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ASSESSMENT FOR A YOUTH SERVICE
FAMILY PLANNING PROGRAM PROPOSAL
FOR
JAMAICA'S NATIONAL FAMILY PLANNING PROGRAM

A Report Prepared By:

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PREFACE

Every courtesy and complete freedom was given to me during the development of the teen proposal. Special acknowledgement should be given to Miss Thelma Thomas, Mrs. L. Fenton, and Mrs. E. Daley for their generous support, time and energy given to the development of the proposal.

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I. INTRODUCTION AND SCOPE OF WORK

The Government of Jamaica and USAID agreed to the preparation of a proposal for a teen educational and medical program for the area of Kingston, Jamaica under the auspices of the National Family Planning Board (NFPB) and Ministry of Health and Environmental Control (MOHEC) with funding through the Jamaica Bilateral program.

The assessment and development of the proposal took place from February 17, 1979 to February 23, 1979 by a team consisting of the author and

Miss Thelma Thomas, National Family Planning Director
IE&C Division, Planning Board

Mrs. Edmira Daley
Answering Service Officer

Mrs. Lois Fenton
Answering Service Officer

Dr. D. Ashley
Medical Officer (MCL/FP)

Mr. Andre Singleton
Planned Parenthood Association, Chicago Area
Vice President of Training and Research Center
Director of Training

OBJECTIVES OF TECHNICAL ASSISTANCE

1. Assess other programs that offer services for youth with the sole purpose of setting up a referral base for the Teen Family Planning Program.
2. Develop a Community Outreach and Educational Program connected with the Teen Family Planning Clinic.
3. Review the present mass media program and develop additional support to advertise the clinic.
4. Develop an appointment system and various forms for use in the Teen program.
5. Assist in the further development of a proposal for the support of a teen clinic.

The proposed pilot program which would combine an educational as well as clinical program, should provide an environment through which teenagers will be

helped to understand their sexuality and be encouraged to accept responsible patterns of sexual behavior, including the use of contraceptives. The program should also be designed to realize that every teen that comes to the program is not necessarily sexually active but seeking a place to comfortably talk and receive education concerning their own sexuality and feelings.

II. BACKGROUND

Background information was given to the team by Mrs. Dorian Powell, M.P. (Sociologist), Department of Sociology, University of West Indies, Kingston, Jamaica.

A. Demographic Information on Jamaica

The end of year population in Jamaica in 1976 stood at 2,085,200. The population has increased over its 1975 level by 24,900. The components of this increase have been natural increase accounting for 47,100 and net outward migration for 22,200. The rate of growth for the year was 1.2 percent.

The Jamaican population is essentially a young one. More than half of the population is under 20 years of age. The 0-9 population represents approximately 27.7 percent in 1976, a fall from its 1970 level of 33.7 percent. This is indicative of the downward trend of the crude birth rate noticeable over the period. There is currently an estimated 400,000 women in the childbearing age. Sex selective outward migration has been affecting this age group. The new outward movement in 1976 for women in the age range 15-54 was over 10,000.

The crude birth rate in 1977 stood at 28.8 per 1000. This represents a fall below previously existing rates. Present demographic movements suggest that the decline will be maintained, but it seems unlikely that the government's anticipated target of a crude birth rate of 25 per 1000 by 1980, will be realized by that time.

The crude death rate also for 1977 was 6.8 per 1000. Unlike its fertility performance the island has shown much success with control of mortality. With an average length of life of 70 years for females in 1970, its overall mortality approximates that of European societies.

The disparity between mortality and fertility gives Jamaica a high growth potential. The fact that it has been able to keep its annual growth rates under 2 percent, has been influenced to a large extent by external migration. The disadvantages of external migration particularly as it tends to deplete the country's skilled and professional personnel must be recognized. The promotion of a policy of emigration as a means of keeping population growth within manageable limits seems hardly to be a likely one. Further, the migration policies of host countries may change at short notice, thus making it very tenuous to place great dependence on emigration as a chief population control measure. With mortality as stabilized as it is, continued efforts to achieve reductions in fertility seems the likely path at this time.

Jamaica's tendency towards urbanization helps to aggravate its population problem. The island is divided geographically into 14 parishes. Two of these, Kingston and St. Andrew form the Kingston Metropolitan Area. Most governmental activities have been centralized in this area. As the main urban center of the

island, the KMA attracts rural migrants. Twenty-nine percent of the population of the island live in this area. The island is essentially rural and agricultural, but has been showing a vigorous trend towards urban concentration. Forty-one percent of the island's population now live in areas classified as urban. Over 60 percent of these urban dwellers are in the Kingston Metropolitan Area.

In conclusion, as the demographic situation of Jamaica now appears, a policy direction towards the continuation of a vigorous fertility control program is both relevant and urgent.

B. Government of Jamaica Population Policy

In 1964 the GOJ started offering Family Planning services in some of its hospitals. This marked the beginning of implementation of a governmental policy towards fertility control. The government's official position was publicly expressed in the Five Year Independence Plan published in 1966. In the same year a Family Planning unit was established within MOHEC, and was located in close proximity to the largest government maternity hospital in the island, the VJH. In 1967 the NFPB was established as a statutory body charged with the responsibility to coordinate the FP of the government. The Second Five Year Plan of the Ministry of Health (1968/73) stated that the National Family Planning Program was considered the most important project in the Ministry of Health. It further stated that the overall goal of the program was to stabilize and bring the population growth of Jamaica to a level that would allow every individual child and adult a reasonable opportunity to have a productive and satisfying life.

In the Three Year Program of the NFPB (1968/71) the objective of the FP program included:

1. lowering Jamaica's birth rate from the 1968 level of 35.94 per 1000 to a level approaching 25 per 1000 by 1977;
2. having in operation enough clinics (160) to serve the needs of all the people who wish birth control information, facilities and devices;
3. involving about 75,000 patients in family planning methods by the end of the period 1971; and
4. organizing and implementing facilities for the early detection and treatment of cases of uterine cancer.

GOJ policies on Family Planning were implemented through the National Family Planning Board. The years 1967-1974 saw the increasing development of the Board's structure, associated with the expansion of Family Planning services.

In 1974 the GOJ announced new policies and plans for the total health program. Organizational changes would result in the integration of the services of NFPB

with the services of MOHEC. Ministry Paper No. 1, 1974 described the philosophy underlying the new policies. The measure, the paper states, was to provide for an adequate framework within which a comprehensive and expanded program could be carried out. Family Planning was at that point refocused as part of an overall development effort. It would no longer be regarded as an isolated entity but would become part of the total social and economic development policies. The specific objectives relating to family planning were to continue, but the means of their achievement would, as of April, 1974, be embedded in the multifaceted educational, motivational and comprehensive health delivery framework.

The Medical Director of NFPB was to be appointed Principal Medical Officer and would have responsibility for Maternal and Child Health, Nutrition and Family Planning. The PMO would also be Vice-Chairman of the NFPB in order to strengthen its liaison with NFPB and MOHEC.

The Board's new role was defined. It was relieved of its responsibility for Clinical Services and Education. This was the first phase of integration.

The second phase of integration took place in July 1976. The existing Board resigned to give way to the appointment of a new Board, which would be a part of this new phase of integration. A new In-house Board (discussed later) was appointed in 1977. Plans are now in progress for the final stage of integration.

C. The Health Delivery System of Jamaica

The Jamaica health delivery system includes two basic types. They are:

1. the fee-paying type in which the person pays a private medical practitioner for medical services. There are also a number of private fee-paying hospitals which operate independently of the private practitioner. If the individual receives medical care from a private practitioner, and then is found to need institutional care, he may choose to enter a private or a public institution.
2. The Free Service Type is the government health program. A patient who seeks medical care from a government physician within the hospital setting, and is found to require hospitalization may enter a government hospital free of charge. However, if he wishes and is able to pay, he may seek referral from the government physician to a private hospital.

There is one type of hospital in the island which does not fit directly into either of these two types. This is the University Hospital of the West Indies. It is a regional teaching hospital supported by contributing governments to the University of the West Indies. Its costing system is based on a means-test which assesses the capacity of the patient to pay. The base-rate is, however, so minimal, that it becomes for the majority of patients almost a free service.

The Ministry of Health and Environmental Control (MOHEC) has primary responsibility for health delivery services. However, the Ministry of Local Government has some responsibility for health services at the parish level.

Traditionally the Health Services have been divided into two distinct areas:

- a) The Public Health or Preventive Services
- b) The Curative Services

Administration of the services naturally follow these lines of distinction. More recently the Health Policy has moved towards an integrative approach aimed at enhancing efficiency and effectiveness. Integration is being achieved on a phased basis with priority being given to Primary Health Care Delivery.

Inter-agency involvement is considered pivotal to the success of primary health care. So, too, is inter-sectoral and inter-ministerial cooperation. The Ministries of Youth, Sports, and Community Development and of Education have been cooperating mainly in the areas of Family Life, Health and Nutrition Education.

The primary health care system is not an isolated entity. It operates in an interlocking relationship with the secondary and tertiary health care services to make up the total system of health care delivery. The service as conceptualized is not yet fully functional.

To facilitate the administration of the service, the island is divided into four large administrative areas with the parish as the basic organizational unit.

- | | |
|---|-------------|
| Area 1 - including Kingston/St. Andrew, St. Thomas | - Southeast |
| Area 2 - including Portland, St. Mary, St. Ann | - Northeast |
| Area 3 - including St. Catherine, Clarendon, Manchester | - South |
| Area 4 - including St. Elizabeth, Westmoreland, Hanover,
St. James, Trelawny | - West |

Services are delivered through 26 hospitals, 10 Maternal and Child Health Centers and 251 Health Centers. Postpartum services are now offered in nine of the government's hospitals. The cadre of personnel who staff these outlets include:

Doctors - Medical Officers (Health)
Medical Officers
Gynecologists

Nurses - General Trained
Public Health
Nurse-Educators
Midwives
Assistant Nurses

Outreach
Workers - District Midwives
Community Health Aides

The Health Centers are classified according to staff and functions, from type 1 to type 5. Type 1 carries the least technically qualified staff member

of the Health Team and offers the most basic Maternal Child Health, Nutrition and Family Planning Services. Type 5 is staffed by a complement of staff from the most to the least technically qualified and offers comprehensive services. The intermediary types, type 2-4, vary in staffing and functions as one moves along the continuum. Each ascending type has an interlocking relationship with the one or ones below.

III. METHODS OF ASSESSMENT AND DEVELOPMENT OF PROGRAM PROPOSAL

The following methodology was used to develop the program proposal:

A. Meeting and interviewing personnel responsible for the development and running of the prospective teen Family Planning Program.

B. Reviewing appropriate space and making plans for the medical teen program.

C. Collecting and reviewing present information for the proposal, and collecting and reviewing existing forms that could be used in the program.

D. Meeting and interviewing personnel in various agencies requesting teen services and now referring to the adult Family Planning program in order to assess the support and participation in the prospective teen Family Planning program and clinic.

Time constraints prevented more visits to other family planning programs and the full completion of the proposal. The Jamaica members of the team will complete the proposal and submit it to the U.S. Agency for International Development.

The first two days in Kingston were spent briefing with Terrence Tiffany, Population Advisor, USAID Mission in Jamaica, American Embassy and Miss Thelma Thomas, Director IE&C Division, who was responsible for my future itinerary. Miss Thomas arranged visits at various agencies which work with teens. They were possible referral agencies for the proposed program.

The first meeting took place with Dr. Ashly, (MOHEC), Mrs. Annie Straw, Director of the National Family Planning Board, Miss Thomas, Mr. Singleton and myself. Review of the objectives were discussed with full support for the Ministry of Health Family Planning Division.

A visit was then made to the Women's Center, operated by Mrs. McNeil and assisted by Sheila Grant, MSW, to discuss the pilot two-year program for pregnant girls. This program is well into its second year. The main objective is to help the teens stay in the educational school system both during pregnancy and after delivery. Special programs have been designed for the baby's father and parents of the couples. Nurseries are available for the girls who had delivered (only for a limited time due to needs of other pregnant girls). Contraceptive services and counseling are available. The various family planning program staff assist the Women's Center staff by providing rap sessions and medical services to assist the teens with their future family planning needs. It was stated by the director that the youngest girl at that point in the program was 12 years old with the mean age 15 years.

The evaluation of the success of the program will be determined by the number of students who stay in the educational system and complete their schooling. Because of the numerous requests and maximum use of the facility, they are holding classes in twice a day shifts. Their program appears to be well organized. They are very anxious for the development of a teen program and expressed their strong support in receiving referrals.

During our visit to a drama group located at the Zone 1 Social Development Center we previewed skits written by the National Family Planning Board staff and performed by young people from the Jamaican Youth Corps (JYC). The group performed under the direction of Mr. Donald Morgan, District Officer, Zone 1; Mrs. S. Bowes, Acting Area Supervisor and Mrs. Aileen Frazier, Ministry of Youth and Community Development. We observed the presentation of several plays. The JYC group is composed of young people from the community. With their enthusiasm and dedication they could be used to assist in the development of an outreach program for the teen clinic. They work as a team providing the community with messages on family life education through drama.

The group's interest in the proposed teen program is to perform within the community providing a resource person to answer questions related to the topic at the end of the play. Appropriate referrals would then be made to the teen program. This tool of drama presenting various health related topics has been proven to be a success in many communities as an outreach and educational mechanism for parents as well as youth.

Various prospective clinical locations were visited to show the team members type of space needed.

Based on interviews, experience and discussion, the team initiated work on the proposal but did not complete it. As mentioned above, the remaining team members will finalize the proposal.

IV. TASKS TO BE COMPLETED

Mrs. Daly and Mrs. Fenton are responsible for the following tasks to complete the proposal and prepare for the initiation of the program.

A. Medical portion of the proposal must be cleared with Dr. Ashly and what the Ministry of Health will provide for the teen program must be clarified.

B. Follow-up procedures must be determined and designed.

C. Brochures must be designed. Other sources for brochures will be investigated. (Samples of brochures were left).

D. A record system for statistical information must be designed and a manual for its use written.

E. Various modes of outreach must be designed. Set up drama group and outpost. Write the extensive report for proposal. Write job description for outreach worker.

F. Various forms and systems for the teen clinic must be designed. Check Ministry of Health data base now in place. This could be used in the program. Special forms to be checked are:

- Social history
- Medical history
- Statistical sheets
- Laboratory forms
- Clinic directories
- Client ID cards

G. The Ministry of Health should be queried concerning what space and medical services they will provide to support the program.

H. The budget must be completed. (The budget could not be completed until the Ministry of Health decided what programmatic aspects they will support and at what budgeting level.)

V. BUDGET (INCOMPLETE)

Personnel	\$42,950.00
Fringe Benefits	4,295.00
Laboratory	5,150.00
Contraceptive Supplies	6,443.00
Educational Supplies	4,300.00
Office Supplies	150.00
Equipment Purchase	1,916.00
Equipment Contracts	1,800.00
Personnel Contractual Services	5,824.00
Communications	2,500.00
Project Travel	4,206.00
Staff Development	2,100.00
Furniture	<u>1,938.00</u>
	<u>\$89,098.00*</u>

*Incomplete Budget

Missing: Space
Medical equipment and furnishing
Kitchen and refreshments

VI. STAFFING PATTERN

Director of Program	Fulltime:	\$ 6,000.00
Receptionist/Appointment Clerk	Fulltime	3,000.00
Clerk Typist or Secretary	Fulltime	4,000.00
Social Service Specialist	Fulltime	6,000.00
Rap Leader/Outreach	Parttime	1,498.00
Community Outreach Coordinator	Fulltime	5,000.00
Health Educator/Interviewer	Fulltime	5,000.00
Clinical Nurse Assistant	Parttime	1,229.00
Charge Nurse (follow-up)	Fulltime	6,000.00
Lab Technician/Nurse Assistant/Follow-up	Fulltime	4,000.00
Accountant	Parttime	1,223.00
		<u>\$42,950.00</u>
	10% Fringe	<u>4,295.00</u>
	TOTAL	\$47,245.00

VII. FINAL RECOMMENDATIONS

1. The National Family Planning Board staff who worked with the proposal with the community and teens in Jamaica should be seriously considered to direct the program.

2. The pilot program should be extended as a two-year project. It will take six months to fully develop the program systems.

3. The National Family Planning Board and Ministry of Health should reach definite agreement about who will administer and operate the program. (The responsibility could be shared). Early and continued coordination is essential for a viable program.

4. Effective outreach, follow-up and evaluation are necessary program elements and should be included. The various community groups assisting in the initiation of this proposal should be utilized in these areas.

APPENDIX A
INDIVIDUALS CONTACTED

1. **Ministry of Health and Environmental Control (MOHEC)**
 - Mr. Terrence Goldson Permanent Secretary
 - Dr. A. Patterson Chief Medical Officer
 - Dr. D. Ashley Medical Officer (MCH/FP)

2. **National Planning Board**
 - Mrs. A. Straw Acting Executive Director
 - Miss Thelma Thomas Director, IE&C Division
 - Mr. E. Canton Administrative Officer
 - Mrs. E. Daley Answering Service Officer
 - Mrs. L. Fenton Answering Service Officer
 - Mr. E. Owan Immediate Past Executive Director

3. **Women's Health Center**
 - Mrs. McNeil Director of Program
 - Ms. Sheila Grant MSW

4. **Zone 1 Social Development Center**
 - Mr. Donald Morgan District Officer Zone 1
 - Mrs. S. Bowen Acting Area Supervisor

5. **Ministry of Youth, Sports and
Community Development**
 - Mrs. Aileen Fraser Community and Family Life
Education Officer

6. USAID/Jamaica

Mr. Terrence Tiffany

**Population Officer
Health/Population/Nutrition/Div.**

7. USAID/Washington

Mr. Bill Bair

Coordinator/Latin America

Mr. David Denman

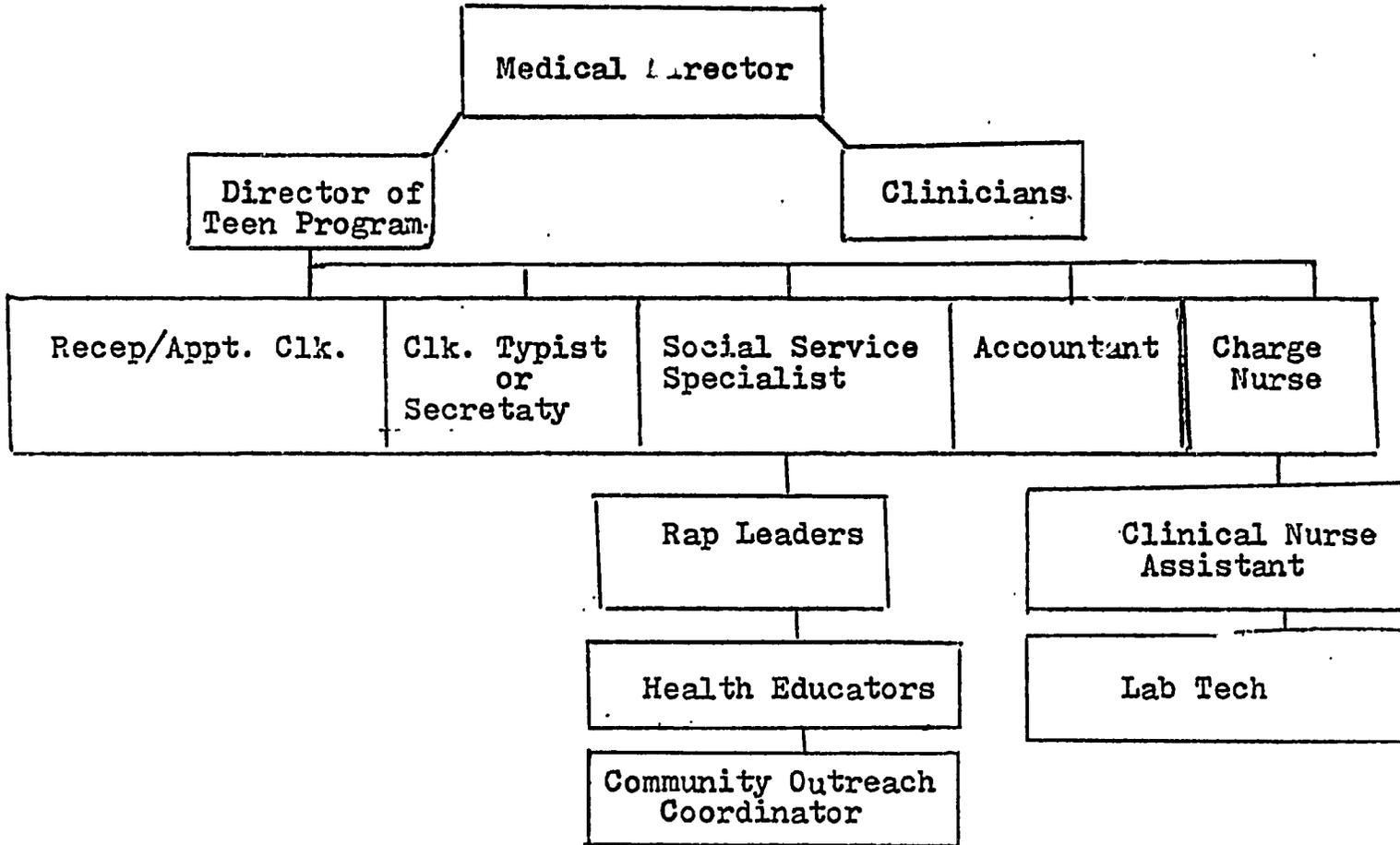
Deputy Coordinator/Latin America

Mr. Grif Davis

**Chief/Information and Education-
Division of Population**

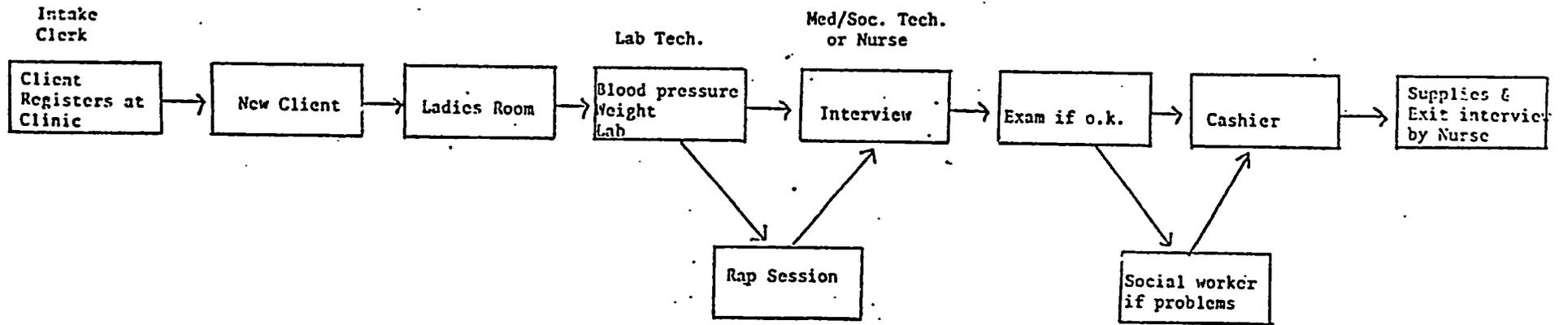
Appendix B

Suggested Teen Clinic Organizational Chart



TEEN CLINIC FLOW CHART
(NEW CLIENTS)

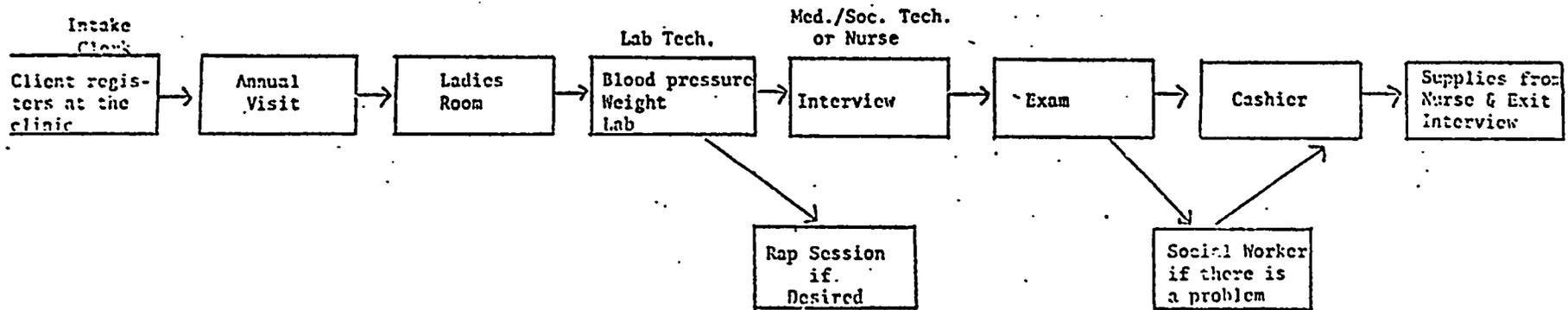
APPENDIX C-1



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TEEN CLINIC FLOW CHART
(ANNUAL VISITS)

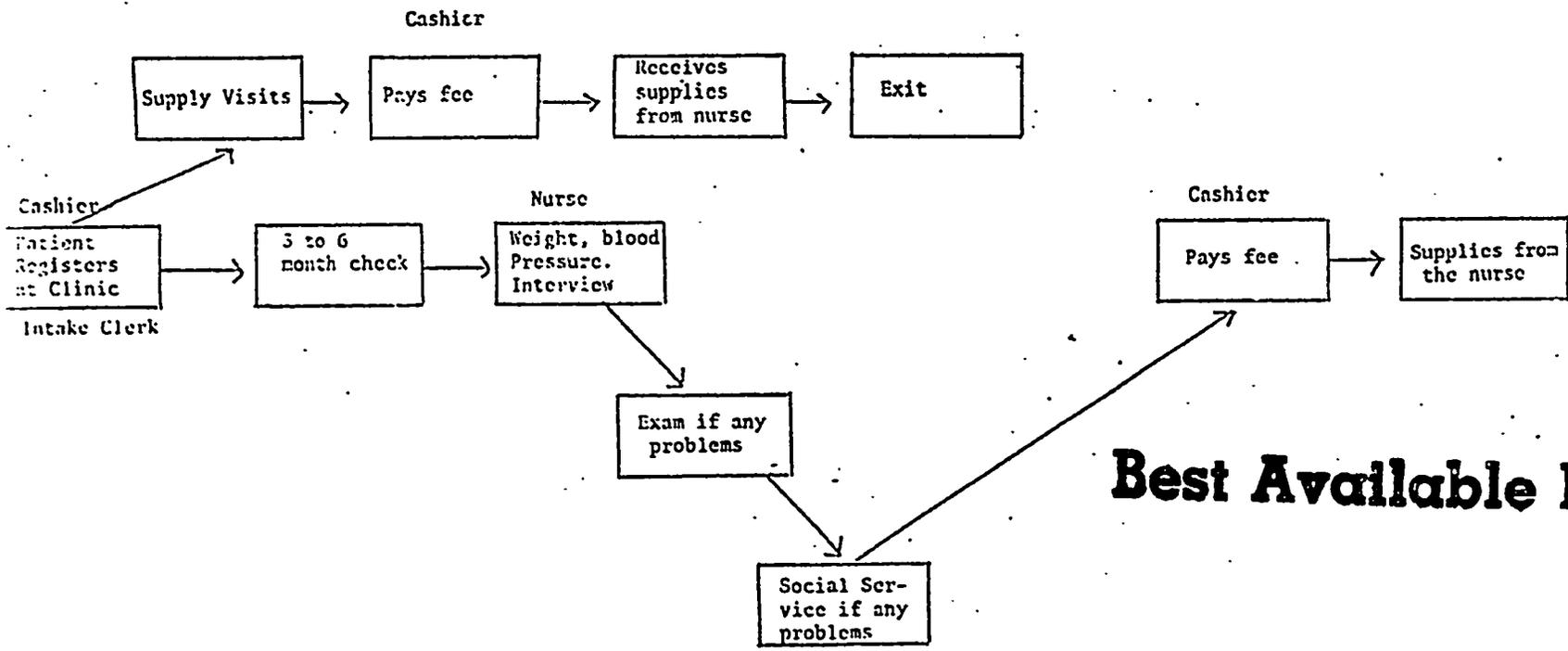
APPENDIX C-2



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TEEN CLINIC FLOW CHART
 (SUPPLY & 3-6 MONTH VISIT)

APPENDIX C-3



Best Available Document

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