COMPREHENSIVE ADOLESCENT FERTILITY PROJECT IN JAMAICA[1]

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INTRODUCTION

Within the last decade there have been numerous professional workshops, seminars, and meetings within the English-speaking Caribbean seeking ways to meet the rapidly changing health and education needs of youth. The period of adolescence has suddenly come to receive priority attention.

One key reason for this activity has been the sudden influx of the media into the region, together with the Caribbean's proximity to North America. Among other things, rapid introduction of the satellite "dish" has caused noteworthy changes, transforming coverage of sex in the media from a "conspiracy of silence" to a "conspiracy of scandal" *(1)*.

In trying to keep up with changing circumstances and the changing needs of youth, many countries have wisely begun to review their legislation, policies, and practices—especially those dealing with maternal and child health, family planning, and sexual health services for youth. One result, to the benefit of all, is that a regional policy in support of sexual health services for adolescents is now becoming well-established in the West Indies *(2)*.

Each of the more than a dozen countries within the English-speaking Caribbean is now trying to develop both traditional and new approaches to reach youth through maternal and child health and family planning programs *(3)*. This article will take a closer look at the emergence of one such model project in Jamaica that enjoys a high level of intersectoral cooperation. This project, known as the Duhaney Park Youth Project, recently completed its first three years of operation. Key elements of the project include skills training, education, counseling, and a special evening youth clinic. What follows is a general description of the project's basic components that devotes special attention to some of the characteristics of patients seen during the youth clinic's first year of operation. It is hoped that some of the observations reported here will help other agencies and governments within the area in developing projects to meet their unique but often similar needs.

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[1] This article will also be published in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*, vol. 105, 1988.

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THE DUHANEY PARK PROJECTS

The health of young women in Jamaica has been supported through development of a formal family planning policy at the national level. As in other Caribbean countries, clinical and out-of-school education programs for youth have become more important as evidence has increased that young Jamaican women who have higher levels of education tend to have fewer children *(4)*.

The present Duhaney Park Youth Project is really the second of two projects aimed at the same eight target communities. The first, the Duhaney Park Primary Care Project, began with construction of a major primary care health center in 1982. This project has received attention previously because of its high level of community support and participation *(5)*.

The most recent project, the Duhaney Park Youth Project, began field operations in 1985 with construction of a youth center and initiation of education, skills training, counseling, and medical services for youth.

These two projects' eight target communities have a total population of nearly 100,000 people. Located in the same compound, the projects work closely together and continue to benefit from a high degree of intersectoral cooperation. The Duhaney Park Health Center is administered by the Ministry of Health and Environmental Control, while the Duhaney Park Youth Center is managed by the Ministry of Youth and Community Development. Both projects were implemented by PAHO/WHO.

Community Participation

Previous efforts at intersectoral collaboration and community participation in Jamaica have not always been successful. In this vein, it has been widely recognized that community participation does have risks, may not be appropriate for all communities, and often takes a long time to develop *(6)*.

These circumstances make it easier to understand both the Duhaney Park Youth Project and the fact that both project staff members and community leaders have identified "politics" as the single greatest continuing threat to the project's eventual success *(7)*. Regarding the latter point, community leaders and parents fear the effects of divisive politics upon the project. They agree that special clinical, counseling, and educational programs for young people are urgently needed because of the inability of the school and family to provide basic information on sexual health, an inability that has been well-documented by previous studies *(8)*.

The Need for Urban Services

The need to develop specialized sexual health services for adolescents has been sharpened by rapid urbanization in the Caribbean, and by the fact that urban females are now experiencing menarche significantly earlier than their rural counterparts *(9)*. A considerable increase in sexually transmitted diseases, especially gonorrhea, among Caribbean youth since the 1960s further underscores the need for specific programs to reach young people *(10)*. In addition, young women are considerably more prone to maternal morbidity and mortality than are their older counterparts; indeed, complications of pregnancy and childbirth remain the third leading cause of death among young people 15–24 years of age in the Caribbean *(10)*.

The Preliminary K.A.P. Survey

In order to more clearly define the health-related needs and problems of the nearly 100,000 people living within the eight target communities, a K.A.P. (Knowledge, Attitudes, and Practices) survey was completed in 1983. This house-to-house survey, conducted by a group of trained interviewers, covered a random sample of 306 households representing 2% of all the households within the eight project communities.

Among other things, it confirmed the immediate need for a major comprehensive primary care facility. At the time of the survey no such project had yet been attempted in any of the eight communities *(11)*. For this reason, area residents were forced to travel up to two hours to reach overcrowded and poorly equipped health facilities in downtown Kingston or at the University Hospital in Kingston.

As can be seen from Table 1, many of the household heads surveyed felt that youths in their communities were in great need of social, recreational, educational, vocational, and sporting services. When the survey subjects were asked to specify what health services were needed in their communities, they specified the areas of primary care, services for children, dental services, and environmental health services *(11)*.

Later on in the K.A.P. survey, these residents were asked specific questions relating to maternal and child health and family planning. This revealed that some 22% of the household mothers involved had experienced complications during pregnancy and 14% had experienced birth problems *(11)*. This finding indicated a need for more effective or available prenatal services, and also for more access to family planning and sexual health care services. The fact that Jamaica currently has the third highest incidence of cervical cancer in the world *(12)* underscores the need to provide health education for young women in the sexually active age group.

When asked specifically about family planning (Table 2) over a third of the respondents (37%) gave no reason

TABLE 1. Needs of youth in the eight Duhaney Park Project communities, as perceived by heads of the 306 households surveyed in 1983.

Type of need	Heads of household citing need	
	No.	(%)
Social, recreational, sporting	86	(28)
Employment	86	(28)
Education, vocational training	61	(20)
Counseling, sex education, health care	43	(14)
No needs ("youth are hopeless")	18	(6)
No opinion	12	(4)
Total	306	(100)

Source: Pan American Health Organization/World Health Organization *(11)*.

TABLE 2. Reasons given by the 306 heads of household surveyed for not using family planning.

Reason cited	Heads of household citing reason	
	No.	(%)
Not stated	113	(37)
Not at risk (over age, pregnant, just gave birth)	83	(27)
Fear of side-effects	40	(13)
Do not believe in family planning	27	(9)
No partner	12	(4)
Other	31	(10)
Total	306	(100)

Source: Pan American Health Organization/World Health Organization *(11)*.

for not using family planning. Another 13% cited fear of side-effects. Both of these findings strongly indicated a need to provide more and better maternal and child health/family planning education through the new primary care facility.

Initiating Primary Health Care

The new Duhaney Park Health Center was completed in late 1983. During its first nine months of operation, it was visited by over 24,000 patients *(13)*. This heavy use supported the earlier findings of the K.A.P. survey pointing to a need for primary care services.

After the center was operating, community leaders continued meeting monthly to monitor ongoing project activities. In addition, a special workshop was held to familiarize community leaders with the findings of the K.A.P. survey and the project's long-range goals *(14)*.

Initiating Specialized Youth Services

The development of specialized services for youth in Jamaica follows a recent Caribbean trend toward upgrading and improving adolescent services—especially ones contributing to reduction of teenage pregnancies. The Duhaney Park Youth Project currently meets five of the seven criteria for activities at the national level that are set forth in the recent PAHO strategy document "Caribbean Cooperation in Health" *(15)*.

Among other features, key elements of the Duhaney Park Youth Project have included the following:

- establishment of posts for four youth counselors;
- a multi-phase peer counseling training program;
- delivery of family life education (FLE) in out-of-school settings;
- a full-time female sports coach, as part of the FLE team;
- a weekly evening youth clinic offering curative, family planning, and sexually transmitted disease services;
- a central focal point for activities made possible through a new youth center (sewing classes, skills education[4]);
- provision of transportation services and audio-visual equipment in support of the project.

Staff Development and Peer Counselor Training

The four full-time youth project staff members (one senior youth educator, two youth educators, and one female sports coach) were selected largely for their ability to work with and relate to adolescents, a key element of any such program *(16)*. During the first 12 months of the program, these four staff members received more than 750 hours (cumulative total) of training in adolescent growth and development, adolescent fertility, human reproduction, substance and drug abuse, fertility regulation, peer counseling, and program development and evaluation *(17)*.

During the first 12 months of the project, over 30 especially selected young people from the target communities were given more than 80 hours of training in peer counseling. The training itself employed basic but effective training modules previously used in similar peer counselor training programs *(18)*. While project funds were not sufficient to pay the peer counselors for their time

[4] Including sessions on how to market sewing products, how to apply for employment, etc.

(a frequent request), special certificates were awarded to every participant who successfully completed the 80 hours of training.

The project staff members and trained peer counselors residing in the target communities became the key source of most referrals to the weekly evening clinic. One young peer counselor, previously known as a cocaine abuser, became renowned among youth in the community for her compelling and humorous talks on the evils of drug abuse.

Youth Workshops and Recreational Services

Youth workshops on various special topics have been well-attended. Topics dealt with have included substance and drug abuse, seeking employment, nutrition, family relations, sexually transmitted diseases, and AIDS. Most of these special workshops have lasted two or three days and have included 30 or more participants. Lunch has been provided to the participants between workshop sessions. Each workshop has concluded by having each participant complete a questionnaire asking whether he or she benefited from the workshop and how the workshop was useful; the questionnaire responses have then been used for planning further special topic workshops.

Recreation services have also grown within the program, and the female sports coach has already organized soccer, basketball, and track competitions between youth groups from the various communities. The project has provided basic sports equipment, supplemented in some cases with equipment contributed by local companies. The practice of awarding trophies and certificates of achievement to winning competitors has helped spur enthusiasm. These trophies and citations are paid for by project funds and local companies.

In addition, a sewing course was recently added to the project. Sewing machines have been provided by the Dutch Government, and the classes are given three days a week by a local volunteer teacher. Students of both sexes are also given assistance in getting job placement after they have successfully completed the course. Each course lasts about 10 weeks and includes about a dozen students per class.

Community Participation

Leaders of the Duhaney Park communities have remained active in their support of the overall project. Local food shops sometimes provide food and drink, and community leaders meet monthly to discuss the health program, the youth clinic, sports activities, and problems of young people. In this vein, a special series of "round table" discussions have been set up to provide young people an informal vehicle for discussing special problems (drug abuse, etc.) with community leaders. Several of these round tables have been held to encourage young people to discuss special problems with members of the local police force.

Development of the Youth Clinic

The youth clinic, which first opened in early 1985, offers services between the hours of 4:00 p.m. and 7:00 p.m. one night a week. These hours afford access to both in-school and out-of-school youths, and help to provide confidentiality. Previous studies have shown that young people often avoid seeking sexual health care services at "estab-

lished" adult or daytime clinics in small communities, for fear of being recognized by family friends or neighbors.

The basic staff members present at the evening clinic include a medical officer, a nurse-midwife (trained in family planning), and a records clerk. All young people coming to the clinic are counseled by a youth educator and evaluated on an individual basis. Services offered include curative care, referral services, family planning (all methods), and sexually transmitted disease diagnosis and treatment.

Use patterns. The number of clinic visitors was uneven and grew slowly at first, there being an average of 22 patient visits per month during the first nine months of clinic operation. However, during the last quarter the average number of visits more than tripled to 73 per month. This dramatic increase will probably continue, as youth clinics generally begin slowly because they are required to earn the respect of youth in the community over time. Also, there would naturally tend to be reduced utilization during the summer months, when young people out of school frequently leave the area.

Regarding repeated use, 30% of all the patients attending the youth clinic made two or more visits. Such multiple visits are a good sign of success in youth clinics, where young people are often receiving primary care on their own for the first time. In this project, multiple visits were especially encouraged to help gain trust and respect. As might be expected, the frequency of multiple visits was especially high among family planning and sexually transmitted disease patients.

Many of the patients said it was the first time they had visited a health center, confirming the impression that the clinic afforded their first contact with primary health care services. Women far outnumbered men in terms of the total number of visits made, while persons aged 20–22 years accounted for the greatest number of visits (30%) for both sexes. Also, the average female patient seeking services for the first time was younger than her male counterpart.

Family Planning and Sexually Transmitted Disease Services

A breakdown of patients by type of visit (Table 3) shows that over half (53%) of all the patients attending the clinic received family planning and/or sexually transmitted disease services, while the balance received curative, counseling, or referral services.

Besides the factors already mentioned, the gradual growth in clinic attendance can be partly explained by the fact that only one other "teen" or "youth" clinic was attempted in Jamaica between 1982 and 1986. Because all government and most private clinics operate from 9:00 a.m. to 5:00 p.m., young people in Jamaica were not accustomed to late afternoon or evening clinics. Many patients expressed high satisfaction and sometimes surprise that this clinic had evening hours, allowing them an opportunity to attend after school or work *(7)*.

Methods of Contraception Used

Oral contraceptives represented the contraceptive method of choice in a preponderance of the family planning visits where a contraceptive method or device was accepted (Table 4). Barrier methods accounted for most of the remainder.

TABLE 3. A breakdown of services by the reason for the visit at the Duhaney Park Youth Clinic, April 1985 to March 1986.

Year and month	Number of visits in indicated category			
	Family planning visits	Sexually transmitted disease visits	Other visits[a]	Total visits
1985:				
April	4	—	—	4
May	12	5	1	18
June	10	3	3	16
July	1	3	1	5
August	3	4	8	15
September	13	9	24	46
October	7	7	27	41
November	9	6	27	42
December	11	0	3	14
1986:				
January	10	16	26	52
February	20	34	43	97
March	20	15	34	69
Total No.	120	102	197	419
%	29	24	47	100

Source: PAHO/WHO, Kingston, Jamaica, 1986.
[a] For counseling, curative care, or referral.

TABLE 4. Contraceptive methods accepted during family planning visits to the Duhaney Park Youth Clinic, April 1985 to March 1986.

Contraceptive method accepted	No. of acceptor visits	% of all family planning visits
Oral contraceptives	58	48%
Condoms and foams	24	20%
Injections	12	10%
IUDs	1	1%
Total	95	79%[a]

Source: Duhaney Park Youth Clinic, 1986.
[a] The total is less than 100% because visits for certain noncontraceptive purposes such as pregnancy tests were counted as family planning visits.

It should be noted, however, that 12 of the 95 acceptors chose the injectible (Depo-Provera) method. While this may seem a high proportion for some youth clinics, it is not surprising in Jamaica, which worldwide has the highest percentage of Depo-Provera users (21% of all contraceptors) *(19)*.

The reasons given by some patients for rejecting contraception were similar to reasons given by young people in many countries, usually centering around the feeling that a contraceptive method was not necessary *(20, 21)*. Some young people associated with a subcultural group unique to Jamaica and known as "Rastafarians" object to any form of contraception.

The prevailing contraceptive preferences found, and especially the popularity of noncondom methods (orals, injectibles), should receive careful

attention in developing future health education strategies because of the current AIDS epidemic.

Abortion

In contrast to attitudes found in some other Caribbean countries *(22)*, abortion is not considered a viable option by most Jamaican youth. Even very young mothers (those 13–16 years old) tend to carry their pregnancies to term and rely on parents or extended family for support or child-rearing.

Fewer than 20% of the young people counseled in this project requested any information about pregnancy termination. It seems unlikely that this lack of interest is due to regulations or laws, because Jamaican legal statutes do permit abortion under broad (health) circumstances on medical grounds *(4)*.

Sexual Abuse

While sexual abuse was not one of the subjects specifically examined in the present study, it should be noted that the counseling team reported an increasing incidence of reported sexual abuse among young girls. While this trend has also been observed in various other developing countries *(23)*, it appears advisable to undertake additional studies in order to more clearly define the extent and seriousness of this problem in the Caribbean.

Conclusions

Model and experimental youth projects that try to meet the needs of youth in different ways are relatively new in the English-speaking Caribbean. As one of these, the Duhaney Park Youth Project has continued to successfully combine the following elements: a well-trained youth education staff, continuing community participation, peer counseling, skill-building activities, cooperating government ministries, a female sports program, and an evening youth clinic.

Extrabudgetary support has allowed the Duhaney Park project to differ markedly from more traditional projects in Jamaica. Specifically, its approach is holistic and seeks to meet young people's social and emotional as well as medical needs. Its design is not vertical or managed by one government ministry, but is horizontal and enjoys the ongoing administrative cooperation of two government ministries (the Ministry of Youth and Community Development and the Ministry of Health and Environmental Control). Finally, and most important, the project is directly influenced by the close two-way communication it enjoys with its young target population—as well as with community leaders, who have persisted in their support. Accordingly, young people often decide for themselves upon future activities or topics for discussion.

In general, it appears that the experience gained with this project to date stands some chance of benefiting other Caribbean agencies or governments that are seeking to develop their own youth-specific programs to meet the special needs of young people within their countries.

Summary

In 1985 an undertaking known as the Duhaney Park Youth Project was established in urban Kingston, Jamaica. Since then it has provided extensive staff training, utilized supportive community participation, and expanded its range of activities to include peer counseling, female sports, skills training, and a weekly evening youth clinic.

This article describes the basic precepts and features of the project, together with relevant characteristics of the young people attending the evening clinic. (Over half of all these young patients were seeking assistance for family planning or sexually transmitted diseases.)

Experience over the years has shown that vertical programming to reach adolescents and postadolescent young people has not been very successful. This project, one of the first such comprehensive youth programs in the Caribbean region and similar in orientation to "The Door" in New York City, is more comprehensive and offers a variety of services for youth. It therefore appears that the program could prove to be a useful model, serving as a source of experience and fresh ideas for similar efforts in other countries.

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New Deputy Director-General of WHO Appointed

Dr. Hiroshi Nakajima, Director-General of the World Health Organization, has nominated Dr. Mohamed Abdelmoumène of Algeria as Deputy Director-General, with effect from 21 July 1988. He succeeds Dr. T. A. Lambo (Nigeria), who retired from the Organization on 30 June.

Dr. Abdelmoumène has a background in neurophysiology, neurology, and neuropsychiatry. Since 1983 he has served as Chief of WHO's Office of Research Promotion and Development.

Source: World Health Organization, Press Release WHO/26, 21 July 1988.