



# **UPLIFTING ADOLESCENTS PROJECT**

## **WORKSHOP REPORT**

### **“REPRODUCTIVE HEALTH FOR ADOLESCENTS AGED 10-14”**

**FOR**

### **NON-GOVERNMENT ORGANIZATIONS (NGOs)**

*Medallion Hall Hotel, Kingston 10*

Part I March 3-4, 1998

Part II March 18-19, 1998

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## INTRODUCTION

The Uplifting Adolescents Project (UAP) Workshop on "Reproductive Health for Adolescents Aged 10-14" was held on March 3-4 & 18-19, 1998. This Workshop evolved from extensive discussions at a UAP "Round-Table on Reproductive Health" on December 9, 1997, which identified priority training needs of NGOs involved in the delivery of services to adolescents.

Except for two (2) participants from the Youth Division of the Ministry of Local Government, Youth and Community Development, participants represented fourteen (14) non-governmental organisations (NGOs) and were selected on the basis of their job responsibility for training and/or counselling in the subject area. (*See Appendix I: List of Participants*, pg. 45).

Some NGOs were unable to release the same staff members every day and so, although the average daily attendance was 43 persons, Certificates of Achievement were presented only to the 34 persons who attended all the Workshop sessions over the 4-day period.

Dr. Barbara A. Dicks, Fulbright Scholar attached to the Department of Sociology and Social Work at The University of the West Indies, served as Workshop Director. She received delivery and organisational support from a team of 11 guest presenters (*See Appendix II: Workshop Agenda*, pg. 47), Mrs. Lois Hue of Jamaica Red Cross, and UAP key and administrative staff.

## WORKSHOP OBJECTIVES

The objectives of the Workshop were to:

1. provide appropriate curriculum content on Adolescent Reproductive Health for work with 10-14 year olds;
2. upgrade participants' teaching skills in Adolescent Reproductive Health;
3. address staff development issues and 'burnout' in work with adolescents; and
4. enhance development of an Adolescents Reproductive Health-Providers' Network.

This Report provides a permanent summary of the Workshop's proceedings so that it can serve, *inter alia*, as a source of reference for participants and other NGO staff who were unable to attend.

**DAY 1: MARCH 3, 1998**

## **OPENING SESSION**

After introductory remarks from Dr. Barbara Dicks, an official welcome was extended to all by Mr. Francis Valva, Chief of Party, UAP. He expressed special appreciation of the time and effort participants had expended to attend and hoped that the new knowledge gained would enhance their work and be shared with their absent colleagues.

Greetings were then brought by Mr. Daniel Gordon, Program Specialist, USAID and Miss Gloria Nelson, Director, Youth Unit, Ministry of Local Government, Youth & Community Development.

Mr. Gordon outlined the UAP's scope, history and linkages with USAID and the Youth Unit for the purpose of strengthening NGOs to efficiently deliver a package of services to 'at risk' adolescents in the 10-14 age group. **He reminded the audience that the Project's main strategic objective was to equip young Jamaicans for the 21st Century, and he stressed that the emphasis was on impact and results.** It was in that context that tracer studies would be undertaken to determine how graduates of the various programmes were doing. Efforts to meet the initial targets set (e.g., number of beneficiaries, number reinstated in school) would also be assessed at the mid-term stage and just before closure.

He also said it had been anticipated that, during the course of the Project, NGOs would develop the capacity to undertake their own research on particular problems and treatments used. The ultimate goal of that evaluative research would be the production of tested and proven models of effective interventions.

Mr. Gordon encouraged participants to continue to work hard despite the difficult circumstances which prevailed, and said he looked forward to continued collaboration with Development Associates, Inc. staff, who were doing an excellent job.

Miss Nelson noted that the workshop content was important, relevant and practical. She urged participants to make good use of the opportunity to learn all they could for the betterment of "Jamaica, Land We Love" so that at the end they could say, "It was good to be here".

# PRESENTATIONS

## 1. OVERVIEW OF FAMILY LIFE EDUCATION (FLE)

*Dr. Deloris Brissett, Asst. Chief Education Officer, Guidance Counselling Unit, Ministry of Education & Culture*

Dr. Brissett outlined the scope of the Ministry of Education & Culture's FLE curriculum and defined "Health and Family Life Education" as:

"a continuous process of preparing individuals to understand and cope with themselves and others. It fosters conditions that strengthen the family's socialising function, especially in the transmission of values, attitudes and cultural identity, highlighting the importance of affection, the sense of belonging and the respect of family members. It recognises the importance of human sexuality and incorporates the importance of reproductive health education."

It was anticipated that, through exposure to the Health and Family Life Education (H&FLE) curriculum content, children would:

- gain a more complete understanding of themselves in relation to their families, communities and the environment;
- develop positive regard for themselves and others;
- foster social and sexual responsibility; and
- enhance their ability to make constructive contributions to the society.

The FLE Programme was introduced in schools between 1983 and 1986/87 with separate curricula for Grades 1-6 and Grades 7-11. Experience had shown, however, that certain content changes were necessary, and delivery was inconsistent throughout the system for various reasons. The Ministry was now seeking to redress the situation through various initiatives.

As a first step, there had been a curriculum name change to "Health and Family Life Education". The curriculum content was being revised accordingly and would be in context with what was being done in NGOs. As well, the curriculum would be more relevant and 'student friendly'. Prototype materials were also being developed.

Another current focus was in-service training of FLE teachers, to help them to become better prepared mentally, emotionally and psychologically to deal with sensitive topics, such as Adolescent Sexuality. One cassette tape which had been found to be particularly helpful in this regard was *Plain Speaking About Sex*.

In addition, community resource persons were being involved to help sustain the school programmes. Dr. Brissett envisioned that, where feasible, trained NGO personnel could be called upon to provide this type of assistance to schools in their areas.

A Parenting Education Programme had been in existence for about four years and several groups of parents across the island were involved in workshops to help them understand how to relate to their children in more appropriate and helpful ways. In keeping with that thrust, the Ministry was revitalising parent-teachers' associations so that they could play a more active and pro-active role.

While responding to participants' questions on evaluation of curriculum impact and success in reducing the incidence of teenage pregnancy, Dr. Brissett cited Glenmuir High School as an example of success. She also made the point that NGOs were freer to:

- experiment with different delivery approaches;
- call upon each other for assistance;
- set up partnerships with other external agencies.

There was general support for one participant's view that goals and goal setting should be included in H & FLE training, to assist young people to develop productive and realistic goals.

In closing, Dr. Brissett appealed to participants to become aware of their own stage of personal development and comfort level in dealing with sensitive issues. While learning about their environment and the children with whom they must interact, they should endeavour to accept people with different points of view and different sets of values..

### ***SMALL GROUP ACTIVITY***

Participants were divided into four (4) groups. Each group was asked to discuss and report on a specific topic related to Family Life Education. Highlights of their reports to the reconvened plenary session were as follows:

#### **GROUP 1: Materials and Resources for Family Life Education**

**Leader** — Mrs. Esther Reinford-Clarke, *Women's Centre of Jamaica Foundation*

**Rapporteur** — Ms. Olga Williams, *Mel Nathan Institute for Social Research*

In this group's opinion, it was very important to have clients in the target age group (10-14 year olds) physically involved in learning activities as they loved doing things. Creative, economical ways should also be found to get information across to them. Some examples given in relation to this recommendation were:

- use of the performing arts (role play, DJ, dub poetry, dance, singing performances by students or invited guests to highlight selected themes/topics)
- students' art and craft work on related themes, and displays of their best work

- camping
- informal talks/presentations by resource persons (e.g., ASHE; representatives from the Ministry of Health, Ministry of Education & Culture, Family Planning Board; parents; police; businessmen/business women, peers)
- use of waste material to create attractive displays and colourful charts
- supervised field trips for students to see the effects of undesirable/desirable situations, behaviours, etc., for themselves
- easy-to-understand books, pamphlets, audio and video cassette tapes.

The group also recommended the exercise of caution in selecting resource persons, to ensure that they were persons worthy of emulation as role models; and development of a resources directory for the information of all NGOs.

**GROUP 2: Appropriateness of the FLE Curriculum**

**Leader** — Ms. Christine Lawson, *St. Patrick's Foundation*

**Rapporteur** — Ms. Michelle Thompson, *Mel Nathan Institute for Social Research*

This group looked at the Grades 7-11 curriculum and concluded that its content was appropriate for the targeted age group and relevant to the UAP's focus. They agreed that its successful impact depended greatly on presenters' subject knowledge and ability to deliver.

Recommendations made in respect of content were:

- encourage sense of belonging regardless of family type;
- augment section on "Communication" with the importance of effective verbal/non-verbal communication within the family (and with others), and the use of appropriate disciplinary measures;
- include more on treating people with courtesy and respect
  - ⇒ respect for 'individual freedom of choice'
  - ⇒ respect for other people's sexual orientations, and stereotypes concerning heterosexuality, homosexuality and bi-sexuality;
  - ⇒ respect for the occupational choices of other people who are doing socially important jobs, even if those jobs are traditionally regarded as being of low status (e.g. street cleaners);
- emphasise the effects of teen-age pregnancy on young parents, their families, and the society;
- stress the importance of making positive but realistic career choices.

With respect to curriculum delivery, it was recommended that presenters should become familiar with the curriculum and modify to fit their various situations. Activity booklets and copies of the curriculum should be made easily available, and dissemination of key concepts could be made more interesting through adaptation for drama and role play.

**GROUP 3: Training of FLE Teachers**

**Leader** — Miss Naska Llits, *Jamaica Family Planning Association*

**Rapporteur** — Mr. Donovan Murphy, *Children First*

In the opinion of the group, although some counsellors had received training (e.g., from Mico Teachers' College), many had not been trained and were teaching and offering counselling based only on their own experience and opinions.

Teacher selection should not be based on stereotypes (e.g., Christians or 'shirt and tie' people), but on the basis of subject knowledgeable and having the right personality for the task. Teachers should also be good role models and practise what they preach.

Teacher training should be a formal and informal ongoing process with a less theoretical and more practical approach. No matter how well trained they are, however, teachers must be supplied with copies of the curriculum if they are to perform well.

The group also felt strongly that some method of impact evaluation should be introduced for FLE teachers, so that they would put out more effort to meet curriculum objectives.

**GROUP 4: Evaluation of Family Life Education**

**Leader & Rapporteur** — Mr. Ceibert Hines, *Hope for Children*

The consensus of the group was that evaluation of family life education efforts was needed, because it was necessary to know whether the goal of motivating desirable behaviours and/or achieving behavioural change had been achieved.

Evaluation methods suggested were:

- informal 'pre- and post-tests' using the conversational style/focus group method;
- identification of measurable change indicators (e.g., number of pregnancies per client before participation and within a pre-determined follow-up time-frame), monitoring, and consistent record-keeping;
- National Assessment Programme (NAP)-type appraisal to determine if teachers are giving quality instruction.

Support requirements were identified as being trained professionals able to organise and deliver the curriculum effectively; peer dissemination, and networking with other NGOs for mutual collaboration/sharing.

## 2. REPRODUCTIVE HEALTH AND CONTRACEPTION

*Dr. Olivia McDonald, Medical Director, National Family Planning Board*

Dr. McDonald defined adolescence as the period of transition from childhood to adulthood. Important changes occurred during this period — organic (physical changes), psycho-social (e.g., decision-making, self-esteem) and cognitive (“thinking like adults, but not most of the time or in most instances”). The characteristics of this developmental stage manifested themselves in adolescent attitudes toward contraception:

- tendency not to plan ahead
- unsure or unmotivated to use contraceptives
- embarrassed to seek information
- lack of power and skill to negotiate with their partners about use of contraception
- belief that they are not ‘at risk’.

Other barriers to access were lack of transportation or money to make purchases, and fear of discovery (they often don’t want adults to know they are sexually active).

The presenter said some of the sexual risks which many adolescents faced, because of ignorance, inadequate knowledge, peer pressure or adult perversion, were unintended/too-early pregnancy, sexually transmitted diseases (STDs including HIV/AIDS), unsafe abortions, unwanted sexual activity and sexual violence. The adverse medical, psychological, social and economic consequences of adolescent sexual activity were generally significant:

### CONSEQUENCES

#### Medical

- Early sexual experience usually means several partners over time, even if only one at a time (serial monogamy). These multiple exposures, together with inconsistent condom use resulting from the circumstances in which sex partners are recruited or in which sexual intercourse occurs, increase risk of pregnancy and STDs.
- Lining of cervix thin and more susceptible to infection agents.
- Complications arise due to lack of/poor pre-natal care and poor nutrition
- Disorders associated with early-age pregnancy [hypertension, eclampsia (convulsions), cerebral haemorrhage, etc.], can be fatal for both mother and child
- High infant morbidity (abnormality)/mortality rates.

Note: STDs caused by bacteria are curable, but those caused by viral agents (e.g., herpes and AIDS) are incurable and can lead to chronic disease or death. However, many of the bacterial infections are becoming resistant to traditional treatments

#### Psychological

- Depression, loss of self-confidence, lack of hope
- Substance abuse (indirect effect on sexual behaviour)
- Entry to commercial sex trade often the result of sexual violence experience(s).

### **Socio-Economic**

- Social stigma
- Limited education
- Fewer career or job opportunities
- Inter-generation poverty cycle maintenance
- Heavy economic burden on society.

Dr. McDonald noted that a mix of professionals provided reproductive health and contraception information and services to adolescents, and it was regrettable that some displayed negative attitudes towards this client group. She emphasised that nothing meaningful would be achieved if such attitudes were maintained. The reality was that many in the target age group were already sexually active or were likely to become so unless there was appropriate and adequate intervention.

Next, she highlighted some of the preparation which information and service providers needed to perform their role well, and the main information that adolescents need:

### **Service Providers' Training & Communication Skills Requirements**

- Technical knowledge
- Knowledge of issues facing young adults
- Gender Awareness
  - Expectations of sexual activity of boys and girls
  - Views regarding responsibility for contraception
  - Cultural acceptance of harmful behaviour and practices
  - Social consequences of pregnancy
- Counselling Skills
- Positive Body Language
- Reflective Listening
- Open-Ended Questioning
- Personal Characteristics: sincerity, honesty, respect, sense of humour, non-judgement, confidentiality.

### **Main Information Adolescents Need**

- Male and female fertility issues and what male and female reproductive systems look like
- Issues of identity, societal roles, human relations
- How their bodies, minds and feelings are changing
- Risks and consequences of sexual activity

- STDs and contraception, including abstinence
- How to handle societal and peer pressure
- How to make responsible decisions about sexual activity
- Alternate ways of Expressing Sexuality (e.g., holding hands, hugging, kissing, body rubbing, masturbation)

To assist information delivery by participants, the presenter also gave specific information concerning male/female fertility and the pros and cons of various contraception methods. A summary of that information is as follows:

#### MALE/FEMALE FERTILITY

1. Males are fertile all the time (even vasectomy does not immediately end fertility as sperm remains in the reproductive tract for some time).
2. Women are fertile only at a specific time (beginning about 6 days before ovulation) in each menstrual cycle.
3. The length of the menstrual cycle varies between individual women, and the cycle begins with the first day of bleeding.
4. Ovulation takes place **14 days before the start of the next period**, which means that it does not always take place in the middle of the menstrual cycle (it only occurs in the middle of the cycle if the female usually has a 28-day cycle!).

#### CONTRACEPTION

- **Consistent and correct use of contraception is the key to its effectiveness.**

**Abstinence** — the only method 100% sure, if faithfully practised. Intercourse is not experienced but other forms of sexual expression can be enjoyed. Success requires a high level of motivation, self-control, communication and support and so this method is not for everyone.

**Temporary abstinence or withdrawal is not recommended for the adolescent age group.**

**Barrier Methods** — male and female condoms, spermicides, diaphragms and cervical caps. No systemic effects. Condoms are highly recommended for use as they can be easily and discretely carried around, and are very appropriate for those having sex infrequently. Female condoms provide effective protection but are not yet widely used in Jamaica as they are expensive.

Male condoms are widely available and **can/should be used with other contraceptives to provide protection against STDs.** Users/potential users should be advised to:

- open package carefully
- start putting on condom before unrolling
- hold rim of condom during withdrawal
- use only water-based lubricants (no Vaseline)

**Oral Contraceptives** — Can be used independently of sexual intercourse and without partner's knowledge. Pill-taking should be linked to daily routine, as taking pills at the same time each day helps to avoid risk of skipping intake on some days. Sometimes nausea, weight gain, breakthrough bleeding are experienced.

**Negatives for Adolescent:** Usually requires visit to clinic or other trained provider; offers no STD protection; benefit only 1 month at a time; more expensive than male condom.

**Injectables and Implants** — offer 3 years of continuous protection but give no STD protection. No daily action required but clinic visit necessary. **Not a first choice method for adolescents.**

**Intrauterine Devices (IUDs)** — clinic visit required for insertion and removal. No STD protection and user must monitor frequently to ensure that the device has not been accidentally/spontaneously expelled.

**Emergency Contraception** — prevents pregnancy after unprotected intercourse. Pills must be taken within 72 hours after intercourse. **Not intended to be a regular contraception method.**

**Lactation Amenorrhea Method (prolonged suppression of menstruation/fertility through breast-feeding)** — For this method to work, all of the following 4 factors must be true at the same time:

- i) the female has just delivered a baby
- ii) the baby is under 6 months old
- iii) the mother's milk is the baby's only food
- iv) the mother's period has not yet re-appeared.

**Sterilisation** — not a first choice method.

In conclusion, Dr. McDonald said the greatest challenge in working with adolescents was convincing them to delay sexual intercourse despite the socio-cultural influences, and their own sexual feelings, which were impelling them towards early copulation. They needed contraception information and to understand the consequences of early sexual activity. They also needed to be taught ways of:

- increasing their self-esteem;
- making and following through on decisions which are in their own best interest;
- becoming more assertive in order to combat peer/partner/societal pressure.

## **OPEN DISCUSSION**

Following the presentation, an Open Discussion was chaired by Mr. Sam Dowding, UAP NGO Co-ordinator. Additional information given by Dr. McDonald, in response to participants' questions, was as follows:

1. If someone experienced an allergic skin reaction to a particular brand of condom, another brand should be used.
2. Latex condoms are best, but there are certain benefits to using polyurethane condoms.
3. As an aid in counselling, an NGO could develop a Community Directory of Services for the geographic area in which it operates. This directory could include location of clinics, days/times Family Planning or STD service providers are available, providers/agencies willing to give demonstrations, talks, reference material, teaching aids, etc. This would entail 'networking': going around to meet neighbouring organisations/agencies, telling about what the NGO programme offers, finding out what they offer, negotiating mutual support.
4. The World Health Organisation (WHO) did a large collaborative study which found that there was no significant risk of human breast cancer from use of the depo-provera injectable contraceptive.
5. In deciding what is appropriate information to pass on to a 10, 12 or 14 year-old, first realise that within Jamaica 60 out of every 100 have been sexually active...the majority didn't plan to, but it happened! Share basic information, and call on other experts as necessary. Questions/feedback will also give guidance on information needs.
6. NGOs can get illustrative material by copying material from books (observing copyright regulations) and getting a professional service (e.g., City Graphics, Xerox) to enlarge/convert for use as coloured posters, transparencies or slides. The best products of students' poster competitions could also be reproduced.
7. Debating Competitions could be used as a method of getting students to research, argue/defend a position related to a topic in this subject area.

## **3. EDUCATING PARENTS & PEER EDUCATION**

*Mrs. Lois Hue, National Youth Director, Jamaica Red Cross Society*

Mrs. Hue stressed the importance of parental involvement in efforts to influence adolescent behaviour, as parents played a vital role in shaping their children's moral, spiritual, emotional and social development. She pointed out that not every parent/household had the natural ability to provide the necessary training, so assistance had to be provided by others.

Using the analogy of cake-baking she showed that, just as certain basic ingredients had to be included in the mix to produce a good cake, parents had to be a part of the education thrust if the most successful outcome was to be achieved.

Areas in which parents could be helped to do a better job, and ways in which NGOs could provide them with support and education, were identified as follows:

**Parents Need Help with:**

Giving love, attention, encouragement, positive stimulation, moral & spiritual guidance

Communicating effectively

Teaching about Sexuality

Administering appropriate discipline

Providing good health Care, Nutrition, Day Care

Providing shelter and a safe living environment.

**NGOs Can Give Help by:**

Counselling

Information

Networking

Offering training in Child Rearing, Health & Sanitation, Nutrition, Verbal Skills, Human Sexuality, Contraception

Arranging for/providing resources

Arranging 'Open Days' at the Centre

Making home visits

Serving as Role Models.

Mrs. Hue reminded participants of the need to schedule education events for parents' non-working hours and of the importance of being relevant, interesting, culturally appropriate and sensitive to adult learning theory.

A handout on "Adult Learning Theory" was distributed and it indicated that adults learn best when:

- they are treated with respect;
- they are actively involved;
- the information given relates to their daily lives;
- their previous knowledge and experience is utilised;
- delivery takes into account different styles of learning (visual, small groups, large groups, dyads)
- they have some input regarding the choice of topics to be discussed;
- they have breaks that provide time to integrate what they have been learning.

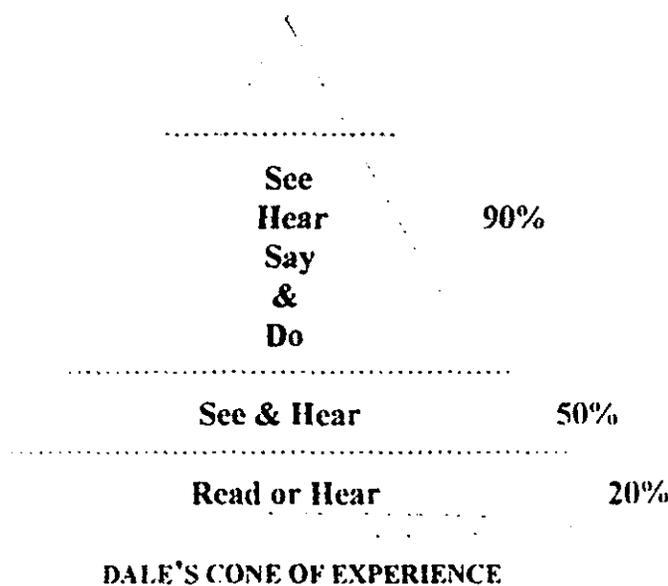
Emphasis was placed on the way information was delivered. Participants were urged to take into account the following key words:

**Inform**  
**Explore** (needs assessment)  
**Advise** (arrange referral if necessary)

**Build** (on previous knowledge)  
**Enlist** (involve trainees)  
**Educate**  
**Respect** (courtesy, confidentiality)

and the fact that effort should be made to involve both the creative/imaginative and logical/rational hemispheres of the brain.

Reference was also made to the "Dale's Cone of Experience" theory, which postulates that effective learning is best achieved through seeing, hearing, saying and doing:



Mrs. Hue saw *peer education* as another effective method of influencing adolescent values, attitudes and behaviour. She said that adolescents were often likely to pay greater attention to information conveyed by their peers. She also noted that age was not the only decisive factor in determining who was considered a "peer"; other shared characteristics could carry more weight.

Effective Peer Educators needed to be knowledgeable and have good communication skills. They also had to be comfortable with discussing sensitive issues, confidential, friendly, courteous, interested, and aware of resource persons/agencies to which referrals could be made.

### **GROUP EXERCISE**

An exercise was conducted to illustrate how performance improved when enough information was given beforehand. First, Workshop participants were given a sheet of paper on which numbers appeared to have been randomly printed. They were instructed to use a pen or pencil to join the numbers sequentially, and given a limited time in which to do so.

Most participants were unable to join more than 3 or 4 numbers. Next, a second sheet with the same numbers was distributed, but this time participants were told that the odd numbers were on the left side of the sheet and the even numbers were on the right. Most participants dramatically improved their performance in the second round, although the time limit set was the same as for the first round.

### ***SUMMARY/FEEDBACK***

In the summary/feedback session which followed, participants expressed the need for more resource material to support their NGO training activity. Dr. Robinson said that if materials were ordered in bulk, cost savings were likely. She suggested, therefore, that NGOs liaise with each other to identify needs, source what was available, and collaborate on an application to UAP for financial assistance to purchase the required materials.

Useful resource material recommended by Mrs. Hue were:

1. *Peer Education Manual* (published by the Department of Social & Preventive Medicine of The University of the West Indies);
2. *Pathways to Parenting — A Caribbean Approach* (produced by Parenting Partners *et al*)
3. *Do You See What I See? — Youth Education Programme Action Pack* (International Federation of Red Cross & Red Crescent Societies).

### ***INDIVIDUAL HOME WORK TASKS***

Prior to the end of the day's proceeding, Dr. Dicks asked participants to prepare and bring the following data to the next day's session:

- a booklet or flyer on their NGO programme
- a list of any materials (e.g., video titles, booklets) found helpful for handling topics listed on the Workshop Agenda
- the number of persons, distributed by gender, in their agencies who work with adolescents.

**DAY 2: MARCH 4, 1998**

## **PRESENTATIONS**

### **1. ISSUES OF ABUSE**

#### **A. Sexual Abuse**

*Superintendent A. Brown-Getton, Head, Police Rape Investigation & Juvenile Unit*

Supt. Brown-Getton informed participants that under the "Offences of the Person Act" rape, attempted rape, assault with intent to rape, carnal abuse, incest, buggery, gross indecency and indecent assault were defined as criminal acts of sexual abuse.

#### Legal Definitions

**RAPE:** Unlawful intercourse committed by a man upon a woman by force, fear or fraud against her will. Penetration must have taken place.

**CARNAL ABUSE:** Sexual intercourse with a girl under 16 years of age.

**BUGGERY:** Sexual intercourse in the anus of any human being.

**INCEST:** Sexual intercourse between a female and a male relative with whom she is too closely related by blood to marry. A female over 16 years of age can be charged with incest if she knowingly permits her father, grandfather, brother or uncle to have sex with her.

**GROSS INDECENCY (Applicable only to men):** Private or public sexual activity that is scandalous, offensive and injurious to public morals.

Supt. Brown-Getton said that she regarded rape as a most vicious and atrocious crime perhaps equal to murder, because it killed and destroyed pride and left lifelong psychological scars. While penalties of life imprisonment and whipping were 'on the books' for rape, the maximum sentences have rarely if ever been imposed because judges have discretionary sentencing power.

Rape, carnal abuse and incest were prevalent and regularly perpetuated on adolescents. Poor guidance and lack of love in the home were often contributing factors. Mothers sometimes refused to report these offences, not realising the suffering their daughters were undergoing. However, she attributed the recent decline in the number of sex crimes reported to the success of the Unit's education efforts rather than to reluctance to report incidents.

|                             | No. of Reports Received |               |
|-----------------------------|-------------------------|---------------|
|                             | 1966                    | 1997          |
| Rape                        | 844                     | 743           |
| Carnal Abuse                | 855                     | 745           |
| Incest                      | 61                      | 37            |
| Assault with Intent to Rape | 34                      | 56            |
| Attempted Rape              | 34                      | 29            |
| Gross Indecency             | 1                       | 1             |
|                             | No. of Reports Received |               |
|                             | 1/1/97-1/3/97           | 1/1/98-1/3/98 |
| Rape                        | 130                     | 65            |
| Carnal Abuse                | 124                     | 27            |

The presenter then explained how the Rape Unit went about its work. The Rape Unit had been established in December 1989 because the Police High Command realised that more empathy was needed in dealing with the victims of sex-related crimes. There are Rape Units in all parish capitals and they are under the jurisdiction of the Unit in Kingston. Where there is no easy access to a Rape Unit, crimes have to be reported to the nearest Police Station. The main objectives of the Rape Units were to:

- i) create a more conducive atmosphere for the reporting of sexual offences;
- ii) ensure quick and effective investigation and medical examination of victims;
- iii) preserve the status, self-esteem and moral values of victims;
- iv) enhance the rapid rehabilitation of victims through therapy and counselling;
- v) present a proper education programme to the community at large through the electronic media, social groups, schools, Neighbourhood Watch and Youth Clubs.

Victims are interviewed in private and their statements recorded. They are then taken to be examined by one of the doctors designated to do work for the Unit. Available exhibits (evidence) are collected and prepared for analysis by the Forensic Laboratory. Victims are counselled at the Unit and/or referred for counselling to other agencies (e.g., Crisis Centre). Contact is maintained with those agencies to get feedback.

During the open discussion which followed, some participants cited instances in which rural police stations had not adhered to the principle of privacy for rape victims to make their reports, and expressed their concern. Constable Anne Marie Henriques-Brown of the Rape Investigation Unit, who had accompanied Supt. Brown-Getton, promised to investigate and ensure such procedural breaches did not recur.

In response to other questions, Constable Henriques-Brown pointed out that:

- Rape Units were open between 7.00 a.m. and 11.00 p.m.
- It was difficult to locate a doctor after 9.00 p.m.

- Rape can be reported at anytime after the alleged incident, but the victim's case was weakened by delay since it then became more difficult to collect evidence.
- DNA analysis was now one of the laboratory techniques used.
- Rape Units can temporarily relocate juveniles at risk to Places of Safety or the homes of relatives willing to house them. There is not enough provision for alternative accommodation and sometimes, regrettably, juvenile victims have to be kept at police stations until space elsewhere becomes available.
- Brochures on the Rape Unit services will be sent to the UAP Office (Dr. Robinson) for distribution to NGOs.

## **B. Substance Abuse**

*Mrs. Sonita Morin-Abrahams, Executive Director, Addiction Alert Foundation*

Mrs. Abrahams began her presentation by giving an overview of what Drug Abuse was all about. She explained certain key concepts which trainers/counsellors had to grasp, if they were to understand the nature of the problem, and its treatment and recovery issues, properly.

### **DEFINITIONS:**

**A drug** is any substance capable of altering the functioning of the mind and body and whose use can give rise to physical, emotional, familial and social problems. Examples given of drugs which are misused or habit-forming were: tobacco (nicotine), cocaine, crack, heroin, alcohol, steroids, tranquillisers or sleeping pills, prescription pain pills, PCP, LSD, inhalants (e.g., glue, 'White out', gasoline) and marijuana (ganja).

**Addiction** is a bio-psycho-social illness characterised by obsession, irresistible compulsion and doses of increasing quantity and frequency.

**The Stages of Addiction are:**

Use  
Tolerance  
Increased Use  
Increased Tolerance  
Dependence (drug needed in order to function)  
Compulsive Use. Loss of Control.

**Tolerance** is a key concept in understanding the development of a drug problem. It sets in when the user needs even higher doses of a drug to feel the same effects.

**Psychological Dependence** has occurred when a user is mentally and emotionally preoccupied with obtaining and using a drug. In other words, the users starts thinking constantly about the drug and its effect.

**Physical Dependence** indicates full-blown addiction.

**Denial** is a customary and major barrier to recovery. An addict cannot be successfully treated if he/she does not think there is a problem.

**Withdrawal** — the physical effects can be very severe, and those suffered during withdrawal from alcohol addiction may be more severe than those caused by withdrawal from cocaine dependency.

**Relapse** often occurs when a recovering user remembers the ways the drug made him or her feel good and forgets the problems the drug caused.

**Who Gets Addicted?** Anybody who uses an addictive drug can get addicted, regardless of their age, sex or background. Young people become addicted faster than adults, and some people have a greater chance of becoming addicted if:

- their parents, grandparents or even great-grandparents had a problem with alcohol or other drugs (inherited predisposition);
- their friends smoke, drink or use other drugs;
- they use drugs to deal with uncomfortable feelings;
- they have other compulsive behaviours.

As far as adolescents were concerned, some warning signs of drug use could be sudden deterioration in school work and/or changes in personality and the friends with whom they usually associate.

All drugs should not be lumped together for education purposes, as they work differently and their biological and psychological effects become evident in different ways and over differing periods. Many drugs are addictive, but some are more addictive than others. For instance, nicotine (in tobacco), cocaine speed and ice are very addictive. Ganja and tobacco are 'gateway' drugs; that is, most users of 'hard' drugs first used ganja and/or tobacco.

Mrs. Abrahams indicated that many adolescents experimented with drugs because they wanted to:

- fit in - to be a part of the peer group
- act grown up
- satisfy curiosity
- relax
- get 'high'.

Having sex, usually unprotected, becomes very appealing to the drug user, and a direct link has been found between becoming 'high' on drugs and increased sexual activity.

She then described some of the effects of prolonged ganja use:

- mental confusion

- impaired short-term memory
- distorted perception of time
- delayed decision-making
- loss of co-ordination
- panic attacks and hallucination
- ganja-induced psychosis [80% of people in the Bellevue (Mental) Hospital]
- lack of motivation to work

Mrs. Abrahams considered that the challenge was to find interactive ways to teach adolescents about drug misuse, so as to get them to understand why those chemicals were bad for them. They should be trained to take responsibility for themselves, their bodies and their lives through self-esteem building and other personal development strategies. Information on the warning signs and symptoms of drug abuse should also be shared with them, as positive peer intervention could be very effective in preventing or curtailing drug use.

In response to questions about available treatment, mention was made of Patricia House (3 months) as well as Detoxification Units at the University Hospital of the West Indies (28 days) and other hospitals.

[After her presentation, Mrs. Abrahams made copies of a brochure, "Addiction" (See *Appendix III*, pg. 48), available for distribution to participants.]

### C. Physical Abuse

*Inspector Wesley Christie, i c o Community Relations and Island Supervisor,  
Neighbourhood Watch Groups*

Inspector Christie defined physical abuse as "acts of unnecessary force often leading to serious injury" which were usually the result of the aggressor's desire to control, administer discipline, inflict punishment or unleash rage. Parents often physically abused each other and their children, because of their anger and failure to listen. Foster parents and step-parents were frequently the culprits.

He said that experiences of physical abuse affected children physically, mentally and emotionally, and some of the effects were:

- serious bodily injury
- fear of 'opening up' and expressing themselves
- aggressive behaviour at home and at school
- pretending things were better at home than the reality of the situation

- carrying ‘unresolved issues’ and a sense of being unjustly treated/ throughout their lives
- mental and emotional regression or withdrawal
- self-blame for parental conflict
- running away.

Abused children needed sources of help but often those sources are lacking or in short supply. Nevertheless, help could be accessed through probation officers, Children’s Services officers, police stations and the Community Relations Officers of the Police Juvenile Units in each parish.

Inspector Christie indicated that, when a case of physical abuse are reported to, or are discovered by, the police, effort was made to quickly remove the child to a Place of Safety or the Children’s Hospital, as the case may be. The person who took the child to the clinic, police station or Juvenile Unit had to explain the injury or other evidence of abuse.

The police did not only make arrests. Their goal was to reduce the number of physical abuse cases. Therefore, they also worked with the parties involved to identify the underlying causes of the conflict and to bring about positive changes. They often provided group or individual counselling and mediation to the parties involved and Victim Support Groups were available to work with the person over a period of time. Students were also frequently referred to their school guidance counsellors for follow-up help.

In addition, to counselling and mediation, the police provided education on conflict resolution and alternative forms of punishment.

NGOs were encouraged to make use of the services of the Police Force’s Community Relations Office at 1 Ruthven Road (Phone: 926-8790, 926-8793, 926-0066) when necessary.

Responding to participants’ comments, Inspector Christie pointed out that lack of suitable alternate facilities often caused the wrongful remand of children in police lock-ups. He agreed that more provision was needed for the temporary care of abused children until permanent arrangements could be made for them.

### ***SMALL GROUP ACTIVITY***

Participants were divided into four (4) groups. The groups were asked to discuss short Case Studies relating to abuse and to develop response strategies for dealing with the issues identified. Groups 1 & 4 were asked to discuss and report on “Scenario B: Maureen”, while Groups 2 & 3 were assigned “Scenario A: Monica”.

#### **SCENARIO B: MAUREEN**

Maureen, 14, has been coming to the local Youth Centre. She seems to be a loner but has attracted the attention of Lloyd, one of the outgoing youth. Maureen recently shared after a session on Sexual Identity that she is pressured to date boys but feels very uncomfortable with them. She was physically attacked and raped by 2 boys.

It was reported that she has been experimenting with drugs and became sexually active a year ago. While Maureen identifies personally as being lesbian, she has only recently shared this with you in individual session and begged that you not tell her parents — especially her father who is a Minister. There is also a rumour that two of the boys in group have a plan to convert Maureen into changing her sexual identity. They are planning a party and will supply her with drugs. Rumour is that Maureen will have sex if 'high'.

Summaries of the reports from Groups 1 & 4 to the reconvened plenary session are given below:

**GROUP 1: Leader & Rapporteur** — Ms. Theresa Bryan, *Women's Centre of Jamaica Foundation*

The issues to be addressed were identified as being confidentiality of information, Maureen's problem with her sexual identity, and the effects of peer pressure, her past and potential experience of rape, possible drug use, and fear of her father's disapproval.

The group reported members' mixed feelings about lesbianism and felt that, in such circumstances, referral to an external counsellor would be the best strategy for helping Maureen to resolve that problem. There was concern about taking action on rumours and confidential information, but it was agreed that a stern general warning could be given to the group of boys allegedly planning to take advantage of Maureen. The police could also be alerted about what might take place at the party.

**GROUP 4: Leader** — Mrs. Glenda Drummond, *Western Society for the Upliftment of Children*  
**Rapporteur** — Ms. Marsha McIntosh, *Youth Opportunities Unlimited*

This group felt that the problems revealed by the Case Study were rape, lesbianism, experimenting with drugs, peer pressure, and violation of Maureen's sexuality by plans to change her sexual orientation. The ethical issues raised were seen as being how to deal with a different sexual orientation and confidentiality (her father must not know).

Reporting Maureen's earlier rape was identified as a legal concern, but the group was unsure if it was still worthwhile to report it since the Case Study did not state how long ago the incident had occurred.

Action proposed to deal with Maureen's problems were:

- i) convince her to report the rape and get counselling for drug use;
- ii) refer Maureen to the Rape Unit and Addiction Alert;
- iii) expose plans to change Maureen's sexuality and talk to the boys about the rights of others and the need to respect other people's bodies.

## SCENARIO A: MONICA

Monica, a 12-year old who has been attending sessions at your agency, recently shared in group that she has been sexually abused by her step-father. You are concerned since you know she is several months' pregnant, and allegations have been made that a 14-year old boy is the father. Recently, she rushes home each mid-day to meet her step-father for lunch. Her attitude has become very positive about this man whom she used to fear. She informs you that he asked that their meetings be kept secret.

Highlights of the reports from Groups 2 & 3 to the reconvened plenary session were as follows:

**GROUP 2:** Leader — Ms. Naska Llits, *Jamaica Family Planning Association*  
Rapporteur — Ms. Avis Williams, *Kingston YMCA*

Problems Identified: Teenage pregnancy; possibility that Monica continues to be sexually active; carnal abuse.

Ethical Issues: Confidentiality, guilt, child abuse, possible decision to terminate pregnancy because of Monica's age.

Confidentiality: Counsellor should be careful not to divulge information without the child's consent.

Legal Concerns: Child Abuse; Carnal Abuse; Removal to a Place of Safety; Adoption.

NGO Response:

- i) Be objective; avoid being judgmental or making snap decisions. In-depth investigation will determine what action is best.
- ii) Give Monica guidance and counselling to help her to 'open up' and gain a sense of direction; help her to make decisions. Tell her what can be done for her, offer her options (e.g., referral to Rape Unit, Women's Centre)
- iii) Talk to her parents; let them know Monica can be put up for adoption if incidents persist; let her step-father know that his actions are criminal.
- iv) Try to get her out of the house; involve others in a strong support system — the police, Child Care Officer, school guidance counsellor and a doctor (depending on the age of the pregnancy the doctor may recommend its termination).

**GROUP 3:** Leader — Mr. Philip Earle, *ASHE*  
Rapporteur — Mrs. Dahlia Shields-Thaxter, *Women's Centre of Jamaica Foundation*

Problems Identified: Teenage pregnancy; carnal abuse (“step-father is depraved”); interrupted education; health risk; psychological problems; economic strain; poor mother-daughter relationship.

Ethical Issues: Guilt (should client/counsellor confidentiality be breached?); Child Abuse (“step-father should be plucked like a chicken”).

Confidentiality: Counsellor will have to boost Monica’s self-confidence so that she can expose the situation.

Legal Concerns: Child Abuse; Carnal Abuse; Adoption; Removal to a Place of Safety.

NGO Response:

- i) Counselling for the whole family including the step-father, with a view to getting Monica to sever all sexual ties with her step-father.
- ii) Medical attention for Monica.
- iii) Referral for Monica to Rape Unit and Women’s Centre.

An interesting question raised during the discussion of the group reports was: “What stance should counsellors take when aware that the sexual partner of an under-age girl was much older than her?” The consensus was that the counsellor would need to identify the legal and ethical considerations involved, examine his/her judgements in light of these, and ensure that the actions taken were in the **best interest of the client**.

## ***HOMWORK TASK***

Before the close of the session, participants were given a list of questions by Dr. Dicks (See *Appendix IV*, pg. 49) which they were asked to take home and use to identify what they needed to know to be more effective in their work with adolescents regarding Reproductive Health. A list of *Counselling Commandments* was also distributed, to serve as a reminder of some important counselling requirements:

### **COUNSELLING COMMANDMENTS**

1. Be non-judgmental
2. Begin where the Adolescent is
3. Acceptance
4. Individualisation
5. Purposeful Expression of Feelings
6. Confidentiality.

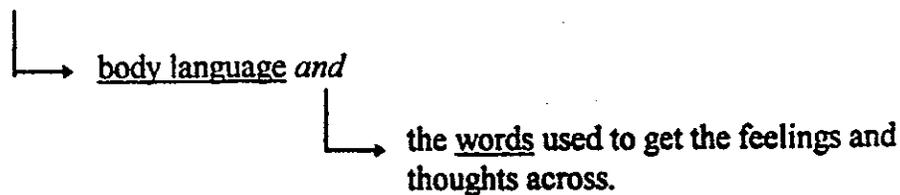
Adapted from Biestek’s “Casework Relationship”

## 2. COMMUNICATION STRATEGIES WITH ADOLESCENTS & PARENTS

*Miss Marguerite Newland, Communications Specialist and Trainer*

This presentation stressed the importance of effective face-to-face communication for persons seeking to be agents of change. Effective communication was defined as “an exchange of thoughts and feelings whereby the same understanding was shared”. Therefore, the meaning intended by the source or sender should be the same as the meaning received by the listener or receiver.

Miss Newland emphasised that 50% - 70% of what people reacted to was what they saw. Face-to-face communication involved both verbal and non-verbal expressions of thoughts and feelings through



Any mismatch between body language and the words spoken could be expected to result in distorted and ineffective communication.

The basic rules for effective communication were to organise the message, deliver it and check for understanding. Therefore trainers should:

- i) tell the audience (one or more persons) what you are about to tell them;
- ii) deliver the “message” in the most creative way possible, bearing in mind audience interests, information needs and average comprehension level
- iii) ensure accurate exchange of information by seeking feedback;
- iv) review what has been said.

She also said it should not be assumed that the speaker knew more about a topic just because he/she had been formally trained and the audience had not. It was important when communicating with adults or children, therefore, to respect the knowledge they already had by asking them, in creative and culturally appropriate ways, what they knew. Their responses would determine what they needed to know and should influence the particular communication strategies to be used.

### **GROUP EXERCISE**

Participants were then involved in a simple game in which each person was given a slip of paper with an identifying name and found his/her partner ( e.g., peas and rice, cup and saucer) through communication with others in the group. Next, four groups were formed and each was given a sheet of paper on which to list definitions of effective communication.

Groups exchanged their lists several times on a given signal. At the end of this second exercise, Miss Newland collected the lists and made reference to the listed items as she continued her presentation.

Additional information conveyed to participants was as follows:

### **TIPS FOR EFFECTIVE SPEAKING**

- \* Develop knowledge of target audience
- \* *Think through what is to be said*
- \* Find appropriate way(s) of passing on information
- \* Use language that will deliver message clearly
- \* Maintain eye contact
- \* Display good posture
- \* Be audible - good voice projection
- \* Pleasant tone, pitch, diction/enunciation
- \* Appropriate dress
- \* Positive body language
- \* **KISS: Keep it short and simple — don't crowd too much information into one exchange.**
- \* Ensure understanding through feedback responses.
- \*

### **TIPS FOR EFFECTIVE LISTENING**

- \* Create right atmosphere (conducive environmental conditions).
- \* Pay attention — really listen.
- \* Maintain eye contact.
- \* Don't interrupt unnecessarily.
- \* Try to understand the speaker's position; start from point of agreement and move on...
- \* Understand the Message...focus on what is actually being said, not what the listener understands about the subject.
- \* Respond...give appropriate feedback
- \* Be trustworthy — avoid developing reputation for lack of confidentiality.

### **COMMUNICATION BARRIERS**

- \* Language and cultural differences
- \* Literacy level
- \* Prejudice/lack of empathy
- \* Bias/differences of opinion
- \* Environmental distractions (e.g., Noise)
- \* Sender's lack of preparation, ambiguity, or circumlocution
- \* Receiver's preoccupation with other thoughts, lack of interest, hunger, or mental and physical disabilities.

### **EFFECTIVE COMMUNICATION CHANNELS**

- \* Letter writing
- \* Speech
- \* Performing Arts
- \* Phone and facsimile messages
- \* Photographs
- \* Printed material - books, magazines, comics, posters
- \* Music
- \* Electronic media - news reports, advertisements, etc.

Miss Newland also made the point that when dealing with sensitive subjects, an effective communication delivery strategy was to:

- i) outline the pros and cons
- ii) explain the risks and consequences, then
- iii) allow the client to make the choice.

If the counsellor's own value system prevented objectivity, he/she should ask someone else to deal with those subjects.

### ***GROUP ACTIVITY***

As the final group activity, each of the four groups previously formed was given a Jamaican proverb to discuss among themselves and asked to demonstrate effective communication strategies by using the assigned proverb as a theme for a 3-minute presentation on any topic already addressed during the Workshop.

The group presentations, including the use of role play in two instances, demonstrated participants' improved understanding of adolescent reproductive health issues and indicated that they were likely to use creative and appropriate communication techniques in their work.

**DAY 3: MARCH 18, 1998**

## **PRESENTATIONS**

### **1. SEX AND SEXUALITY: STEREOTYPES & MYTHS**

*Mrs. Althea Bailey, Regional Co-ordinator, National HIV/STD Control Programme*

The presentation began with a group activity in which two signs ("Agree" and "Disagree") were first mounted on opposite walls. Mrs. Bailey then asked participants, who had been grouped at the back of the room, to move each time she made a statement and stand under whichever sign corresponded to their opinion on the matter. The statements made and participants' reactions were as follows:

- |   |   |   |
|---|---|---|
| "Men love sex more than women"  | - | Most agreed   |
| "There can be no sex without penetration"   | - | All disagreed eventually                                  |
| "Oral sex is nasty"   | - | Most disagreed  |
| "Anal sex is nasty"   | - | Most agreed   |
| "If I found out that my best friend was homosexual, I would no longer be his or best friend". | - | All disagreed, although a few expressed some reservations |

Mrs. Bailey explained that the purpose of the exercise was not to determine what was wrong or right but to get each participant to examine his or her feelings and to expose some of the things believed, so as to see whether those feelings and beliefs were based on fact.

She pointed out that in working with adolescents, teachers and counsellors would have to face their own sexuality. Some graphic transparencies were displayed and participants were asked to express their spontaneous feelings about each one. From the comments made, it was clear that there had been a rapid and significant decrease in the overall level of comfort as the displays changed from a picture of two babies fondling themselves, to male and female genitalia, and then scenes of heterosexual and homosexual sex acts. Participants were asked to think about the basis of their values and attitudes, and given an Information Sheet about different forms of sexual expression (*See Appendix V*, pg. 50).

The presenter pointed out that each person was a sexual being. Sexuality began in the womb and birth gender determined the socialisation process, as all societies specified different gender roles for girls and boys. Other factors affecting perceptions of sexuality were:

- explicit or implicit information received about sex, and the language used
- own sexual experiences
- race (e.g., "black men are good studs")
- religious teachings
- economic circumstances
- cultural norms and values
- level of personal self-esteem.

After participants had listed the various words they knew to be used in Jamaica to describe the sex act (32 words), a penis (26 words) and a vagina (26 words), Mrs. Bailey drew attention to the fact that words describing the vagina were suggestive of food, eating and strong smells; those describing the penis had connotations of strength and power, while those describing the sex act generally denoted violence and pain. It could be expected, therefore, that this language pattern would be reflected in sexual behaviour.

Mrs. Bailey reminded participants they might not like what others do, but it was possible that they might also do things that others would not like to do. She implored them, therefore, to find some level of objectivity that would enable them to deal with issues and behaviours which they might not endorse. She also distributed two additional handouts, "Human Sexuality" (*Appendix VI*, pg. 51) and "General Guidelines for Answering Sexuality Questions" (*Appendix VII*, pg. 53).

In the final group activity, participants gathered at the back of the room. Six persons were chosen at random and each of their heads was banded with a sheet of paper on which there was a written label that the wearer could not see. The six labels were "Bi-Sexual", HIV Positive - Drug Addict", "Pregnant 10 Year Old", "Has Sex with Animals", "Lesbian", and "Whore". The other participants were instructed to talk and react to each wearer, without telling them what was written on their head bands. After a few minutes, everybody resumed their seats.

The six persons who had been given head bands were asked to report what people said to them and how would those remarks would have made them feel if it had happened in real life. Except for the "Pregnant 10 Year Old", who reported that a few persons had offered help, all agreed that the hostile remarks, making them feel bad and like a non-person.

Mrs. Bailey said the point of the exercise had been to expose the way in which certain members of the society are labelled and treated on the basis of preconceived notions. In discriminating against them, people were made to feel bad about themselves. No concern was displayed for any good qualities they might have or their capacity for usefulness to the society. Such persons usually resigned themselves to, or rebelled against, the treatment they received. She urged participants to be as non-discriminatory as possible because, in order to be able to work with people, it was necessary to relate to them as human beings and not as labels.

## **2. AIDS & STIs: ISSUES AND CONCERNS**

*Miss Jennifer Hopwood, Jamaica AIDS Support*

Miss Hopwood informed Workshop members that Jamaica AIDS Support dealt with the care, support and counselling of persons infected with HIV/AIDS. The organisation operated a 16-bed hospice (11a Osborne Road, Kingston) for persons in the last stages of their illness and offered a home-based care programme in Kingston. The organisation had offices in



Some major myths were dispelled including the belief that most persons infected with HIV/AIDS were 'gays', promiscuous, and/or unemployed 'losers'. Available information on reported cases in Jamaica, up to 1996, revealed the following:

|                      |       |
|----------------------|-------|
| Heterosexuals        | 1,432 |
| Homosexual/Bi-sexual | 142   |
| IV Drug Use          | 9     |
| Haemophiliac         | 5     |
| Blood transfusion    | 4     |
| Mother-to-Child      | 183   |

Forty percent of those infected were professionals or skilled, self-employed persons. Other categories of numeric significance were housewives, agricultural workers and security/uniformed personnel.

Other pertinent HIV/AIDS facts shared by Miss Hopwood were:

- Before 1985 there was no testing in Jamaica for the presence of HIV/AIDS in blood, so persons receiving blood transfusions prior to that date could have been at risk.
- In 1997, there were 12 million persons living with AIDS, 24 million living with HIV including 1 million children were living with HIV; 9 million children have been orphaned because of AIDS.
- The virus dies within 30 seconds of exposure outside the human body.
- The virus enters an individual's blood stream through cuts or bruises.
- It is possible to become infected from only one exposure.
- Someone with HIV may look and feel healthy.
- Once infected, an individual can infect others.
- Blood, semen and vaginal fluids are the known sources of infection because of the high concentration of white blood cells in those fluids; breast milk may also be a source of infection.
- Extreme caution should be exercised in all situations (including ear piercing, barbering) in which there might be exposure to someone else's blood.
- Saliva, sweat, tears and urine are not sources of infection, and casual (non-sexual) contact does not put someone at risk.
- Fretting can make 'symptoms' appear even when the HIV/AIDS might not be present.
- At present, there is no known cure for AIDS. Some treatments were available, however, which may slow or even halt the progress of the disease. These drugs were very expensive (the cost for a recommended course of treatment was normally between US\$ 2,000-4,000 per month)

- It is possible to live a 'healthy' life for an extended period with proper nutrition, drugs, counselling and support.
- Behaviours that Transmit HIV
  - ⇒ Unprotected (that is, not using a condom) vaginal, oral or anal sex with an infected person. A latex condom is best for vaginal or anal sex, and a Dental Dam or a piece of Saran Wrap (plastic) should be used to protect the mouth in oral sex situations.
  - ⇒ Sharing injection needles.
- The Role of Trainers/Counsellors
  - ⇒ Responsibility to inform, educate and help—great patience was needed and rapport must be developed with those needing help.
  - ⇒ What a trainer/counsellor believes personally was one thing; what was done professionally was another—don't judge or criticise.

Miss Hopwood distributed two handouts, "Facts About AIDS and the HIV Antibody Test" (*Appendix IX*, pg. 55) and "What To Do If You Test Positive for the HIV Antibody" (*Appendix X*, pg. 57). She requested a list of NGOs from the UAP Office so that she could maintain contact, and some Workshop participants indicated that they would offer their services as volunteers in the *Jamaica AIDS Support Friends Programme*.

### **3. AIDS & STIs: BASIC CONTENT & TEACHING TECHNIQUES BEST SUITED FOR 10-14 YEAR OLDS**

*Mrs. Lois Hue, National Youth Director, Jamaica Red Cross Society*

In introducing her presentation, Mrs. Hue said that, since all participants had attended school and some had even been teachers, she was sure most of them could remember how subject content information had been exposed in progressive increments over time. The underlying principle was that not every stage of development required the same treatment of a topic. It was important, therefore, to recognise what constituted appropriate content for teaching the target age group of 10-14 year olds about AIDS and sexually transmitted infections (STIs).

She indicated that the World Health Organisation (WHO) defined **sexual health** as:

*the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively increases and promotes personality, communication and love*

and noted out that the UAP was equipping participants to confidently and expertly carry out education programmes related to sexual health.

As far as subject content was concerned, she said that the main goal was to provide adolescents with information which would help them to recognise that they had choices and also show them how to make informed choices. Adolescents should be made aware of:

- how they viewed their own sexuality and that of others;
- the freedoms and constraints within their culture, and the socio-economic situations that might affect the way they express their sexuality;
- how to develop relationships that would maintain their self-esteem, health and lives;
- how to maximise the enjoyment of their sexuality while minimising the risks;
- how the issue of reproduction should be perceived and the considerations that should govern the decision to have a child.

Mrs. Hue then distributed a handout, "Sexual Learning - Life Spiral" (*Appendix XI*, pg. 59), which showed:

1. the environmental factors affecting the development of sexuality from birth to death; and
2. the considerations involved in making decisions about sexual activity.

Recommended components of a Reproductive Health Programme were:

- Sexual Health
- Changes in Adolescence
- Relationships and how they change
- Fertility and Pregnancy
- Methods of Contraception (abstinence being the first option)
- Forms of Sexual Expression
- STIs, HIV and AIDS

e.g., What is AIDS?

How can you get it?

How can you not get it?

How can you prevent it?

What is the relation between alcohol and drug abuse and HIV/AIDS?

- Sex and Drugs
- Other Issues, including traditional vs. modern values, gender roles, abortion, rape, sexual abuse, commercial sex workers.

Relevant handouts distributed were "Most Common Sexually Transmitted Diseases" (*Appendix XII*, pg. 60), "Sexually Transmitted Diseases: Key Facts" (*Appendix XIII*, pg. 61), "What Is AIDS?" (*Appendix XIV*, pg. 62)

Effective programme implementation required:

- Needs Identification — taking into account what adolescents say they want to hear.
- Goal Setting
- Collecting Information
- Identifying Resources
- Choosing Methods
- Practising before the start of training.

**Collecting Information** from as many available sources as possible could involve obtaining teaching aids; talking to people, observing the media, surfing the Internet, comparing information and listing differences. Subject knowledge should be kept current.

**Identifying Resources** meant deciding what time, money, people and materials were needed.

**Resource Persons** could include community and religious leaders, parents, nurses, doctor, other teachers. Personnel from the various NGOs should also rely on each other for help, support and strength.

As far as information delivery was concerned, Mrs. Hue emphasised that trainers/counsellors should **SHARE FACTS...NOT OPINIONS**. Effort should also be made to find out what adolescent already know, so that any misconceptions could be corrected. Use should be made of media popular with the target age group — e.g., music, drama/role play, fashion, story-telling, debate, rap session — to arouse interest and get their active participation in the learning process.

Next, participants were asked to engage in a group activity Each participant, except one, was given a blank card and instructed to go around the room and obtain the signatures of 3 other persons. A few cards had “C” written on their reverse sides. The person who had not been given a blank card was secretly given a card which read:

|   |
|---|
| Sit down<br>Do not sign any cards or have<br>anyone sign your card. |
|---|

After a few minutes, the other participants were asked to resume their seats. As each person read out the names entered on his/her card, the individuals named were asked to stand. Soon almost everybody was standing.

Mrs. Hue then explained that the activity was one which could be used to convey the message of how HIV can be easily transmitted to a vast number of persons. The persons listed on each card could be assumed to have engaged in sex with the card-holder and, except

for those persons whose names had been entered on cards with the "C" to indicate that the card-holders always used a condom, all could have experienced exposure to HIV/AIDS. Those listed on more than one card would have multiplied their exposure risk. The only person who definitely had not been exposed was the individual who had abstained from sex; that is, she had not signed any card or had anyone sign her card.

Following the group activity, two participants demonstrated, through role play, how assertiveness could be used effectively to refuse involvement in an undesirable sexual situation by employing one or all of the following strategies:

1. saying NO without further explanation
2. saying NO and giving a reason
3. saying NO and leaving the scene.

Participants were asked to complete "A Read and Do Test" (*Appendix XV*, pg. 63), which asked that they "read all that follows before doing anything". The last line on the sheet stated: "NOTE: PLEASE BE QUIET AND WATCH THE OTHERS FOLLOW DIRECTIONS". Evidently, few had read "all that follows", because most people began immediately to do the various tasks listed. Observing this, the presenter asked if anybody had read to the last line. Since some persons had done so, they had not started on any of the tasks. Some others realised their error and ceased work. Mrs. Hue pointed out that the responses of the latter group illustrated how people could learn from a mistake when the error was brought to their attention.

### **Introduction of Person Living with HIV**

Focusing once more on HIV/AIDS, participants were asked to consider what questions they would ask of a person who knew himself to be HIV positive. Their responses were listed on a flip chart. Stressing the need to maintain confidentiality, Mrs. Hue introduced a surprise guest — someone who was HIV positive. The young man, who appeared to be in good health, answered questions and described his personal experience with HIV and the coping strategies he had been using for over 10 years. After his presentation, several participants indicated that their perceptions and understanding of the issue had been positively changed by the opportunity provided for face-to-face dialogue.

### **VIDEO PRESENTATIONS**

Participants were divided into two groups to watch two sex education videos. Their instructions were to identify the main message, assess their appropriateness for an adolescent audience and, in evaluating the effectiveness of the strategies used, decide why those strategies were effective or not effective.

Group 1 viewed the video "Come Listen to We", a Hope for Children (NGO) production, while "Vibes: In A World of Sexuality", a video produced by The Little People and Teen Players Club was shown to Group 2.

Highlights of the Group reports were as follows:

**GROUP 1: Rapporteur** — Miss Theresa Bryan, *Women's Centre of Jamaica Foundation*

The group found that the video clearly illustrated how peer pressure, misconceptions/ inaccurate information and poor self-esteem led a naive adolescent girl to engage in sex, without consideration of the risks involved. The adverse consequences to her were clearly shown. The dialogue was understandable, and the dramatic action would be appealing to young people.

It was felt, however, that some direct adult involvement could have been introduced into the situation, to demonstrate adult understanding of the problems of adolescence and that adults could be a better source of authentic information on sexual issues.

**GROUP 2: Rapporteur** — Mrs. Patricia Miller, *Rural Family Support Organisation*

This group reported that the video's main message was how to cope with sexual issues. The video was thought to be well-produced and captivating, and the content was appropriate for 10-14 year-olds. The positive message was also likely to be motivational, but a few of the words used in dialogue (e.g., urge, trust) might first have to be explained by programme leaders of some groups.

On the other hand, because of the wealth of information presented, the video's duration might be too long for many 10-14 year-olds, whose attention span on average was short. It might be possible to get around that problem by showing the video in two sessions like a serial.

## ***EVALUATION & FEEDBACK***

Each participant was provided with a special Evaluation Sheet which consisted of a drawing of a tree with people at different levels — from standing on the ground to being at the top of the tree (See *Appendix XVI*, pg. 64 ). Participants were asked to circle one of the figures on the Sheet to indicate the effect of the day's activities on their understanding of, and confidence in dealing with, the topics discussed.

Participants were also invited to give oral feedback. Favourable mention was made of the good presentation styles, varied group activities and "lots of handouts". The consensus was that the best feature of the day had been the opportunity to see a HIV positive person, as the experience "brought them down to earth". Several persons also said that, in the future, they would react differently and, by becoming more attuned to the feelings of others, would treat each person as an individual rather than as a label.

**DAY 4: MARCH 19, 1998**

## **PRESENTATIONS**

### **1. STAFF ISSUES — EMPOWERMENT & COPING STRATEGIES**

*Mrs. Joan Meade, Asst. Lecturer/Training Officer, Advanced Training in Fertility Management, The University of the West Indies*

#### **A. Empowering Adolescent Service Providers**

Mrs. Meade began by offering the following definitions of “empowering”: *instilling a sense of power; enabling; giving control, power and influence.* Becoming empowered also required strengthening belief in one’s self, taking responsibility and being accountable for one’s actions.

The normal sources of power were identified as being position/rank, personal characteristics (expertise, charisma, ability to coerce and/or apply sanctions), control over resources and key information, networks and alliances.

She said that to be empowered, staff had to be equipped with the necessary skills, resources and authority to perform their assigned roles. In addition, they ought to be encouraged to participate in the organisation’s development and decision-making process.

Staff empowerment can be achieved by **management/leaders** through:

- developing employee skills so they can do their jobs well (train, evaluate performance and provide feedback; give remedial training when necessary to correct deficiencies)
- sharing power (delegating/distributing responsibilities)
- sharing, in a timely manner, information that will affect employees
- fostering involvement to achieve greater commitment to the organisation (consult, ask for ideas — act on as many as possible; give credit for those adopted)
- facilitating financial participation, where feasible
- encouraging commitment to quality (set standards, give responsibility for work quality — explain, don’t over-supervise)
- providing positive emotional support (e.g., how to deal with stress, counselling, encouragement, expressing confidence in their ability, minimising negative effects of workplace irritants)
- providing rewards for achievement in a personal and visible way (praise, commendations)

- building on success (i.e., gradually assigning tasks of greater complexity and difficulty, on the basis of previous successes)
- serving as a role model and/or providing suitable models of success.

**Staff** can contribute to their own empowerment if they:

- look at their organisations to determine what is necessary to gain power and then “go for it”.
- increase the number of internal and external contacts whom they can call upon for assistance or with whom they can collaborate.

Copies of an “Empowerment Profile” were then distributed (*See Appendix XVII*, pg. 65). Participants were asked to complete the questionnaire and score themselves to determine whether they were in fact empowered.

## **B. Assessing your Work Environment**

The work environment was defined as its total surroundings and all the elements of which it was comprised. Using the systems approach, Mrs. Meade said that the organisational sub-systems which affected staff significantly were:

|                         |  |
|-------------------------|--|
| <b>GOALS AND VALUES</b> | The organisation’s culture, philosophy (what it believes) and overall goals (what it wants to get done); individual goals. When individual goals conflict with group goals, the aim should be compatibility. |
| <b>TECHNICAL</b>        | This pertains to technology — knowledge, techniques required, facilities and equipment.  |
| <b>PSYCHO-SOCIAL</b>    | This concerns the human resource — their attitudes, perceptions, motivation, leadership, group dynamics, communication and interpersonal relationships.  |
| <b>STRUCTURAL</b>       | This relates to the tasks, workflow, work group, authority, information flow, procedures and rules — usually captured in Organisation Charts and Procedures Manuals.   |
| <b>MANAGERIAL</b>       | This applies to goal setting, planning, assembling resources, organising, implementing, controlling, and other management functions.   |

For an assessment of a particular work environment, it was necessary to look carefully at those five elements in order to understand their nature and how they were implemented.

### **Steps in Environmental Assessment**

1. Audit Environmental Influences.
2. View Nature of Environment (complex? dynamic? hostile? pace of change: rapid, slow?)

3. Do Structural Analysis (identify key forces– why significant? inter-relationships).
4. Examine Competitive Position.
5. Identify Strengths And Weaknesses to determine where change is needed.
6. Identify Opportunities And Threats in the internal and external environment.
7. Weigh Strengths and Weakness against Opportunities and Threats, and find workable solutions for the weaknesses identified.
8. Take action.

Two typical organisational problems were discussed and possible solutions proposed. The first scenario was one in which a visitor/resource person arrived at an NGO Centre for a scheduled activity to find that the other persons to be involved were either late or absent. Likely organisational weaknesses suggested were poor time management, communication breakdown/failure to communicate, lack of a contingency plan. Depending on the source of the problem, recommended solutions were improved internal communication including feedback about participants' availability and development of a contingency plan (e.g., timely cancellation of visit if principals will be unavailable, or alternative use of visitor's time if the original programme cannot be implemented at the scheduled time).

The second scenario was one in which an NGO had no computer equipment and was having difficulty in recording/storing a great deal of statistical information and submitting several periodic reports. Environmental opportunities for getting the work done elsewhere, or for securing the equipment at little or no cost, could be identified and taken advantage of through contacting:

- small area businesses which might be willing to have one of their employees enter data on diskette, and/or produce reports, when work demands were not heavy;
- organisations willing to donate or give financial assistance for purchasing computer equipment.

It was further suggested that specific needs in terms of computer hardware, software and operating time should first be identified. Another prerequisite, if computer equipment was to be obtained, was training someone within the organisation or identifying someone who already had the necessary operating skills.

### **C. Strategies to Avoid Burnout**

Participants were asked to complete a "Diagnosis of Stress" questionnaire (See *Appendix XVIII*, pg. 66) to assess for themselves how well they were dealing with stress. Mrs. Meade said a moderate level of stress could be invigorating and a certain amount of stress was almost inevitable in modern life. A handout provided (See *Appendix XIX*, pg. 67) showed that many normal life events had inherent stress factors.

However, excessive stress could have negative effects, e.g., 'burnout'. Burnout was described as "the total depletion of physical and mental resources caused by excessive striving to reach unrealistic work-related goals". Excessive stress could be avoided or

prevented, but the individual needed to recognise what was happening and needed to do something about it.

Recommended coping strategies (See also *Appendix XX*, pg. 68) were:

- Break your patterns – develop a healthier, well-rounded lifestyle.
- Get away from it all periodically – take time out for one's self without guilt.
- Reassess your goals in terms of their intrinsic worth – are they attainable and worth the sacrifice that will have to be made?
- Think about your work – could as good a job be done without being so intense or by also pursuing outside interests?
- Reduce stress – practise better time management; build better relationships; do not internalise client problems.

If self-examination indicates the need for remedial action, something should be done. Action could involve one or more of the following options: *changing one's self, changing the situation, changing the job, getting professional counselling, discussing the problem with others, meditation.*

## **2. STAFF ISSUES — DEVELOPING AN ADOLESCENT PROVIDERS' NETWORK**

*Dr. Barbara Dicks, Workshop Director*

Continuing the focus on providers' needs, Dr. Dicks said that the idea of developing an Adolescent Providers' Network came out of a request made at the 1997 UAP Round-Table, when people indicated a need for support from others and a need to link with other NGOs providing similar services.

As a first step, Dr. Dicks demonstrated to participants how they could compile a directory of agency contacts by starting to document the support services which they were already accessing, and those which they found were available. A Table that could be used for the purpose was illustrated as follows:

MY AGENCY: \_\_\_\_\_

| PROBLEM                               | AGENCY  | SERVICE   | RELATIONSHIPS  |
|---------------------------------------|---|---|--|
| Drug Abuse                            | National Council on Drug Abuse  | Counselling                                       | Mrs.....<br>Phone:.....                                      |
| Reproductive Health training material | Jamaica Red Cross,<br>Central Village<br>National Family Planning Board | Manuals, Brochures,<br>Activity Kits<br>- ditto - | Mrs. Lois Hue<br>Phone: 984-7860<br>Mrs. ....<br>Phone:..... |
| Substance Abuse                       | Addiction Alert   | Counselling, Rehabilitation Referrals             | Mrs. S. Abrahams<br>Phone:.....                              |
| Violence                              | P.A.L.S.  | Training programme and materials                  | Mrs.....<br>Phone:.....                                      |
| Rape & Physical Abuse                 | Police Rape Investigation Unit  | Advice, speakers for group sessions               | Sgt.....<br>Phone:.....                                      |
| Lack of Clothing and food             | Red Cross   | Donations   | Mrs.....<br>Phone:.....                                      |
|                                       | Food for the Poor   | - ditto -   | Mr.....<br>Phone:.....                                       |
| (etc.)                                |   |   |  |

In terms of developing a network among themselves, participants were encouraged to decide just what they would be hoping to accomplish — a self-help group? a support group? In addition, there would have to be mutual agreement on other major considerations:

- **Interim Co-ordination** — who would 'get the ball rolling'?
- **Goals and Objectives** — define the focus
- **Model** — formal or informal?
- **Meetings** — frequency and location?
- **Structure** — officers? regional representatives?
- **Programme Focus** — Continuing Education? Information provided by professionals or knowledge shared with each other?

### 3. STAFF ISSUES — RELAXATION TECHNIQUES

*Miss Mary Naughty, Reflexology & Fitness Trainer*

Miss Naughty explained how touch therapy, deep breathing, stretching routines, and exercising specific muscles could relieve stress, improve circulation, increase flexibility and promote an overall sense of well-being.

She showed participants how to self-massage essential stress points in the neck and shoulders and, using a volunteer, demonstrated several stretching and breathing exercises which could be done anywhere and needed no special equipment for their performance.

Miss Naughty said Reflexology was based on the theory that various zones of the body were connected to reflex points in the hands and feet. Using a diagram of the feet to illustrate these reflex points, she indicated that application of pressure to a reflex point could relieve or normalise the related body zone.

In describing the principles of reflexology, Miss Naughty stressed that, while it had proved to be of therapeutic value in certain situations, reflexology was not a substitute for traditional medical diagnosis and treatment.

Dr. Dicks emphasised how important it was for providers to strike a balance between the work they did for others and the satisfaction of their own inner needs. If they only gave to others and never to themselves, they would stay out of balance. She recommended three publications for the advice they gave on how to take better care of one's psyche:

- *124 Prayers for Caregivers*
- *Acts of Faith - Daily Meditations for People of Color* (Iyanla Vanzant, 1993). NY: Fireside Press (Simon Schuster). ISBN# 0-671-86 416-5
- *Black Pearls: Daily Mediations, Affirmations and Inspirations for African-Americans* (Eric Copage, 1993). NY: Quill (William Morrow Publ). ISBN# 0-688-12291-4

#### **4. STAFF ISSUES — NGO FORUM: REFLECTIONS FROM THE FIELD**

Chairman: *Dr. Joyce Robinson, UAP Training Co-ordinator*

Dr. Robinson said that the Forum had been included in the Agenda to capture feedback 'from the field' on matters related to Reproductive Health generally and to topics covered throughout the Workshop. She invited participants to share information on their successful programmes and resource material which had proved helpful to them. Information was received from the following persons:

1. Mrs. Esther Reinford-Clarke & Miss Gay Williams (Women's Centre Foundation of Jamaica, Kingston) exhibited a large Chart, "Methods of Family Planning", which had been prepared to provide information on, and show samples of, short-term, long-term and permanent contraceptive methods. The Chart was used as a teaching aid during presentations and was also on permanent display. The goal was to promote family planning education and defer second occurrences of teenage pregnancies.

The following questions were asked and answered, sometimes with assistance from resource persons present:

- |  |  |
|--|--|
| <b>Question:</b> Can a vasectomy be reversed?                                | <b>Answer:</b> Highly unlikely.  |
| <b>Question:</b> Does a vasectomy cause impotence?                           | <b>Answer:</b> No. Although there will be no sperm, the man will still be virile.  |
| <b>Question:</b> For how long is the injectable contraceptive effective?     | <b>Answer:</b> Up to 5 years.  |
| <b>Question:</b> How is the female sponge used?<br>How often can it be used? | <b>Answer:</b> It is inserted up into the vagina before sex, left there for at least 8 hours afterwards, removed, washed, dried and kept clean for future use. |

2. Mrs. Flo George (Jamaica Family Planning Association, St. Ann's Bay) highly recommended the publication, *Life Planning Education — A Youth Development Agency Manual, rev. ed. 1995*, published by Advocates for Youth, 1025 Vermont Avenue Suite 200, N.W. Washington, DC 20005 [Phone: (202) 347-5700] which contained a wealth of interesting ideas for role play and other activities.

As a result of the enthusiasm aroused, Mr. Valva said that the UAP would explore the possibility of getting a free or discounted copy of the book for each of the NGOs represented at the Workshop.

3. Ms. Sherree McDonald Russell, Mr. Philip Earle and Ms. Angela Johnson (ASHE), using volunteers from the audience, demonstrated a game that other NGOs could use to reinforce the principle: "Don't Drink and Drive". Each player in turn placed a finger on a sheet of paper on the ground and, without lifting the finger, circled the paper 10 times, ran to sit on a chair placed a little distance away, then returned to the end of the line. The demonstration showed how easy it was to become dizzy and unable to complete the task. This result could be interpreted as being similar to not being able to drive safely to one's destination after drinking alcohol.
4. Miss Pauline Morris (YWCA, Kingston) and Mrs. Lois Hue (Red Cross, Central Village) displayed charts of the Male and Female Reproductive Organs and the Menstrual Cycle, available from the Red Cross, which they used to teach adolescents the names of those organs and how they worked. Two activities used to reinforce learning were making chart reproductions into jigsaw puzzles which students fitted back together; and having students to draw and label their own diagrams.
5. Mrs. Patricia Miller and Mrs. Genevieve Barnes (Rural Family Support Organisation) described their "Star Chart" Programme. Adolescents were assisted to define personal goals (e.g., for the correction of specific undesirable behaviour) and their names and

goals were entered on charts. The children were reminded each morning about their goals and a star was affixed to the chart each day if the desired behaviour had been maintained. Up to three (3) lapses were allowed daily without loss of eligibility for a star. The children were very honest about saying whether or not they deserved their stars. Every 5 days, certificates were awarded to those who had received a star on each day of the week and copies of the certificates were displayed in the classrooms.

6. Mr. Cebert Hines (Hope for Children) reminded participants about his organisation's training video, *Come Listen to We*. The video and its accompanying *Teacher's Guide* were still available for \$700.00 each.
7. Mrs. Lois Hue drew participants attention to several items available from the Red Cross and other organisations. Red Cross material continued to be available free of charge while present stocks lasted. Items mentioned were:

| ITEM   | SOURCE   |
|--|--|
| <i>Together We Can (Activity Kit)</i>            | - Jamaica Red Cross Society  |
| <i>Sexual Health</i>                             | - International Red Cross (Mrs. Hue will request a copy for each NGO). |
| <i>Awareness</i>                                 | - National Family Planning Board                                       |
| <i>The Miracle of Life</i>                       | 5 Sylvan Ave, Kingston 5 (office also in Montego Bay)                  |
| <i>A Girl Grows Up</i>                           | - Bureau of Health Education   |
| <i>A Boy Grows Up</i>                            |  |
| <i>NET Peer Education Manual</i>                 | - YWCA National Council  |
| <i>Sexually Transmitted Diseases Are Serious</i> | - Ministry of Health, Epidemiology Unit.                               |

Dr. Robinson asked Mrs. Hue to provide the UAP Resource Centre with one copy of everything available from the Red Cross.

## FORMAL PROJECT EVALUATION

Dr. Dicks distributed copies of the Workshop Evaluation form (See *Appendix XXI*, pg. 70) which participants were asked to complete and hand in.

The consensus of the 40 participants who completed the forms was clearly that the Workshop was well planned and executed. There were far more positive features identified than negative areas, and the most popular comment was: "Informative and productive workshop".

Participants' responses also indicated the need to follow up with improving the networking between NGOs, supporting the wider availability of training materials and equipment in NGOs, and conducting additional detailed workshops in the reproductive health area.

Participants' responses also indicated the need to follow up with improving the networking between NGOs, supporting the wider availability of training materials and equipment in NGOs, and conducting additional detailed workshops in the reproductive health area. A complete analysis of the participants' course evaluation is attached as *Appendix XXIII* (pg. 75).

## GRADUATION CEREMONY

Dr. Joyce Robinson, UAP Training Co-ordinator, set the tone for the ceremony by acknowledging the contributions made by the trainers (presenters), the support given to the project by NGO administrators, and the enthusiasm of the participants.

Mr. Francis Valva, UAP Chief of Party, expressed appreciation to the NGOs for their support of the training and presented Certificates of Achievement to the 34 participants who had attended all sessions over the 4 days of the Workshop. (A list of persons receiving Certificates has been attached as *Appendix XXII*, pg. 74.)

Participants expressed their heartfelt thanks to Mr. Valva and staff of the UAP. They also thanked and presented plants to Dr. Barbara Dicks, Workshop Director for development of the Workshop, and to Mrs. Lois Hue (Jamaica Red Cross) for her outstanding contributions to its implementation.

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**UAP WORKSHOP ON ADOLESCENT REPRODUCTIVE HEALTH**

March 3 - 4 & 18 - 19, 1998

**LIST OF PARTICIPANTS**

| NGO   | PARTICIPANTS               | ADDRESS   | PHONE/FAX       | ATTENDANCE |        |         |         |
|---|----------------------------|---|-----------------|------------|--------|---------|---------|
|   |                            |   |                 | 3/3/98     | 4/3/98 | 18/3/98 | 19/3/98 |
| ASHH:   | Ms Sheree McDonald Russell | 143 Mountain View Ave<br>Kingston 3   | Phone: 928-4064 | ✓          | ✓      | ✓       | ✓       |
|   | Ms Sharida Sharpe          |   | Fax: 967-0721   | -          | ✓      | -       | -       |
|   | Mr Philip Earle            |   | ✓               | ✓          | ✓      | ✓       |         |
|   | Ms Angela Johnson          |   | ✓               | ✓          | ✓      | ✓       |         |
| Hope for Children   | Ms Venese Morrison         | 74 Spanish Town Rd<br>Kingston 13   | Phone: 923-3549 | ✓          | ✓      | ✓       | ✓       |
|   | Mr. Cebert Hines           |   | Fax: "          | ✓          | ✓      | ✓       | ✓       |
| Jamaica Family<br>Planning Assn                           | Mrs. Flo George            | 14 King St.<br>Box 92, St. Ann's Bay  | Phone: 972-0260 | ✓          | ✓      | ✓       | ✓       |
|   | Ms Naska Llits             |   | Fax: 972-2224   | ✓          | ✓      | ✓       | ✓       |
| Kingston Restoration<br>Company                           | Mr. Donovan Dumetz         | Higholborn St.  | Phone: 972-0260 | ✓          | ✓      | ✓       | ✓       |
|   | Ms. Daceita Ellis          | 35 Baker Street   | Fax: 972-2224   | ✓          | ✓      | ✓       | ✓       |
|   | Ms. Valerie Hibbert        |   | Phone: 967-7485 | ✓          | ✓      | ✓       | ✓       |
| Kingston YMCA   | Ms. Avis Williams          |   | Phone: 926-8081 | ✓          | ✓      | ✓       | ✓       |
|   | Mr. Noel Whyte             |   | Fax: 929-9387   | ✓          | ✓      | ✓       | ✓       |
| Ministry of Local Govt<br>Youth & Comm. Dev.<br>& Culture | Ms. Nadiagh Martindale     | Youth Division  |                 | ✓          | ✓      | ✓       | ✓       |
|   | Ms. Stacy-Ann Leon         |   | ✓               | ✓          | -      | -       |         |
| Mel Nathan Institute<br>for Social Research               | Ms Olga Williams           | 31 Mannings Hill Rd<br>Kingston 8   | Phone: 931-4989 | ✓          | ✓      | ✓       | ✓       |
|   | Ms. Michelle Thompson      |   | Fax: 931-5004   | ✓          | ✓      | -       | -       |
|   | Ms Maureen Blake           |   | -               | -          | ✓      | ✓       |         |
|   | Ms. Sherry Todd            |   | -               | -          | ✓      | ✓       |         |
|   | Mr. Deane Wilson           |   | -               | -          | ✓      | ✓       |         |
|   | Ms. Michelle Bennett       |   | -               | -          | ✓      | ✓       |         |
|   | Ms. Nordia Fennell         |   | -               | -          | ✓      | ✓       |         |
| Jamaica Red Cross<br>Society                              | Ms. Daisy Lilly            | Kingston<br>Watermount<br>Four Paths<br>Four Paths<br>May Pen<br>Portmore<br>Central Village<br>St. James |                 | ✓          | ✓      | ✓       | ✓       |
|   | Mrs M Whervin Maxwell      |   | -               | ✓          | -      | ✓       |         |
|   | Ms. Veletta Lawson         |   | ✓               | -          | ✓      | ✓       |         |
|   | Mrs Prudence Brown         |   | ✓               | -          | ✓      | ✓       |         |
|   | Ms. Udalee Hutchinson      |   | ✓               | -          | ✓      | ✓       |         |
|   | Ms. Homa Rose              |   | ✓               | ✓          | ✓      | ✓       |         |
|   | Mrs Lois Hue               |   | ✓               | ✓          | ✓      | ✓       |         |
|   | Ms. Sylvilyn Forbes-Clarke |   | Phone: 984-7860 | ✓          | ✓      | ✓       | ✓       |
|   | Mr. David Reid             |   | -               | -          | ✓      | ✓       |         |

| NGO  | PARTICIPANTS  | ADDRESS  | PHONE/FAX                        | ATTENDANCE                           |                                      |                                      |                                      |
|--|---|--|----------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
|  |   |  |                                  | 3/3/98                               | 4/3/98                               | 18/3/98                              | 19/3/98                              |
| Rural Family Support Organisation              | Mrs. Genevieve Barnes<br>Mrs. Patricia Miller   | 5 Main Street<br>May Pen P.O.  |                                  | ✓<br>-                               | ✓<br>-                               | ✓<br>✓                               | ✓<br>✓                               |
| St. Patrick's Foundation                       | Ms. Christine Lawrence<br>Mrs. I. Mendez-Ballentine<br>Mrs. Barbara Barracks<br>Ms. Norma Wallace   | Riverton City<br>Seaview<br>Seaview<br>St. Margaret  |                                  | -<br>✓<br>✓<br>✓                     | ✓<br>✓<br>✓<br>✓                     | -<br>✓<br>✓<br>✓                     | ✓<br>✓<br>✓<br>✓                     |
| Youth Opportunities Unlimited                  | Ms. Marsha McIntosh   | 2b Camp Road<br>Kingston 5   | Phone: 968-0979<br>Fax: "        | ✓                                    | ✓                                    | ✓                                    | ✓                                    |
| Western Society for the Upliftment of Children | Mrs. Glenda Drummond<br>Mrs. Lurline Greene-Daly  | 4 Kerr Crescent<br>Montego Bay P.O.  | Phone: 952-3377<br>Fax: 952-6187 | -<br>✓                               | ✓<br>✓                               | -<br>✓                               | -<br>✓                               |
| Children First                                 | Mrs. C. Richardson-Pious<br>Mr. Donovan Murphy<br>Mr. Nerald Peat   |  | Phone: 999-2476<br>Fax: 984-0367 | -<br>✓<br>-                          | ✓<br>✓<br>✓                          | -<br>-<br>✓                          | -<br>-<br>-                          |
| Women's Centre of Jamaica Foundation           | Miss Gay Williams<br>Mrs. E. Reinford-Clarke<br>Ms. Theresa Bryan<br>Miss Maxine Williams<br>Mrs. Marjorie Daley<br>Mrs. Sherraine Galbraith<br>Mrs. D. Shields-Thaxter<br>Mrs. Andrea Mitchell | Kingston<br>Kingston<br>Kingston<br>Sav-la-mar<br>Montego Bay<br>St. Ann's Bay<br>Mandeville<br>Port Antonio | Phone: 929-7608<br>Fax: 926-5768 | ✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>✓ | ✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>✓ | ✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>-<br>✓ | ✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>-<br>✓ |
| YWCA   | Mrs. Violet Jones<br>Miss Audrey Daley<br>Ms. Pauline Morris  | Spanish Town<br>Spanish Town<br>Kingston   | Phone: 926-6109                  | ✓<br>✓<br>✓                          | ✓<br>✓<br>✓                          | ✓<br>✓<br>✓                          | ✓<br>✓<br>✓                          |
| USAID  | Mrs. Noia Mignott<br><br>Miss Grace-Ann Gray<br>Mrs. Bridget Fong Yee<br><br>Ms. Hazel Silburn<br>Ms. Marsha Rigazio  |  |                                  | (a.m.)<br>✓<br>(p.m.)<br>✓<br>✓      |                                      | /                                    | /                                    |
| UAP STAFF:                                     | Mr. Francis Valva<br>Mr. Sam Dowding<br>Dr. Joyce Robinson<br>Mrs. Marsha Hylton  |  |                                  | ✓<br>✓<br>✓<br>-                     | ✓<br>✓<br>✓<br>-                     | ✓<br>✓<br>✓<br>✓                     | ✓<br>✓<br>✓<br>✓                     |

NOTE: See Appendix II: UAP Reproductive Health Workshop Agenda for names of presenters.

# UAP REPRODUCTIVE HEALTH WORKSHOP AGENDA

March 3-4 & 18-19, 1998

|  | TUESDAY, 3/3/98  | WEDNESDAY, 4/3/98  | WEDNESDAY, 18/3/98  | THURSDAY, 19/3/98  |
|--|--|--|---|--|
| 8.30 - 9.00                            | <b>REGISTRATION</b><br>Dr. Joyce Robinson  | <b>ISSUES OF ABUSE:</b><br><b>Sexual Abuse</b><br>Supt A. Brown-Getton<br><i>Rape Investigation &amp; Juvenile Unit</i>            | <b>SEX &amp; SEXUALITY:</b><br><b>Stereotypes &amp; Myths:</b><br>Mrs. Althea Bailey<br><i>National HIV/STD Control Programme</i> | <b>STAFF ISSUES:</b><br><b>Empowering Adolescent Service-Providers</b><br>Mrs. Joan Meade<br><i>Fertility Management Unit, UHWI</i>                                |
| 9.00 - 9.30                            | <b>Welcome</b><br>Mr. Francis Valva<br><b>Greetings:</b><br>Mr. Danny Gordon<br><i>USAID</i><br>Miss Gloria Nelson<br><i>ME&amp;C</i><br><b>Training Overview</b><br>Dr. Barbara Dicks<br><i>Workshop Director</i> | <b>Substance Abuse</b><br>Mrs. Sonita Abrahams<br><i>Addiction Alert Foundation</i>  | <b>SEX &amp; SEXUALITY, contd.</b>  | <b>STAFF ISSUES, contd.</b><br><b>Assessing Your Work Environment</b><br>Mrs. Joan Meade   |
| 9.30 - 10.30                           | <b>Overview of Family Life Education (FLE)</b><br>Dr. Deloris Brissett<br><i>ME&amp;C</i>  | <b>Physical Abuse</b><br>Insp. Wesley Christie<br><i>Police Community Relations</i>  | <b>SEX &amp; SEXUALITY, contd.</b>  |  |
| <b>10.30 - 10.45 a.m. COFFEE BREAK</b> |  |  |   |  |
| 10.45 - 11.30                          | <b>Group Activity</b>  | <b>Open Discussion</b><br><i>Chair: Mr. F. Valva</i>   | <b>AIDS &amp; STIs: Issues and Concerns</b><br>Miss Jennifer Hopwood<br><i>Jamaica AIDS Support</i>                               | <b>STAFF ISSUES, contd.</b><br><b>Strategies to Avoid 'Burnout'</b><br>Mrs. Joan Meade   |
| 11.30 - 12.30                          | <b>Group Reports</b><br>Group Leaders  | <b>Identifying Methods for Handling Abuse Issues</b><br><i>Chair: Dr. B. Dicks</i>   |   | <b>Developing An Adolescent Providers' Network</b><br><i>Chair: Dr. B. Dicks</i>   |
| <b>12.30 - 1.30 p.m. LUNCH</b>         |  |  |   |  |
| 1.30 - 2.30                            | <b>Reproductive Health and Contraception</b><br>Dr. Olivia McDonald<br><i>National Family Planning Board</i>   | <b>Communication Strategies with Adolescents &amp; Parents</b><br>Miss M. Newland<br><i>Communication Specialist &amp; Trainer</i> | <b>AIDS &amp; STIs: Basic Content &amp; Teaching Techniques Best Suited for 10-14 Year Olds</b><br>Mrs. Lois Hue                  | <b>Meditation/Relaxation Techniques</b><br>Ms. Mary Naughty<br><br>(2.00 p.m.) <b>The NGO Forum: "Reflections from the Field"</b><br><i>Chair: Dr. J. Robinson</i> |
| 2.30 - 3.00                            | <b>Open Discussion</b><br><i>Chair: Mr. S. Dowding</i>   | <b>Group Activity</b> (prepare presentations)  |   |  |
| <b>3.00 - 3.10 p.m. FITNESS BREAK</b>  |  |  |   |  |
| 3.10 - 3.40                            | <b>Educating Parents and Peer Education</b><br>Mrs. Lois Hue<br><i>Jamaica Red Cross</i>   | <b>Group Presentations:</b><br>"Communication in Action"   | <b>Videos:</b> "Come Listen to We" and "Vibes"  | (NGO Forum, cont'd.)   |
| 3.40 - 4.00                            | <b>Open Discussion</b><br><i>Chair: Dr. B. Dicks</i>   | <b>Open Discussion</b><br><i>Chair: Miss M. Newland</i>  | <b>Group Discussion &amp; Reports</b>   | <b>Day's Summary &amp; Formal Project Evaluation</b><br><i>Chair: Dr. B. Dicks</i>   |
| 4.00 - 4.30                            | <b>Day's Summary</b>   | <b>Day's Summary</b>   | <b>Day's Summary</b>  | <b>Graduation Ceremony</b><br><i>Chair: Mr. F. Valva</i>   |
|  | <b>Evaluation &amp; Feedback</b><br><i>Chair: Dr. B. Dicks</i>   | <b>Evaluation &amp; Feedback</b><br><i>Chair: Dr. B. Dicks</i>   | <b>Evaluation &amp; Feedback</b><br><i>Chair: Mrs. Lois Hue</i>   |  |

WORKSHOP RAPPORTEUR: Mrs. Beverley Butler



## IDENTIFYING NEEDS

Please identify what you think you need to know to be more effective in your work with adolescents regarding Reproductive Health.

### QUESTIONS:

1. WHAT KNOWLEDGE DO I NEED ON A PERSONAL LEVEL?

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2. WHAT INFORMATION DO I NEED?

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3. WHAT TEACHING SKILLS DO I NEED?

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4. WHAT ORGANISATIONAL SKILLS DO I NEED?

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5. WHAT PERSONAL ATTITUDES DO I NEED TO ASSESS?

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**INFORMATION**

Many forms of sexual expression exist in every culture even if some cultures do not recognise them. Individuals do not fit into a sexual category. Sexual expression is dynamic; it changes over an individual's lifetime and responds to the environment in which people live. There are many forms of sexual expression, some of which are:

- Heterosexuality* — men and women who are attracted to and seek sexual relationships with members of the opposite sex.
- Homosexuality* — men and women who are attracted to and seek sexual relationships with members of their own sex.
- Bisexuality* — men and women who are attracted to and seek sexual relationships with members of their own and their opposite sex.
- Transvestism* — men and women who enjoy and often gain sexual satisfaction from dressing in clothes of the opposite gender. This is called cross-dressing. Transvestism is not specific to any one form of sexual orientation.

Those who express their sexuality in non-heterosexual ways may suffer from social attitudes and stigmas. Many societies still recognise and approve only certain forms of sexual expression. They may find it difficult to find others with whom they can discuss how they are feeling. They may be frightened about people's reactions. Taking the opportunity to discuss general cultural attitudes toward sexual behaviour allows people to begin to accept sexual differences.

Discuss the following questions with participants:

**In your culture do people have the freedom to express their sexuality without fear?**

If you choose to discuss this topic, remember that some group members may express their sexuality in ways other than those accepted in your culture. It will help to concentrate on the positive side of any relationship mentioned and to stress the need for group confidentiality. Local counselling services may be available for those who find it difficult to come to terms with their own or others' sexuality. Participants should know how to gain access to these services.

## HUMAN SEXUALITY

### A DEFINITION OF HUMAN SEXUALITY

Sexuality is not only an awareness of the sex organs and their functions and the opportunity for sexual relationships. It is also an awareness of one's self as a male or female person.

It includes an understanding of the similarities and differences of both sexes and how the sexes complement each other.

It involves respect and appreciation of men for women and of women for men.

It involves love and respect for life, growing into manhood and womanhood, and being able to enjoy one's role and live creatively as a male or female person.

### EDUCATION IN HUMAN SEXUALITY OR SEX EDUCATION

Education in human sexuality or sex education is a series of guided experiences to help a person grow in knowledge and understanding of his/her sexuality and develop wholesome attitudes towards the role of sex in his/her private and social life.

It also includes the willingness and ability of the individual to translate his knowledge, understanding and attitudes into conduct that will bring benefit to himself and others. Learning experiences should be designed to enable the individual to see clearly not only what he wants to do but what he wants to avoid and why. In other words, the individual should be able to approach his/her sexuality with good judgement.

### ATTITUDES ARE IMPORTANT

Human sexuality is concerned with knowledge about sex, our attitudes towards sex, and our sexual behaviour. Ignorance of the true facts about our sexuality and the absence of positive attitudes towards sex can create fear, anxiety, and an unhealthy curiosity. On the other hand, a positive attitude towards sex and opportunity for conversation and education, through which wholesome attitudes towards sex are learned and established, are of paramount importance.

Do we believe, for example, that sex is a good and enabling gift given for our enjoyment, expression and development or do we feel that sex is unclean, a duty, or for the biological release of tension and having little to do with the expression of love?

Do we accept our maleness or femaleness and try to develop our attributes as males or females to the fullest potential or are we in competition with the other sex?

### SEX IS AN INTEGRAL PART OF OUR RESPONSIBILITY

Sex is admittedly a basic human drive. We cannot address ourselves to a person's sexual life without speaking of the individual's total person and needs. A healthy view of sex begins with a healthy view of life, and a healthy view of life includes its sexual aspects.

PHYSICAL  
SEXUAL  
ACTIVITY IS AN  
IMPORTANT  
MEANS OF  
EXPRESSING  
SEXUALITY BUT  
IT IS ONLY ONE  
OF THE MEANS

The basic purposes of sex are companionship, sex relations and procreation. Human beings need one another. They need others socially, physically, emotionally, psychologically and spiritually.

Many human needs are heterosexual in nature and satisfaction of them is found in relationships with the other sex. When men and women *share emotions, share ideas and share their lives, each gives to the other an outlook which neither could have alone.* In this respect the sexes are not opposite to each other, but complement each other.

SEXUAL  
INTERCOURSE  
SHOULD BE  
MORE THAN A  
PHYSICAL ACT

What a man and a woman give each other emotionally, intellectually and socially in other events of life is focused when they give each other themselves in the human act of sexual intercourse. The most meaningful preparation for sexual intercourse is not knowledge of various techniques, but the lifelong practice of the art of being a loving person.

A loving sexual relationship brings physical satisfaction, emotional fulfilment and personal growth.

EDUCATION  
FOR SEXUALITY  
MUST HAVE AT  
ITS BASE  
*EDUCATION  
FOR LOVE*

Every individual whether married, unmarried, single or celibate, needs to establish personhood sexually. The endeavour to find one's self sexually may take various directions which may be either positive or negative in effect. A positive approach to sexual expression demands concern for the other person as well as for self and the weighing of possible consequences by both individuals. Whatever form sexual expression takes, the real search should be to love and be loved. Every person wants happiness and every person wants to feel worthwhile.

Happiness is found in relationships -- in loving and in being loved. If we choose to be loving persons, we are building a life which is satisfying and fulfilling. *If we choose to be selfish and self-centred, we are building a life of frustration and a restless search for excitement which can never quite compensate for what we really want: love.*

Human beings can direct their sexual feelings rather than being directed by them.

(Extracts from Paper prepared by Mrs Jean Tulloch-Reid.)

**GENERAL GUIDELINES FOR ANSWERING SEXUALITY  
QUESTIONS**

1. **FEEL FREE NOT TO ANSWER PERSONAL QUESTIONS.**
2. **BECOME FAMILIAR WITH THE ADOLESCENT ENVIRONMENT** — their language, jokes, music, the TV and news programmes they see. This will enable you better to interact with adolescents regarding sexuality.
3. **WHEN ADOLESCENTS ASK QUESTIONS, TRY TO FIND OUT WHAT THEY ALREADY KNOW** so that you can determine what they already understand (if anything) and any misconceptions they might have.
4. **IF YOU DON'T KNOW THE ANSWER, ADMIT IT.** Then find the answer. Have resource materials available.
5. **IF YOU FEEL NERVOUS OR UNCOMFORTABLE ABOUT A QUESTION, BE HONEST ABOUT YOUR FEELINGS.** Ask for some time to think about your answer.
6. **BEWARE OF VALUE-LADEN QUESTIONS.** Answer them by discussing the range of values that are held in our society. However, do **REINFORCE UNIVERSAL VALUES**.
7. **LET THE ADOLESCENT DIRECT THE CONVERSATION IF HE/SHE IS BRINGING A CONCERN TO YOU.**
8. **WHEN APPROPRIATE, INITIATE CONVERSATIONS ABOUT SEXUALITY.** For example, after a movie or TV programme; after a problematic sexual situation has occurred in the Centre, or after overhearing myths discussed. Teenagers are less likely than younger children to ask sexuality questions (unless they are participating in a group discussion or class).

Quiz:*ARE YOU RACING TOWARDS HIV?*

| Questions  | Score   |
|--|---|
| 1. Have you started to have sex?                                       | 0 No<br>20 Yes/Once or twice<br>20 Yes — on a regular basis |
| 2. When you have sex, do you have more than one sex partner?           | 0 Never<br>20 Sometimes<br>40 Yes                           |
| 3. When you have sex, do you use a condom?                             | 20 Never<br>12 Sometimes<br>0 Always                        |
| 4. Have you ever had sex when you were high on alcohol or other drugs? | 0 No<br>32 Yes  |
| 5. Have you ever had herpes, syphilis or any STD?                      | 0 No<br>40 Yes  |

TOTAL SCORE: If between 0 and 30 — low risk for HIV virus  
 30 and 60 — medium risk for HIV virus  
 60 and 90 — high risk for HIV virus  
 90 and 120 — DANGER ZONE!

## FACTS ABOUT AIDS AND THE HIV ANTIBODY TEST

### *What Is AIDS?*

AIDS (acquired immune deficiency syndrome) is a disease that is caused by the human immunodeficiency virus (HIV). In the years following HIV infection the body's immune system breaks down and people with HIV get rare infections (called opportunistic infections) and/or some unusual cancers. The viruses, bacteria (germs), and fungi that cause the opportunistic infections of AIDS may also be in the bodies of healthy people but do not cause serious disease if the immune system is healthy.

The two fatal diseases most commonly found in AIDS patients are *Pneumocystis carinii* pneumonia (PCP), a lung infection caused by a parasite, and Kaposi's sarcoma, a rare form of cancer or tumor of the blood vessel walls. The nervous system, including the brain can also be involved. Other less serious conditions are often found in HIV-positive people long before any serious breakdown of the immune system has occurred.

HIV was officially declared to be the cause of AIDS in 1984. Shortly after the discovery of HIV, a test was developed to detect antibodies to the virus.

### *How Does a Person Get HIV?*

HIV is present in bodily fluids such as blood, semen, and vaginal discharge of infected people. To get HIV, a person must get infected bodily fluids into the bloodstream. HIV is spread through sexual contact and through exposure to blood or some blood products. It is spread through sharing needles or equipment used for injecting drugs, because some blood gets into these and remains there after injection.

Health workers may become infected if exposed to infected blood. A woman infected with HIV can give it to the fetus in the womb or to the child at the time of birth or through nursing. HIV cannot be spread by casual means. HIV cannot be transmitted through touching, hugging, shaking hands, sneezing, coughing or kissing or from mosquito or other insect bites.

### *What Is the HIV Antibody Test?*

When a person is infected by a germ of any kind, including a virus, the body's white blood cells begin to fight the infection by producing things called antibodies. A different antibody is produced for each different germ. A lab test can be done on a person's blood to look for the specific HIV antibody, and a positive result means that the HIV antibodies have been found in the person's blood.

### *Who is at Risk? Should You Be Tested?*

The following individuals may be at risk of HIV infection and should be tested:

- a. gay or bisexual men, or men who have had sexual contact with other men;
- b. people who share needles and works to shoot drugs;
- c. people who have hemophilia;
- d. sexual partners of gay or bisexual men, of people who share needles (works) to shoot drugs, or of hemophiliacs;
- e. sexual partners of HIV-positive people or people with AIDS;
- f. people who have multiple sex partners (or those whose partners have multiple sex partners) -- the more sex partners, the greater the risk;
- g. women who have had artificial insemination with untested donor semen;
- h. anyone who received a blood transfusion from 1978 through March of 1985.

Women considering becoming pregnant, or already pregnant and planning to continue the pregnancy, may also wish to have an antibody screening test.

Some sexually transmitted infections (such as syphilis and herpes viruses), hepatitis, and other diseases have been shown to increase the risk of getting HIV. Reducing the risk of all sexually transmitted infections helps reduce the risk of infection with HIV and may slow down progression to AIDS.

Anyone may get an antibody screening test simply by requesting it. You should discuss your situation with the medical staff in deciding whether to be tested for antibodies to HIV. If the result is positive, it is worth knowing in order to start to obtain better medical care and also to avoid infecting others. High-risk people with negative test results can change their sexual practices and/or drug using practices to reduce the chance that they will get HIV and other infections.

A positive HIV antibody test result can have a big psychological impact on both the person tested and those who are close to him or her. At the present time, there is no cure for HIV. Some treatments are available, however, which may slow or even halt the progress of the disease, including antiviral therapy. It is possible that some insurance companies or employers may seek information from you about whether you have ever had an HIV antibody test, or about positive test results, as a condition of coverage or employment.

#### *What about Confidentiality or Anonymity?*

We understand a person's need for confidentiality or anonymity in connection with an HIV antibody test. Anonymous testing means that you never give your name to anyone at the clinic and there is no record of your test results. Illinois allows anonymous testing, although some other states do not. For confidential testing (available at Planned Parenthood/Chicago Area), you must sign a consent and your name will be known to clinic staff. The consent and your test results will be kept under lock and key with your other medical records (if such is on file). For anonymous testing (not available at Planned Parenthood/ Chicago Area but a referral can be provided), a unique number or word is used to process your test and you never give your name to the testing clinic.

#### *What Does a Positive Test Mean?*

A positive test result nearly always means the person has been infected with HIV, the virus that causes AIDS. Among persons at high risk for having the infection, false positive HIV antibody test results (where the test is positive but the person really doesn't have HIV) are extremely rare. If you think that a mistake has been made in your test results you may be tested again. Infection with HIV is for life. There is no cure--yet--for HIV or for any other virus. A positive test doesn't necessarily mean a person has AIDS, but it does mean she or he may have it or may develop it in the future.

As many as 50% of people with HIV may develop AIDS within the first seven years of infection. A person with HIV infection must take better medical care of herself or himself and regular medical evaluations are strongly recommended. Antiviral therapy is available, and may slow or even stop the progress of the disease. More HIV infected people develop AIDS with increasing age and the longer they have HIV infection. However, some people have had HIV for over 10 years and have not developed AIDS.

An HIV-positive person can give the virus to someone else even though he or she may look and feel healthy. A person can get infected with HIV, develop AIDS, and die, even if the person who gave HIV to her or him remains healthy. There are many important steps you should take if your antibody test result is positive that will improve your chances of staying and protect your partners and family.

#### *What Does a Negative Test Mean?*

A negative antibody test does not guarantee that a person is HIV-negative. When a person is infected with HIV, antibodies begin to be made right away but it can take weeks to months from the time a person is infected until the time antibodies can be detected in the blood. During this time the person may have a negative result on an HIV antibody test, even though she or he has been infected. For this reason, people in high risk groups who no longer have risky behavior should have two negative tests six months apart to be sure of the negative results.

Even with negative antibody test results, people in high risk groups should continue to refrain from donating blood, plasma, or semen for artificial insemination and should have safer sex and should not share needles or works to inject drugs.

## **WHAT TO DO IF YOU TEST POSITIVE FOR THE HIV ANTIBODY**

If you have recently received a positive result in a test for the HIV antibody that causes AIDS, it is important for you to understand what the positive result means, what it doesn't mean, and what steps you should take now.

### ***What Does a Positive Test Mean?***

A positive test result nearly always means the person has been infected with HIV. False positive HIV antibody test results (where the test is positive but the person really doesn't have HIV) are extremely rare. If you think that a mistake has been made in your test results you may be tested again.

Infection with HIV is for life. There is no cure--yet--for HIV or for any other virus. A positive test doesn't necessarily mean a person has AIDS, but it does mean she or he may have it or may develop it in the future.

As many as 50% of people with HIV may develop AIDS within the first seven years of infection. A person with HIV infection must take better care of herself or himself and regular medical evaluations are strongly recommended. Some treatments are available that may slow or even stop the progress of the disease, including antiviral therapy.

More HIV infected people develop AIDS with increasing age and the longer they have HIV infection. However, some people have had HIV for over 10 years and have not developed AIDS.

An HIV-positive person can give the virus to someone else even though he or she may look and feel healthy. A person can get infected with HIV, develop AIDS, and die, even if the person who gave HIV to her or him remains healthy.

***There are important steps you should take if you are HIV-positive that will improve your chances of staying healthy and protect your partners and family.***

### **DO:**

- Take care of yourself. Smoking, alcohol, recreational drugs, and stress all put strains on your body when you need to be your healthiest. Eat healthy and get moderate exercise.
- Get regular medical exams. HIV-positive women especially need pelvic (internal) exams because they have a higher risk than HIV-positive men of progressing to AIDS.
- Have your blood tested for its CD4 count/ratio by a Medical professional every four-to-six months. The CD4 count is a reasonable indicator of how far the HIV infection has progressed, and is currently used by many medical professionals to decide when to begin the various treatment that exist to help control the disease.
- At any CD4 count: have some "baseline" tests done. These may include testing for sexually transmitted infections, toxoplasmosis titre, testing for tuberculosis, and anergy skin testing. Women should have regular pelvic exams and Pap smears.
- At a CD4 count of less than 200: begin CD4 testing every four months; federal guidelines suggest certain treatments including PCP prophylaxis for pneumonia, and AZT therapy which can slow production of the HIV virus and postpone other opportunistic conditions. These and other treatments can be recommended by a medical professional familiar with care for HIV-positive patients.

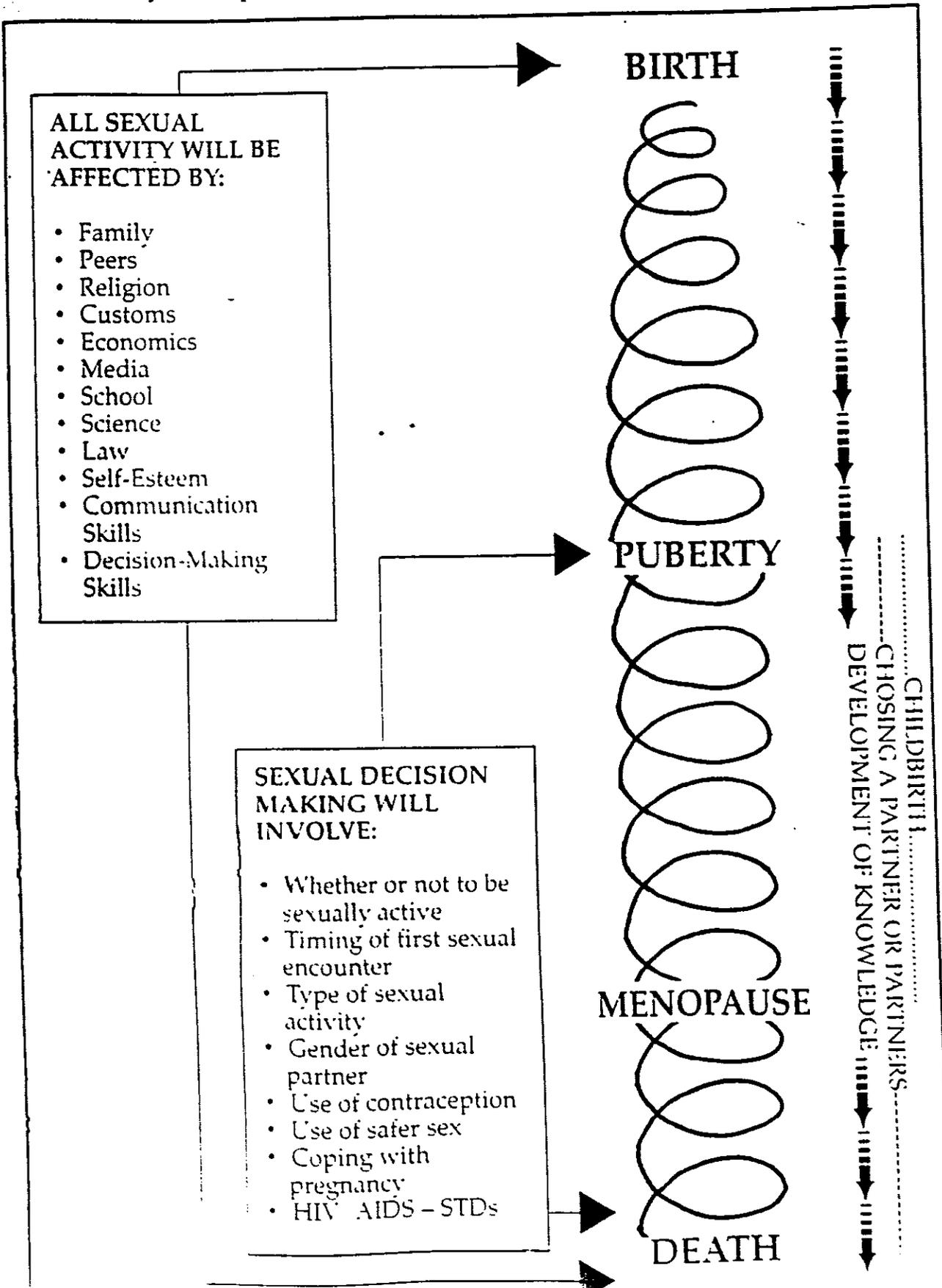
- At a CD4 count of less than 100: increase CD4 testing to every three months; there are also additional treatments recommended at this stage of the disease -- continue seeing your medical professional every three months.
- If you do shoot IV (intravenous) drugs, try to get off them if you can. Go for detox and treatment so you can stop using drugs. Always use works that are either new or sterilized with bleach and rinsed with running water. In the How to Avoid Getting or Transmitting HIV fact sheet, you will find instructions on how to clean your works. Do not let others use needles and works you have used and do not use someone else's needles and works.
- Be honest with sexual partners. The decision whether to have sex should be jointly made by you and your sexual partner, who must decide how much risk he or she wants to take.
- After accidents resulting in bleeding, all surfaces with blood on them should be cleaned with household bleach and rinsed with water.
- Let any doctor and dentist that you see know that you have a positive HIV antibody test so that they can do their best in caring for you and in preventing spread of the virus.
- You should be very cautious about with whom you share the results of the test so as to guard against discrimination at work, in seeking housing, or in obtaining insurance.

#### **DON'T:**

- Don't have sex where exchange of body fluids such as semen and vaginal secretions takes place -- don't have vaginal, oral or anal sex without using a latex condom or latex vaginal barrier (like a dam) (Get a copy of the How to Avoid Getting or Transmitting HIV fact sheet and you should follow its suggestions.
- Don't donate blood or plasma, sperm, body organs or other tissues.
- Don't breast feed newborn infants -- HIV-positive women have a 30% (one in three) chance of giving HIV to a fetus in the womb, or to a baby while it is being born, or when it is breast feeding. Pregnancy has not been shown to be good or bad for an HIV-positive woman's health.
- Don't share toothbrushes, razors or other implements that could have blood on them.
- Don't worry about casual social contacts or change the way you behave with friends, with people at work, or in the community -- this is not the way HIV is transmitted.

## SEXUAL LEARNING – LIFE SPIRAL

Sexuality develops and is affected by our environment from birth to death.



WHAT IS SEXUAL HEALTH?

**MOST COMMON SEXUALLY TRANSMITTED DISEASES (STDs)  
INCLUDING HIV/AIDS**

| <b>Name</b>   | <b>Some Symptoms</b><br><i>Many people have NO symptoms<br/>or may have some of these:</i>               | <b>Most Common Outcome<br/>If Not Treated</b>  |
|---|--|--|
| <b>HIV/AIDS<br/>Acquired<br/>Immuno-deficiency<br/>Syndrome [Big A]</b> | <b>May have no symptoms for many<br/>years</b>   | <b>No known cure for HIV/AIDS.</b> Some<br>treatments and medicines may prolong<br>life.<br><br>Mother can infect her baby.          |
| <b>Chancroid</b>  | Painful open sores (chancres) in or on<br>male and female sex organs or around<br>anus.                  | Untreated sores can let other diseases<br>enter body, especially HIV.  |
| <b>Chlamydia<br/>[open back]</b>  | Burning when urinating.<br>Males: abnormal discharge from penis.<br>Females: abnormal vaginal discharge. | May damage sex organs; can make it<br>difficult or impossible to have children.  |
| <b>Genital Herpes<br/>[herpes]</b>                                      | Painful blisters or bumps on male and<br>female sex organs and in or near<br>rectum.                     | <b>No known cure.</b> Medicines can<br>control new flare-ups. Mother can<br>infect her baby during delivery.                         |
| <b>Genital Warts<br/>[venereal warts]</b>                               | Growths or bumps around anus; also<br>for males on penis and for females in or<br>near vagina.           | May cause cancer of female sex organs;<br>elsewhere, large growths may bleed.  |
| <b>Gonorrhoea<br/>[clap, guns, leak, or dose]</b>                       | Males: abnormal discharge from penis.<br>Females: abnormal vaginal discharge.                            | For females, may make it difficult or<br>impossible to have children. Baby may<br>become blind.                                      |
| <b>Syphilis<br/>[syph, bad blood]</b>                                   | Painless sore on or around genitals,<br>mouth or rectum; may get a rash.                                 | Skin rashes, tumours (growths) on<br>many parts of the body; can cause brain<br>damage and death.<br><br>Mother can infect her baby. |
| <b>Trichomoniasis<br/>[trich]</b>                                       | Males: may have abnormal discharge<br>from penis.<br>Females: green or yellow vaginal<br>discharge.      | For females, may make it difficult or<br>impossible to have children.  |
| <b>Viral Hepatitis B<br/>[hepatitis B]</b>                              | Mild flu-like symptoms; sometimes skin<br>or whites of eyes can turn yellow.                             | No health problems or may cause<br>health problems for the rest of life, even<br>liver damage and cancer                             |

**IMPORTANT THINGS TO REMEMBER**

- You can prevent STDs
- You can have more than one STD at the same time
- You can't tell by looking at someone if they have an STD
- Your doctor or clinic can test you for STD and should treat you.

# Sexually Transmitted Diseases: Key Facts

## What are STDs?

- 1** Sexually transmitted diseases (STDs) are spread through sexual intercourse, or other sexual activities. The old name for STDs was venereal disease (VD).
- 2** AIDS is an STD. But, there are more than 20 other STDs, including gonorrhoea ("dose" or "a leak"), syphilis, genital herpes, genital warts, and chlamydia.

## Who gets STDs?

- 3** Anyone who has sex can get an STD. STDs do not respect age, marital status, wealth, or educational level.
- 4** More and more young people in Jamaica are getting STDs.
- 5** You cannot tell by looking at someone if that person has an STD.

## Is there a cure?

- 6** Some STDs (like gonorrhoea and syphilis) can usually be cured with antibiotics. Others (like herpes and HIV/AIDS) cannot be cured at this time.
- 7** If someone thinks they might have an STD, they must not hide it. They must go to a doctor or clinic. Only a doctor or nurse can tell if someone has an STD, and give the right treatment. After the treatment, the doctor will also make sure that the STD has been completely cured.
- 8** If you get an STD, you may have no symptoms. So, you could have an STD for a long time without knowing

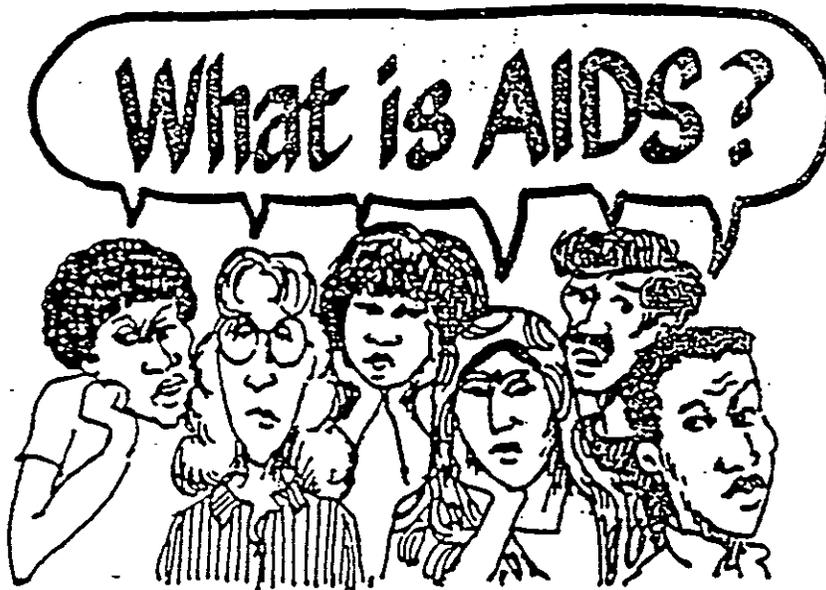
it. Always tell your partners if you have an STD (so they can also get treatment). People who know they have an STD may need to be counselled on how best to notify their partner, because the partner could also be infected and will need to get medical treatment.

## What do STDs do?

- 9** STDs have serious consequences. If untreated, they can possibly damage your sex organs, damage your health, and make it difficult or impossible to have children.
- 10** Often people (especially women) don't know they are infected because they have no symptoms until serious damage has occurred.
- 11** Many STDs cause sores or rashes on the sex organs. These sores or rashes are openings and therefore promote the transmission of HIV/AIDS. So, someone with an STD has a greater chance of getting HIV if they have sex with a person who has HIV.

## How are STDs prevented?

- 12** You can reduce your chances of getting an STD (including HIV) by—
  - Delaying sex until you are older, and can have a more permanent relationship.
  - Only having sex with one person who does not have an STD and who only has sex with you (mutual faithfulness).
  - Always using a latex condom when having sex, and using it correctly



THE MEDICAL NAME FOR A COMBINATION OF ILLNESSES WHICH RESULT WHEN THAT PART OF THE BODY WHICH PROTECTS IT FROM INFECTIONS AND DISEASES - THE IMMUNE SYSTEM - IS WEAKENED OR DESTROYED.

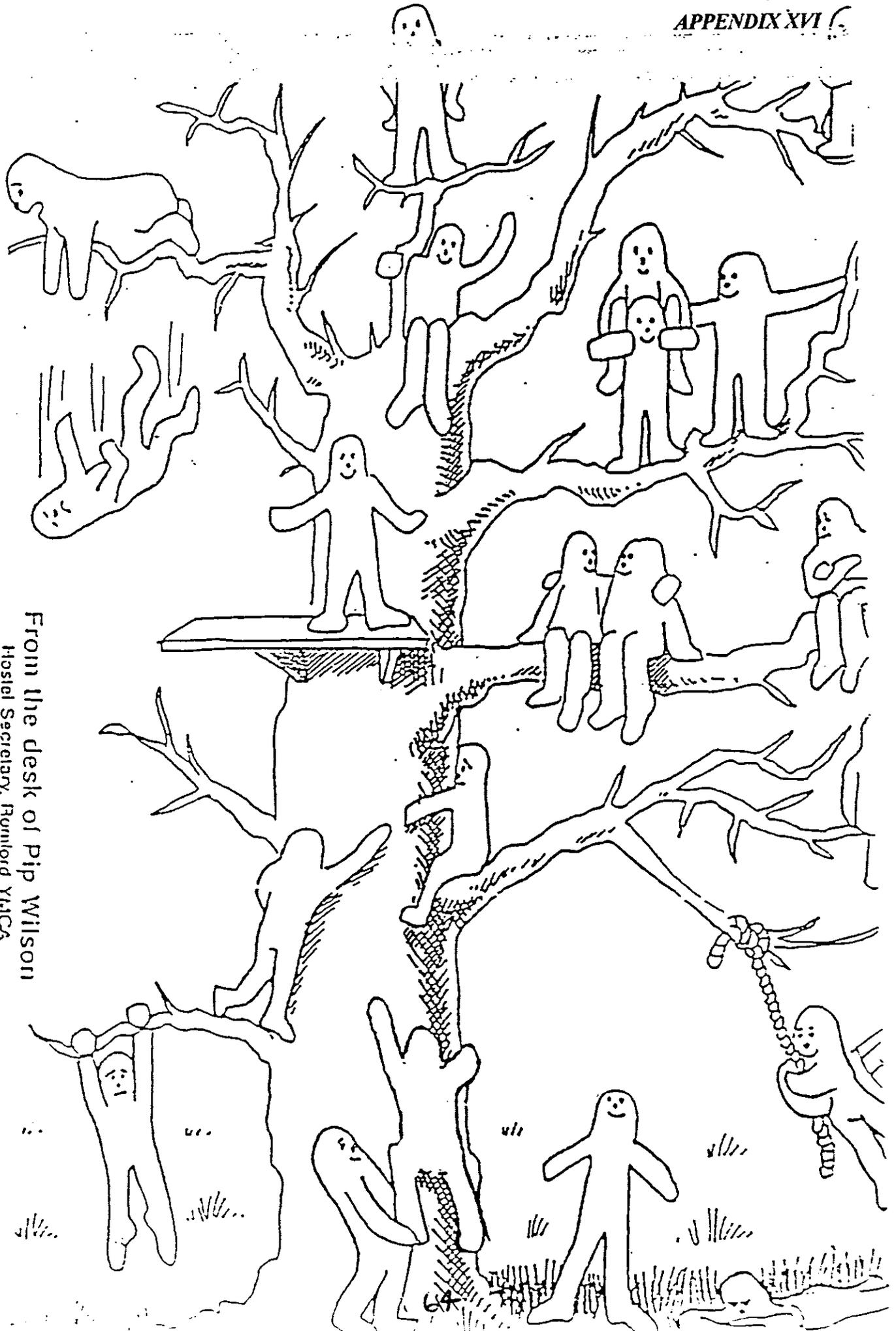
|                    |   |
|--------------------|---|
| <b>A</b> QUIRED    | BECOME INFECTED                           |
| <b>I</b> MMUNE     | THE IMMUNE SYSTEM WHICH PROTECTS THE BODY |
| <b>D</b> EFICIENCY | BECOMES WEAKENED BY THE VIRUS             |
| <b>S</b> YNDROME   | THE ILLNESS HAS A VARIETY OF SYMPTOMS     |

**Time Limit: 3 Minutes**

|                                  |
|----------------------------------|
| <p><b>A READ AND DO TEST</b></p> |
|----------------------------------|

1. Read all that follows before doing anything.
2. Write your name in the upper right-hand corner of this page
3. Circle the word "corner" in sentence two.
4. Draw five small squares in the upper left-hand corner of this page.
5. Put an "X" on each square.
6. Put a circle around each square.
7. Sign your name under line five (5).
8. After your name, write "yes, yes, yes".
9. Put a circle around number 7.
10. Put an "X" in the lower left-hand corner of this page.
11. Draw a triangle around the "X" you just made.
12. Call out your first name when you get to this point in the test.
13. If you think you have followed directions carefully to this point, call out, "I have!"
14. On the reverse side of this paper add 6950 and 9805.
15. Put a circle around your answer.
16. Count out loud, in your normal speaking voice, from 10 to 1.
17. Put three small pencil holes in the top of this page.
18. If you are the first person to get this far, yell out, "I am the first person to get to this spot" and "I am the leader in following directions".
19. Say out loud, "I am nearly finished. I have followed directions".
20. Now that you have finished reading carefully, do only those things called for in the sentences numbered 1 and 2. Did you read everything on this page before doing anything?

**NOTE: PLEASE BE QUIET AND WATCH THE OTHERS FOLLOW DIRECTIONS.**



From the desk of Pip Wilson  
Hosiery Secretary, Romford Y.A.C.A.



**Empowerment Profile**

**Step 1:** Complete the following questionnaire.

For each of the following items, select the alternative with which you feel more comfortable. While for some items you may feel that both a and b describe you or neither is ever applicable you should select the alternative that better describes you most of the time.

1. When I have to give a talk or write a paper, I . . . .  
 a. Base the content of my talk or paper on my own ideas.  
 b. Do a lot of research, and present the findings of others in my paper or talk.
2. When I read something I disagree with, I . . . .  
 a. Assume my position is correct.  
 b. Assume what's presented in the written word is correct.
3. When someone makes me extremely angry, I . . . .  
 a. Ask the other person to stop the behavior that is offensive to me.  
 b. Say little, not quite knowing how to state my position.
4. When I do a good job, it is important to me that . . . .  
 a. The job represents the best I can do.  
 b. Others take notice of the job I've done.
5. When I buy new clothes, I . . . .  
 a. Buy what looks best on me.  
 b. Try to dress in accordance with the latest fashion.
6. When something goes wrong, I . . . .  
 a. Try to solve the problem.  
 b. Try to find out who's at fault.
7. As I anticipate my future, I . . . .  
 a. Am confident I will be able to lead the kind of life I want to lead.  
 b. Worry about being able to live up to my obligations.
8. When examining my own resources and capacities, I . . . .  
 a. Like what I find.  
 b. Find all kinds of things I wish were different.
9. When someone treats me unfairly, I . . . .  
 a. Put my energies into getting what I want.  
 b. Tell others about the injustice.
10. When someone criticizes my efforts, I . . . .  
 a. Ask questions in order to understand the basis for the criticism.

- b. Defend my actions or decisions, trying to make my critic understand why I did what I did.
11. When I engage in an activity, it is very important to me that . . . .  
 a. I live up to my own expectations.  
 b. I live up to the expectations of others.
12. When I let someone else down or disappoint them, I . . . .  
 a. Resolve to do things differently next time.  
 b. Feel guilty, and wish I had done things differently.
13. I try to surround myself with people . . . .  
 a. Whom I respect.  
 b. Who respect me.
14. I try to develop friendships with people who . . . .  
 a. Are challenging and exciting.  
 b. Can make me feel a little safer and a little more secure.
15. I make my best efforts when . . . .  
 a. I do something I want to do when I want to do it.  
 b. Someone else gives me an assignment, a deadline, and a reward for performing.
16. When I love a person, I . . . .  
 a. Encourage him or her to be free and choose for himself or herself.  
 b. Encourage him or her to do the same thing I do and to make choices similar to mine.
17. When I play a competitive game, it is important to me that I . . . .  
 a. Do the best I can.  
 b. Win.
18. I really like being around people who . . . .  
 a. Can broaden my horizons and teach me something.  
 b. Can and want to learn from me.
19. My best days are those that . . . .  
 a. Present unexpected opportunities.  
 b. Go according to plan.
20. When I get behind in my work, I . . . .  
 a. Do the best I can and don't worry.  
 b. Worry or push myself harder than I should.

**Step 2:** Score your responses as follows:

*Diagnosis*

3. Think of some experiences you have had that confirm your score.
4. Think of some experiences you have had that disconfirm your score.
5. How does this information help you to act more effectively in organizations?

Total your a responses: \_\_\_\_\_  
 Total your b responses: \_\_\_\_\_

(Your instructor will help you interpret these scores.)

**Step 3:** Discussion. In small groups or with the entire class, answer the following questions:

*Description*

1. Look at the two totals. Which score is highest? Which is lowest?
2. Do your scores describe you well? Why or why not?

"The Empowerment Profile" from *The Power Handbook* by Pamela Cuming. Copyright © 1980 by CBI Publishing. Reprinted by permission of Van Nostrand Reinhold Co., Inc.



## Diagnosis of Stress

**Step 1:** Complete the following questionnaire by checking the appropriate column:

| Do You Frequently   | Yes | No | Do You Frequently                              | Yes | No |
|---|-----|----|--|-----|----|
| 1. Neglect your diet?   |     |    | 24. Spend a lot of time lamenting the past?    |     |    |
| 2. Try to do everything yourself?   |     |    | 25. Fail to get a break from noise and crowds? |     |    |
| 3. Blow up easily?  |     |    |  |     |    |
| 4. Seek unrealistic goals?  |     |    |  |     |    |
| 5. Fail to see the humor in situations others find funny?   |     |    |  |     |    |
| 6. Act rude?  |     |    |  |     |    |
| 7. Make a "big deal" of everything?   |     |    |  |     |    |
| 8. Look to other people to make things happen?  |     |    |  |     |    |
| 9. Have difficulty making decisions?  |     |    |  |     |    |
| 10. Complain you are disorganized?  |     |    |  |     |    |
| 11. Avoid people whose ideas are different from your own?   |     |    |  |     |    |
| 12. Keep everything inside?   |     |    |  |     |    |
| 13. Neglect exercise?   |     |    |  |     |    |
| 14. Have few supportive relationships?  |     |    |  |     |    |
| 15. Use psychoactive drugs, such as sleeping pills and tranquilizers, without physician approval? |     |    |  |     |    |
| 16. Get too little rest?  |     |    |  |     |    |
| 17. Get angry when you are kept waiting?  |     |    |  |     |    |
| 18. Ignore stress symptoms?   |     |    |  |     |    |
| 19. Procrastinate?  |     |    |  |     |    |
| 20. Think there is only one right way to do something?  |     |    |  |     |    |
| 21. Fail to build in relaxation time?   |     |    |  |     |    |
| 22. Gossip?   |     |    |  |     |    |
| 23. Race through the day?   |     |    |  |     |    |

**Step 4:** Think about a stressful situation you have experienced.

1. Describe the situation.
2. What symptoms of stress did you experience at the time?
3. What caused the stress?
4. How did you reduce the stress?

**Step 2:** Score your responses by scoring 1 for each yes answer and 0 for each no answer. Total your score.

1-6: There are few hassles in your life. Make sure, though, that you aren't trying so hard to avoid problems that you shy away from challenges.

7-13: You've got your life in pretty good control. Work on the choices and habits that could still be causing some unnecessary stress in your life.

14-20: You're approaching the danger zone. You may well be suffering stress-related symptoms, and your relationships could be strained. Think carefully about choices you've made, and take relaxation breaks every day.

Above 20: Emergency! You must stop now, rethink how you are living, change your attitudes, and pay scrupulous attention to your diet, exercise, and relaxation programs.

**Step 3:** Discussion. In small groups or with the class as a whole, answer the following questions:

**Description**

1. What was your score?
2. How much stress does this represent?
3. How does this compare to scores of others in the class?

**Step 5:** Individually or in small groups, offer a plan for coping with or reducing stress.

Source: Adapted with permission from "Stress Index" by A. E. Slaby, M.D., Ph.D., M.P.H., *60 Ways to Make Stress Work for You* (Summit, N.J.: PIA Press, 1988).

Events                      Stress

Complete the scale by circling the mean value figure to the right of each item if it has occurred to you during the past year. To figure your total score, add all the mean values circled (if an event occurred more than once, increase the value by the number of times). Life event stress totals of 150 or less indicate generally good health, scores of 150 to 300 indicate a 35-50 percent probability of stress-related illness, and scores of 300+ indicate an 80 percent probability.

| Life Event  | Mean Value |
|---|------------|
| 1. Death of spouse  | 100        |
| 2. Divorce  | 73         |
| 3. Marital separation from mate                               | 65         |
| 4. Detention in jail or other institution                     | 63         |
| 5. Death of a close family member                             | 63         |
| 6. Major personal injury or illness                           | 53         |
| 7. Marriage   | 50         |
| 8. Being fired at work  | 47         |
| 9. Marital reconciliation with mate                           | 45         |
| 10. Retirement from work                                      | 45         |
| 11. Major change in the health or behavior of a family member | 44         |
| 12. Pregnancy   | 40         |
| 13. Sexual difficulties                                       | 39         |
| 14. Gaining a new family member                               | 39         |
| 15. Major business readjustment                               | 39         |
| 16. Major change in financial state                           | 38         |
| 17. Death of a close friend                                   | 37         |
| 18. Changing to a different line of work                      | 36         |
| 19. Major change in the number of arguments with spouse       | 35         |
| 20. Taking out a mortgage or loan for a major purchase        | 31         |
| 21. Foreclosure on a mortgage or loan                         | 30         |
| 22. Major change in responsibilities at work                  | 29         |
| 23. Son or daughter leaving home                              | 29         |
| 24. In-law troubles   | 29         |
| 25. Outstanding personal achievement                          | 28         |
| 26. Wife beginning or ceasing work outside the home           | 26         |
| 27. Beginning or ceasing formal schooling                     | 26         |
| 28. Major change in living conditions                         | 25         |
| 29. Revision of personal habits                               | 24         |
| 30. Troubles with the boss                                    | 23         |
| 31. Major change in working hours or conditions               | 20         |
| 32. Change in residence                                       | 20         |
| 33. Changing to a new school                                  | 20         |
| 34. Major change in usual type and/or amount of recreation    | 19         |
| 35. Major change in church activities                         | 19         |
| 36. Major change in social activities                         | 18         |
| 37. Taking out a mortgage or loan for a lesser purchase       | 17         |
| 38. Major change in sleeping habits                           | 16         |
| 39. Major change in number of family get-togethers            | 15         |
| 40. Major change in eating habits                             | 15         |
| 41. Vacation  | 13         |
| 42. Christmas   | 12         |
| 43. Minor violations of the law                               | 11         |

SOURCE: Reprinted with permission from *Journal of Psychosomatic Research*, 11, Thomas H. Holmes, Social Readjustment Rating Scale, Copyright 1967, Pergamon Press, Inc.

## Burnout

### burnout

The total depletion of physical and mental resources caused by excessive striving to reach an unrealistic work-related goal.

Dr. Herbert Freudenberger, an expert on the overachiever, says that many people may be falling victim to **burnout**—the total depletion of physical and mental resources caused by excessive striving to reach an unrealistic work-related goal. Burnout, he contends, is often the result of too much job stress, especially when that stress is combined with a preoccupation with attaining unattainable work-related goals. Freudenberger lists other signs of possible impending burnout:<sup>87</sup>

You are unable to relax.

You identify so closely with your activities that when they fall apart you do too.

The positions you worked so hard to attain often seem meaningless now.

You are working more now but enjoying it less.

Your need for a particular crutch such as smoking, liquor, or tranquilizers is increasing.

You are constantly irritable, and family and friends are often commenting that you don't look well.

You would describe yourself as a workaholic and constantly strive to obtain your work-related goals to the exclusion of almost all outside interest.

What can a burnout candidate do? Here are some suggestions:

*Break your patterns.* First, survey how you spend your time. Are you doing a variety of things or the same one over and over? The more well rounded your life is, the better protected you are against burnout. If you've stopped trying new activities, start them again—for instance, travel or new hobbies.

*Get away from it all periodically.* Schedule occasional periods of introspection during which you can get away from your usual routine, perhaps alone, to seek a perspective on where you are and where you are going.

*Reassess your goals in terms of their intrinsic worth.* Are the goals you've set for yourself attainable? Are they really worth the sacrifices you'll have to make?

*Think about your work.* Could you do as good a job without being so intense or by also pursuing outside interests?

*Reduce stress.* Organize your time more effectively, build a better relationship with your boss, negotiate realistic deadlines, find time during the day for detachment and relaxation, reduce unnecessary noise around your office, and limit interruptions.

Based on a survey of 1,299 employees by one insurance company, the researchers suggest the following steps employers can take to reduce workplace stress:

Allow employees to talk freely with one another and to consult with colleagues about work issues.

Reduce personal conflicts on the job.

Give employees adequate control over how they do their work.

Ensure adequate staffing and expense budgets.

Have open communication between management and employees.

Support employees' efforts, for instance, by regularly asking how they are doing.

Provide competitive personal leave and vacation benefits.

Maintain current levels of employee benefits, since benefits reductions lead to stress.

Reduce the amount of red tape for employees.

Recognize and reward employees for their accomplishments and contributions.

Ensure effective job fit, since stress overload can result when workers are mismatched with jobs.<sup>88</sup>

In his book *Stress and the Manager*, Dr. Karl Albrecht suggests the following to reduce job stress.<sup>81</sup>

Build rewarding, pleasant, cooperative relationships with as many of your colleagues and employees as you can.

Don't bite off more than you can chew.

Build an especially effective and supportive relationship with your boss.

Understand the boss's problems and help him or her to understand yours.

Negotiate with your boss for realistic deadlines on important projects. Be prepared to propose deadlines yourself, instead of having them imposed on you.

Study the future. Learn as much as you can about likely coming events and get as much lead time as you can to prepare for them.

Find time every day for detachment and relaxation.

Take a walk around the office now and then to keep your body refreshed and alert.

Make a noise survey of your office area and find ways to reduce unnecessary noise.

Get away from your office from time to time for a change of scene and a change of mind.

Reduce the amount of trivia to which you give your attention. Delegate routine paperwork to others whenever possible.

Limit interruptions. Try to schedule certain periods of "uninterruptibility" each day and conserve other periods for your own purposes.

Don't put off dealing with distasteful problems.

Make a constructive "worry list." Write down the problems that concern you and beside each write down what you're going to do about it, so that none of the problems will be hovering around the edges of your consciousness.

Source: Dressler, G. 1997. Human Resource Management. New Jersey: Prentice Hall. pp 641-643

|                               |
|-------------------------------|
| UPLIFTING ADOLESCENTS PROJECT |
|-------------------------------|

## TRAINING OF TRAINERS SEMINAR/WORKSHOP ON ADOLESCENT REPRODUCTIVE HEALTH

### PARTICIPANTS' EVALUATION OF THE WORKSHOP

- A. Please review the statements given below and give your opinion on each by ticking the box which represents your views most closely. The following key should be used for the boxes:

- a. **Strongly Agree**
- b. **Agree**
- c. **No Opinion**
- d. **Disagree**
- e. **Strongly Disagree**

*The Workshop's Objectives were to:*

- i) provide appropriate curriculum content on Adolescent Reproductive Health;*
- ii) upgrade participants' teaching skills in Adolescent Reproductive Health;*
- iii) address staff development issues and 'burnout' in work with adolescents;*
- iv) enhance development of an Adolescent Reproductive Health-Providers' Network.*

1. The objectives of the Workshop were met.  
a.  b.  c.  d.  e.
2. The organisation of the Workshop, in terms of its sequencing of activities, was well structured.  
a.  b.  c.  d.  e.
3. Workshop materials distributed were relevant to the programme.  
a.  b.  c.  d.  e.
4. Workshop materials were readily available.  
a.  b.  c.  d.  e.
5. The teaching methods used in this Workshop were effective.  
a.  b.  c.  d.  e.
6. The Workshop's content is relevant to my work with adolescents through the NGO.  
a.  b.  c.  d.  e.

7. I feel that I am now in a better position to successfully undertake responsibilities in my NGO relating to teaching Reproductive Health to adolescents.

- a.  b.  c.  d.  e.

8. I plan to utilise the techniques learned at this Workshop in my work.

- a.  b.  c.  d.  e.

9. I would recommend others from my organisation to attend a similar workshop.

- a.  b.  c.  d.  e.

10. My overall evaluation of the Workshop is positive.

- a.  b.  c.  d.  e.

---

**B. Please take a few moments to write some comments on the Workshop.**

1. What were the two most positive features of the training presented at this workshop?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe any negative aspects of the Workshop.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Is there any content that you think should be omitted in future workshops on Adolescent Reproductive Health?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Is there any content that should be de-emphasized in future workshops on Adolescent Reproductive Health?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Note briefly any barriers or limitations which may exist in your NGO which would make it difficult for you to implement what you have learned at this Workshop.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What kind of follow-up activity would you like to see in this area?

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C. Please rate the Workshop Presenters on the following scale:

- A *Excellent*
- B *Good*
- C *Fair*
- D *Ineffective*

| <b>EVALUATION FACTORS</b><br> | <b>Presenter's Knowledge of the subject matter</b> | <b>Presenter's Quality of Presentation</b> | <b>Presenter's Material was easily understandable and absorbed</b> | <b>Presenter's Inclusion of Teaching Techniques</b> |
|--|--|--|--|---|
| <b>PRESENTERS</b>  |  |  |  |   |
| Dr. D. Brissett<br><i>F.I.E.</i>   |  |  |  |   |
| Dr. O. McDonald<br><i>Rep. Health &amp; Contraception</i>  |  |  |  |   |
| Mrs. Lois Hue<br><i>Ed. Parents &amp; Peer Education</i>   |  |  |  |   |
| Supt. Brown-Getten<br><i>Sexual Abuse</i>  |  |  |  |   |
| Mrs. S. Abrahams<br><i>Substance Abuse</i>   |  |  |  |   |
| Insp. W. Christie<br><i>Physical Abuse</i>   |  |  |  |   |
| Miss M. Newland<br><i>Communication</i>  |  |  |  |   |
| Mrs. Althea Bailey<br><i>Sex &amp; Sexuality</i>   |  |  |  |   |
| Miss Jenny Hopwood<br><i>AIDS &amp; STIs</i>   |  |  |  |   |
| Mrs. Lois Hue<br><i>AIDS &amp; STIs</i>  |  |  |  |   |
| Mrs. Joan Meade<br><i>Staff Issues</i>   |  |  |  |   |
| Ms. Mary Naughty<br><i>Mediation/Relaxation Techniques</i>   |  |  |  |   |

D. Please rate the administrative support to the Workshop as follows:

- a. **Strongly Agree**
- b. **Agree**
- c. **No Opinion**
- d. **Disagree**
- e. **Strongly Disagree**

1. Meals and snacks were made available on-time and in sufficient quantity.

- a.  b.  c.  d.  e.

2. Meals were appetizing and sufficiently varied.

- a.  b.  c.  d.  e.

3. Registration and other administrative support were satisfactory.

- a.  b.  c.  d.  e.

4. The meeting venue was satisfactory.

- a.  b.  c.  d.  e.

---

Any other overall comments?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REPRODUCTIVE HEALTH WORKSHOP — MARCH 1998

## PARTICIPANTS AWARDED CERTIFICATES OF ACHIEVEMENT

| <u>NAME</u>                      | <u>ORGANISATION</u>                            |
|----------------------------------|--|
| 1. Barnes, Mrs. Genevieve        | Rural Family Support Organisation              |
| 2. Barracks, Mrs. Barbara        | St. Patrick's Foundation                       |
| 3. Bryan, Ms. Theresa            | Women's Centre of Jamaica Foundation           |
| 4. Daley, Miss Audrey            | YWCA   |
| 5. Daley, Mrs. Marjorie          | Women's Centre of Jamaica Foundation           |
| 6. Dumetz, Mr. Donovan           | Kingston Restoration Company                   |
| 7. Earle, Mr. Philip             | ASHE   |
| 8. Ellis, Ms. Daceita            | Kingston Restoration Company                   |
| 9. Forbes-Clarke, Ms. Sylvilyn   | Jamaica Red Cross Society                      |
| 10. Galbraith, Mrs. Sherraine    | Women's Centre of Jamaica Foundation           |
| 11. George, Mrs. Flo             | Jamaica Family Planning Association            |
| 12. Greene-Daly, Mrs. Lurline    | Western Society for the Upliftment of Children |
| 13. Hibbert, Ms. Valerie         | Kingston Restoration Company                   |
| 14. Hines, Mr. Cebert            | Hope for Children                              |
| 15. Hue, Mrs. Lois               | Jamaica Red Cross Society                      |
| 16. Johnson, Ms. Angela          | ASHE   |
| 17. Jones, Mrs. Violet           | YWCA   |
| 18. Lilly, Ms. Daisy             | Jamaica Red Cross Society                      |
| 19. Llits, Miss Naska            | Jamaica Family Planning Association            |
| 20. Martindale, Miss Nadiagh     | Ministry of Education & Culture (NYS)          |
| 21. McDonald Russell, Ms. Sheree | ASHE   |
| 22. McIntosh, Ms. Marsha         | Youth Opportunities Unlimited                  |
| 23. Mendez-Ballentine, Mrs. L.   | St. Patrick's Foundation                       |
| 24. Mitchell, Mrs. Andrea        | Women's Centre of Jamaica Foundation           |
| 25. Morris, Ms. Pauline          | YWCA   |
| 26. Morrison, Ms. Venese         | Hope for Children                              |
| 27. Reinford-Clarke, Mrs. Esther | Women's Centre of Jamaica Foundation           |
| 28. Rose, Ms. Homa               | Jamaica Red Cross Society                      |
| 29. Wallace, Ms. Norma           | St. Patrick's Foundation                       |
| 30. Whyte, Mr. Noel              | Kingston YMCA                                  |
| 31. Williams, Miss Avis          | Kingston YMCA                                  |
| 32. Williams, Miss Gay           | Women's Centre of Jamaica Foundation           |
| 33. Williams, Miss Maxine        | Women's Centre of Jamaica Foundation           |
| 34. Williams, Ms. Olga           | Mel Nathan Institute for Social Research       |

UPLIFTING ADOLESCENTS PROJECT  
WORKSHOP  
ON  
REPRODUCTIVE HEALTH FOR ADOLESCENTS AGED 10-14  
March 3-4 & 18-19, 1998

PARTICIPANTS' COURSE EVALUATION

The first UAP Workshop on "Reproductive Health for Adolescents Aged 10-14" was held on four days in March 1998: 3<sup>rd</sup>, 4<sup>th</sup>, 18<sup>th</sup> and 19<sup>th</sup> at the Medallion Hall Hotel in Kingston. The goals of the workshop were to:

- ◆ Provide appropriate curriculum content on Adolescent Reproductive Health for work with 10-14 year olds;
- ◆ Upgrade Participants' Teaching Skills in Adolescent Reproductive Health;
- ◆ Address Staff Development Issues and "Burn-out" in work with Adolescents; and
- ◆ Enhance Development of a Network of Providers of Adolescent Reproductive Health.

The workshop was coordinated by Dr. Barbara Dicks, Visiting Fullbright Professor at the University of the West Indies, and Mrs. Lois Hue, National Youth Director of the Jamaica Red Cross, an NGO which has received financing via a UAP sub-grant. The UAP Training Coordinator, Dr. Joyce Robinson, worked closely with the coordinators and presenters in the planning and implementation of the workshop.

A total of fifty four participants attended on one or more days of the four day workshop: fifty two (52) represented 14 non-governmental organizations (NGOs) and two (2) were from the Youth Division of the Ministry of Local Government (National Youth Service). Thirty two(32) participants attended all four days of the workshop, and were presented Certificates of Achievement on the final day.

Forty (40) participants completed the participant's evaluation form, providing some feedback to the course organizers on the conduct and value of the course. The report provided below summarizes the views of the participants who completed the evaluation form.

Evaluation Form

The evaluation form contained four sections, which evaluated:

- a. Workshop Content
- b. Participants' Comments
- c. Evaluation of Workshop Presenters, and
- d. Evaluation of UAP Administrative Support.

### Evaluation Completion Rate

Forty (40) of the forty five (45) participants who were present on the final day completed the evaluation form, for an 89% completion rate. Several of the participants had already left by the time the evaluation forms were distributed, and this would have accounted for the non-completions.

### Form Interpretations and Averaging

Most participants completed all sections of the form, but there were several who did not fully complete Sections A, B and D. In Section A, whenever a question was not rated, it was imputed as a "No Opinion", and measured at "3". In sections B and D, a blank in answer to any of the sections was rated as "None Stated" and counted along with those indicating the answer "None". In section C, rating of the presenters, many of the participants completing the form showed evidence that they had not attended all sessions.

Accordingly, since the number of evaluations for each presenter varied, the averaging of scores required use of a different denominator for each presenter, in order to make the averages fair and comparable. As a result, the 40 completed evaluations were assigned to three groups:

- i. those who had evidently attended 2 days or less (4);
- ii. those who had attended 3 days (5); and
- iii. those who had attended on 3+ to 4 days (31).

The groupings were done to see if there would be any difference between the scores in the statistical sections of the form. Such differences as could be discerned are discussed below.

### General Evaluation Results

The general response of the 40 participants who completed the forms was overwhelmingly that the workshop's objectives were met, that the teaching methodologies used were effective, and that their overall evaluation was positive. On a scale of 1 to 5, the overall average rating of views on workshop content was 4.45. The overall rating for the twelve presenters was 3.32 out of a maximum 4 points. For UAP Administrative Support, the overall rating was 4.38 of a maximum 5.

Sixteen (16) different positive features of the workshop were identified, of which 8 received 4 or more endorsements. On the negative side, 8 different features were identified, but only three of these received more than two endorsements. Of items to be omitted from or de-emphasized in future workshops, "Nothing" or "Not Stated" was the overwhelming response. Nine different barriers or limitations to implementation in the NGOs were identified. Of these, only three received three or more endorsements.

Details on the assessments in each section are provided below.

#### Section A: Workshop Content

As noted above, the overall rating in this area was an average of 4.45 out of a maximum 5 points. Of ten evaluation factors, six were rated at 4.50 or higher, and nine of the ten rated above 4, that is either "strongly agree" or "agree". These ratings could be considered testimony to a workshop successfully planned and conducted.

The notable areas which were highly rated were :

- *The workshop's objectives were met ((4.63)*
- *The teaching methodologies used were effective (4.63)*
- *My overall evaluation of the workshop is positive (4.63)*
- *I plan to utilize the techniques learnt at this workshop in my work (4.58); and*
- *I would recommend others from my organization to attend a similar workshop (4.58).*

The sixth factor to score an average over 4.5 was "*Workshop materials distributed were relevant to the program*" (4.53).

It was disappointing that the factors "*relevance of the workshop content to my work in the NGO*" and "*I feel I am in a better position to undertake Adolescent Reproductive Health Responsibilities in my NGO*" were rated only at 4.35 and 4.48 (9<sup>th</sup> and 7<sup>th</sup> overall). Both Group I (2 days or less) and Group III (3+ to 4 days) rated "*relevance of workshop content*" fairly low (3.50 and 4.42 respectively, which were the lowest and next to lowest ratings in either group). The scores for these two areas could point to fact that NGOs do not have enough staff on board to dedicate to the area of adolescent reproductive health. In addition, although all of the UAP sub-grantees were represented at the workshop, it should be noted that only nine of the twelve committed in their sub-grants to delivering a reproductive health component through their own staff resources. It would thus appear that responsibility for reproductive health in the NGOs generally falls to staff who have other primary responsibilities. This finding is corroborated by some of the comments under "*Barriers/Limitations in the NGOs*".

It was not surprising that the lowest rated factor was that "*Workshop materials were readily available*". This was very evident during the conduct of the workshop, as many presenters did not send their handouts to the UAP before hand, and also did not bring with them adequate numbers of copies for the average daily attendance of 46 participants.

#### Section B: Participants' Comments

This section had six areas:

- a. *Positive Features,*
- b. *Negative Features,*
- c. *Items to be Omitted,*
- d. *Items to be De-Emphasized,*
- e. *Barriers/Limitations in the NGOs, and*
- f. *Desirable Follow-up Activity.*

"None", "Nothing" or "None Stated" was the most popular response in five of the six areas. For "*Positive Features of the Workshop*" only one participant had no comment. For "*Items to be de-emphasized in future workshops*" 37 (93%) of the forty respondents either left this section blank or used the response "Nothing". For "*Items to be omitted from future workshops*" 39 (98%) felt that nothing should be omitted.

Unlike previous workshops, in identifying "*Barriers/ Limitations in the NGOs to Implementing the Workshop's Techniques*", fewer people (11) felt that limited NGO resources (financing, staff and

equipment) were an encumbrance to their work, than the overwhelming 23 persons who either saw no impediment or did not state any.

The most popular *positive features* about the workshop and their frequencies were:

- ▶ AIDS/STI presentation by Mrs. Hue: teaching techniques (use of the sticks and the HIV game) [10 endorsements]
- ▶ Dealing with Stress, Burn-out and the Relaxation Techniques (presented by Mrs. Meade and Miss Naughty) [9 endorsements]; and
- ▶ Opportunity to meet and hear from the HIV-positive person [8 endorsements].

Other significantly endorsed *positive features* were:

- ▶ Involvement of participants by presenters (7);
- ▶ The quality of the presenters and the opportunity to hear from a wide range of them (6) and
- ▶ The session on Sex and Sexuality (6).

The sessions on *Communication* (Ms. Newland) and *Reproductive Health and Contraception* (Dr. Mc Donald) also came in for multiple mention with 4 endorsements each.

Two valuable *positive features* identified, which should be highlighted, even though they received minimal endorsements were:

- ▶ The workshop was "empowering adolescent service providers" (2); and
- ▶ The workshop provided "the opportunity to realize that I should be less judgmental" (1).

For the *Negative Features*, seventeen (17) participants reported either "None" or left this blank, and were therefore imputed as "None Stated". The other pre-dominant negative features identified were "Time seemed too limited to treat all subjects in adequate detail. We were constantly short of time." (13 endorsements), and not surprisingly, "More handouts should have been made available" (9 endorsements). Of the other six negative features identified, only two "Unpunctuality of some participants" (3) and "Too many presenters used the lecture format, instead of involving the participants" (2) got multiple responses. Following on the latter comment, the other notable negative feature identified was "Participants should be given the opportunity to share skills more".

In terms of the *Barriers and Limitations in the NGOs* to implementing what the Participants learnt at the Workshop, the most commonly identified barrier was in the area of "limited NGO resources in terms of financing, staff, equipment and space", which was a combined response of the several limiting factors identified. 15 participants identified this limitation via the following responses and frequencies:

- ▶ Financing (4)
- ▶ Not enough NGO staff: at least 2 should be there (4)
- ▶ Need TV/VCR and other audio-visual equipment (3)
- ▶ Lack of teaching material and teaching aids (2)
- ▶ Space Limitations (1)
- ▶ Lack of transportation for presenters willing to come to the NGO. (1)

For the first time, "None or None Stated" was the most popular response to *Barriers/Limitations*, with 23 of the 40 responses being in this area.

Perhaps, because of the sensitive nature of the subject, it should not be surprising that the following two views were advanced as barriers:

- ◆ Some parents may resent certain information being passed to their adolescents (1); and
- ◆ Supervisors may not allow certain things to be taught.

Under *Desirable Follow-Up Activity*, "None or None Stated" was again the most frequent response (19). The significant activities identified for follow up and their frequencies were:

- ▶ Networking with other UAP sub-grantees (6);
- ▶ Future workshops which go into greater detail on some specific areas of this workshop (5);
- ▶ Monitor the NGOs to see how effective their delivery is after this course (4); and
- ▶ Provide copies of all the workshop materials to the participants (3).

Other notable comments on follow-up activity included "Provide books and other technical material to the NGOs to enhance this training" and "Request reports at least twice per year from NGOs to assess progress they are making".

#### Section C: Evaluation of Workshop Facilitators

Eleven presenters were used at this workshop, one of whom presented twice. The average for all 12 presentations was 3.32 out of a maximum of 4.0, and five of the 12 presentations were rated above that average, and in fact above 3.50 as well. Eleven (11) of the 12 were rated at an average above 3.00 (Good), the only exception being Inspector Christie's, which received an average rating of 2.47.

Four of the 12 presentations were not rated at all by the 4 persons in Group I, and even for Group II which had 5 persons, only one or two rated these same 4 presentations. All of the presentations on the first two days of the workshop were rated by only one person in Group I and both presentations on the first day were rated only by one person in Group II. It is therefore evident that some participants arrived late on the first two days and missed those presentations.

All of the presenters were rated highest on their "knowledge of the subject matter". Ms. Newland, followed by Mrs. Hue's two presentations attained the highest average ratings in this area, as well as overall. Ms. Hopwood, Mrs. Bailey and Dr. Mc Donald also were highly rated in this area. Only three presentations (Mrs. Abrahams, Inspector Christie, and Ms. Naughty) were rated below 3.50 in this area, and only one (Inspector Christie) below 3.00.

All presentations, except Mrs. Meade's, were next highest rated for their "quality of presentation". For Mrs. Meade's presentation, the second highest rating was for "Presenter's material was easily understandable and absorbed" and this view was held through all groups (I, II and III). Five presentations (Mrs. Hue twice, Ms. Newland, Mrs. Bailey and Ms. Hopwood) were rated above the 3.5 average for quality of presentation. This is probably a reflection of the negative comment that "too many presenters used the lecture format, rather than involving the participants". It will be recalled that all of the latter 5 mentioned presentations (except Ms. Hopwood's) were highly inter-active with the participants.

*Presenter's inclusion of teaching techniques*, which may not have been easy for some presenters given the nature and subject of the presentations, was rated above the 3 (good) average for 8 of the 12 presentations. Those rated below the 3 average are noteworthy: Dr. Brissett (Overview of Family Life Education), Superintendent Brown-Getton (Sexual Abuse), Inspector Christie (Physical Abuse) and Mrs. Meade (Empowering Adolescent Service Providers, Assessing the Work Environment, Strategies to prevent Burnout, and Developing the Providers' Network).

While the numerical rating of Mrs. Meade's presentations seems lukewarm (an overall 3.02 average, 11<sup>th</sup> of 12 presentations), it is apparently contradicted by the particular mention of the Stress, Burnout and Empowering Adolescents service providers sessions as positive features of the workshop by 11 participants, and the identification of the need for networking between providers as a desirable follow-up activity by 6 participants.

Inspector Christie (incidentally the only male presenter) scored lowest of all presentations (overall 2.47) and in fact was rated 3 or below in every category of both the overall and Group III averages. Participants were especially severe in rating the inspector's *use of teaching techniques* and *ease of understanding his material*. In mitigation, it should be noted that the Inspector was a last minute stand-in for another prior selected presenter.

#### Section D: UAP Administrative Support, and General Comments

The overall average for UAP Administrative Support was 4.38 of a maximum 5, with "Registration and Administrative Support" and "Meeting venue was satisfactory" being rated highest. Lowest rating was assigned to "Meals were appetizing and sufficiently varied" (4.18). These scores were reflected in both Groups II and III and overall. The fact that the four days of the workshop included two Wednesdays, and that the Medallion Hall Hotel's menus vary only day to day may have contributed to this lower score, since the menu on both Wednesdays were identical.

For the General Comments, twenty (20) separate comments were made with 10 receiving multiple endorsements. The most popular comment was "Informative and productive workshop", with 13 endorsements. Five persons felt that "Dr. Robinson has done a great job; a role model and standard of excellence".

#### Other interesting comments included:

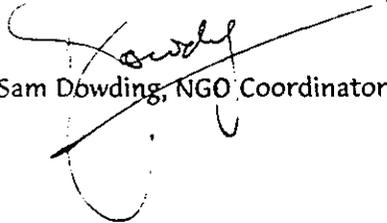
- ◆ I learned many new things and ways to teach (3)
- ◆ Should be extended to Government workers (2)
- ◆ Well organized workshop with relevant topics (2)
- ◆ A source of empowerment (2)
- ◆ UAP workshops have always opened my eyes, but this one deserves a standing ovation (2)
- ◆ Organizations in close proximity should keep in touch (1)
- ◆ Distribute name tags to aid in easy identification (1) and
- ◆ Mrs. Hue should be commended for a job well done. (1)

SUMMARY AND CONCLUSION

The consensus of the participants at this course was clearly that the workshop was well planned and executed. There were far more positive features identified than negative areas, and positive features and General Comments were the only areas in which "None or None Stated" received a very low frequency of responses (1/40 and 4/40 respectively).

There are many useful lessons to be learnt from this workshop, and many indicators provided by the participants for improvement in not only the delivery of workshops, but also the delivery of the UAP activities through the NGOs as a whole. Notable among these are the need to follow up with improving the networking between NGOs, supporting the wider availability of training materials and equipment in NGOs, and doing additional detailed workshops in the reproductive health area.

Prepared by:

  
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