(359)
4. None of the above	16.4	(198)	10.8	(105)
Not answered	1.5	(18)	.9	(9)
Total	99.9	(1205)	100.0	(975)

Table 5
 Distribution of Responses to Test Question No. 39 on the
 Availability of Family Planning Services

	Pre Test		Post Test	
	%	(n)	%	(n)
The Family Planning Clinic services are available to:				
1. Young ladies and young men who have never had intercourse (made love)	8.3	(100)	6.8	(66)
2. Only young ladies who have had intercourse	3.7	(44)	2.6	(25)
3. Only young ladies who are pregnant	6.9	(83)	4.8	(47)
4. Young ladies and young men who have had intercourse	11.5	(139)	16.5	(161)
5. Both 1 and 4	41.3	(498)	46.5	(453)
6. Both 2 and 3	26.2	(316)	20.5	(206)
Not answered	2.1	(25)	2.4	(23)
Total	100.0	(1205)	100.1	(975)

Summary of Teen Clinic Chart Review

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	Before School Program Initial Visit - 1977	After School Program Initial Visit - 1978	
	n = 19	Not from School n = 15	From School n = 15
<u>Age Breakdown</u>			
14 and Under	0	4	1
15 and 16	2	7	10
17	6	2	2
18 +	11	2	2
<u>Status</u>			
Active	5	5	7
Pregnant	1	2	0
Delinquent	9	8	8
Closed	4	0	0
<u>Ever Used Contraceptives Prior to Initial Visit</u>			
yes	11	2	4
no	8	13	11
<u>Ever Been Pregnant Prior to Initial Visit</u>			
yes	5	8	2
no	14	7	13
<u>Ever Been Pregnant Since Initial Visit</u>			
yes	1	1	0
no	5	5	7

Figure 1
Percent Distribution of First Encounters to Teen Clinic
by Source of Referral

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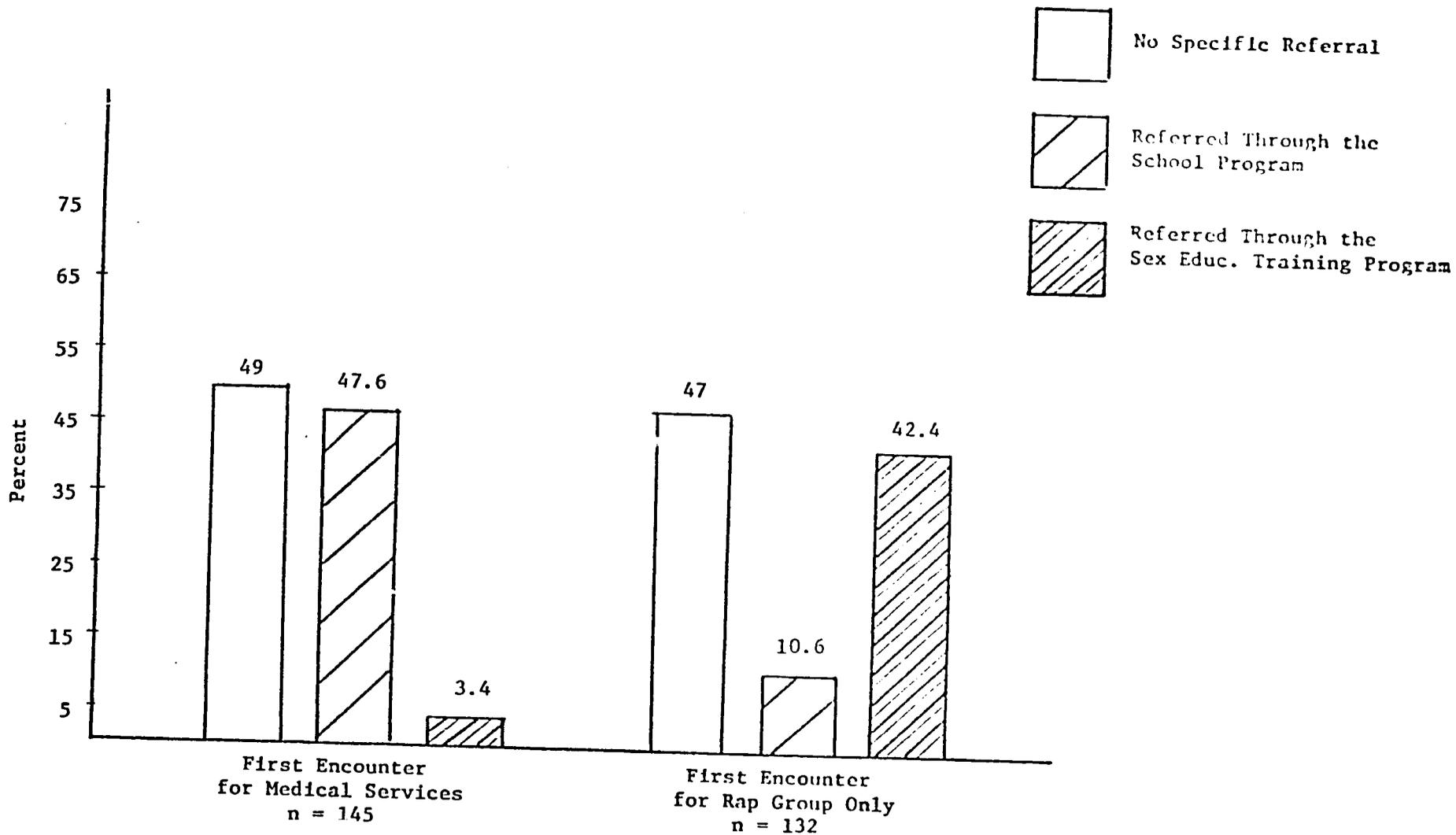
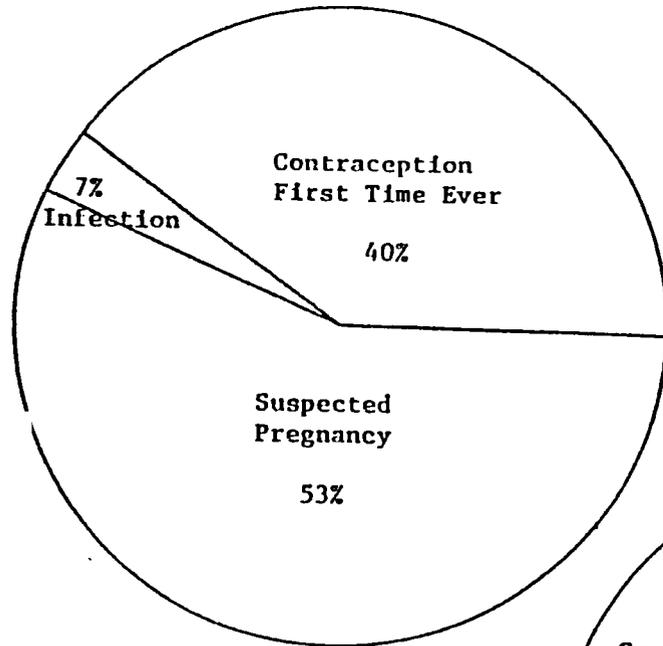
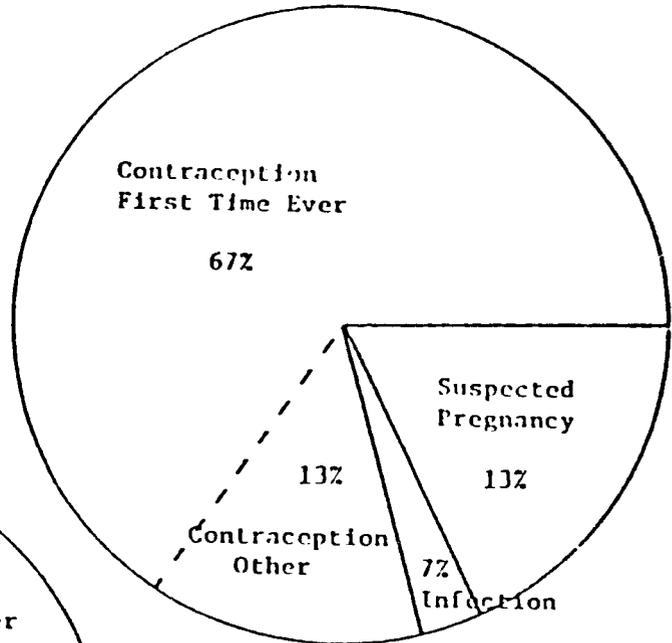


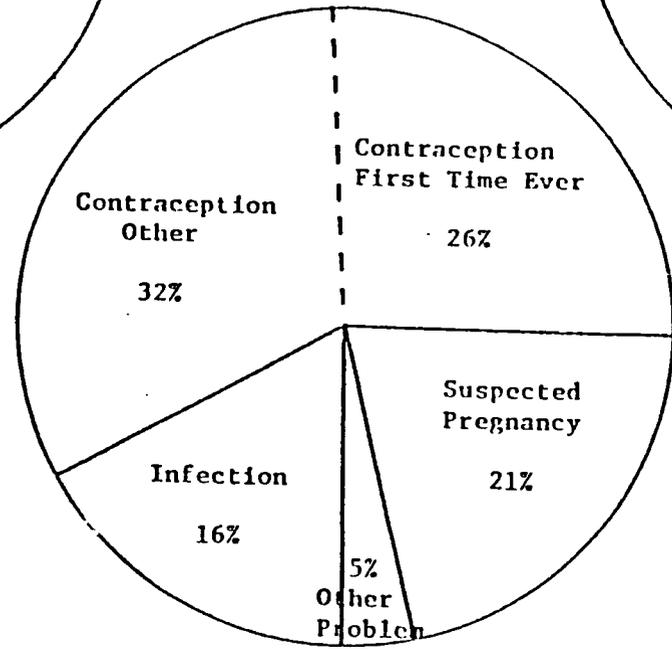
Figure 2
Percent Distribution of Presenting Problems at Initial Medical Visit
for a Sample of Patients at Teen Clinic



Initial Visit in 1978
Not from School Program
n = 15



Initial Visit in 1978
From School Program
n = 15



Initial Visit in 1977
Prior to School Program
n = 19

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