

# Access to contraception by minors in Jamaica: a public health concern

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## Abstract

**Background:** Access to contraceptive by minors (pre-adolescents and adolescents) has spurred policy and legislative debates, part of which is that in an effort to successfully meet government's objective of a healthy sexual lifestyle among minors. **Aims:** This study examined factors affecting sexual reproductive health in minors, namely: access to contraceptive advice and treatment, pregnancy, number of sexual partners, sexually transmitted infections (STIs) and confidentiality. **Materials and Methods:** This research involved quantitative and qualitative data. Two hundred and thirty eight sexually active cases were investigated in Jamaica by the researchers, during the period 2006-2007. The age group population was 9-11, 12-14, and 15-17. **Results:** The study showed that access to contraceptive advice and treatment by minors was more favorable to males than females. The difference in access to contraceptive between male and female was statistically significant ( $\chi^2 = 20.16$ ,  $p < 0.05$ ). Of the 80 male respondents, who are contraceptive users, 11 encountered challenges in legitimately accessing contraceptive methods, while 38 of the 40 female users also encountered challenges. This resulted in unintended pregnancies and impregnation (33.2%), as well as the contracting of STIs (21%). **Conclusion:** The findings of this study will be important in informing the development of reproductive health services and family life education programs for pre-adolescents and adolescents in Jamaica and other Caribbean countries.

**Keywords:** Contraceptive; minors; adolescents; pre-adolescents; Caribbean countries; Jamaica.

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## Introduction

Adolescents aged 10-19 years comprise about one-fifth of the world's population, which is equivalent to 1.2 billion young persons [1]. In the Caribbean, adolescents (10-19 years) represent about 20% of the population or approximately 1 million people [2]. One in every five Jamaicans is an adolescent. In general, this age group enjoys good health, accounting for only 2% of the deaths in 2003 [2]. Sexual activity begins at an early age for many Jamaican adolescent as among young people aged 15-17 who were surveyed in the 1997 Reproductive Health Survey, 38% of females and 64% of males reported having had sexual intercourse. The younger adolescents

are when they begin sexual activity, the less likely they are to practice contraception, thus increasing their risk of pregnancy [3].

In Jamaica, as elsewhere, adolescent pregnancy presents a serious social and public health problem [4]. Forty percent of Jamaican women have been pregnant at least once before they reach the age of 20, and more than 80% of adolescent pregnancies are unplanned. The total fertility rate has been falling over the past decades, reaching 2.5 children per woman in 2002 [5]. While birth rates have been falling and adolescent fertility rates reached 79 live births per 1,000 women aged 15-19 in 2002, the percentage of teenage pregnancies remains at 20%. One in

every four girls aged 15-19 years is sexually active, and 12% of the female population aged 15-19 has had two or three pregnancies. Twelve percent of girls ages 15-19 who are sexually active report having been pregnant. Of those pregnancies, 30% did not end in a live birth [6]. Early pregnancy has far-reaching effects on young people's educational, economic and social opportunities. Studies estimate that anywhere from 50% to 80% of young women do not return to school after giving birth [7, 8]. For young men, adolescent fatherhood is similarly linked to high rates of school drop-out, as young men are forced to enter the workforce and, oftentimes, the informal, lower-wage workforce, in order to support their young families [9].

The 2002-2003 Jamaica Reproductive Health Survey indicated that condoms are the contraceptive method most widely used by adolescents aged 15-19 years [5]. Contraceptive use at first intercourse in this age group was 76% for females and 44.9% for males. The average age of sexual initiation was 15.8 for females and 13.5 for males [5]. In the 2001 condom survey, 85% of sexually active girls, 15-19 years old, and 88% of boys reported that they have ever used a contraceptive [10]. The data reveal a startling gender disparity. While the contraceptive use rate for males increased from 31%, the first time they had sex, to 68% at most recent sex, females reported a drop from 58.8% to 52.6% respectively [10]. An estimated 19% of young women, ages 15-19, and 15% of those ages 20-24 have an unmet need for contraceptive services [11, 12].

The majority, 54%, of 15-19 year old males purchased their supplies from a small grocery or retail store. Most females, 46%, relied on their partners to provide the methods [10]. Approximately 21% of young women sourced contraceptives from clinics or health centers, compared to 8.6% of young men. Pharmacies were the main source of methods for 8% of young men surveyed and 13.5% of young women [10].

Access to contraceptive by minors has in recent time raises much policy concern by policy decision-makers, political supporters, government ministries, schools, parents and children in Jamaica. The conflicting position between the Reproductive Health [RH] Policy Guideline 2004, the Child Care and Protection Act 2004, have often times resulted in its contents not being adhered to, especially by health care providers, who expressed that the said legislation does not protect them (unlike the case of the United Kingdom), regardless of the contents of the RH policy guideline.

Sexual activity in Jamaica often begins in the early teenage and even pre-teenage years, and attitudes about gender roles, sexual activity and family planning are likely to be formed during these early years. While a number of studies have investigated pregnancy, sexual knowledge, attitudes and behavior among adolescents in the Caribbean [13], none have examined access to contraceptive among pre-adolescents and adolescents. The purpose of this article is to examine the sexual practices among pre-adolescent and adolescent in Jamaica and their

challenges in accessing contraceptives. Methods of contraception used by minors are also examined.

## Materials and Methods

This study is informed by quantitative and qualitative data. The former is derived from field research, using the statistical package for social scientists (SPSS 15.0) for data analysis, while the latter was obtained from secondary information including case studies, and related policies and legislations.

The units of analysis were 238 sexually active cases, comprised in-school pre-adolescents (9 year-olds) and adolescents (10-17 year-olds). This was disaggregated as follows: 9-11, 12-14 and 15-17 year-olds. The physical status of these groups was defined as able-bodied, visually impaired, speech impaired, physically challenged and other. The researchers were not prejudiced regarding sexual orientation; hence captured responses from those who considered themselves to be heterosexual, homosexual and bisexual.

The sampling method was involved a 21-item close-ended questionnaire. Of the 300 questionnaires that were self administered, 79% were favorably completed and analyzed to inform this study. These represented 119 males and 119 females, who claimed to have had professional exposure to health and family life education (HFLE), and who were knowledgeable of the various contraceptive methods and the implications in engaging in unprotected sexual activities.

This study was conducted during the period October 2006 to July 2007 with the subjects having represented a wide cross section of Jamaica (14 parishes). The respondents were asked to complete the questionnaire and place it in a sealed envelope and return same to the researcher. Some opted to be interviewed face to face (19), owing to their literacy level, which was not favorable to them completing the questionnaire on their own.

All the participants were informed about the purpose of the study and the level of confidentiality that would have been exercised. They were further instructed to not reveal their names or any other form of identification relating to them, the health care providers, guidance counselors, their intimate partners, *inter alia*. Owing to the sensitive nature of the subject (minors accessing contraceptive), the respondents were also told by the researchers that should they at any time during the questionnaire or interview process, feel uncomfortable they should, without hesitation, decline from further participation. The 62 respondents who opted-out, were not coerced to participate further in the study, neither were they counted as part of the 238 cases. The outcome of the suggestion to discontinue if they felt uncomfortable resulted in a more open and relaxed participation by the respondents, who also gave additional information that was not required by the questionnaire, but helped to provide novel insight to this paper.

The researchers held discussions with guidance counselors, health care providers and school nurses in order to confirm some of the information provided by the minors (without revealing any form of identification), as well as to clarify observations made by the researchers.

The questionnaires were pilot tested and it was realized that some of the language (although appeared simple) were not in-keeping with that of the minors/adolescents. As a result, the questionnaires were revisited and adjusted to suit the language of the minors of today's era. These set of questionnaires were again pilot-tested and having reached a satisfactory level in terms of language, culture and youth-friendliness, they were used in the final dissemination. The pilot tested questionnaires were not included in the final study, neither was that group of minors/adolescents allowed to participate in the main study.

The data analysis also included a range of correlation coefficients, such as Chi Square, Pearson (r) using SPSS, with a confidence interval of 95%.  $P < 0.05$  was taken as statistically significant.

## Results

Of the 238 respondents, 119 are males and 119 are females. The 9-11 sexually active group represents three males and six females respectively, while the 12-14 year olds represent 50% male and 21% female and the 15-17 year olds represent 47% male and 74 % female respectively (Table 1). Included in these age categories, are heterosexuals, homosexuals and bisexuals - of which heterosexual dominates (113 males and 108 females) and bears significant difference between homosexuals (3 males and 5 females) and bisexuals (three males and six females).

**Table 1** Demographic characteristics of respondents

Variables	Male (n = 119)		Female (n = 119)	
	N	%	N	%
<i>Age (years)</i>				
9-11	3	2.5	6	5
12-14	60	50.0	25	21
15-17	56	47.0	88	74
<i>Sexuality</i>				
Heterosexual	113	94.9	108	91
Homosexual	3	2.5	5	4
Bisexual	3	2.5	6	5
<i>Physical status</i>				
Able bodied	112	94.0	119	100
Visually impaired	1	0.8	0	0
Speech impaired	3	2.5	0	0
Physically challenged	2	1.7	0	0
Other	1	0.8	0	0

The physical statuses of these sexually active minors are

mostly able-bodied, reflecting similarities between males (over 90%) and females (100%) followed by those who are speech impaired (3), physically challenged (2), visually impaired (1) and otherwise challenged (1). While their physical attributes do not inhibit sexual activities, these individuals did not share more than one sexual partner (Table 1).

**Table 2** Contraception challenges

Variables	Male (n = 119)		Female (n = 119)	
	N	%	N	%
<i>Accessing contraceptive</i>				
Yes	3	2.5	29	24.4
No	69	58.0	2	1.7
Sometimes	8	6.7	9	7.6
<i>Reasons for challenges</i>				
Too young for sex	3	2.5	6	5.0
Afraid of implications	1	0.8	8	6.7
Parental consent required	2	1.7	6	5.0
Stigma	2	1.7	17	14.3
Others	3	2.5	1	0.8
<i>Contraceptive methods</i>				
Every sexual activity	47	39.4	10	8.4
Inconsistent use	33	27.7	30	25.2
Not use contraceptive at all	39	32.7	79	66.4
Dual methods	0	0	83	69.7
<i>Type of methods</i>				
Hormonal pills	0	0	9	7.6
ECP	0	0	16	13.4
Injection	0	0	0	0
Surgical	0	0	3	2.5
Coitus interruptus	4	3.4	47	39.5
Condom	76	63.9	29	24.4
Other	0	0	19	15.9

ECP: Emergency Contraceptive Pill

Sexual activity is less prevalent among males (56) than females (88) aged 15-17 with sexual partners mainly over 17 years old. There are respondents (three males and one female in the 9 - 11 year old group) with sexual partners under nine years old. None of the female respondents have sexual partners within the 15-17 age category. While majority of the respondents have one sexual partner (65 males and 92 females), males are more likely to have two. At the same time, there is similarity in the number of respondents, who shares up to three sexual partners (14). There are no females with more than three partners, but 10 males (Table 3). The difference in the number of sex partners between male and female is statistically significant ( $\chi^2 = 21.36, p < 0.05$ ).

While there are more male users (80) of contraceptives than females (40) and also more consistent male users (47) than females (10), the latter also uses dual methods (83). On the other hand, there are respondents who do not use

any form of contraceptive during sexual activities (39 males and 79 females) - representing 32.7% and 66.4% respectively. These include the eight homosexual respondents of this study (3 males and 5 females). The male respondents who use contraceptive inconsistently are not significantly different from the females, thus representing 27.7% and 25.2% respectively (Table 2).

Table 3 - Types of sexual activities and partners

Variables	Male (n = 119)		Female (n = 119)	
	N	%	N	%
<i>Type of sexual activity</i>				
Vaginal	66	55.4	40	33.6
Anal	3	2.5	43	36.0
Oral	50	42.0	36	30.3
<i>Sexual partner (n)</i>				
1	65	54.6	92	77
2	30	25.2	13	10.9
3	14	11.8	14	11.8
>3	10	8.4	0	0
<i>Sexual partner age</i>				
<9	3	2.5	1	0.8
9-11	2	1.7	2	1.7
12-14	11	9.2	15	12.6
15-17	46	38.7	0	0
>17	93	78.2	113	95.0

$\chi^2 = 21.36$ ;  $p < 0.05$

The most prevalent methods (Table 2) are the condom (63.9% male, 24.4% female) and coitus interruptus (4 males, 47 females) followed by the emergency contraceptive pills (13.4% female) and other methods such as spermicidal, dental dam, intrauterine device and diaphragm (16% female). Very few of the respondents use hormonal pills (8% female) and surgical methods (4% female). Of the nine 9-11 year olds, two take oral contraceptive pills, two take Emergency Contraceptive Pill (ECP), two practice coitus interruptus, two use condoms (females only), and one uses another form of method.

The respondents, having complained about the various challenges encountered in accessing contraceptives, informed that their alternative means to access is usually facilitated by the respondents' partners (22 males, 11 females), friends (15 males, 10 females), parents (4 males), other sources include relatives (12 males and 5 females) and/or by the respondents themselves (31 males and 2 females). The various contraceptive methods are obtained from health centers (four males, 14 females), the National Family Planning Board (NFPB) and/or display booths during World AIDS Day or at SRH-related fairs (10 males, one female), social workers (seven males, three females), private pharmacies or shops (11 males, 24 females; Table 5). In addition, some parents expressed that in order to relinquish the fear of their daughters becoming pregnant, they would place one oral contraceptive pill every morning in the minor's tea, whether or not they suspect

their child to be having sex. Some fathers provide their sons with condoms and encourage them to engage in sexual activity, as they claim that this is evidence that they would not become homosexuals.

The challenges to accessing contraceptive could become indicative of contracting sexually transmitted infections (STI) and/or HIV. The findings of this study (Table 5) show that more females (28) contracted STIs at some point in time than males (22). Although there are more male users of contraceptive than females, more males (48) impregnated their partners than the females (31) who became pregnant. The outcome of the 48 partners who became impregnated resulted in criminal abortion (36), miscarriage (8), still birth (1) and live birth (3). The 31 cases of pregnant females resulted in criminal abortion (19) and miscarriage (12).

The most likely form of sexual practice is vaginal, endorsed mostly by males (55.4%). There are more females (36%) than males (2.5%) who practice anal sex, while those who are more likely to engage in oral sex represent 42% male and 30.3% female (Table 3). The female respondents claim that anal and oral sex not only prevents pregnancy, but keeps their hymen intact. These practices are deemed as protection for their sexual status whenever their parents take them to the medical practitioner to determine whether they are a virgin. There is greater fear for pregnancy than STIs and HIV/AIDS, because pregnancy is visible and attracts discrimination, while STIs and HIV/AIDS can be properly treated and persons could still live a very normal life without anyone knowing their health status.

Table 4 Influences of sexual activities

Influential Factors	Male (n = 119)		Female (n = 119)	
	N	%	N	%
Peer pressure	46	38.2	46	38.7
Everyone is doing it	24	20.2	19	16.0
Can't communicate to parents	13	10.9	14	11.8
Money	8	6.7	12	10.1
Music (dancehall genre)	12	10.1	4	3.4
Cellular phone	5	4.0	9	7.6
Environment	7	5.9	4	3.4
Don't know/uncertain	4	3.4	7	5.9
Others	0	0.0	4	3.4

The respondents, in further postulating the reasons for their sexual practice, note the following (Table 4): (i) peer pressure (46 males and females), (ii) everyone is doing it (24 males, 19 females), (iii) inability to communicate sexual feelings with parents (13 males and 14 females) – parents treat the subject of sex with disdain and anger, (iv) money (eight males, 12 females) – the respondents obtain money from their partners in order to support being in the latest fashion and to feel important, (v) music of the dancehall genre (12 males, four females) - the respondents claim that they are stimulated by the sexual connotations

and graphical descriptions, especially from the dancehall – often played on public transportation on which they travel and/or within their homes or at the street corner (vi) cellular phone (five males, nine females) - this being another factor put forward by the respondents (see Table 4), tend to heighten the feeling of belongingness and libido. The respondents claim that they are able to speak with their intended or already intimate partners frequently and for very long hours (depending on the mobile network facility), even at nights when parents already retire for bed, (vi) environment (seven males, four females) – exposure to sexual demonstration by adults in their community and within their homes, (vii) uncertain (four males, seven females) and (viii) others (four females). This represents a lack of self-confidence, poor self-esteem and the desire to belong to the “in-crowd” who is “doing it,” which were reiterated by the respondents.

**Table 5** Contraception, STIs/HIV and pregnancy

Variables	Male (n=119)		Female (n=119)	
	N	%	N	%
Contraception challenge	11	9.2	38	32.0
Contracted STI or HIV	22	18.5	28	23.5
Pregnant or impregnated	48	40.3	31	26.0
<i>Outcome of pregnancy</i>				
Criminal abortion	36	30.3	19	16.0
Miscarriage	8	6.7	12	10.1
Stillbirth	1	0.8	0	0
Live birth	3	2.5	0	0
<i>Means of contraceptive access</i>				
The respondents	31	26.0	2	1.7
Partners	22	18.5	11	9.2
Platonic friends	15	12.6	10	8.4
Parents	4	3.4	0	0
Relatives	12	10.1	5	4.2
Health centers	4	3.4	14	11.8
<i>National family planning</i>				
Board and/or display booths	10	8.4	1	0.8
Social workers	7	5.9	3	2.5
Private pharmacies or Shops	11	9.2	24	20.2

Some guidance counselors and teachers attested to such remarks, and further added that that they observed that where physical education (PE) was absent, students exerted sexual energies, unlike in previous times when such activity was mandatory under the school curriculum. It should be noted, however, that in Jamaica, physical education is part of the secondary school's curriculum from pre-school to third form (grade nine). The absence of PE from the curriculum of fourth and fifth formers (ten and eleven grades) is owing to increase course load in preparation for the Caribbean Secondary School Education Council.

## Discussion

Contraceptive use among adolescents has been studied in many parts of the world. Consonant with the finding of this study that access to contraceptive methods is more favorable to males than females, the literature points out that gender inequity profoundly affects the right to have access to health information, education and care when it limits contraceptive use and choice. Traditionally gender roles often deny women control over their own sexual decisions, and create pressures that compel some men to undertake risky sexual behaviors. This form of inequity has serious health implications because of the increased risk of unwanted pregnancy and STIs, particularly HIV/AIDS [14]. Access to contraceptives is essential in helping to reduce the number of unintended pregnancies, high risk child birth and incidence of abortion [15]. According to Thomas et al [16], the International Conference on Population and Development [17], Action 6.15, stressed the importance of information and services concerning reproductive and sexual health, including the prevention of early pregnancies, HIV/AIDS and other STIs. These resulted in serious implications, especially where in middle income countries, for example, high rates of maternal mortality and morbidity among young women (ages 15-19) are usually fueled by too early childbearing, unplanned and unwanted pregnancy and complications from unsafe abortion [18].

The findings of this study showed that more females contracted STIs than males. Adolescents are believed to represent at least one third of cases of chlamydia trachomatis infection worldwide and perhaps an equal share of gonorrhoea infection [19]. In some settings, almost half of adolescents at high risk may have either gonorrhoea or chlamydia or both [20]. In several studies, adolescent girls accounted for the highest level of chlamydial infection detected by culture among all age groups, and among younger adolescents prevalence was higher than among older ones [21, 22]. Existing studies show that the prevalence of gonorrhoea among adolescent girls is usually lower than that of chlamydia [23, 24]. Prevalence data for adolescent boys is scarce, partially because so many studies have been limited to family planning clients. Studies from Namibia, Tanzania and the USA show either no STIs at all in adolescent boys [25] or a prevalence of less than 2% [26]. Higher rates have also occasionally been reported, however. In one study in rural Uganda, 26% of a small sample of boys had chlamydia [27]. Of adolescent boys in detention in the USA, 5-7% had gonorrhoea or chlamydia [28].

As evidenced in findings of this study, there is a relationship between male and female who encounter challenges in accessing contraceptive advice and treatment. Such challenge derives from the females being characterized as promiscuous for engaging in sexual activities. On the other hand, the males are encouraged in sexual activity for the sake of promoting their masculinity and for fear of becoming homosexuals. The respondents also posit that some health professionals (because of moral

standards and Christian principles) claimed that the distribution of contraceptives to school children is a sin and that this contributes to them becoming adults too early. Health care providers, however, expressed the view of not being protected under the Child Care and Protection Act 2004, section 9(1), which considers them to be *exposing the minor* [29], should they provide such minor with contraceptive advice and treatment. This is so despite the Reproductive Health Policy Guidelines for Health Professionals 2004 [30] (implemented after the amended 2004 Child Care and Protection Act), which permits health professionals to provide counseling upon contraceptive advice and treatment where the minor is adamant regarding sexual intercourse without the use of contraception and if physical and mental health is at risk [31]. This is not unique to Jamaica, as research has shown that policies and programs in several countries have been hampered by adults' beliefs about what young people should know, and that many adults fears that sex education might lead to promiscuity [32].

Consistent use of effective contraception requires an understanding of the consequences of unprotected sexual activity. Unfortunately, the inability of many adolescents to plan ahead and to anticipate the consequences of their actions leads to risk-taking behavior. As Hewell and Andrews [33] have noted, it is the adolescents' *perception* of risk rather than the actual risk itself that determines their use of contraception. This study reveals that where the minor is denied contraception, this result in inconsistency or none-use of the various methods. In another Jamaican study, adolescents continue to have sex without consistent condom use [34]. The World Bank [35] also found that contraceptive use remains low, in that only a quarter of sexually active adolescent schoolers within the Caribbean Community, use some form of contraceptive and slightly worry about getting pregnant or causing a pregnancy. In a study in the United States of America, out of 846 sexually active cases of 8-18 year old children entering out-of-home care, more than one-third were not using contraceptive [36]. With regard to Jamaica, more than 40 per cent of sexually active adolescent girls reported that they had not used a contraceptive method at last intercourse and 87 per cent of teenage pregnancy had not been planned [35].

Health care providers, including pharmacists, are often reluctant to serve young clients with contraceptive and condom information and supplies, especially those below the legal age of consent. In Jamaica, for example, family planning providers said they were hesitant to serve clients younger than 16 [37]. Countries such as Mexico, Brazil, Colombia and Peru have adopted policies and programs to serve adolescents, but implementation has been uneven and the lower age limit is not clear [38]. Majority of the respondents suggested that contraceptive methods should be distributed in schools by nurses or guidance counselors, so as to alleviate the challenges faced in having to obtain same at health care facilities, pharmacies or regular stores. However, this is forbidden under the Government of Jamaica's Ministry of Education. Unlike the United States

of America (in some States) and the United Kingdom (under the portfolio of the Office of Standards in Education), contraceptive methods are allowed in schools [39]. In the United Kingdom, part of the Government's 10-year teenage pregnancy strategy (launched in 1999) is to halve the under 16 contraception rate by 2010. For want of achieving such goal, the country's legislation makes provision for health care providers, including doctors to provide the under 16 year olds with contraceptive, sexual and reproductive health advice and treatment without knowledge of the parents/guardian, providing that the minor understands the advice given and the implications involved. In addition, where abortion occurs and the young pregnant woman is competent to consent and cannot be persuaded to involve her parents, then arrangement should be made for such [40].

For most adolescents, regular sexual activity commences soon after puberty but prior to social maturity. Much of that sexual activity is casual, outside of formal unions, and devoid of social or emotional commitment. Among Jamaican males, there is substantial peer group pressure to engage in sex in order to avert the stigma of homosexuality, and sexual initiation may occur as early as the age of 8 years [41]. In support of this study that music (particularly the dancehall genre) was a sexual stimulant (13.5 per cent), Music Psychologist, Schubert [42] states that music evokes intense pleasure, sometimes sending shiver or chills down the spine. In addition, McFarlane 2008 [43] postulated that a North Carolina University study revealed that children who have a heavier sexual media diet when they are 12 to 14 years old are twice as likely as kids who have a lighter sexual media diet to have had sexual intercourse by the time they are 16 years old.

Many factors discourage young people from using health services. These include a lack of privacy and confidentiality; insensitive and disapproving staff; threatening environments; cost; and the requirement that minors be accompanied by an adult [32]. The Reproductive Health Policy Guidelines for Health Professionals 2004 [30] gives the directive for health professionals to first (i) ascertain whether the minor is in the care of a parent or guardian; (ii) seek to persuade the minor to involve same and (iii) ensure that the minor does not wish his/her consultative visit with the health care provider to be revealed. Confidentiality should be exercised except in cases of STIs, pregnancy and sexual violence. In such a case, the health professional should inform the minor that such information would have to be disclosed [31]. The 2001 condom survey identified several barriers to youth's access to contraceptives. Some 80% of 15-19 year olds reported that it was easy to acquire the male condom; few respondents report that condom outlets refuse to sell to young adolescents, or the young person's own embarrassment, poses difficulties in accessing contraceptives [10]. The majority, 54%, of 15-19 year old males purchased their supplies from a small grocery or retail store. Most females, 46%, relied on their partners to provide the methods [10]. Approximately 21% of young women sourced contraceptives from clinics or

health centers, compared to 8.6% of young men. Pharmacies were the main source of methods for 8% of young men surveyed and 13.5% of young women [10].

A lack of confidentiality is expressed by the respondents as a sore point, which discourages their seeking advice regarding sexual and reproductive health. This inhibits communication with health care providers at the health centers and guidance counselors at their schools, on sexual related matters. Reservations sometimes also stem from having shared social settings (church, family circle, clubs) with health professionals, hence fear for a breach of confidentiality. Confidentiality in adolescent healthcare is important [44]. An Adolescent Health Service Clinic, a public health clinic, was established in Antigua and Barbuda specifically for adolescents. In 1996 and 1997, 153 teenage women accepted contraceptive services, 7% of all women seen at public health clinics [45]. Types of contraception made available included injection, used by 45%; oral contraceptives, used by 40% and condoms used by 13% [45]. The benefits and safety of various contraceptive methods must be explained and a motivational type of interview must be used [46, 47]. Side effects, reported in 48% of women in Jamaica, may limit use of injections or oral contraceptives [48]. Other barriers to contraceptive use include sexual attitudes, cultural norms and gender-specific issues in the USA as well as in the Caribbean [48]. It is of interest that school based interventions to affect lifestyle changes in adolescents were recently shown to be ineffective [49].

Unlike this study which reveals that condom is the most likely used contraceptive method, the injection is the most prevalently used among individuals 12-17 year olds at the Women's Centre of Jamaica Foundation (WCJF) [50] during the period 2005-2006. This represents 54.6 per cent of the 1,625 registered teen mothers [50]. Similarly, the NFPB reports the said method as the most popular choice of contraceptive among public sector family planning clients, thus accounting for 49 per cent in 2005 [51]. In view of the Eastern Caribbean Islands, similar to the findings of the WCJF and the NFPB, injection (1,404 acceptors) is the most prevalent method, followed by oral contraceptive pill (1,380 acceptors) then the condom (283 acceptors) among teenagers 15-19 in the Commonwealth of Dominica in 2003 [52]. In Barbados, other contraceptive methods (spermicidal, cervical cap, withdrawals/coitus interruptus) are more prevalent among the under 19 year olds - representing 25 and 43 per cent respectively during the period 2004 and 2005. These methods are followed by the use of oral contraceptive pills (25 and 40 per cents), the condom (17 and 9 per cents) and the injection (9 and 5 per cents) within the same period [53]. While in Anguilla, in 2003, there are reported cases (15-19 year olds) of 56 per cent males and 58 per cent females who have never had sexual intercourse. The remaining percentages are sexually active with 36 per cent males and 30 per cent females not using any form of contraceptive methods. However, 13 per cent male and 13 per cent female claim that accessibility is a problem [54], hence the initiative of the commercial banks in distributing

condoms.

On the point of contraception, research has shown that modern contraceptive use has increased, but remains low among sexually active young women in many low and middle income countries. Take for instance, in Haiti, 33 per cent of single sexually active young women and nine per cent of their married peers used a modern method of contraception [55]. Among sexually active female students from Nigerian high schools, 47 per cent used the rhythm method of contraception; 21 per cent, oral contraceptive pills and six per cent, condoms [56]. The findings of this study demonstrate the use and types of contraceptive methods. Unlike this study, where condom and coitus interruptus were the most prevalent methods, the adolescent/teenage mothers who are registered at the WCJF mostly use the injection method. After the teenage mothers deliver their babies, parental consent via completed consent form is part of the package for minors 12-17 year olds at the WCJF receiving the injection method, which is the most prevalent [50]. While the minor at the WCJF may not be faced with the challenge of having to obtain such contraceptive on her own, she is faced with having to accept that which might not be her preference. The involvement of parents in providing contraceptive methods to their children is viewed in some circles as encouraging promiscuity among minors [50].

## Conclusions

Access to contraceptive advice and treatment is also more favorable to male than female, thus resulted in unsafe sexual practice, pregnancy and the contracting of HIV/STIs. The research described here may provide important insights from pre-adolescents and adolescents themselves for designing useful information, education and counseling programs for pre-adolescents and adolescents and for developing services that may be useful to adolescents. The findings of this study will be important in informing the development of reproductive health services and family life education programs for pre-adolescents and adolescents in Jamaica and other Caribbean countries.

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## References

1. United Nations Population Fund. State of world population. Making 1 billion counts: investing in adolescents' health and rights. New York, UNFPA, 2003.

2. Pan American Health Organization. Health in the Americas. Volume 1. Washington DC, PAHO; 1998.
3. Jamaica National Family Planning Board. Young adult report: Sexual behavior and contraceptive use among young adults. Jamaica Reproductive Health Survey; 1997.
4. Barnett B, Eggleston E, Jackson J, Hardee K. Case Study of the Women's Center of Jamaica Foundation Program for Adolescent Mothers, Research Triangle Park, North Carolina, USA: Family Health International, 1996; and McNeil P et al. The women's centre in Jamaica: an innovative project for adolescent mothers, *Studies in Family Planning* 1983; 14(5):143-149.
5. Jamaica National Family Planning Board; Statistical Institute of Jamaica; Centers for Disease Control and Prevention. Jamaica Reproductive Health Survey (RHS) 2002-2003.
6. Ministry of Health. Adolescent Contraceptive Survey. Kingston: Ministry of Health; 2001.
7. De Bruin M. Teenagers at Risk. *JARH*; 2002.
8. Olenick I. Among young Jamaicans, sex and childbearing often begin during adolescence. *International Fam. Plan. Perspectives* 1999; 25:206.
9. Gayle H. Adolescent Male Survivability in Jamaica. *Kingston Youth Now*; 2002.
10. Hope Enterprises, Adolescent Condom Survey Jamaica. Kingston Jamaica; 2001.
11. McFarlane C, Hardee K, DuCasse M, McCloskey, R. National Family Planning Board, Reproductive Health Survey: Jamaica 1997, 1999; Young Adult Report: Sexual behavior and contraceptive use among young adults. Kingston: National Family Planning Board; 1999.
12. Reproductive Health Policy Guidelines for Health Professionals. Providing contraceptives to persons under sixteen years of age. Kingston: Ministry of Health; 2004.
13. Archer E, Campbell J, Medford G, Scantlebury M. Profile of teenage mothers and their parents' attitudes to teenage sexuality and pregnancy, *West Indian Medical Journal* 1990;39(17, suppl. 1):1-78.
14. The Manager. Managing reproductive health services with a gender perspective. Management Strategies for Improving Health and Family Planning Services. Volume IX (3&4): Fall/Winter 2000/1; 2000.
15. Population Action International. Contraceptive use helps reduce the incidence of abortion. Fact Sheet. Washington DC: Population Action International; 2005.
16. Thomas T, Nesvaderani T, Dhingra N. Affirming the Rights of Young People at United Nations World Summits and Conferences: A Guide for Youth Advocates. The Facts. Washington DC: Advocates for Youth; 2006.
17. International Conference on Population and Development. Countdown 2015: Sexual and Reproductive Health and Rights for All. Published by Population Action International, Family Care International, and International Planned Parenthood Federation; 2004.
18. Ackerman B, Cheetham N, Hauser D. One Billion Dollars for U.S. International Family Planning Assistance: An Urgent Appropriations Request that will Save Young Women's Lives. Policy Brief. Washington DC: Advocates for Youth; 2008.
19. Cates W, Mc Pheeters M. Adolescents and sexually transmitted diseases: current risks and future consequences. Paper prepared for the workshop on adolescent sexuality and reproductive health in developing countries: Trend and interventions. Washington, D.C.: National Research Council; 1997.
20. Behets F, Williams Y, Brathwaite A, Hylton-Kong T, Hoffman I, Dallabetta G, Ward E, Figueroa J. Management of vaginal discharge in women treated at a Jamaican sexually transmitted disease clinic: use of diagnostic algorithms versus laboratory testing. *Clinical Infectious Diseases*, 1995; 21:1450-1455.
21. Brabin L. Providing accessible care for adolescents with sexually transmitted disease. *Acta Tropica*. 1996; 62:209-216.
22. Smith P, Phillips L, Faro S, McGill L, Wait R. Predominant sexually transmitted diseases among different age and ethnic groups of indigent sexually active adolescents attending a family planning clinic. *Journal of Adolescent Health Care* 1988; 9:291-295.
23. Blankhart DM. Evaluation du projet jeunes pour jeunes de l'ABBEF Ouagadougou, Burkina Faso. Ouagadougou: ABBEF; 1997.
24. Kilmarz P, Black C, Limpakarnjanarat K, Shaffer N, Yanpaisarn S, Chaisilwattana P. Rapid assessment of sexually transmitted diseases in a sentinel population in Thailand: prevalence of chlamydial infection, gonorrhoea, and syphilis among pregnant women-1996. *Sex Trans Inf.* 1998; 74:189-193.
25. Harms G, Radebe F, Iyambo S, Fehler H, Ballard R, Corea A. Perceptions and patterns of reproductive tract infections in a young rural population in North-West Namibia. *International Journal of STD & AIDS* 1998; 9:744-750.
26. Todd J, Hayes R, Changalucha J. Maximizing the power of a community randomized trial in rural Mwanza: the randomization procedure in the Mema Kwa Vijana Project. Presented at the National Multisectoral AIDS Conference in Tanzania, Arusha, 6-10 December. (abstract no. P118: A45); 1998.
27. Wagner HU, Van Dyck E, Roggen E, Nunn AJ, Kamali A, Schmid DS. Seroprevalence and incidence of sexually transmitted diseases in a rural Ugandan population. *International Journal of STD & AIDS* 1994; 5(5):332-337.
28. Oh M, Berman S, Cloud G, Fleenor, M., Bailey, D. Population specific targeted STD program for high-risk adolescents: why did it work? Helsinki: Tenth International Meeting of the International Society for STD Research (abstract no. 129); 1993.
29. Jamaica Laws. The Child Care and Protection Act, 2004. (Act II of 2004). Jamaica Printing Services; 2004.
30. Reproductive Health Policy Guidelines for Health Professionals. Providing Contraceptives to Persons

- under Sixteen Years of Age. Jamaica: Ministry of Health; 2004.
31. Ministry of Health. Policy Document on the Reproductive Health of Children. Implementation Handbook for Professionals. Jamaica: Ministry of Health; 2004.
  32. Audelo, S. Revisiting the United Nations General Assembly Special Session on HIV and AIDS. The Facts. Washington DC: Advocates for Youth. In UNAIDS. Children and young people in a World of AIDS. Geneva: UNAIDS, 2001; 2006.
  33. Hewell S, Andrews J. Contraceptive use among female adolescents. *Clin Nurs Res* 1996; 5(3):356-363.
  34. Hope Enterprise. Knowledge, Attitude, Practice and Behaviour. In Jamaica's Solution to Youth Lifestyle and Empowerment (2006:12). Literature Review and Conceptual Framework for Serving Adolescents in the HIV Epidemic. Jamaica: United States Agency for International Development; 2004.
  35. World Bank. In The World Bank (2003:17). Caribbean Youth Development: Issues and Policy Directions. Washington DC: The World Bank; 2001.
  36. Risley-Curtiss C. Sexual activity and contraceptive use among children entering out-of-home care. *Child Welfare*, 1997; 76(4):475-499.
  37. Eggleston E, Jackson J, Hardee K. Sexual attitudes and behavior among young adolescents in Jamaica. *International Family Planning Perspectives* 1999; 25(2):78-84 & 91.
  38. Ali M, Cleland J, Shah I. Trends in reproductive behavior among young single women in Colombia and Peru: 1985-1999. *Demography* 2003; 40(4):659-673.
  39. Aron, J. United Kingdom Schools Handing Out the Morning-After Pill. Consent of the Governed. *The Daily Mail* (16 April 2007);2007.
  40. United Kingdom Laws. The Sexual Offenses Act 2003. United Kingdom; 2003.
  41. Chevannes B. Sexual behavior of Jamaicans: a literature review. *Soc Econ Stud* 1993;42(1):1-45
  42. Schubert E. The influence of emotion, locus of emotion and familiarity upon preference in music. *Psychology of Music*. 2007; 35(3):499-515.
  43. McFarlane P. Kartel's response not convincing. Jamaica: National Secondary School Council; 2008.
  44. Stevens-Simon C. Providing effective reproductive health care and prescribing contraceptives for adolescents. *Pediatr Rev* 1998;19:409-417.
  45. Health Information Division, Ministry of Health. Annual Statistical Digest. St. Johns, Antigua: Ministry of Health;1998
  46. Gearing J. Family planning in St Vincent, West Indies: a population history. *Soc Sci Med* 1992; 35:1273-1282.
  47. Joshi NP, Battle SF. Adolescent fathers: an approach for intervention. *J Healt Soc Policy* 1990; 1:1733.
  48. Fox K. The impact of side effects on family planning use among female clients of the public health services in Jamaica. *West Indian Med J* 2001; 50:209-213.
  49. DiCenso A, Guyatt G, Willan A, Griffith L. Interventions to reduce unintended pregnancies among adolescents: systematic review of randomized controlled trials. *BMJ* 2002; 324:1426.
  50. Women's Centre of Jamaica Foundation. Annual Report 2005-2006. Kingston: Women's Centre of Jamaica Foundation; 2006.
  51. Planning Institute of Jamaica. Economic and Social Survey of Jamaica. Kingston: Planning Institute of Jamaica; 2005.
  52. Dominica Planned Parenthood Association. Contraceptive Distribution. Dominica: Ministry of Health and Central Statistical Office; 2003.
  53. Barbados Family Planning Association. Fifty-First Annual Report 2005. Barbados: Barbados Family Planning Association; 2005.
  54. Anguilla Family Planning Association. Anguilla Reproductive Health Survey 2003. Anguilla: Anguilla Family Planning Association; 2003.
  55. Population Reference Bureau (2006), in Graczyk K. Adolescent Maternal Mortality: An Overlooked Crisis. The Facts. Washington DC: Advocates for Youth; 2007.
  56. Okpani A, Okpani J. (2000), in Graczyk, K. Adolescent Maternal Mortality: An Overlooked Crisis. The Facts. Washington DC: Advocates for Youth; 2007.