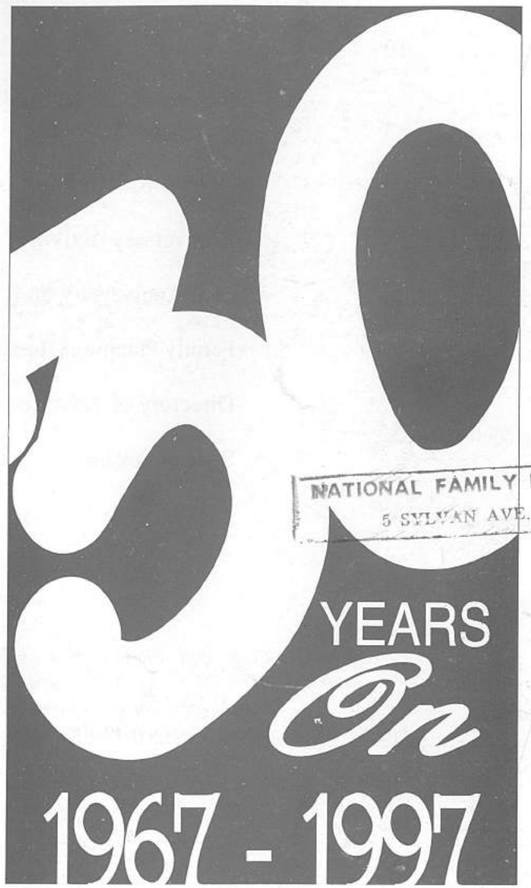
National Family Planning Board



Doing It Right
30 Years & Beyond

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Correction: *Photo caption on Page 67 should read:- STORES: (L-R): Andy Lindo, Technician; Julaine May, Storekeeper; Jomo Jackson, Sideman; Wayne Gordon, Stores Manager; Paul Coke, Sideman*

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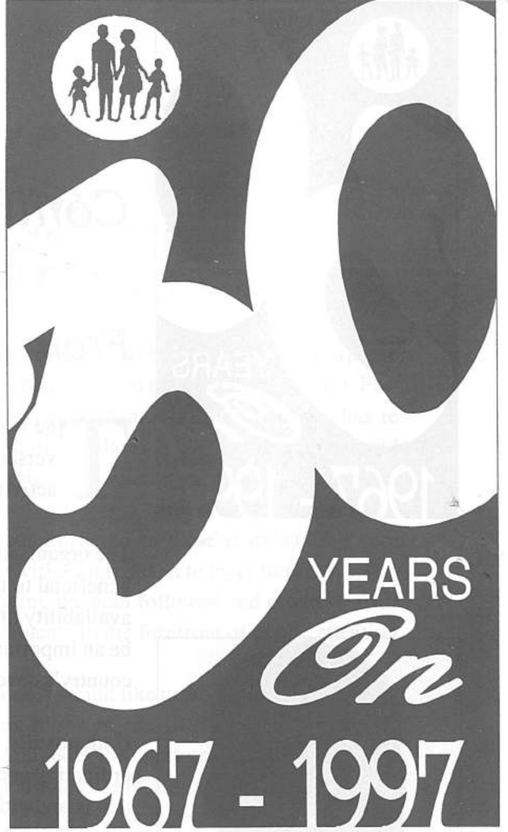


30th Anniversary Commemorative Journal

The National Family Planning Board (NFPB) as the premier organisation in Jamaica responsible for spearheading the national population and family planning initiative, celebrates three decades of achievement fueled by a commitment to foster equal relationships between men and women in matters of sexual relations and reproductive health.

Commemorative Messages:

From The Governor General

The National Family Planning Board (NFPB) celebrates its 30th Anni versary this year, and I am pleased to extend my patronage for the activities being planned in celebration of this milestone.

The organisation's mission statement which is "to promote family planning as beneficial to the health and well-being of all Jamaicans, and ensure the ready availability of affordable, high quality family planning services", continues to be an important issue in controlling population growth for sustainability in the country's development.

His Excellency The Most Hon. Sir Howard Cooke
Governor General

Undoubtedly, the Board from its inception has pursued a programme of co-ordinating and monitoring all family planning and family life education activities islandwide, to ensure that the appropriate message was being sent to all target groups with some measure of success.

Jamaica's National Population Policy aims at reducing the current average of three children per family to two by the year 2000 or shortly thereafter. If this goal is achieved, we would be on the road to the success envisaged.

The Board must be congratulated for the achievements gained, but there are many challenges ahead that will require both public and private sector support, and the commitment from the public to pass the message received through the wide range of media.

I wish the National Family Planning Board every success with the innovative programmes planned and the celebration of this 30th Anniversary.

Howard Cooke
GOVERNOR GENERAL

Kings House
Jamaica

From The Minister

An effective family planning service is necessary in maintaining a proper balance between population growth and national development. For thirty years, the National Family Planning Board (NFPB), has responsibly and vigorously carried out its mandate of implementing and providing sustainable family planning services to Jamaicans from all walks of life.

The Hon. Dr. Peter Phillips
Minister of Health

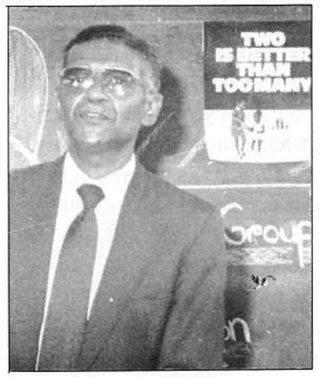
Without doubt, much has been accomplished over these years and this commemorative publication and the activities undertaken to mark the anniversary, are not only important in documenting the path followed and progress made, but serve to bring these accomplishments to the forefront of public attention.

As we mark this significant milestone, I would like to acknowledge the pivotal contribution of the family planning pioneers, and all those who have given exceptional service to the cause throughout the many communities across the country. Indeed, it is the work of thousands of individuals, community groups, professional staff, the media, private sector companies, as well as the support of the international donor community which have made these accomplishments possible.

As we look ahead, Jamaica's current population growth rate and age structure continue to pose challenges to our society especially in terms of our ability to adequately satisfy basic human needs and improve the quality of life of our people. And so, thirty years on, let us not lose sight of the goal and take the important accomplishments of the past for granted. The next thirty years promise to be even more difficult and challenging, not only requiring substantial investments, but a commitment on the part of every Jamaican to actively participate in this meaningful and necessary development process.

Finally, to all who have contributed to the success of the NFPB and the advancement of the national family planning effort, I offer heartfelt appreciation on behalf of the Government and people of Jamaica. I feel certain that inspired by past achievements, we can only continue to make further progress.

From The Chairman



Professor Hugh Wynter
Chairman

On scanning 30 years of activities of the National Family Planning Board (NFPB), it cannot be denied that there has been success in every area albeit varying in the degrees of achievement. The Programme has not only been lauded as one of the most successful in the world, but as far back as twenty years ago, the NFPB was honoured with the National Press award for its outstanding contribution in the field of family planning.

As we mark the 30 year milestone, we can pause to pay tribute to the many who have brought the Programme to this degree of development; our Past Chairmen and Members of the Board, the office staff, both present and past, and the hundreds of persons throughout the country, employed to the Board, the Ministry of Health and those who gave voluntary work. The Board must also pay tribute to the funding agencies, among them the US Agency for International Development (USAID), United Nations Population Fund (UNFPA) and the World Bank. Over the years too, various Ministers and Ministry of Health officials have been involved with us as well as a host of associated organisations - local and foreign and our own private sector. All must be given due credit.

While contraceptive awareness is over 90%, usage falls well below at 60%. We have yet to alleviate anxieties about side effects and the effects of long term usage. Such issues must be addressed if we are to achieve the goal of replacement level fertility (mean number of children born equal 2:1) by the year 2000. The country's total fertility rate has improved from about 6.3 birth per woman in the late 1960s to 3 births per woman at present. This statistic in itself looks good but with 74% of the pregnancies which occur being unplanned and a growing level of teenage pregnancies, adolescent fertility remains an important challenge.

As we stand at the onset of another decade, priority must be given to this age group, and family life education is an obvious vehicle through which an impact can be made. Information must be channelled through schools, social clubs, youth organizations and all agencies involved in the development of children. The importance of reproductive health in national development is recognised.

As we look forward, let us remember ***"we make our future by the best use of the present."***

From The Executive Director

Mrs. Beryl Chevannes
Executive Director

The National Family Planning Board (NFPB) is humbled by the many lives it has touched and enriched through provision of high quality family planning services and contraceptives over the past thirty years. The growing acknowledgement and acceptance of contraceptives has led to the realizing and unleashing, by innumerable persons, of their potential and the careful spacing and planning of family sizes.

The devotion and dedication of the Board of Directors, staff of the NFPB and donor agencies past and present, which has impacted on our noteworthy achievements, is greatly appreciated. As we celebrate our thirtieth anniversary, these activities continue to be paramount on our agenda. The NFPB renews its commitment to the Government and people of Jamaica as we enter the next millennium, embracing the ideal of replacement level fertility and the many facets of reproductive health.

This commemorative publication provides a mirror for reflection on our thirty years of sterling service. So that all Jamaicans can share in the information contained in these pages, the articles were carefully thought through to create a favoured blend for a wider range of age groups. The research information will benefit our young secondary school researchers as well as researchers of many years standing, while others will be interested in the past activities captured in photographic form, or the articles contributed by staff, volunteers, or sourced from other relevant publications. This potpourri has lent varied perspectives to an important archival treasure. The end product aptly reflects our theme, for this anniversary year, "Doing it right ...30 years and beyond".

It is my wish that you will enjoy the historic flashback and relive many of the precious moments with us.

Members of the Board

(l-r) Dr. Barbara Noel; Mr. Basil Lue; Mr. Lennox Deane; Mrs. Beryl Chevannes;
Prof. Hugh Wynter (Chairman); Mrs. Terry Miller; Dr. Verna Brooks-McKenzie; Dr. Olivia McDonald
(insert) Ms. Melanie Gardener

30 YEARS On 1967 - 1997

30 Years of Solid Achievement

The achievements of Jamaica's family planning programme over the past thirty years are impressive by any standard. How else can one view the rise in the contraceptive prevalence rate from 30% in the 1970s to 64% in 1993; the 40% drop in the total fertility rate from 5 children per woman to just under 3 children, and a population growth of just about 1% per annum.

At the centre of these achievements is the work of the National Family Planning Board (NFPB), the agency set up by government thirty years ago to implement and promote family planning services in Jamaica. With a mission *to promote family planning as beneficial to the health and well-being of all Jamaicans and ensure the ready availability of affordable, high quality family planning services",* the NFPB has succeeded in providing more than 70% of the island's family planning service needs, through a network of over 300 clinics across the island. It is interesting that while the NFPB has been the driving force in the delivery of family planning services, serious attention is now being given towards re-orienting the service supply sources to include greater private sector participation.. In fact, the goal is to achieve a shift to 60% private sector service delivery by the year 2000.

Dr. Herbert Eldermire, addresses the establishment meeting of the National Family Planning Board in 1967

As one of the national service agencies which enjoys a high level of public satisfaction among users, the three dacades of NFPB achievements have seen the implementation of some far reaching and innovative programmes, from the procuring and distribution of contraceptives, to conducting research on Jamaica's fertility and population policy initiatives, training, media communications, community outreach and clinical and counseling services in family planning. In fact, the operations and successes of the local family movement has created interntaional recognition for the NFPB as a model success story.

The expansion and development of the NFPB over the years has been outstanding. Building on its early successes, by 1974 the government saw it fit to integrate family planning into the general health care system of the Ministry of Health. This single move not only saw added responsibility, but rapid expansion with 120 educational and clinical staff being added to the Ministry, along with some 290 clinics. It was during this period also that radio and media communications generally became an integral part of the NFPB's programme. At one stage there were as many as 4 programmes a week on radio, along with press advertisements, billboards and tons of educational materials. In 1975, a special hotline/answering service was established, responding to letters, telephone calls and providing counseling to the public.

Some of the early advocates from left, Thelma Thomas, Cynthia Sadler, Rev. Carmen Stewart, Mrs. McGhie and Dr. Lenworth Jacobs

Another innovation in 1975 was the commercial distribution of contraceptives - condoms and oral contraceptive pills, with the birth of Panther and Perle. The move made contraceptives widely available and along with the increased education and public awareness initiatives, increased demand was created for the products. Sales were said to have increased by as much as 20% with the increase in the number of retail outlets climbing from 570 outlets in 1975 to 1,000 in 1978.

Jamaica's family planning success also benefitted from international donor support. The World Bank sponsored a special clinic at the Victoria Jubilee in 1975. Other support came from US-AID and UNFPA. In fact, the United States provided some US$5 million to the national family planning programme between 1966 - 1979. UNFPA provided US$90,000 worth of depo provera per year for acceptors using this family planning method.

25% of the pregnancies occurring are still among adolescents in the 12 - 19 age range .

The local private sector was not to be left out, and the setting up of the Victoria Mutual Building Society/NFPB family life education centre was particularly significant. Another interesting innovation came in 1982, when the NFPB focus shifted to highlight the important role of men in family planning with programmes which implemented to promote male responsibility towards their offspring and partners. An adolescent fertility resource centre was established in 1987 with support from US-AID. Parent education was not excluded and the NFPB implemented special programmes to equip parents and guardians with the skills and knowledge necessary to enable them to better perform their role of family life and family planning educators to their children.

44% of females age 15-17 years are sexually active, with the figure doubling to 80% in the 18-19 age category.

Among the most important programme initiatives of the NFPB over the years, were those targeted to the youth people. Programmes like "Now Entering Education for Tomorrow (NEET), aimed at the 12 to 19 year olds and was implicated between 1982-1986, and 'TEEN SCENE' from 1983-1986. These programmes targeted young Jamaicans linking family life/sex education with contraceptive services, recreation and even vocational training.

The work of NFPB would hardly have had the impact it has without the tireless effort of its field staff, the scores of men and women who assist local communities in identifying family planning needs and organising programmes to address these needs.

In 1983, the NFPB implemented its "Two Child-Family" campaign with its now famous "Judy Smith and Bev Brown" characters. The campaign pointed to the disadvantages of unplanned parenthood and the harsh consequences of not being able to cope financially in satisfying the needs of the family.

Over the years, emphases and direction also changed. Promoting longer term methods and shifting acceptors more towards the private health providers are some of the directions currently being pursued, with the "Personal Choice" programme and its focus on building the capacity of private sector to provide these services.

But even as the NFPB celebrates, other challenges have risen, including the impact of AIDS/STD, adolescent reproductive rights, male responsibility among others, even as it seeks to continue those strategies which have generated so much success over the years. Funding has become even more critical as is the NFPB's own organisational capacity, the role of government, and obtaining a high level of private sector participation in service delivery. All these are important issues for the future direction of family planning in Jamaica. Important too, are the attitudes of our young people toward practicing what they have been privileged to learn from the efforts of those who for the most part did not have that opportunity.

Like any initiative which breeds success, the NFPB from the outset had clearly defined and well articulated goals, whether it was to hold the population to under 3 million up to year 2000, reduce the crude birth rate to 20 per 1,000 by 1985, or achieve replacement level fertility rate and its success is very much a function of remaining focused on the goals set. So yes, significant progress has been made, but we could be in real setbacks if we relax and think the job is done. •

50 YEARS On 1967 - 1997

May Farquharson - A Family Planning Pioneer

Contributor: Phyllis Thomas

Family planning in Jamaica has taken many significant strides in awak ening public consciousness of its importance, and the country owes a great deal to pioneers who had the vision, foresight and determination to see it through in the face of strong opposition.

One of the persons who helped to lay the foundation upon which family planning in this country was built is Ms May Farquharson. "Miss May" as she is affectionately called channeled a lot of her energy in those early days in social work, toiling tirelessly to bring about a better lot for the elderly. The National Insurance Scheme, NIS, is around mainly because of her efforts. She was also interested in education and sponsored many programmes to help the young.

But it was in family planning that her efforts were best known. Miss May was relentless in her work. In 1938, along with people like Amy Bailey and Dr. Hyacinth Lightbourne, she formed the country's first organisation to focus on measures at controlling the national birth rate. The situation was alarming with as many as 68% of birth being outside of wedlock and in no settled home.

"Totally irresponsible," is how the silver haired Miss May described the attitudes then, adding: "the men just went about with no feelings, no responsibility or caring."

Miss May was relentless in her work with family planning. In 1938, along with people like Amy Bailey & Dr. Hyacinth Lightbourne, she formed the first organisation for helping the control of Jamaica's birth rate

And so the ideas of how to apply birth control to the Jamaican situation was conceived with the birth of the *Birth Control League* in 1939. Two years later, the name was changed to the *Jamaica Family Planning League* as many objected to the words 'birth control'.

While it was generally recognised that the birth rate was increasing significantly, there were many, particularly in high places, who strongly resisted family planning. In the end, Miss May and her colleagues came out victorious.

Along with Miss May, other members of the1939 pioneering team that formed the executive of the Family Planning League include Dr. Charles Levy, who was the President, and Dr. W. F. McCulloch, Chairman. Miss May was the Hon. Secretary. They established a clinic in the city with Dr. Lightbourne as its Director.

There was a prolonged and lively newspaper controversy as the programme got underway. For the first couple of years, the clinic opened three days a week mainly for information. The rest of time was spent by the staff canvassing for patients who were asked to attend forthightly sessions held by two volunteer lady doctors. When these doctors were moved away from Kingston, the medical sessions discontinued. "We got a tremendous amount of abuse in The Gleaner and from the Catholics," Miss May recalled.

Canvassing produced poor results. A report on activities of the League noted that only six percent of those canvassed, became patients. In 1944, canvassing was discontinued in the wake of street opposition to the nurses, just around election time. The staff of the clinic was also reduced to one part-time nurse who worked for only four hours each week. By 1954, the movement was gaining strength once again and was able to relocate to larger premises, with a Secretary, who was also a nurse, and three other nurses, who kept the clinic opened all day.

The League continued and expanded its work supplying welfare clinics and some sympathisers in other parts of the Island with materials which required no individual fitting or instructions of an elaborate nature. Advertisements and propaganda were used to help push family planning message.

The work of May Farquharson is recognised both here and abroad. The International Planned Parenthood Federation's "News of Population and Birth" published 1956 featured her and probably the most impressive tribute ever paid to the mother of family planning, was the salute by the Planned Parenthood Federation: "we salute May Farquharson for her dedicated life on behalf of family planning," The special citation was presented to her in 1950.

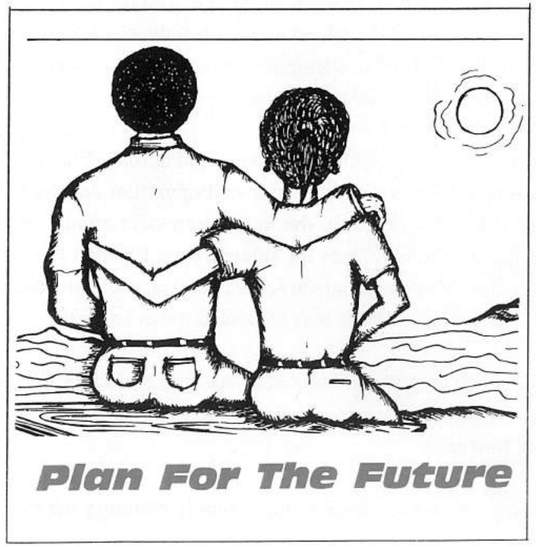
Born in 1894 at a site on Oxford Road, Miss May spent her life as a social worker, economist and lecturer, and was the first woman to be appointed a Justice of the Peace in Jamaica.

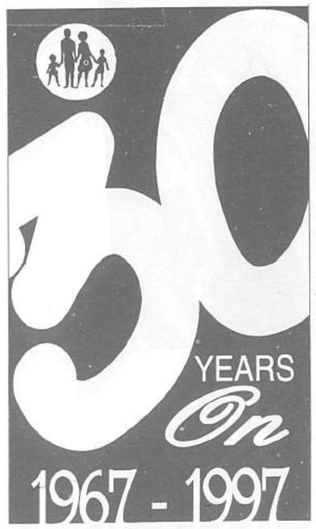
Commenting on what the country has done so far in family planning she said,

"the population has gone ahead of us. They may be getting more patient, I don't know, but they are not sticking to it. And there is still an awful halo of ignorance about it."

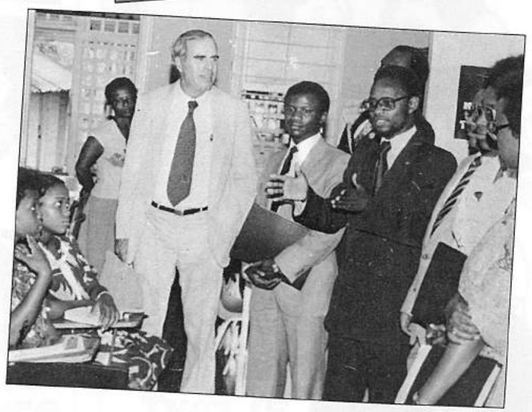
Athough not closely following much of the current initiatives, Miss May feels there could be problems with the two child family concept as it is equally important to point out to people, the importance of having good fatherhood. It is more than just thinking about the kind of life the child is going to have and the people it is going to live with.

The family planning pioneer still feels there are people against family planning: "You just have to listen to obituaries on the radio to still hear of Mr. John Smith having died, leaving seven boys and four girls." For her, Government should provide the financial and human resources necessary for the improvement of the programme for "nobody else is going to do it. Norman Manley helped us first and then my father helped a bit for we only had the nurses." She was glad with the setting up of the National Family Planning Board, and added, "Dr. Hyacinth Lightbourne always said it should be a Government thing, and part of one complex so people would not when someone is going for family planning services." Miss May sees the education of the young people as the key to the planned parenthood and the development of the nation. •





Pictorial Flashback...



50 YEARS On 1967 - 1997

Pictorial Flashback...

50 YEARS On 1967 - 1997

Pictorial Flashback...

Welcome to
Jamaica's Premier Business Hotel

In the very heart of Jamaica's capital city stands a business hotel like no other. Already a favorite executive retreat, the extraordinary Wyndham Kingston has now completed an extensive $15 million renovation.

From the accommodations in our 17-story tower and seven poolside cabana buildings, to our outstanding convention facilities, from our Olympic-size swimming pool to our sever-and one-half-acre lush tropical setting, everything has been renewed, improved upon or made more beautiful.

A spectacular feature of our renovation is our 16,000 square feet of meeting space, which includes the special upgrade of our 10,000-square-foot Independence Ballroom. Also better than ever are our President Club floors. Business Centre, lobby, health club, tennis courts, fine restaurants, specialty shopping and, of course, our guest rooms.

The only thing we haven't changed is our quality of service. As always, we provide complete attention to every detail and complete attention to every guest. Like the exquisite views of Kingston and Jamaica's Blue Mountains, that's something that will never change.

Dining and Entertainment

You'll discover that some of the island's best dining and entertainment awaits with the Wyndham Kingston. Authentic Jamaican and international fare are served in a number of fine restaurants. Our nightclub and casual bars capture perfectly the beat of island nightlife.

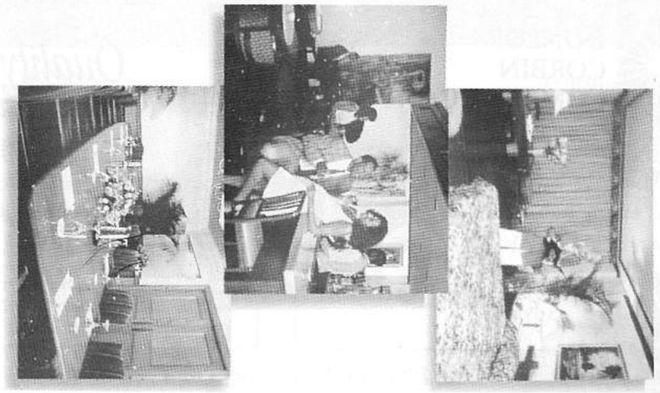
Room Features

Light and airy in decor, the newly renovated guest rooms blend island ambiance with the most modern conveniences. Several penthouse suites are available, including the Prime Minister's Suite with private Kitchen, wet bar and Jacuzzi. Room features include:

- Facilities for disabled persons
- Individual climate control
- AT&T service to the U.S.A.
- Direct-dial telephone
- Satellite color television, with remote control
- Hair Dryer
- Voice mail
- Two-line phones with personal computer portt access (on Presidential Club floors only)
- Poolside balconies
- Tea/coffee makers in each room

Meeting Facilities

The Wyndham Kingston offers over 19,000 square feet of flexible meeting and convention space, highlighted by the recently enlarged 10,000-square-foot Grande Independence Ballroom, one of the Caribbean's largest. The Ballroom can quickly be divided into six separate rooms, each air-conditioned, soundproofed, and offering exceptional audiovisual and lighting equipment. Simultaneous translation of up to three languages is available.



THE RIGHT WAY THE WYNDHAM WAY

WYNDHAM KINGSTON HOTEL
Kingston, Jamaica W.I.

The benefits of intersectoral collaboration

Working In Partnership

Prepared By: Mrs. L. Mullings, Assistant Director, IEC (Field Service)

As the NFPB continues to focus on achieving its objective of reducing fertility to replacement levels, programmes devised to meet this goal will have to bring about a reduction in the number of births per woman from the current average of three children to two, within the next 5 years. This is no easy task, especially given the youthful age of our population.

Programmes will have to reflect wider national impact and The Board itself cannot effect all the changes required. Co-ordination and cooperation with other agencies involved in family planning/family life education programmes will be necessary. Also, working with community-based groups, private sector companies, the private health practitioners and others are vital if such an objective is to be achieved.

As far as the NFPB is concerned, its Information, Education and Communication Department of the Board and its three components, namely, training, communication and field service, will also have a major role to play, as they have to work closely with various target groups in the education process.

In training and field service, groups such as parents, teachers, youth club members, church groups, etc. will be targeted through specially organised seminars. Sometimes in our outreach activities, such groups are identified after which training is then organized. On other occasions, the NFPB acts as resource to these outside groups. Linkages are crucial with both Government and non-Government agencies including Ministries such as the Ministry of Education, Youth and Culture.

Through youth programmes such as the National Youth Service, STEP and other similar youth groups, the NFPB assists in training as well as being a resource in the islandwide youth club network such as HEART/NTA, Garmex Training Centre, Ebony Park, Cobla, Newcastle, Kenilworth Youth Camps.

Another critical linkage is with the Ministry of National Security, through the Police Training School, Police Youth Clubs islandwide, Police Rape Unit, Police Neighbourhood Watch and Community Relations groups.

The NFPB also collaborates with the Jamaica Information Service which

offers assistance in their community outreach programmes by including NFPB officers. The network also includes firemen attached to the Ministry of Local Government,National Water Commission workers, the Women's Centre, officers of the Ministry of Agriculture and especially through RADA.

The in-school population and training colleges such as Paisley Gardens Teachers and Agricultural Colleges, the Ministry of Health's Epi-Unit and health centres islandwide as well as the Friends of Bustamante Children's Hospital also form important linkages in our programme.

As far as the non-governmental agencies are concerned, the NFPB is continuously being called upon to assist with in areas of family life education and family planning. Among some of the agencies with which linkages are maintained are the service clubs such as Kiwanis, Junior Chamber, Lion, and Rotary, where the Board assists in public education and the mounting of health fares. We also work with the Red Cross, YWCA and YMCA, PTAs islandwide, Credit Unions, Boys Town Vocational Centre, Operation Friendship, Drug Abuse Secretariat, A.W.O.J.A. Women Resource and Outreach Centres, Woman Inc., the Mel Nathan Institute, Blue Cross of Jamaica, Drug Abuse Secretariat, Life insurance companies such as LOJ, Deeds Industries (Disabled Group), Heart Foundation of Jamaica, Sickle Cell Support Group, Freezone/Factories in Kingston, St. Andrew, St. Catherine, Clarendon, Trelawny, St. Mary and St. James, and religious groups of various denominations. Most of the orthodox churches have family planning counselling programmes, but request also come from Church of Christ, Church of God, Church of God of Prophecy, Church of the Nazerene, the Seventh Day Adventist church, and many others too numerous to mention. This long list of collaborating and supportive organisations figure prominently in our work on a consistent basis, and from time to time, special requests are received especially during the summer months when camps are organized by various groups.

The approach of the NFPB is to maintain linkages which will support its programmes, and is willing and prepared to provide any assistance it can in helping to create an atmosphere which can translate negative attitudes into constructive, preventative behaviour. •

SOME IMPORTANT FAMILY PLANNING FACTS AT A GLANCE

POPULATION	*FERTILITY*	*CONTRACEPTION*
• Westmoreland, Manchester and St. James had the highest crude birth rate in 1996	• 30% of adolescents become pregnant during the first six months after their first sexual encounter	• Discontinuation rates for contraceptive methods at 12 months is approximately 50%
• Over the last five years, approx. 59,000 babies have been born annually, while 14,000 people die each year.	• Only 29% of all births in Jamaica are planned.	• Median age of women sterilised is 34 years.
• Life expectancy at birth: women - 73 years men - 70 years	• The average age of first pregnancy is 18.6 years	• Majority of women have 4-5 children at the time of sterilization
	• 24% of all births are to females under 20 years	• 14% of women in the fertile age group are in need of family planning (16% in 1989).

Parents Need To Know

INFLUENCES IN ADOLESCENT SEXUAL BEHAVIOUR

A mother was called in by the school's Guidance Counselor as her daughter had an altercation with another student as a result of an ongoing relationship with a young man. She came to the office in a very defensive mood claiming it was all a lie because her daughter was a virgin and of this she was absolutely sure. However, the young lady had already confessed to the Guidance Counselor that she was sexually active with the young man.

Sounds familiar? How many of us as parents ever find ourselves in this position? We think that we can always swear for our 'little darlings'. Some mothers believe that whenever their daughters become pregnant it always happens at their first sexual experience. How unfortunate! As parents we want to believe that we have raised our children in the 'right and proper way' and, sometimes we refuse to face the reality that our children have become sexually active and at an early age too. Yes, we have tried our best but what is it that influences the sexual behaviour needs of our young

Some teenagers were asked this question and their answers varied from peer pressure, ignorance about sex, curiosity, parental influences, cultural expectation to just wanting to satisfy their sexual needs.

The 1993 Contraceptive Prevalence Survey (CPS) showed that 35% of young men are sexually active by age 15 and almost 60% of 15-19 year old report sexual experience. Ignorance about sex is a rather far fetched reason as 80% of adolescents say that they had Family Life Education (FLE) in schools which covered topics of Human Reproduction, Menstrual Cycle and Pregnancy. Most All-Age, Junior High and High Schools now boasts the services of Guidance Counselors and FLE Teachers and it is known that these topics usually generate a lot of interest and discussion. Gone are the days when parents believe that sex education will drive their children to get involved.

In fact, studies have shown that sex education can help delay first intercourse.

Peer Pressure

"Everybody's doing it" is very popular among adolescents especially boys. The feeling of being with the crowds is not easy to deal with. Teenagers like to be "with it" whether with what's wearing - Versace, Nautica, etc. what's eating - burgers, and what's happening - sex.

A teenage girl once expressed shock on being told that there was nothing wrong with being a virgin. "What! are you crazy?" I could not stay in school as I would be ridiculed. So to be accepted she will say that she is doing it.

Boys on the other hand do not want to be labeled as "soft" or "of no use" if he goes out with a girl more than three times and they have not "done it". So they will beg, plead, coerce and the girls will fall for these lines, which brings us back to the myths and misconceptions.

Some common myths regarding sex are:

- young persons need sex because, it is good for the body
- if they don't have sex their "oil" will "freeze" in their backs, causing illness
- sex is the only way of showing love
- sex is good for acne
- it prevents period pains.

Absolute rubbish. You don't make yourself "healthy" by having sex.

Sexual Urge & Low Self-esteem

We are sexual being most, if not all of their lives. The hormones that open our sexual urge start working from puberty and continues to work for most of our lives. However, some adults will try to deny the fact that young persons do have sexual urges. How do they deal with these feelings? Take a cold shower! How long can they stay in the shower? There ought to be more in-depth discussions with adolescents as to how to deal with these sex urges. Students will say if they are hungry they find food, if they are thirsty they find drink, therefore if they need sex (which they do) they will find the ways and means by which to fulfill this need.

The feel for sex is normal and natural. However, young persons must be taught that there is the need to exercise self control. Some young persons suffer low self esteem, and think that the more guys they have sex with the better they will feel about themselves. And where did this "bad" feeling about themselves start - at home -'Gal yu black and ugly like you , pupa'; 'Yu head bad like yu pupa"; Yu wuckless like yu mumma"; Yu jus like yu mumma, no use". Aren't we familiar with negative remarks like these? So here comes 'Mr. Nice Guy' who tells you how wonderful and beautiful a person you are and that he loves her. He moves on her and so too does Mr. Nice Guy # 2,3,4.

Cultural Expectations And Parental Influence

There are some communities in our society where it is natural for an adolescent (age 14) to be in a "serious" relationship. Her parent/s will condone this as the partner could be sending her to school, providing clothes, and other amenities. She may even be encouraged to bear children at an early age to "keep the man". There is also the mentality that the foreigner will offer a solution to all their problems. So here he comes with all his promises of a better life but as soon as he is on that aircraft that's the end of that chapter. Six weeks later the pregnancy test results are positive - another mouth to feed.

During an FLE session at a secondary school one young man said his father took him to exotic night clubs and paid for the service of a commercial sex worker for him, as an eighteen year old male who is still virgin is labeled as a nerd or homosexual. Men will do anything to make sure that their sons are sexually active!

At another youth forum a high school, a young man asked "Why is it that your mother tells you not to have sex and at nights you can hear her doing it? Adolescents exposed to sexual activities at an early age get involved themselves thinking this is the proper thing to do. Adolescents ought to know that they are not ready for sexual intercourse whether physically, emotionally or psychologically. They should be taught to develop refusal skills and be sensible enough to make informed educational choices. •

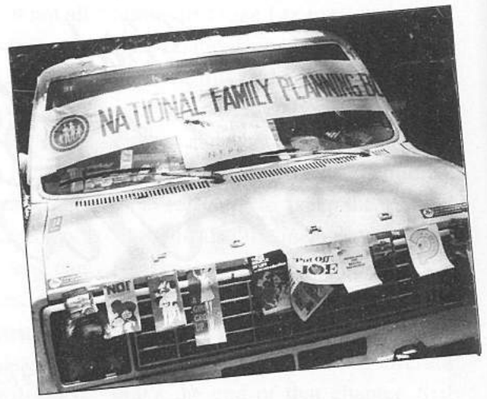
Did You Know?

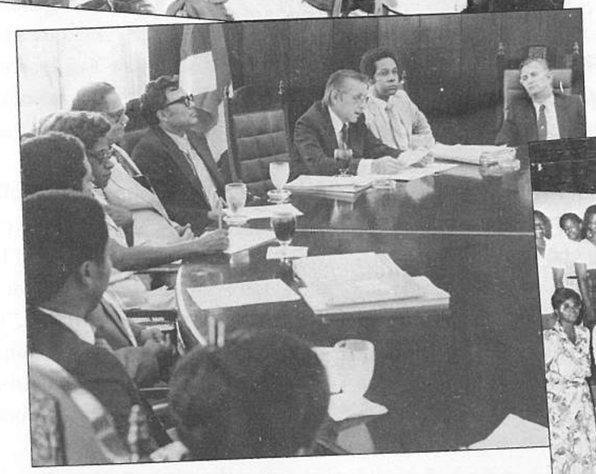
! *The use of contraceptives in Jamaica increased from 38% in 1975 to 63% in 1993. During that same period also, the average number of children per woman decreased from 4.5 children to 3.*

! *Jamaica's national population policy calls for a reduction in fertility to replacement level by the year 2000. This means that the total number of births per woman would have to drop from the current three child average to two children in the next five years*

! *At the current one percent rate of population growth per annum, Jamaica's population is projected to double to 4.8 million by the year 2060. A young child today could expect to see the national population double in his or her lifetime.*

! *There are just under 300,000 contraceptive users in Jamaica at present. The objective of increasing contraceptive prevalence to reach replacement level fertility by the year 2000, means that the number of users will have to be increased by about 50,000*





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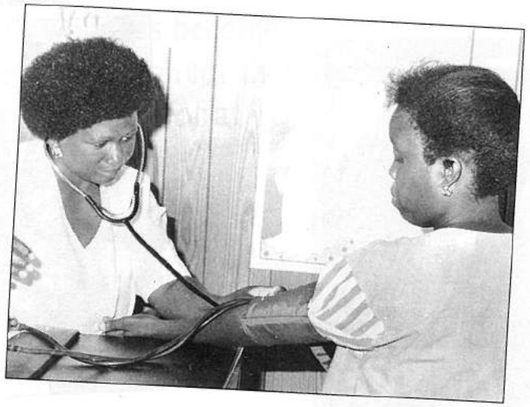

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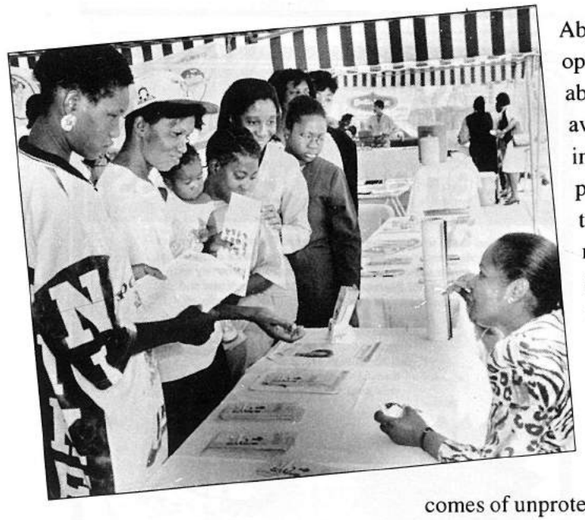
Adolescent Contraception Choice:

Is There a *Wrong* or *Right* Method?

Contributor: Dr. Olivia McDonald

Expression of adolescent sexuality through early sexual activity can have significant health related ramifications for sexually transmitted diseases and unplanned pregnancy. No one can disagree that the best way for adolescents to avoid morbidities from unprotected sexual behaviour is to abstain. Despite efforts to encourage adolescents to exercise primary or secondary abstinence research data indicates that some adolescents forego this action. Therefore, it is necessary to consider how sexually active adolescents can prevent the negative consequences of unprotected sexual intercourse. This article presents the different contraceptives available and the factors that make contraception by adolescents a different issue and in some ways, a more difficult issue, than it is for adults.



Abstinence (sexual activity without intercourse) is the preferred option, and adolescents should be encouraged to think carefully about their values on sexual activity. They should be made aware of the factors which contribute to the likelihood of sexual intercourse, including the effect of peer pressure, partners' expectation, and the length of the relationship. They need to be told that regardless of past sexual activity, they always have a right to say no to sexual intercourse. However, simply urging them to abstain would not be appropriate, they need help to identify and resist pressures to be sexually active and help to rehearse negotiating to avoid sex. In other words, through role playing, as an example, adolescents need to know "how to say 'no' without hurting other people's feelings'. Adolescents should not be the only targets of preventive efforts. Their parents should also be taught the facts about the outcomes of unprotected intercourse and contraceptive choices, so they may help their children to avoid premature sexual activity and its consequences.

Adolescents who are sexually active need to use effective contraceptives to avoid sexually transmitted diseases (STDs), unintended pregnancies and unsafe abortions. *Several factors put adolescents at higher risk than adults for ineffective contraception. These include:-*

- Adolescents are cognitively immature until at least 16 years old, and often engage in sexual intercourse without the capability to foresee the negative consequences of that behaviour
- Feelings of invulnerability can also cause nonuse as many adolescents typically feel that although negative consequences of behaviour can happen to others they are uniquely protected
- Other factors that contribute to nonuse of contraception include inter alia, fear that contraception is dangerous, sporadic and unplanned intercourse, lack of knowledge about contraceptives, fear of parents discovering that they are sexually active, lack of transportation to/ availability of health care facilities that provide contraceptives, providers with the sensitivity to meet the needs of adolescents

Sexually active adolescents must understand that while social and personal factors related to age do influence choice of contraceptive method, age alone does not constitute a medical reason to avoid any contraceptive method.

Even where some health concerns related to young age exist, the advantages of avoiding pregnancy generally outweigh theoretical and /or proven risks

BARRIER METHODS

Latex (male) condom is the only method demonstrated to clearly protect against Human Immune-deficiency Virus (HIV) infection; and many other sexually transmitted diseases. It is well suited for sporadic or infrequent use and can be supplied by either partner. Condoms are more accessible than other methods, at a low cost, and through multiple sources.

Providers who supply condoms to adolescents explain condom use clearly, repeating the instructions, and optimally demonstrating condom use by opening a package and unrolling a condom onto a model. Condoms must be placed on the erect penis before it goes anywhere near the vagina. Some men leak seminal fluid from the urethral meatus when their penis is fully erect. This pre-ejaculatory fluid or lubricating fluid may contain STDs (although not motile sperm capable of causing pregnancy). Concise, illustrated and explicit printed instructions can reinforce the verbal instructions and demonstrations. Condoms requires high motivation to use consistently and correctly. Use directly related to intercourse, may be perceived as inconvenient or as interfering with sexual pleasure.

OTHER BARRIER METHODS

Include the **diaphragm, cervical cap, female condom, & spermicides**. Use may be more easily initiated by women. They are well suited for sporadic, infrequent, as well as frequent use. Some more than others confer at least some protection against sexually transmitted diseases. The diaphragm and cervical cap require special fitting from a provider. Use of these methods require high level of motivation to use consistently and correctly. However, supplies may

be difficult to keep private. These methods requires touching of the genitalia for insertion, which some young women may find uncomfortable. Vaginal irritation, a common side effect of spermicides used with barrier methods, may cause women to stop using contraception, or use it inconsistently.

HORMONAL METHODS

Some adolescents who are at low risk of STDs may find a hormonal method the best choice. Young women can use hormonal methods privately and without male cooperation. Hormonal methods do not require action at each act of intercourse to be effective. Condoms must be used with hormonal methods when STD protection is needed. Combined oestrogen - progestin oral contraceptives (COCs) and injectable offer several non-contraceptive health benefits which may be particularly beneficial to adolescents, for example, painless period and regular periods. Compliance of daily pill taking is of particular concern for the adolescent female. Adolescents need to be advised to link pill taking to a daily routine. Possible side effects such as nausea, weight gain and break through bleeding must be explained to adolescents before use, as these may not be acceptable during the adolescent years. When used consistently and correctly the method offers a very high degree of contraceptive efficacy.

Post coital contraceptives are not a substitute for other family planning methods, but can be crucial for preventing pregnancy when an adolescent female has been coerced into sex; had sex without using contraception; had a condom break; or an IUD came out of place; or has run out of contraceptives.

Prostegin - only oral contraceptives Called 'mini-pills' they are suitable for young mothers who want to use a hormonal method while they are lactating, which itself offers some protection against pregnancy. For other women, lower contraceptive effectiveness rates and high rate of breakthrough bleeding, (especially when not taken at the same time each day) may make them a second choice.

Providers must ensure that adolescents who opt for oral contraceptives, clearly understand what to do if pills are missed, especially in the pill free interval. Misconceptions, adolescents have regarding fertility, cancer, weight gain, vaginal discharges and other issues relating to pill use, must be addressed with concrete, accurate and appropriate information.

INJECTABLES AND IMPLANTS

Progestin - only injectables and implants: Very effective and require no daily pill taking or action at intercourse. These injections are required only every three months for depo-provera; or every two months for noristerat. Return to fertility after discontinuation is often delayed for several months, and occasionally up to a year after receiving the last injection.

Use of progestin-only injectables generally lead to absence of periods in 50% of females by the end of the first year and 66% by the end of the second year for depo provera users. Some evidence suggests that a hypo-oestrogenic state (as evidenced by the lack of periods) within the first two years after onset of the periods, may increase the risk of osteoporosis. The peak strength (destiny) of spinal bone is reached by girls around age 16. However, for those adolescents age 15 and under, for whom progestin only injectables are the most appropriate method, the benefits of the method generally outweigh the risks. These methods are dependent on return to health personal for timely injections, which may be difficult.

Norplant implants: Once inserted can be used for up to five years. Access is required to trained clinicians for insertion and removal. Initial acceptance may be reduced as the privacy of the method may be compromised by a visible dressing at the incision site. Cost may also be problem for adolescents. Users need to understand the changes in menstrual bleeding (missed 'periods', or irregular bleeding) that progestin-only methods are likely to cause. The absence of menstrual bleeding, may present a problem to adolescents who need to explain to their care giver why 'periods' are absent. These methods do not provide the user with any significant protection against STDs.

The intra-uterine device (IUD): Not recommended for any woman who is at high risk for STDs. IUDs lasting up to ten years may be an advantage for some adolescents female. Expulsion and other complications are higher among adolescents. Adolescents who accept the IUDs, must understand STD risk and have access to condoms. Access must also be ensured to IUD removal services if discontinuation is desired.

Sterilization: A permanent procedure which is not easily reversible. The high probability that youth would experience later regret makes contraceptive sterilization an inappropriate method for young people. Where special circumstances indicates that sterilization be considered an option, this should only be offered after comprehensive counselling and fully informed consent.

Traditional and Natural Methods: These include lactational amenorrhoea method (LAM), Fertility Awareness or rhythm method and withdrawal.

For women during the six months following childbirth who are still not menstruating and who are fully breast-feeding, the lactational amenorrhoea method is an effective contraception. Use of another contraceptive method is recommended if supplemental feeding is introduced, menstruation resumes, or six months have past since childbirth.

Periodic abstinence and withdrawal This has a high pregnancy rate in typical use, requires considerable motivation and knowledge, and is difficult to use by adolescent females, with irregular menstrual cycles. Neither of these methods offer any protection against STD. Additionally, only about 30 percent of females have correct knowledge of the fertile period in the menstrual cycle. Withdrawal, if it is the only option available, may be better than no method. It requires the man to do the opposite from his usual desire (i.e. pullout and move away from his partner when his desire is to push deeper, clasp and hold more firmly).

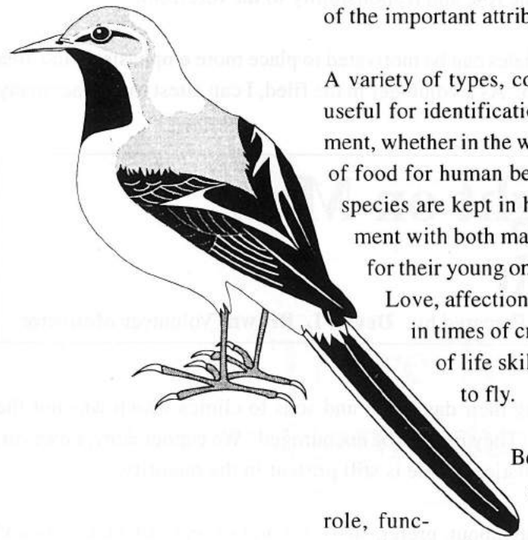
The contraceptive needs of adolescent who have recently borne a pregnancy or experienced a pregnancy loss (spontaneous or voluntary interrupted) are such that most methods may be offered in the post-abortal period, provided there is no infection of the reproductive tract and/or the duration of the pregnancy before loss was less than seven months.

Post abortion contraception: Where pregnancy loss occurs 12 weeks or less, any method can be used if no infection is present or pregnancy loss during 13-28 weeks. However, wait for at least six weeks if the female barrier methods are to be used. For adolescents in the post partum period (up to six weeks after delivery) the timing of initiating contraceptives and the method of contraception used depends on whether or not the mother is breast-feeding.

Post partum contraception: Breast-feeding immediately use LAM, condom, spermicides, IUDs or sterilization; after six weeks use diaphragm, cervical cap, or progestin-only contraceptives. After six months combined oral contraceptives can be used. If not breast-feeding, adolescent can immediately use progestin-only methods, or combined oral contraceptives after three weeks.

In trying to answer the question as to the best approach to contraception for an adolescent who is sexually active, a dual method is recommended, namely a primary method for pregnancy and condoms for STD prevention, or a primary method for pregnancy and STD prevention (condom) and emergency contraception. •

Beyond The Birds And The Bees



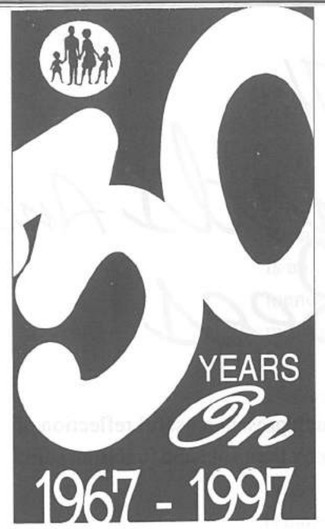
Birds and bees are two types of creatures which present a useful reflection of life. Full of energy and usefulness, they show by their role and function, some of the important attributes of daily living.

A variety of types, colours, shapes and sounds peculiar to each species and useful for identification, birds are beautiful and adjust well to their environment, whether in the wild or in domestic life. Birds contribute to the production of food for human beings and the propagation of plant life, and while a few species are kept in homes as pets, birds live in a family - oriented environment with both male and female parent sharing the responsibility of caring for their young ones until they are mature enough to function on their own. Love, affection and support are provided by the parents, and protection in times of crisis. Birds demonstrate caring, sharing and the teaching of life skills, especially by the female, as in teaching young birds to fly.

Bees on the other hand, are organised into discrete type -- drones, workers and queen bees, each with its specific role, function and defined task fashioned by nature. They live a very busy and active life by night and by day, and their rest periods are not as visible as those of the birds. For survival, they have their own defense mechanism of "stinging" when disturbed and they also display an established system of keeping the family at a size to match their resources of food and space.

Birds and bees are endowed with instincts and function as prescribed by nature. They have highly developed means of communicating among themselves and the quality of this skill contributes to the success with which they achieve their goals, high levels of productivity and longevity.

Human beings are blessed with senses, capable of functioning beyond the realm of bees and birds. These senses help to govern behaviour, make choices, communicate with each other, develop positive life-styles, attitudes and values, and to learn and utilize a variety of life skills suited to each situation. The productive life skills of the birds and the bees such as communication, positive parenting, caring, sharing, production through team work etc. are examples which adults and children can apply to their own situations and thus establish successful relationships in the home or at the workplace. •



Turning The Spotlight on Male Reproductive Health

Prepared by: **Devon L. Brown,** Volunteer Motivator

Why all the fuss about male reproductive health? Firstly, there is a strong belief that every effort must be made to erase many of the prevailing myths on this subject, as the future of our society depends on the health, character and conviction of people. Family life education programmes have traditionally tended to place emphasis almost exclusively on females and I believe there is the need to correct this imbalance by bringing issues of male role and responsibility to the forefront.

I do believe that the males can be motivated to place more emphasis on the area of reproductive health. As a volunteer in the filed, I can attest to the fact many fathers are now taking their daughters and sons to clinics which was not the case in times gone by. They need to be encouraged. We cannot deny, however, that the male chauvinistic attitude is still present in the majority.

What do we really care about, prefer, strive for and expect satisfaction from? Due to economic difficulties, one finds much more emphasis is placed on the value of money than the value and morals of health, sexuality, reproduction, cure and prevention of diseases and life. A great number of young males care mostly about acquiring the title of gallis (girls' man) and prefer to satisfy their ego by engaging in promiscuous sexual behaviour. The term **gallis or girls' man** is popular and drives the desire for sexual pleasure as a common place activity. But shouldn't there be a need to examine the changing pattern of values among males? Afterall, values provide the context for realistic consideration of what is needed to become an individual and build a proper society.

Morals, values and attitudes have got to be primary educational tool in programmes for males, particularly, adolescents if they are to have a better understanding of good reproductive health. There is a saying *"if you want to gather honey, don't kick over the bee hive"*. The fact is that a great number of the male gender do not understand the reproductive system, its importance and function and the part they can play in contributing to making this system a healthy one. It's revealing, that with respect to knowledge of sex education women far outstrip the men, which impacts on the society as evidenced by participation levels in family life education seminars and programmes, where women always outnumber men.

Turning closer to our concern, I think we can safely say that just as how family planning methods have had a positive impact on birth control, the awareness of male responsibility can be increased if there is heightened focus.

There is a need for more family life education programmes at the community level with an emphasis on male awareness in reproductive health matters. Key to its success is that such concerns must also become part of the activities which are male dominated such as sports programmes, football, cricket, basketball, etc. The media, especially television and the movie houses, can also play a part by reducing the promotion of illicit sex and immoral attitudes and play a more positive role in increasing awareness among the youth. Concern for stable relationships and the idea of respect for life and property cannot be ignored.

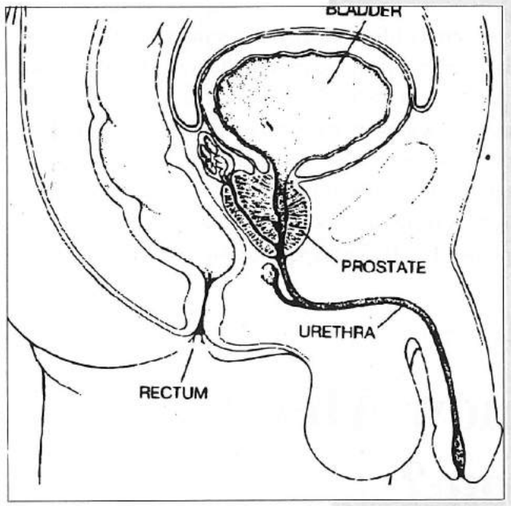
What's There To Know About Human Reproduction ?

Prepared by: ***Newton Wynter***, *Regional Liaison Officer (Southern Region)*

To understand how the human body works, it is important to know about the structures and functions of its systems and organs. A knowledge of the reproductive system can help us better understand issues of sexuality, both our own and others. Afterall, this knowledge can lead to responsible behaviour that will influence your health and well-being.

Think about your family. How much are you like other members of your family and how do you differ? Many of your features were determined by your biological parents and these help you become a total person with developed mental, physical, and social characteristics. Heredity is the transmission of features from one generation to the next and parents and offspring have many features in common. Yet no two persons are alike. Living things are composed of cells and each cell has a nucleus that contains chromosomes with genes. It is these genes that are responsible for transmitting these features from parents to offspring.

The development of a new individual begins with two cells -from the male sperm and the female ovum. These cells unite in a process called fertilization, or conception, forming a single cell or zygote. A zygote is fertilized ovum and contains genes from both parents. In order for us to fully understand the process of fertilization it is important in the first place that we understand both the male and female reproductive system and how each functions.



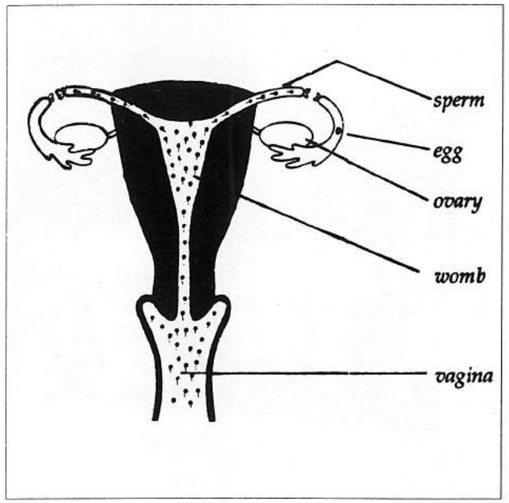
Male Reproductive System

The male reproductive system is not just the penis and testes or testicles that lies outside the body. Inside, there is a system of ducts and glands essential in sperm production and delivery. From puberty to old age, the male produces millions of sperm in the testes on a daily basis. As sperm cannot develop properly at a normal temperature, the testes hang outside the body in the cooler sac called "the scrotum". From the testis, sperm pass into a coiled tube at the back of each testis - the epididymis - where they are matured. When a man ejaculates, muscle contractions squeeze the sperm along the sperm duct or 'Vas Deferens' and into the urethra, passing on its way, the seminal vesicle, and prostate gland. These two glands produce fluids which nourishes and mobilize the sperm and make up the bulk of the semen that is ejaculated form the penis. The penis contains spongy erectile tissues, which are filled with blood during an erection. The head or glans, is highly sensitive. Sperm are ejaculated from the penis through the urethra. This is a normal channel for urine, but the muscles at the bladder entrance contract during erection, so that no urine enters the semen, and no semen enters the bladder. Any sperm that are not ejaculated are reabsorbed within a certain time into the man's body.

Female Reproductive System

The organs which make up the female reproductive system lie in the pelvis where they are protected. This system can be divided into two, an external and an internal reproductive system.

External Organs: During puberty, the external sexual organs or vulva, develop and mature. The vulva is comprised of the mons pubis, which is the pad of fat covering the pubic bone, and it becomes more fleshier and more prominent. There are two outer fleshy lips - labia majora - on which pubic hair grows, and two thinner and hairless inner lips - labia minora. Between these are the clitoris, at front, the opening of the urethra, in the middle, and the larger vaginal opening behind that.



Internal Organs: The internal system includes the eggs or ova in the ovaries, and these are in place at birth. At puberty , one egg matures each month, and is released into one of the fallopian tubes. If sperms are there after recent sexual intercourse, the egg may be fertilized. The fallopian tubes leads into the uterus or womb where the fetus (unborn baby) develops. The uterus is about and it is capable of huge expansion. It is usually tilts forward, almost at a right angle to the vagina. The neck of the uterus is called the cervix. This has a mucus plug which at ovulation (when an egg is released), makes it easier for sperm to swim through. The vagina is an elastic tube running to the opening at the vulva. It is separate from the urinary system, which has its own opening - the urethra.

If an egg is not fertilized by a sperm on its voyage down the fallopian tube, the lining of the uterus, which has prepared itself for the egg, is shed through the vagina,. This monthly shedding of the uterus is called 'period' or menstruation. If on the other hand, fertilization had occurred in the fallopian tubes, the zygote would move to the uterus, where it would become embedded. After a period of approximately 40 weeks, the foetus then leave the body through the cervix via the vaginal passage, and a new life would begin. •

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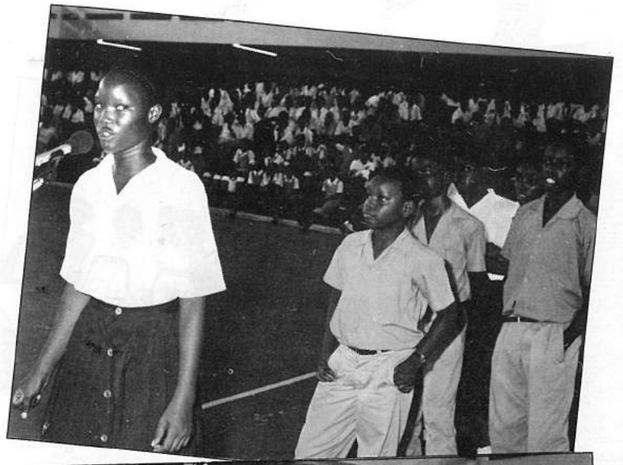

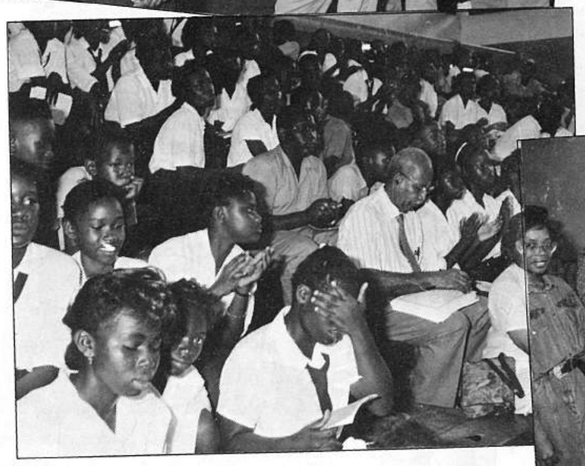

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Decades Of Progress

The Emergent Years, 1930s - 1966

Family planning services were first available in Jamaica in the 1930s through the efforts of a number of committed individuals. In the 1950s, services were strengthened when social work associations and interest groups collaborated and established the Jamaica Family Planning Association. In 1963, the Government of Jamaica (GOJ) officially recognized the problems associated with population growth and the need for family planning. Consequently, the Government initiated services in selected hospitals, and established a special unit in the Ministry of Health (MOH) to give direction to and cooperate with non-governmental organizations (NGOs) in the provision of these services. These initiatives were enhanced by the Bureau of Health Education, which began providing training and educational materials in family planning.

The Development Years, 1967- 1980

In 1967, the GOJ created the National Family Planning Board (NFPB), and throughout the1970s, family planning gained greater visibility and importance in the national development agenda. The NFPB empowered by the National Family Planning Act of 1970, became the Government agency responsible for preparing, implementing, coordinating, and promoting family planning services in Jamaica.

The 1970s were also landmark years for programme implementation: Family Life Education (FLE), teacher training workshops, a scheme for the commercial distribution of condoms and oral contraceptive pills (Panther and Perle), and the use of mass media (radio, television, billboards, and print) in the educational and information dissemination strategies.

In 1974, the GOJ officially integrated family planning services with the MOH's primary health care programme, thereby greatly increasing the number of health centers offering family planning. By the end of the decade, an island-wide-network of family planning clinics was operating and birth rates had decreased from 34 per 1,000 in 1970 to 28.

The Expansion Years, 1981- 1995

Throughout the 1980s, the family planning programme began to soar to new heights as a result of several benchmark events. The NFPB set-up specialized family planning clinics in undeserved areas, and international donors accelerated support for clinical counselling services in public clinics. The GOJ officially adopted the National Population Policy in 1983, which reinforced political commitment to the reduction of fertility and the expansion

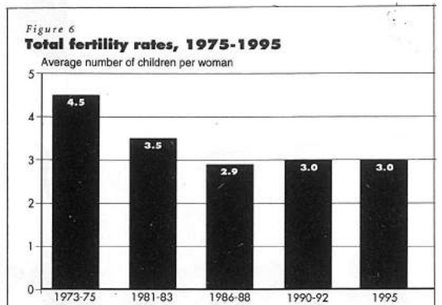
of family planning services for all men and women of reproductive age.

Multiple public and private sector projects increased the availability of family planning and introduced alternative approachs to service delivery. Highlights from this decade included establishing the following:

- male responsibility programmes
- community-based distribution of contraceptives in rural area
- an adolescent fertility centre
- introduction of the Parish Liaison Officers Programme
- mobile units integrating family planning into nutrition programmes
- services designed for teenagers in urban areas.

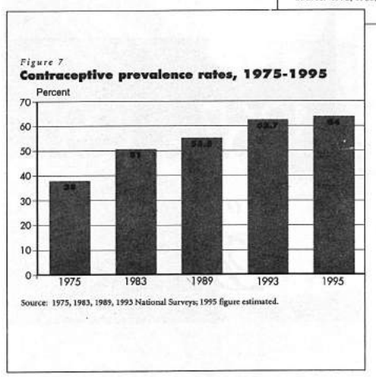
Since 1990, the Programme has focused on increasing consumer access, improving service quality, and achieving financial sustainability. Between 1992 and 1995, surveys and special studies helped to define unmet needs, legal and regulatory constraints to increasing private sector participation in family planning service procision. New technologies were introduced, including NORPLANT, female sterilization under local anesthesia, and no-scalpel vasectomy for men. A commercialised initiative 'Personal Choice' introduced a wide range of safe, low-dose oral contraceptive pills and depo-provera injectables at prices affordable to many more Jamaicans. In 1994, the Government assumed greater financial responsibility for public sector contraceptive procurement due to dwindling donor resources and the growing need for family planning services.

Figure 6
Total fertility rates, 1975-1995



Source: 1975, 1983, 1989, 1993 National Surveys; 1995 figure estimated.

Figure 7
Contraceptive prevalence rates, 1975-1995



Source: 1975, 1983, 1989, 1993 National Surveys; 1995 figure estimated.

Thus, during the expansion phase, the family planning programme significantly increased consumer awareness and service access, expanded contraceptive choice, and consolidated into a cohesive national programme encompassing a large number of public and private sector organizations.

Measurable Achievements

Over the last two decades (1975 - 1995), the National Family Planning Programme has made many remarkable achievements. These include:-

- The average number of children per woman (Total Fertility Rate - TFR) has decreased from 4.5 children to 3
- Contraceptive use (Contraceptive Prevalence Rate - CPR) has increased from 38% to 64%
- The level of awareness of family planning is nearly universal, enabling people to make more informed choices regarding family planning size and the spacing of their children.

With these accomplishments, family planning has made an important contribution to the nation's development goals by contributing to a reduced population growth rate, and increasing Jamaica's capacity to alleviate poverty and achieve economic progress. By helping individuals plan for their future, the initiative has improved the quality of life. Its far-reaching impact continues to influence every sector in the building of a solid foundation for a sustainable future.

Media Role In *Family Planning Empowerment*

Prepared by: ***Llewellyn O'Reggio,*** *Assistant Director IEC (Communications)*

nformation is perhaps the most powerful tool available to people, one that opens up new possibilities for the exercise of both rights and responsibilities. This perspective on information is at the heart of what is known as "IEC", or information, education and communications.

The two primary goals of IEC programmes in family planning are complementary. One is to enhance the ability of couples and individuals to exercise their basic right to decide freely and responsibly on the number and spacing of their children. The other is to raise awareness and understand about the relevance of population related issues to all levels of decision making, whether personal, national or international.

IEC programmes inform and motivate people to make decisions freely and responsibly, and utilize a range of communication channels, from one to one counseling to formal school curricula, traditional theatre, and public seminars and community meetings. The mass media --newspapers, radio, film and television are important carriers of population and reproductive health information. Programmes for teenagers can communicate the health and other risks associated with early pregnancy and childbearing. Schools are an important vehicle for reaching young people, while less formal education on population and reproductive health issues can be conducted at the workplace, health clinics, trade unions, community centre, youth groups, churches, women's organizations, and through vocational training and literacy programmes. In all cases, the design of information programmes should involve the target audiences so as to better ensure the relevance of the information provided.

In its thirty years, the NFPB's Information, Education and Communications (IEC) Department has undertaken many campaigns to empower Jamaicans with the knowledge

and skills to engage in healthy sexuality, infection-free sex, improve parental responsibility and safely achieve their reproductive intentions.

Among some of the specific focus areas of the IEC Department over the years have been:

- Community outreach and development of materials, media programmes and counseling
- Providing information for the service delivery and outreach workers in order to assist them improve the quality of family planning care provided
- Promoting family planning through mass media, printed materials, face to face counseling and other strategies
- Providing more specific information about different contraceptive methods, side effects and advantages/disadvantages.

Currently, the primary audiences for the IEC programme are the teenage population (males and females), the most fertile age group of women (20-29), the discontinued contraceptives users and females with two or more children, particular at postpartum.

The 1970s were landmark years for programme implementation and among the highlights can be included family life education, teacher training workshops, the commercial distribution of condoms and oral contraceptive pills, use of mass media (radio, TV, billboards, and print) and the launch of the "Two Child Family" campaign. An answering service was established in 1975 to reply to letters from clients, as well as answer telephone calls and give counseling and general information. This 'Marge Roper's service continues. In the late 1970s to the mid 1980s, one of the objectives for the IEC Department was to promote and sustain large scale nationwide information, education and communication programmes in family planning, population and family life, utilizing all available channels. To this end a number of activities were developed including a Male Education programme between 1982 and 1986 that sought to promote male responsibility among males towards their partners and children. Also, to motivate males to think and act responsibly in matters relating to childbearing and fatherhood, to practice family planning and to support their partners in its use. The Training Unit within the IEC Department was and still is, responsible for organizing such workshops with support from the Field Service and Communications Units.

"Teen Scene" was another successful activity that was initiated in 1983 which took the form of a walk-in health care, recreational, vocational training and family planning counseling centre for teenagers in a Kingston neighbourhood. NEET (Now Entering Education for Tomorrow) was another successful IEC activity supported by the NFPB. It sought to link family life/sex education and contraceptive delivery services with health screening and recreational and training activities.

By far the most successful IEC campaign carried out by the NFPB was Two Child Family Campaign in 1983. Initially, it addressed issues of unplanned parenthood, bearing too many children, inability to cope financially and socially in meeting the basic needs of children. The message was carried both in the press and electronic media with the most impacting ones being the Judy Smith /Bev Brown advertisements in 1983 and 1985.

A World Bank study of IEC strategies implemented by the NFPB including the "Two Child Campaign" concluded that the objectives had been met as people were more favourable to smaller family size and to family planning. It also found that while people had a high awareness of contraceptives and were positively disposed towards it, usage was comparatively low; an analysis that the IEC Department found very challenging. As such, there had to be a shift in the focus of the mass media strategies. To respond to the tremendous socio/economic challenges of the 1990s, the NFPB developed a broad five year strategic plan, which articulates and prioritizes the key issues and interventions to be implemented. The expansion and sustainability of the family planning service delivery, adolescent health, promoting longer term methods as a more cost effective intervention, and shifting consumers of family planning services more towards the private sector became top priorities.

Targeting specific audiences, such as men, adolescents and young couples, is crucial to the success of IEC programmes.

The 'Personal Choice' programme, the Private Providers Project and the Mass Media Adolescent Campaign are some of the later initiatives, all with IEC components which seek to not only provide a family planning service but create greater awareness of each project and wider family planning issues. The IEC components of these initiatives were managed and coordinated by external communication agencies, with the NFPB's IEC department playing a monitoring role.

The 'Personal Choice' programme deals with introduction of a range of products and services under the "Personal Choice" name including a wide range of safe, low dose oral contraceptive pills and Depo provera injection at prices affordable to many more Jamaicans. The communications/PR component includes TV, radio and print promotional materials.

The 1995 mass media campaign aimed at adolescents and young adults sought to bring about a positive change in attitudes and sexual behaviour among this group of persons as well as encouraging the conscious management and understanding of both. It targeted youngsters from age 9-19 years through radio and TV advertisements, and posters.

The 1995 Private Providers Project was an initiative to test an organised approach at greater participation of private physicians in family planing service delivery. The goal was to increase private provider 'share of overall family planning services delivery in specific geographic areas and all activities were supported by a communications strategy to stimulate a consumer demand for the use of private sector services through promotional material for community an provider awareness.

As the NFPB head into a new millennium, use of the new communication technologies can help bridge the geographical, social and economic gaps that currently exist in access to reproductive health information across Jamaica and the wider region. Television and computer networks, global telephone systems, digital data and new multimedia technologies are tools that people can use to access the information they need.

The Communications Unit of the IEC department at the NFPB has committed itself to upgrading its multimedia capability by acquiring a professional system that includes a camera and non-linear digital editing system that has the ability to network with other production houses islandwide. A desktop publishing system that can integrate video system, thus enhancing its possibilities with regards to the production of high quality brochures, flyers and news and other print product, will also be put in place.

Presently, the Communications Unit has been focusing on using the mass media as an avenue of expression. Public Service Messages (PSMs) have been developed and produced for airing on television stations and for use by IEC in the field. Our Youth Forum during National Family Planning Week takes the form of a television production which is later aired. With new video equipment, our reproductive health video products will expand to cover a variety of issues.

The Library is being upgraded into a computerised Research and Documentation Centre providing for quick input and retrieval of information and reproductive health data. Information coming out of this Centre will also include the Internet and eventually networking with related agencies/ organisations islandwide.

In keeping with the NFPB mandate, we will continue to use all available channels of information, education and communications to empower our people with the knowledge and skills necessary to lead to healthy sexuality and achievement our reproductive intention safely and in good health. •

From Cairo to Beijing:

Prepared By: Mrs Beryl Chevannes, NFPB Executive Director

Whither Jamaica's Population Programme

The Plan of Action of the International Conference on Population and Development held in Cairo, Egypt, September 5 - 13, 1994 calls for reproductive health programmes which are based on a health and development imperative. It calls for an integrated approach to service delivery and for an increased focus on the quality of services.

It demands that increased attention be paid to the involvement of men and young people in programmes of family planning and stresses the importance of free, informed decision making in reproductive health matters, while stipulating that individuals must be involved in the development of services, as partners in a common endeavour.

The Plan agreed on by over 180 countries, calls for universal access to reproductive health which affects and is affected by the broader context of people's lives, namely their economic circumstance, education, employment, living conditions, family environment, social and gender relationships, legal and traditional structures. In addition, reproductive health programmes must address as priority issues - family planning information and services in order to permit couples to make free and informed decisions about the number, timing and spacing of their children.

Other issues to be addressed include:

- prevention of maternal and new born deaths and disabilities
- safe motherhood and the prevention and management of sexually transmitted diseases
- attention to special target groups such as adolescents, men, and women.

It promotes the advancement of gender equality, the empowerment of women, and the elimination of all kinds of violence against women, ensuring their ability to control fertility which is critical to population development.

The 4th World Conference on Women (FWCW), in Beijing from September 4 -15, 1995 reaffirmed and strengthened the Cairo consensus. Much of the language on reproductive health and rights was incorporated directly into the FWCW platform for action. The document states that good health is essential to leading a productive and fulfilling life, and the rights of all women to control aspects of their health, in particular, their own fertility is basic to their empowerment. Human rights include the right to have control over and decide freely and responsibly on matters related to sexuality including sexual and reproductive health, free of coercion, discrimination and violence. It called on Governments to ensure equality and non-discrimination under the law and in practice by taking action to protect these rights.

In response to the Cairo and Beijing Plan of Action, the population plan of action of Jamaica tabled in Parliament and adopted in 1996, has been modified to enhance the international stance. Jamaica's Plan of Action seeks to implement the objectives and recommendations of the Cairo (1994) Conference, with the adoption of a multi-sectoral approach to population and development, which includes reproductive rights and reproductive health.

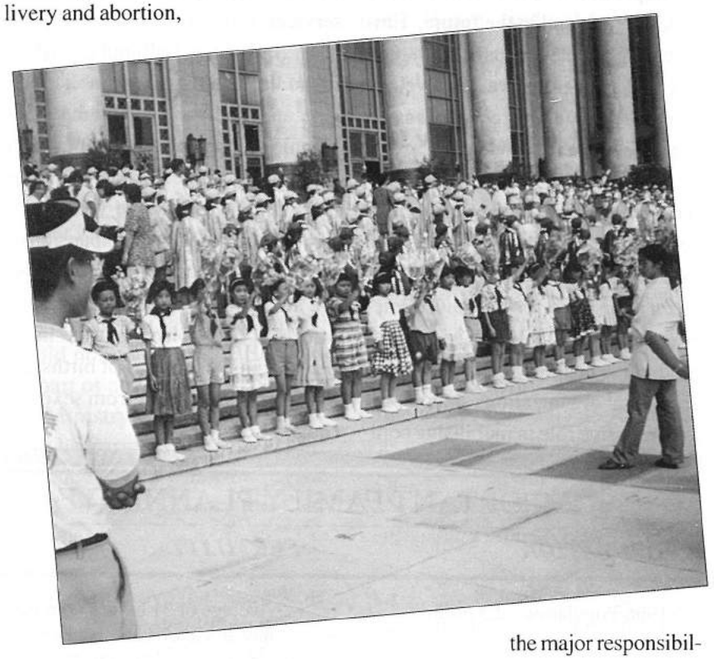
The objectives of reproductive rights and reproductive health are to:

- Ensure that comprehensive and factual information and a full range of reproductive health care services, including family planning is accessible, affordable, accept able and convenient to all users
- Enable and support responsible voluntary decisions about childbearing and methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so
- Meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

The document states that Jamaica should further strive to make accessible through the primary health care system reproductive health care to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of Primary Health Care should *inter alia* include family planning counseling, information, education, communications and services. Services should be provided for parental care, safe delivery and postnatal care especially breast feeding infants and women's health care, prevention and appropriate treatment of infertility.

Management of the consequences of unsafe abortion, treatment of reproductive tract infection, sexually transmitted diseases and other reproductive health conditions and information, education and counseling as appropriate on human sexuality, reproductive health and responsible parenthood should be strengthened.

Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion,



infertility, reproductive system diseases, sexually transmitted diseases and HIV/AIDS should always be available as required.

Reproductive healthcare programmes should be designed to serve the needs of men and women including adolescents and must involve women in the leadership, planning, decision making, management, implementation, organization an evaluation of services.

Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning, domestic and child rearing responsibilities and to accept

the major responsibility for the prevention of sexually transmitted diseases.

Programmes must reach them at their work places, at home and where they gather for recreation. Boys and adolescents with the support and guidance of their parents and in line with the Convention on the Rights of the Child should also be reached through schools, youth organizations and wherever they congregate.

Reproductive behaviour and reproductive rights are closely linked to the attainment of other social rights and opportunities. Both international Plans recognised that sustainable development is defined by, among other things, a better quality of life for all people regardless of gender which means a development agenda that focuses directly on meeting the needs and hopes of individual men, women, children now and in the future. Empowering people to escape from poverty and accelerate overall development will require the recognition and exercise of their basic right.

Jamaica should over the next several years assess the extent of unmet need for good quality family planning services and strive for the future integration of family planning in the reproductive health system. Non-Governmental organizations should play a more active role in mobilising community and family support, in increasing access and acceptability of reproductive health services including family planning. As part of the effort to meet unmet needs, Jamaica must seek to identify and remove all major remaining barriers to the utilization of family planning services. Some of these barriers are related to inaccessibility, inadequacy of and ambivalence toward family planning services.

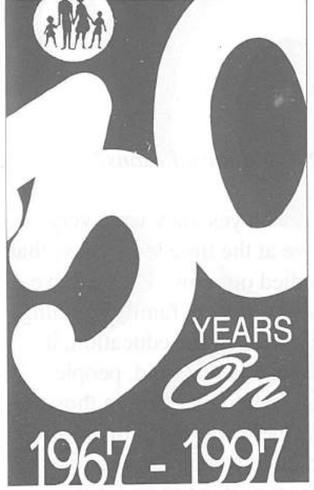
It should be the goal of public, private and non-governmental family planning organizations to remove all programme related barriers to family planning use by the year 2005, through the redesign or expansion of information and services to increase the ability of couples to make free, informed decisions about the number, spacing and timing of births and to protect themselves from sexually transmitted diseases.

The National Plan of Action report 1995-2015 for Jamaica, prepared by the Planning Institute of Jamaica outlines what must be done over the next decade based on these broad objectives as well as those identified for family planning , sexually transmitted diseases, human sexuality and gender relations, adolescents an the basis for action.

The NFPB as an agency of Government responsible for promoting and implementing family planning and population related activities will continue through its strategic plan to implement and improve its reproductive health programmes to improve the quality of life of individuals/ couples can contribute to sustainable development as a result of its interventions. •

IMPORTANT FAMILY PLANNING FACTS AT A GLANCE

POPULATION	*FERTILITY*	*CONTRACEPTION*
1996 Population - 2.5 million	Average of 31 babies born per day at Victoria Jubilee Hospital	Family planning services available at 300 centres islandwide
Male/Female ratio is 1.1 1,259, 500 males 1,268,200 females	Mean age of menarche 14 yrs	70% of women 15-49 yrs. are in a union
42% of population under 20 yrs	Average age of first sexual intercourse for adolescent males is 14 years; and 17 years for females	Contraceptive Prevalance Rate (CPR) in 1993 was 63%
St.Catherine is Jamaica's fastest growing parish (Portmore which was virtually non-existent in 1970 grew to 94,000 in 1991; while Spanish Town grew to 110,000)	Females 20-24 years are the largest contributors to fertility, followed by those 25- 29, and 15 -19 years	Among new public sector clients of family planning services - 36% use the pill, 29% use the condom, & 34% use the injection



ReflectionS

The way it was back then

Interview with Mr. William Lumsden, former NFPB employer conducted by Nadene Newsome, Communications Officer

N.N. *When did you start working with the NFPB?*

W.L. I started working with the NFPB in January, 1970.

N.N. *What were some of the programmes of the Board while you were here?*

W.L. Integration is the one which stands out most in my mind. I recall the implementation of an integration plan back in April 1974 and although the NFPB was retained, its role was altered under the new plan in that while the Board was still responsible for co-ordination, information, training and evaluation of family planning activities, the actual delivery of services was within the Ministry of Health. As of that date all health institutions were expected to include family planning services at anytime a health centre or clinic was open.

N.N. *Was it that integration was about a more uniformed and expanded family planning programme?*

W.L. Yes, when I went there, the Board handled everything, we set out all the policies, we made all the plans, etc. The MOH attended a worldwide conference in Bucharest, I don't know if you have heard about it... but Dr. McNeil participated in that conference and he really came back with the whole idea of integration, that family planning should not be left to the Board but part of an islandwide policy. The Ministry actually took over and The Permanent Secretary at the time became Chairman of the Board and the C.M.O., the Vice Chairman.

It did not remove the powers of the NFPB completely but the Ministry was mainly the Managers. They had to retain the Board if they still wanted to get assistance from USAID. I believe that is the only reason why they retained the Board.

N.N. *Oh... what kind of assistance?*

W.L. They wanted to continue getting contraceptives and other help from USAID, and as it was at the time, it was from USAID to the Board, and not to the Ministry. They actually used the Board really.

N.N. *How was it under integration at the Board?*

W.L. It was confusion at first; the Board was trying to do this and the Ministry was counteracting what they were doing; it was really chaos, and it showed in the statistics, as the first integration came in 1974, and by 1975 there was a drop all over...

N.N. *You mean a drop in contraceptive acceptor levels?*

W.L. Yes, the whole thing. Gradually the misunderstanding started to disappear and the Board came to accept the fact that the Ministry was calling the tunes.

N.N. *When did you leave the NFPB?*

W.L. In 1978

N.N. *Was the Board still integrated with the Ministry of Health?*

W.L. Yes, but by that time they had worked out all their differences, more or less, and everything was running smoothly.

N.N. *What are your impressions of family planning now as opposed to back then?*

W.L. I don't know if I have given it much thought... I don't know what's happened now as I don't go there anymore, but there is no maybe about it; the programme has worked. I don't know about this period, but over the entire period, it has worked.

I think that by the year 2000 they wanted to achieve 2 children per woman but ... do they still have educational officers there?

N.N. *Yes, but under a new name. They are called Parish Liaison Officers and are placed in all the regions. Did they have the Field Services Programme when you were there?*

W.L. No, not before integration.

N.N. *What about Mass Media Campaigns, do you remember the "two child family" campaign, did it start while you were there?*

W.L. Yes, it started while I was there, I think it was 'two is better than too many'. That was part of the goal of having 2 children per woman.

N.N. *What about the public's perception, people caught on to the "two child family" advertisements?*

W.L. Yes, they had it on radio, and Marge Roper became quite popular. You know about Marge Roper?

N.N. *Yes, and we still have Marge Roper.*

W.L. She was extremely popular at one time. There was more talk of family planning in my time than now, because what has happened people have accepted it (family planning) now. They don't discuss it now as in the past.

There was a lot of debate in the early years... oh Lord... a lot of argument about ' if family planning come to kill black man' and arguments to 'have out your lot' and all kinds of things. Oh there was constant arguing in those days.

N.N. *Strong opposition came from the church?*

W.L. Funny enough, the Church in the beginning did not put much opposition, even the Roman Catholic Church that is opposed to contraceptives in their religion, did not interfere much in the family planning programme.

N.N. *Did Rastafarians?*

W.L. Oh yes, they were very active at the time but I guess that has died out now. People have grown to accept family planning, what with all the education, it has gone to the wind, people have caught on. Yes, in those days there was much discussion and there were many arguments against as there were for it.

N.N. *Tell me something about staff relations at that time?*

W.L. Oh... it was terrible at integration, staff were leaving. You know the Nurses at the time could have worked with the NFPB and still do sessions but at integration this was no longer possible, so they left the Board. Then you had the question of what would happen to their pension... I started up the pension scheme, it was really confusing, you don't know whether you were coming or you were going.

N.N. *Who was the Minister of Health at the time?*

W.L. Mr. Ken McNeil, the Chairman of the Board was Dr. Phylis McPherson-Russell.

N.N. *Mr. Lumsden, thank you so much. It was really a pleasure speaking with you.*

30 YEARS On 1967 - 1997

Our Honour Roll of Past Chairmen

Prof. George Roberts (1968-69)

Sir John Mordecai (1969-70)

Dr. R.E.D. Thwaites (1981-89)

Dr. Lenworth Jacobs

Dr. Phyllis McPherson - Russell (1974-76)

Missing are photos of :
Mr. Alvin Rattray
Dr. Ronald Lampart

Mr. Conroy Allison(1976-79)

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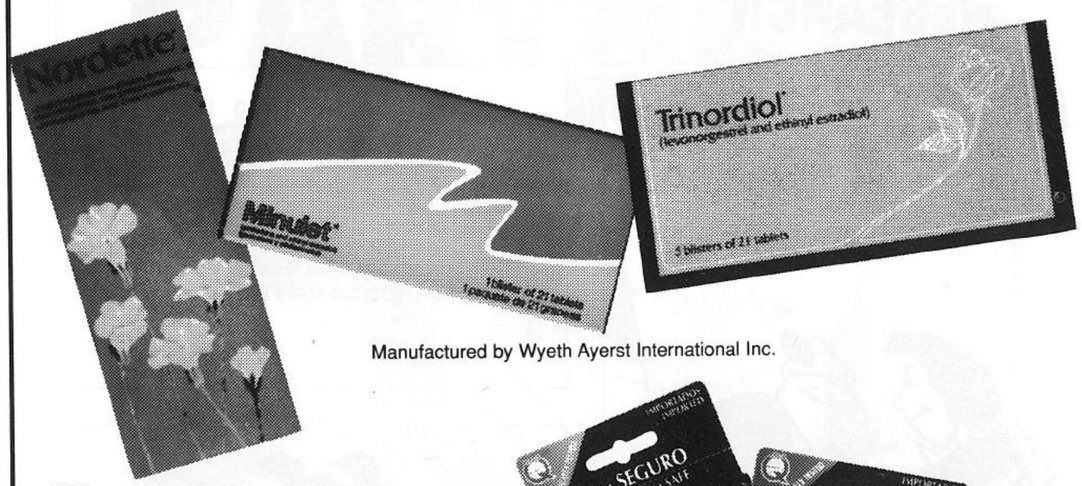

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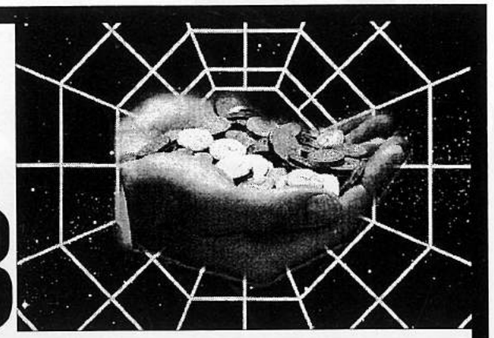

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Special Activities to Mark Anniversary

A range of special events have been planned to mark the 30th. anniversary of the National Family Planning Board (NFPB) and this special magazine, which is one of the strategies, is pleased to highlight, for the benefit of our readers, some of these activities

Addressing a launching press conference to announce details of the 30th Anniversary programme, Committee Chairman, Dr.Olivia McDonald highlighted a long list of activities such as a travelling exhibition, youth forum, quiz competition, staff day, long service awards, special church service, health conference, public forum, and more as among the special anniversary events.

This commemorative journal is also one of the activities and presented below are details of the line up of events and activities and the proposed timing. We also take a pictorial look back at some some of the activities which have already taken place. Still to come among the special anniversary activities are:-

- National Quiz Competition - October 1997
- Public Forum/Health Conference on Reproductive Health - October 1997
- Commemorative Magazine - October 1997
- National Family Planning Week - October 1997
- Travelling Exhibition - October/November 1997
- Staff Day 1997 - October 1997
- Youth Forum - October 1997
- Staff Long Service Awards Ceremony - October 1997
- Staff Fun Day - November 1997
- Quiz Competition Finals - December 1997

1. Rev. Devon Dick greets Mrs. Chevannes at Anniversary Service.
2. Chairman Prof. Wynter (2nd left) leads Anniversary Service
3. Courtesy call on Governor General, 30th Anniversary patron

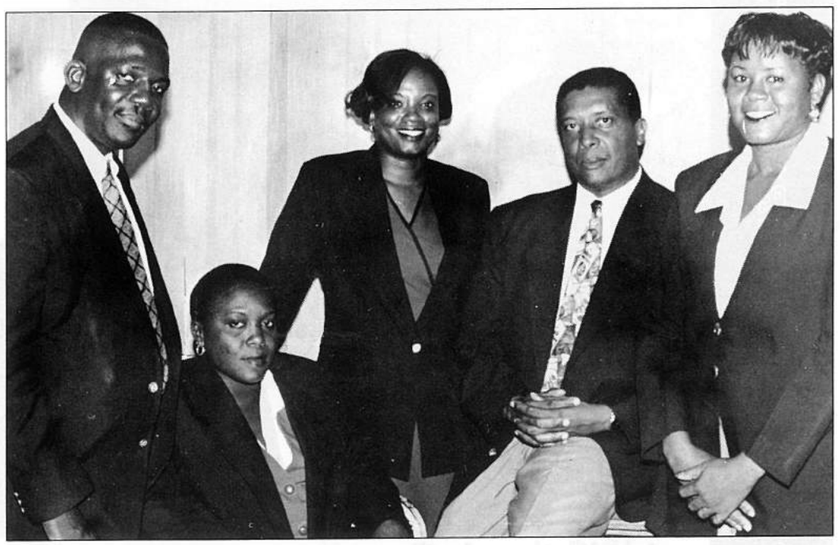
Doing It Right...
30 Years and Beyond

ADMINISTRATION: (L -R) Elaine Barrett, Secretary to Executive Director; Letty Hilton, Registry Clerk; Wayne Mitchell, Vehicular Control Officer; Camille Santo, Administrative Secretary; Vinette Simpson, Logistics Manager; Dianne Thomas, Public Relations Officer

ADMINISTRATION: Beverly Taylor, Snr. Administrative Assistant; Patricia Woolaston, Executive Officer Administration; Wilton DaCosta, XEROX Operator; (insert) Dawn Lindo, Receptionist

ACCOUNTS: Bridgette Thompson, Cashier; Gerald Wright, Accountant; Hyacinth Hall, Secretary Accounts; Milton Knott, Director of Finance; Melrose Barrett, Payroll Clerk; Trevor Lawrence, Accountant; Leonie Barnes, Clerk Accounts

Missing: Pedro Henry, Senior Accountant; Andrea Reynolds, Clerk Accounts; Augustus Moodie, Internal Auditor



COMMUNICATIONS: Neville Donaldson, A.V. Technician; Dorett McLean, Librarian; Nadene Newsome, Communications Officer; Leo O'Reggio, Asst. Director Communications; Nadine Dixon, Secretary

OUR 30TH ANNIVERSARY STAFF

PROJECTS, RESEARCH & STATISTICS: (L-R) Vivienne Soares, Clerk, Statistics; Audrey McDonald - Secretary; Bethgee Stephenson - Statistical Officer; Ellen Radlein, Director, Projects Research & Statistics; (insert) Phillipa Baxter, Statistical Officer

Missing from Photo: Easton Josephs - Statistician

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OFFICE ATTENDANTS: (L-R) Josephine Pratt; Joan Morris; Horace Taylor; Eunice Smith Rickman Donaldson - Chief Office Attendant; Dorothy Nelson

30 YEARS On 1967 - 1997

NFPB Highlights Concerns In 30th Anniversary Plans

FERTILITY RATE STILL TOO HIGH

s the National Family Planning Board (NFPB) marks its 30th year, its sight is set on further reducing Jamaica's total fertility rate(TFR).

The figure which relates to the number of children born to each woman has dropped from six to three children per woman. But according to NFPB Executive Director Mrs. Beryl Chevannes the target for "the year 2000 and beyond" is to push the rate, even further down to two children per woman.

"We recognise that's only three years away and with our young population and early adolescent fertility, it is going to be quite a target to achieve," Mrs. Chevannes said, adding that more realistic targets would be set when the results of the current reproductive health survey become available next year. The last such survey done in 1993, showed a declining fertility rate. "In spite of feelings in some places that the adolescent fertility may have increased, I think this is due more to the fact that we have more adolescents than that we have more pregnancies among them."

Meanwhile, NFPB Medical Director and Chairman of the Anniversary Committee Dr. Olivia McDonald sees a need for greater emphasis on the role of men in safeguarding their own and their partner's reproductive health., as "men's role in terms of contraception is not only in their use. If they can be encouraged to promote continuous use by their female partners or even to initiate use, we will be happy with that", Dr. McDonald said.

The use of condoms has increased in both genders and more so among men than in women. There has also been a 100 per cent increase in male sterilization, moving from 12 to 24 clients since the promotion started a few years ago. "We know from studies conducted elsewhere that it takes about 10 years, from the time a man thinks about (sterilisation) until he actually has the procedure done. Our expectation is that there is a group of men who may not be at the initial stage but could be somewhere in the middle, so maybe in another three years we could see an increase in the number," she said.

Family Planning Glossary

BIRTH RATE: *The number of births per 1,000 population in a given year*

CONTRACEPTIVE PREVALENCE RATE: *The percentage of currently married or in-union women of reproductive age who use any form of contraception*

DEATH RATE: *The number of deaths per 1,000 population in a given year*

EMIGRATION RATE: *The number of emigrants departing an area of origin per 1,000 popultion in a given year*

GROSS DOMESTIC PRODUCT: *The total final output of goods and services produced by an economy. In the case of Jamaica, this excludes the output from Free Zone*

GROWTH RATE: *The rate at whcih a population is increasing (or decreasing) in a given year due to natural increase and net migration, expressed as a percentage of the base population*

IMMATURITY: *Live births weighing less than 2,500g or live births weighing more than 2,500g but who are clearly pre term (36 weeks or less)*

INFANT MORTALITY RATE: *The number of deaths to infants under one year of age per 1,000 live births in a given year*

LABOUR FORCE: *Economically active persons age 14 and over, including the Armed Forces and the unemployed, but excluding housewives, students, and other economically inactive groups*

LIFE EXPECTANCY AT BIRTH: *The average number of years a newborn would live if current mortality were to continue*

LOW-BIRTH WEIGHT: *Infants weighing 2,500g (5 1/2 pounds) or less at birth*

MATERNAL MORTALITY RATE: *The number of women who die from pregnancy and child birth complications up to six weeks postpartum per 100,000 live births in a given year.*

NATURAL INCREASE *(or Decrease)*: *The surplus (or deficit) of births over deaths in a population in a given time period*

PERINATAL DEATH: *A fetal death of a live birth occuring within 7 days of delivery*

POPULATION "DOUBLING TIME": *The number of years it will take for the population to double assuming a constant rate of reltively high concentration of women in the childbearing years*

POPULATION PYRAMID: *A bar chart, arranged vertically, that shows the distribution of a population by age and sex. By convention, the younger ages are at the bottom with males on the left and females on the right*

POVERTY LEVEL: *The absolute poverty line based on the cost of a minimum consumption basket necessary for a recommended caloric intake for an average family of five*

REPLACEMENT LEVEL FERTILITY: *The level of fertility at which a couple replaces themselves in the population. This situation leads to a stationary population size.*

REPRODUCTIVE HEALTH: *A state of complete physical, mental and social well being in all matters related to the reproductive system*

TOTAL FERTILITY RATE: *The average number of children a woman will have assuming the current age specific birth rates remain constant throughout her childbearing years*

UNMET NEED: *Sexually active women in need of contraception service and who are not currently pregnant or desire to be*

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