

**JAMAICA REPRODUCTIVE HEALTH
SURVEY 2002
SUMMARY CHARTBOOK
OF
MAIN FINDINGS**



**NATIONAL
FAMILY PLANNING
BOARD**

PREFACE

Every 5 years, the National Family Planning Board (NFPB) in conjunction with the Statistical Institute of Jamaica (STATIN) conducts a Reproductive Health Survey (RHS)¹. The RHS 2002 is the seventh in a series of periodic inquiries to update measures of fertility among women aged 15-49 and young men aged 15-24. It examines *inter alia* reproductive health knowledge and practices, levels of fertility, and the provision of reproductive health and related services.

These surveys are the primary data-gathering instrument by which the NFPB evaluates the status of family planning and the degree to which the country's reproductive health needs are being met.

McFarlane Consultants undertook the survey with funding from the GOJ. The United States Agency for International Development (USAID) funded the tasks carried out by STATIN as well as the technical assistance provided to the survey team by the Division of Reproductive Health, Centres for Disease Control and Prevention (CDC).

Eligible respondents were selected using a three-stage stratified sample design developed by STATIN. The first stage involved the selection of 659 Enumeration Districts (EDs) followed by the selection of dwellings within these EDs, and finally the selection of one eligible female and one eligible male from each household.

Field work was conducted between October 26, 2002 and May 9, 2003. Interviewers visited approximately 14,000 households and interviewed 7,146 females and 13,000 households to interview 2,520 males. The preliminary results were presented in October 2004 to health and family planning personnel and other stakeholders at a National Dissemination Seminar.

This summary report is prepared to further inform health care providers, family planning personnel, other institutions, researchers and students of the key findings and their implication for reproductive health programme in Jamaica.

No study of this sort could be possible without the cooperation of the citizens of Jamaica, who participated in the survey as respondents. It is with gratitude that we extend thanks and appreciation to them.

Olivia McDonald
Executive Director, NFPB
November 2004

¹ Formerly known as the Contraceptive Prevalence Survey (CPS)

STRATEGIC FRAMEWORK FOR REPRODUCTIVE HEALTH AND FAMILY HEALTH

Jamaica is one of many countries worldwide that is adopting the recommendations of the Programme of Action that was developed out of the International Conference on Population and Development (ICPD) held in Cairo in 1994. Population policies and programme actions being implemented have shifted away from merely achieving demographic targets for reduced population growth toward improving the reproductive health of the population. In recognition of this, Jamaica has sought to ensure the rights-based and holistic reproductive health development of citizens thereby meeting the needs of individuals while seeking to accomplish demographic goals for macro-level development.

In keeping with Jamaica's commitment to the development agenda proposed at the International Conference on Population and Development (ICPD), the Ministry of Health developed a Strategic Framework to respond to the broader linkage between reproductive health and other factors within the individual's environment. This places reproductive health policy and service delivery firmly within the context of overall family health. Three core elements form the basis of the MOH's Family Health Programme namely - (i) **Family Planning**, (ii) **Safe Motherhood**, and (iii) **STI/HIV/AIDS prevention and treatment**.

The primary objective of the **Family Planning** Element of this Strategic Framework is to decrease the number of unplanned pregnancies and reduce the Total Fertility Rate (TFR) to 2.5 by the year 2005.

Strategies being implemented to achieve this objective are:

1. Improve contraceptive method mix
2. Introduce emergency contraceptive protection (ECP)
3. Improve efficacy of contraceptive method use
4. Expand access to reproductive health information and services to adolescents
5. Expand access to reproductive health information and services to men

DEMOGRAPHIC PROFILE AND TRENDS

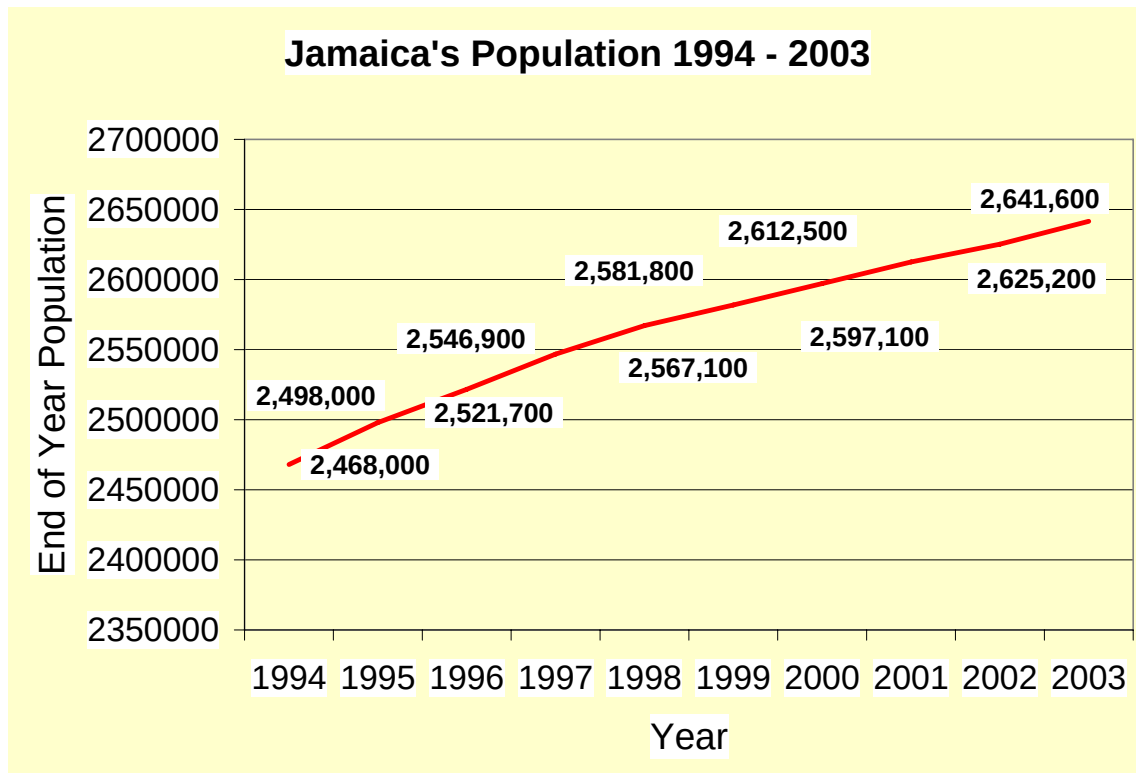
Jamaica's population is estimated to be approximately 2.64 million persons. This population represented an increase of approximately 840,000 over the 1.8 million population in 1970. Current rate of population growth is approximately 0.6%, which is well within the growth targets set under the National Population Policy, 1995.

Population growth is influenced by the combined impact of births, death and migration. Jamaica is currently experiencing a crude birth rate of 19.4 births annually per 1,000 population and 6.4 deaths per 1,000. This results in a rate of "natural increase" of 1.7 percent, sufficient to double the population size every 40 years, were the rate to be maintained.

Life expectancy at birth is currently 74.6 years for females and 71.1 years for males, a level comparable to many of the World's developed countries. Fertility has continued to decline, as it has in all Caribbean countries, over the past two and a half decades. In the mid-1970s, women in Jamaica bore children at a rate that would result in a lifetime average of 4.5 children each. This measure of fertility is referred to as the total fertility rate (TFR). Currently the TFR in Jamaica has been reduced to 2.5.

Jamaica's current population growth rate, increased life expectancy, and age structure continue to present challenges for sustainable development. It is now widely accepted that population concerns are pivotal to sustainable development strategies. Rapid population growth and high fertility limit development and increase poverty.

Jamaica can be described as a country undergoing a "demographic transition" from high fertility and mortality of the past to a relatively low fertility and mortality. The prospect for consistent, although moderate, population growth in the future is expected.

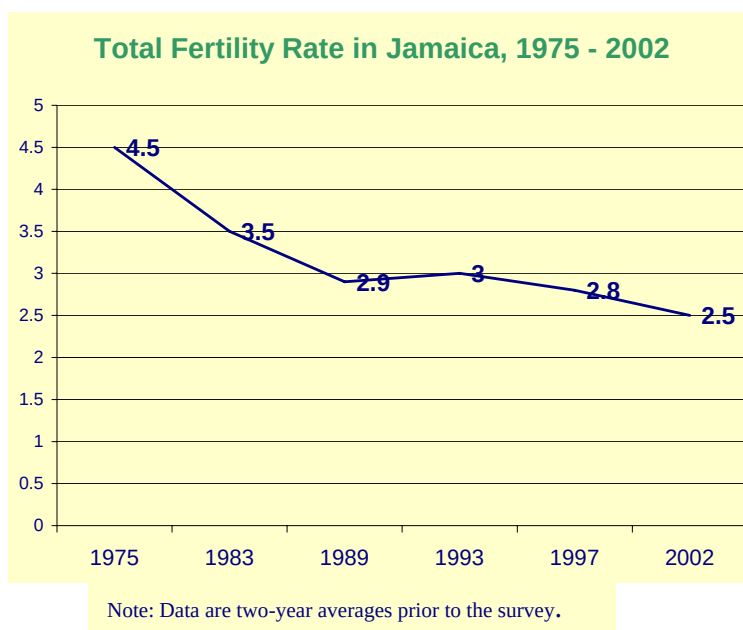


FERTILITY OUTCOME

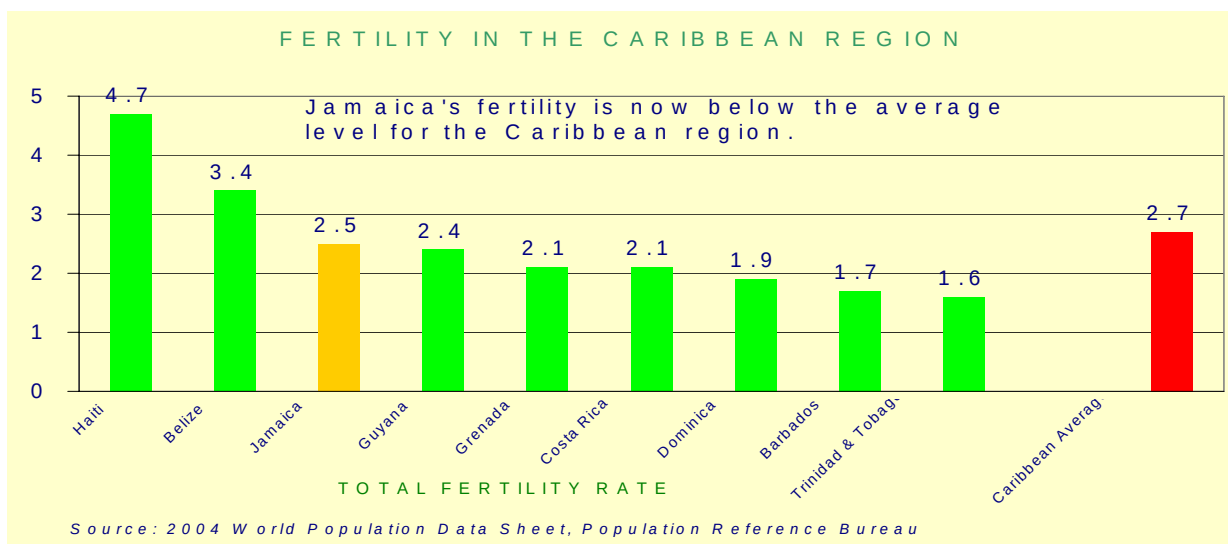
The desired fertility outcome under the strategic framework for reproductive health 2000 – 2005 is the reduction of the Total Fertility Rate to 2.5 by the year 2005. Unwanted pregnancies are also expected to decline.

Declining Fertility

Fertility among Jamaican women aged 15 – 49 continued to decline, following the downward trend observed over the past two decades. The Total Fertility Rate (TFR)² declined from approximately 4.5 in the mid-1970s to 2.8 at the time of the 1997 RHS. Between 1997 and 2002, TFR has further declined to 2.5. This movement comes ahead of the National Population programme target of achieving a TFR of 2.5 by year 2005.

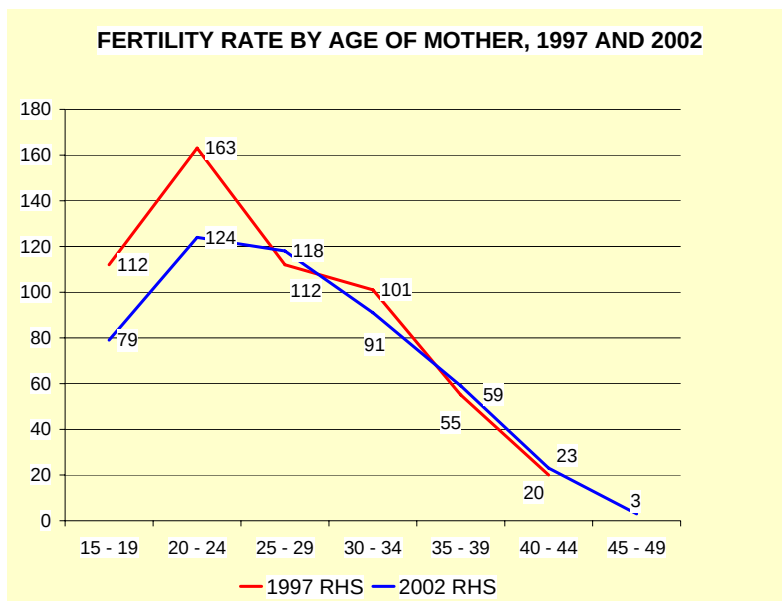


Jamaica's current TFR also compares favourably with the Caribbean average, which is now 2.7.

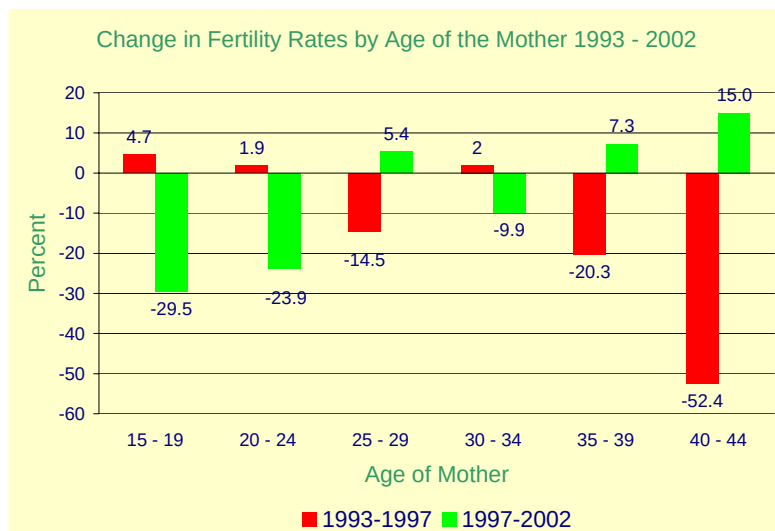


² The Total Fertility Rate (TFR) is the average number of children a woman would have in her lifetime if the age-specific rates of a given year were to remain constant.

The pattern of fertility by age is typical of that observed in the majority of countries. Births peak in a woman's early 20s, before beginning a gradual decline to the close of her childbearing years. The decrease in fertility observed in the 2002 survey was due, for the first time, to a significant decline in fertility among adolescents (aged 15 – 19) and women aged 20 – 24.



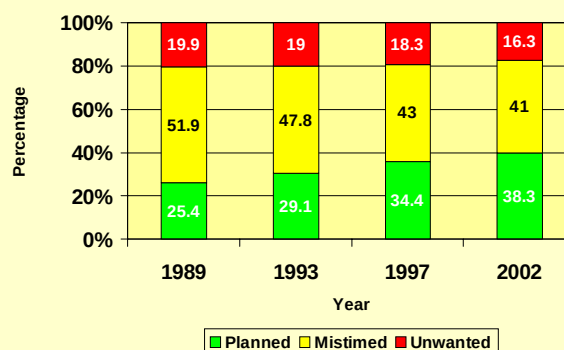
While during the latter half of the 1980s to the early 1990s there was a notable decline in fertility among women aged 35 and over, there is currently an increase in fertility among women in that age group.



Decreasing incidence of unplanned pregnancies

The percentage of pregnancies that are unplanned continues to decline, from 65.6% to 61.7%, as Jamaican women in union continue to take steps to prevent an unintended pregnancy. Although mistimed pregnancies have experienced the greatest decline since 1989, it remains relatively high at 41%.

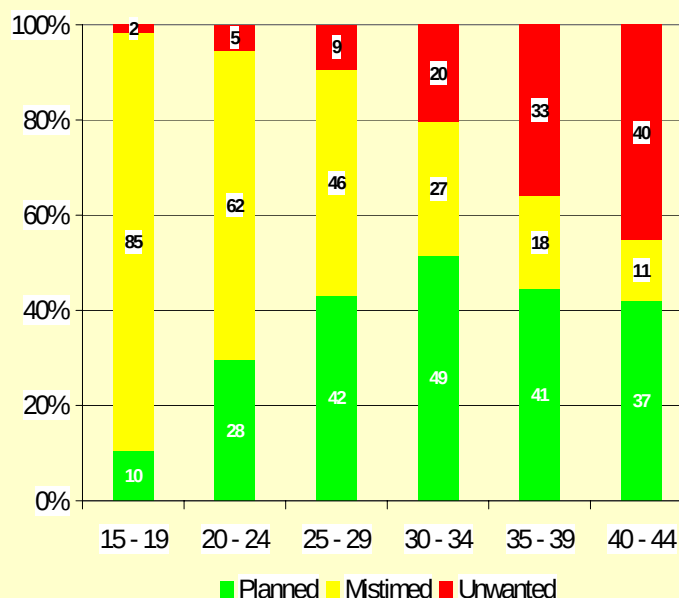
PLANNING STATUS OF PREGNANCIES AMONG WOMEN 15-44 YEARS



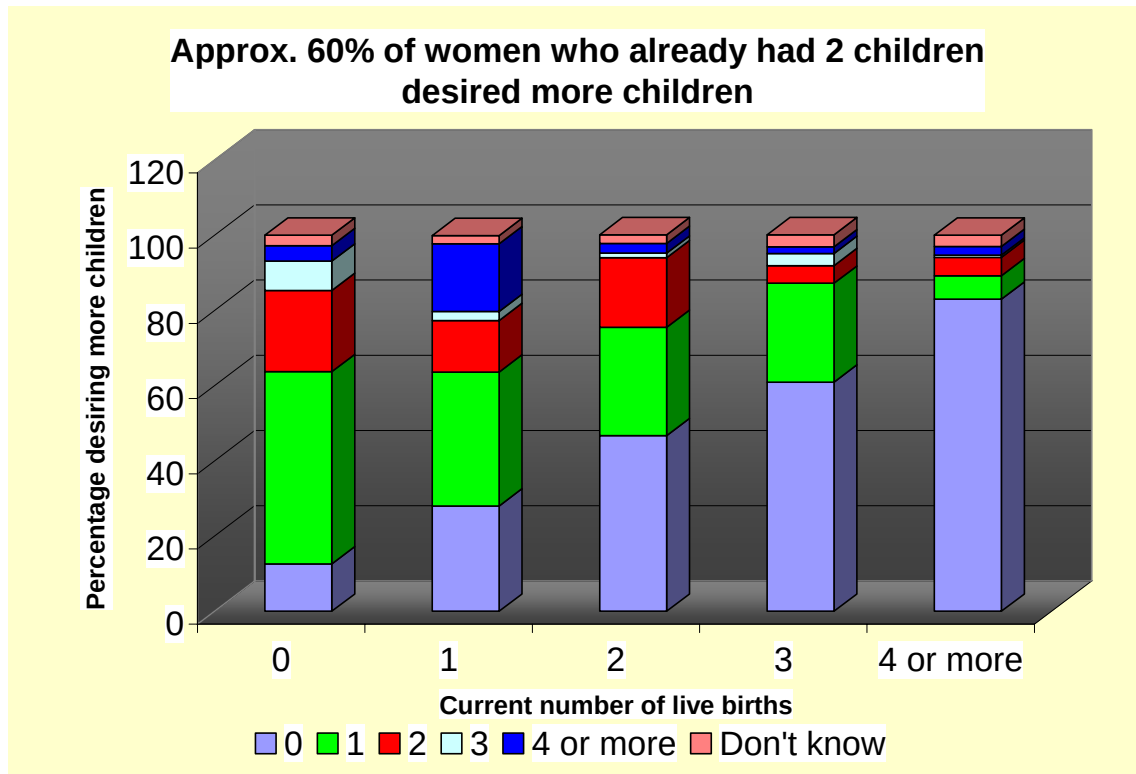
Source: 2002 RHS

The proportion of births reported as mistimed by younger women and unwanted by older women also remains substantial, and is a cause for concern.

Planning Status of Pregnancies



(insert planning status graph by area of residence and comment) – table 3.5.1 in main report.



(insert relevant photo / graphic)

IMPROVING METHOD MIX

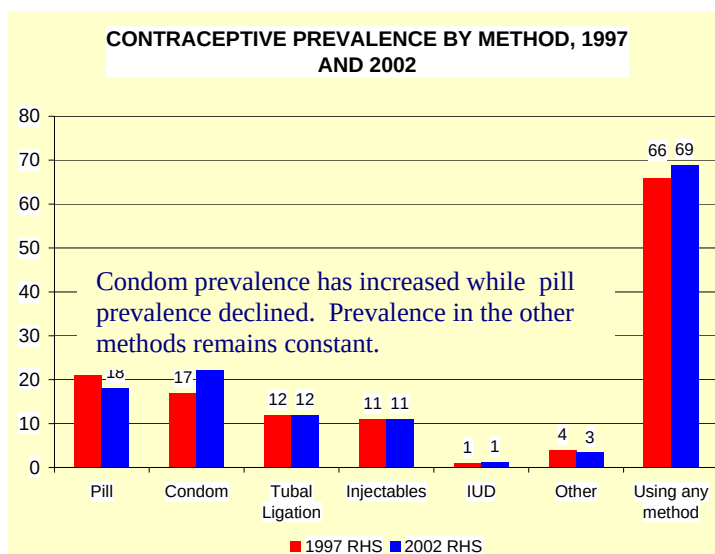
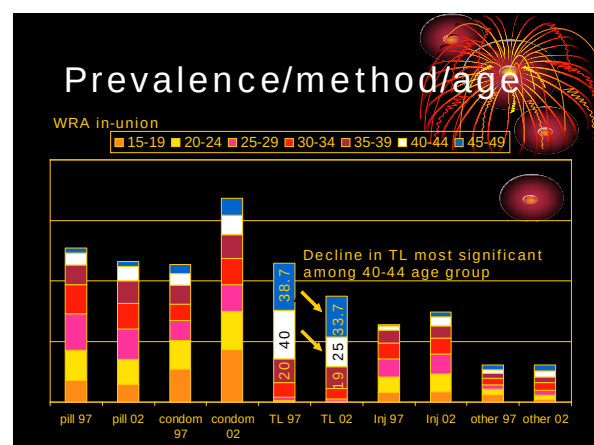
An appropriate contraceptive method mix is one in which every person with a need for family planning is using a method and every user is using a method suited to his/her individual need. (*Strategic Framework for Reproductive Health Within the Family Health Programme, 2000 – 2005. Ministry of Health.*)

“Appropriateness of method mix is important for meeting client lifestyle needs, improving client health, reducing the incidence of side effects and unwanted pregnancies, reducing the risk of STIs, minimizing discontinuation and dissatisfaction with methods, and improving client control and quality of life”. (*Strategic Framework for Reproductive Health Within the Family Health Programme, 2000 – 2005. Ministry of Health.*)

The 1997 Jamaica Reproductive Health Survey (JRHS) identified the following potential contraceptive users: postponers 17%, spacers 25%, and limiters 58%. Given that limiters represented the majority of potential contraceptive users, the family planning programme placed emphasis on increasing acceptance and use of long term methods particularly female sterilisation and the IUD.

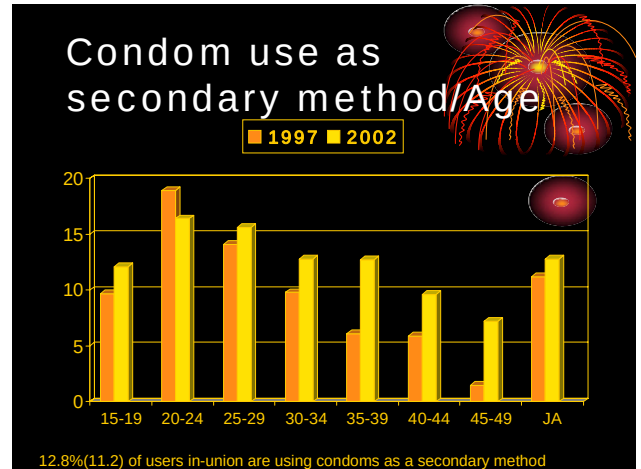
Although contraceptive prevalence increased, method mix did not change in the way expected

Approximately seven out of ten women in union (married, common law union, or visiting relationship) are now using contraceptives. This high rate of contraceptive usage compares favourably with other advanced developing countries. The majority of women in union were users of a “modern” contraceptive method.



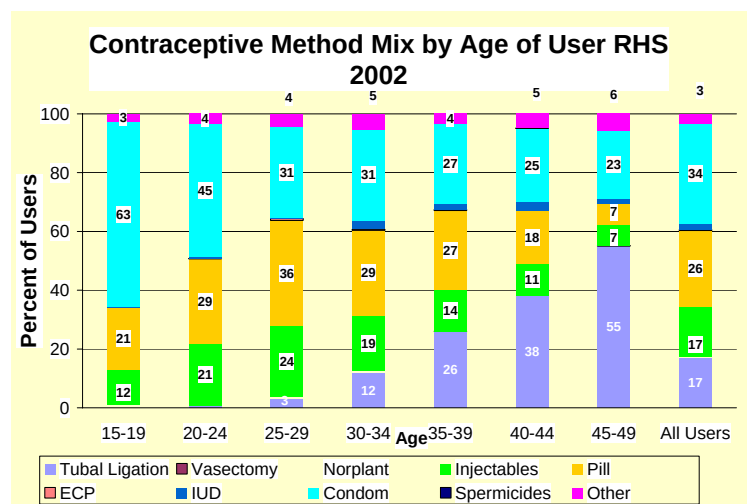
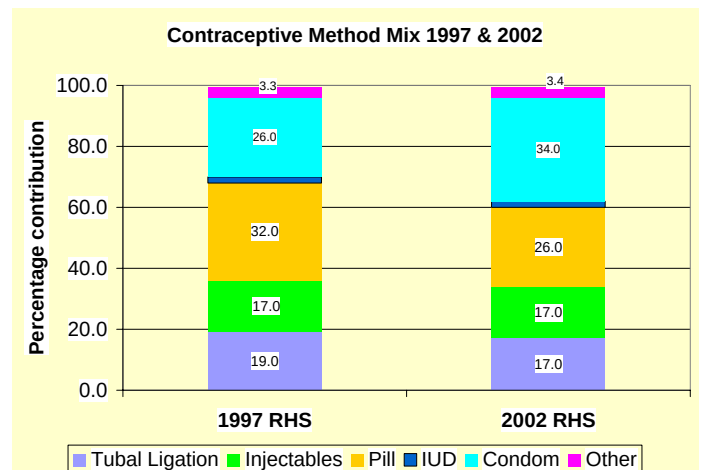
The contraceptive method mix among all women of reproductive age (WRA) was more inclined toward short-term methods primarily the condom and oral contraceptive pills. Condoms have actually increased to 24%.

Oral contraceptive pills and condoms however require continuous supply and use. Condom use also depends on male motivation.



Younger women tended to choose short-term methods while older women choose longer-term contraceptives.

(comment on the change since 1997)

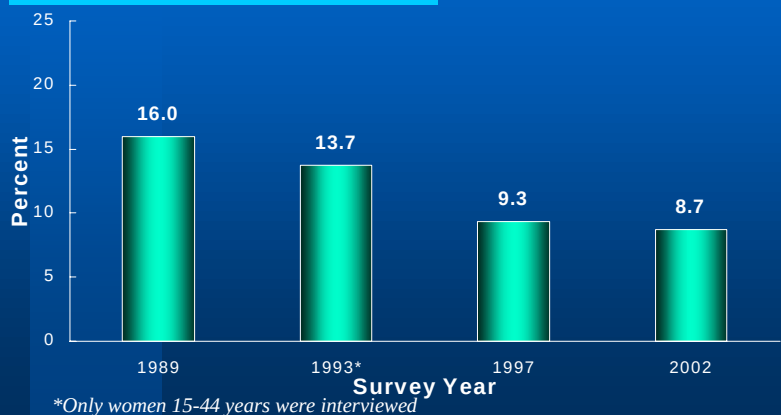


Reducing Unmet Need

A woman is characterised as “in need” if she was sexually active, not currently pregnant, stated that she did not desire to become pregnant and was not using a method of contraception for reasons not related to subfertility.

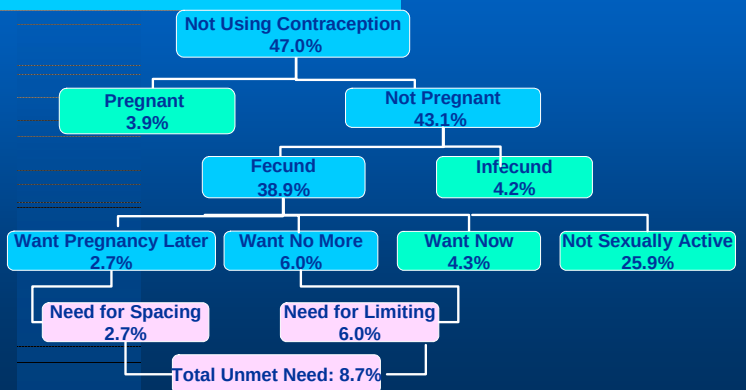
Since 1989, unmet need for family planning in Jamaica has been declining and is currently 8.7%.

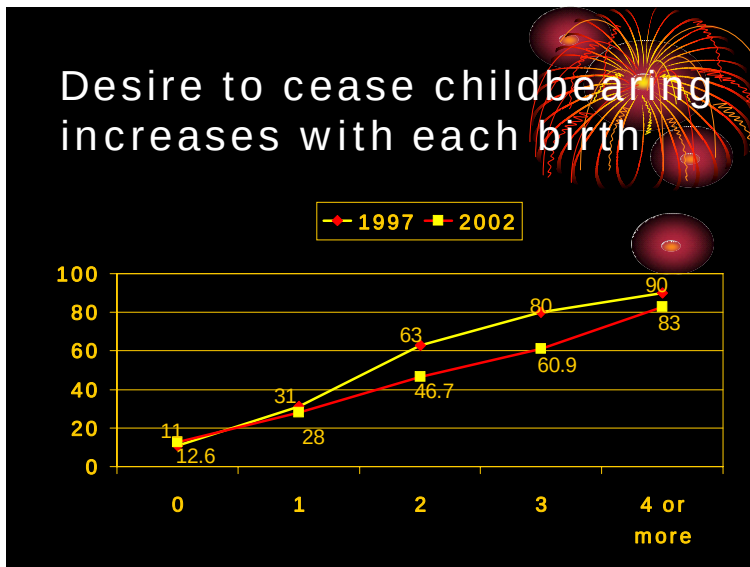
Percent with Unmet Need for Family Planning in Jamaica Among All Women Ages 15-49, 1989-2002



About 2.7% of fecund women of reproductive age have an unmet need for (spacing) childbearing, while 6.0% have an unmet need for limiting childbearing.

Defining the Level of Unmet Need for Family Planning Among All Women 15-49: Jamaica, 2002

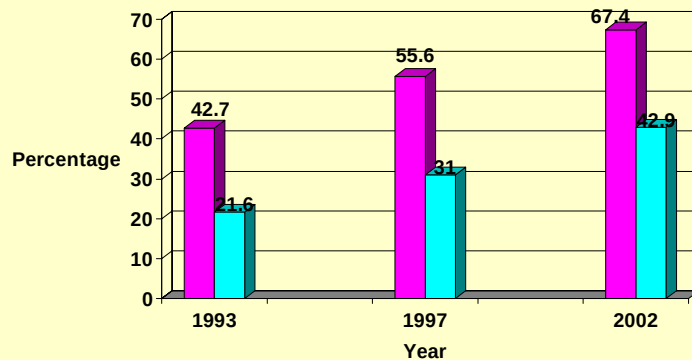




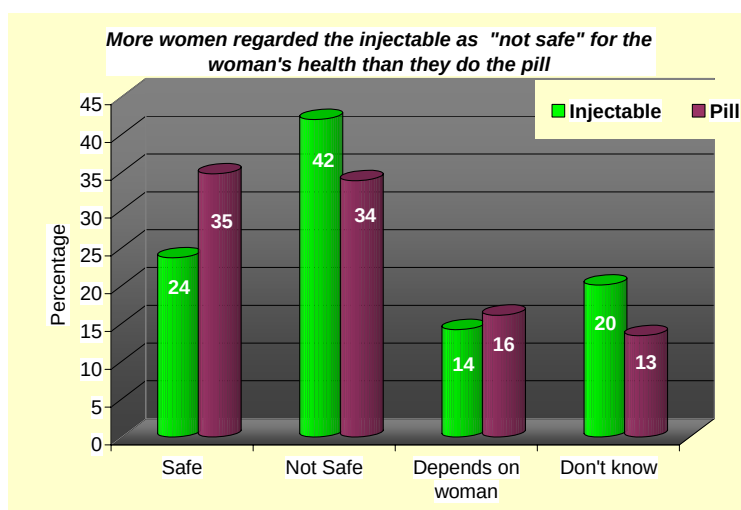
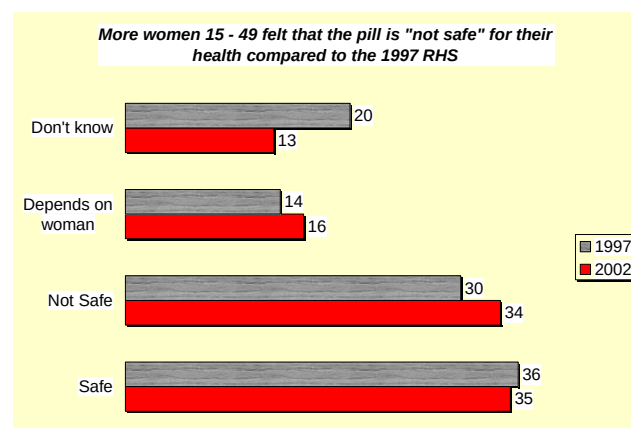
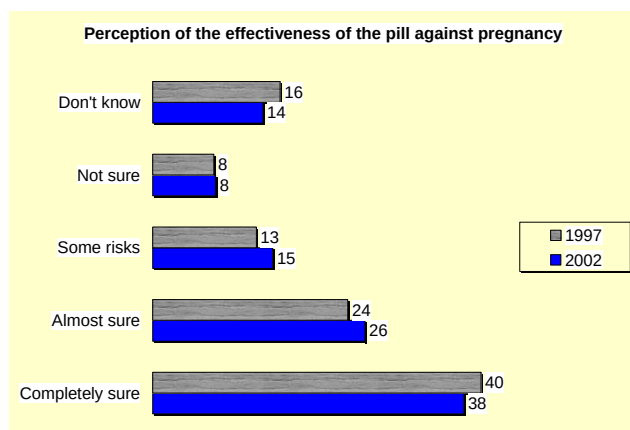
IMPROVE EFFICACY OF CONTRACEPTIVE USE

There is an emphasis on consistent and correct use of contraceptives for users of supply contraceptives. The aim is to keep family planning users on their chosen contraceptive methods for a longer period as long as such contraceptives are appropriate for their stage in reproductive life.

Percentage of sexually experienced women and men 15-24 years who used contraception at first intercourse

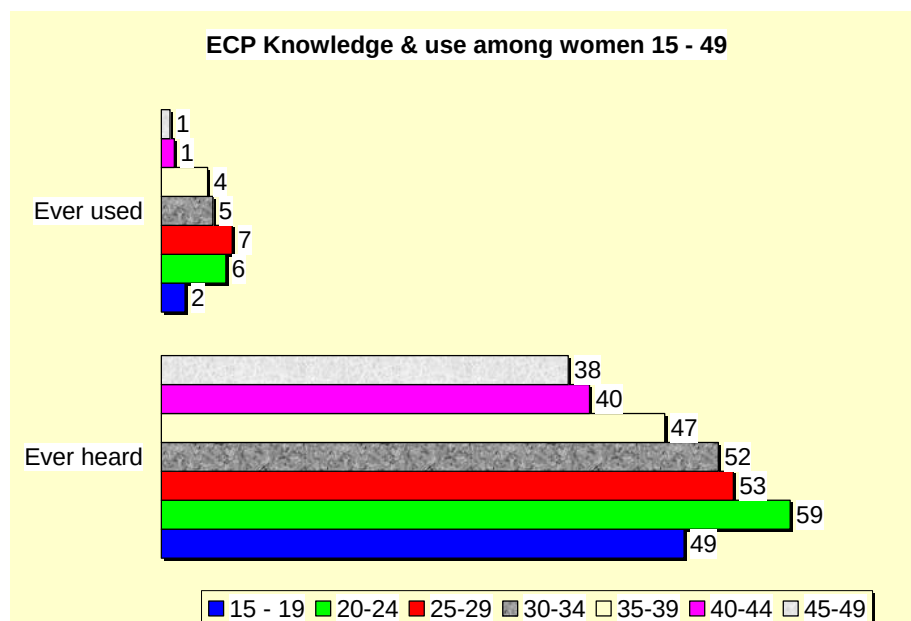


Source: 2002 RHS

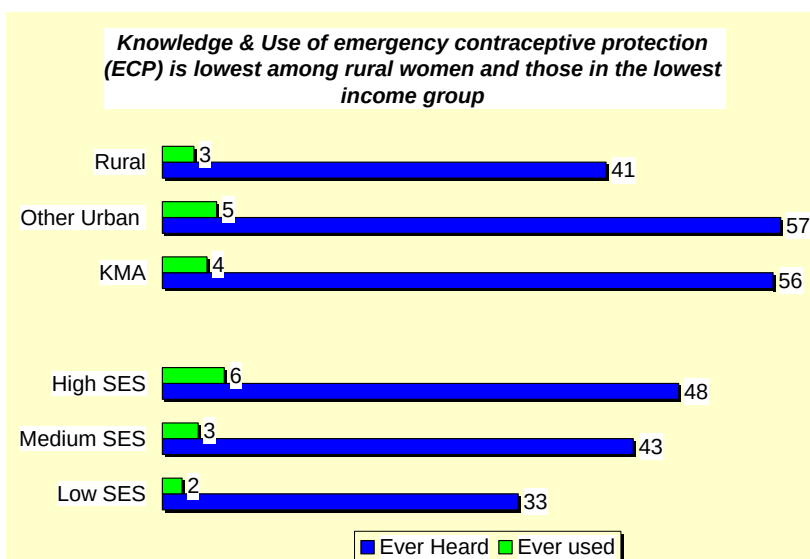


INTRODUCE EMERGENCY CONTRACEPTIVE PROTECTION

Although ECPs are used by only 0.2% of women 15 – 49 who were currently using contraceptives, findings indicate a growing acceptance of emergency contraception particularly among younger women.



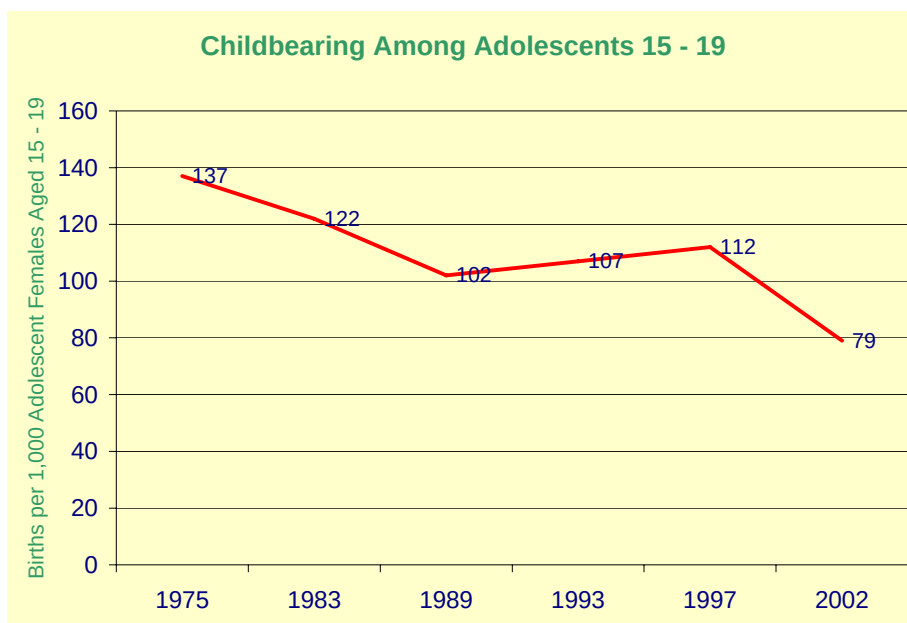
Knowledge of ECP among women in the reproductive age group is however relatively low, as only 49% ever heard of ECP. Less than 4% of these women had actually ever used an ECP. Usage is however highest among women aged between 20 – 34 years, particularly those with more years of schooling, and lowest among rural women from the lowest socio-economic background.



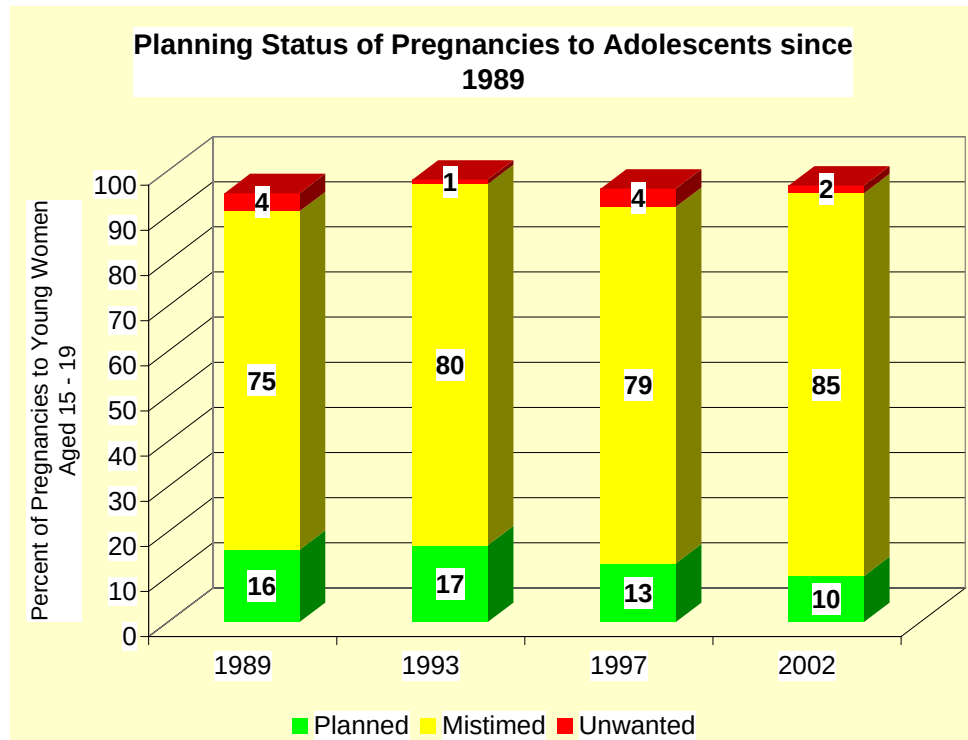
EXPAND ACCESS TO REPRODUCTIVE HEALTH TO ADOLESCENTS

For the first time in nearly 30 years, the age specific fertility rate (ASFR) for adolescents, measured in births per 1000 women aged 15 – 19, has declined to below 100. In 2002 the fertility rate among adolescents had declined to 79.

A possible explanation for this significant reduction in fertility among adolescents is the increase in condom use from just under 27% to 43%. This may indicate the success of various promotional programmes targeting this group that have been undertaken by the Ministry of Health and other agencies.



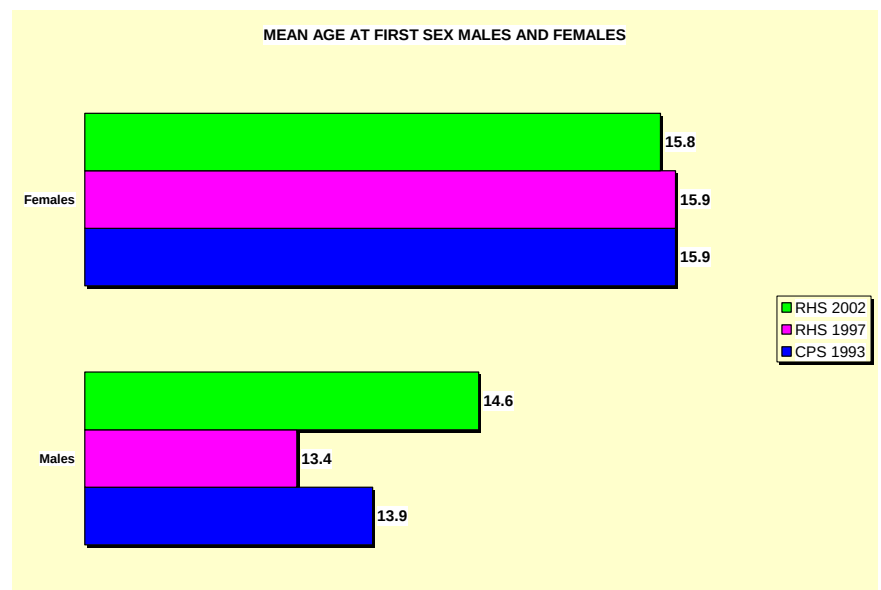
Even as ASFR for adolescents has declined, the proportion of mistimed and unplanned pregnancies / births within this age group remains exceptionally high. In fact, the proportion of unplanned pregnancies among adolescents is approximately 87%. The implication of this finding is that for the most part, fertility intention – to delay childbearing – is not borne out in practice. Contraceptive prevalence though increased, does not translate in consistent use by adolescents.



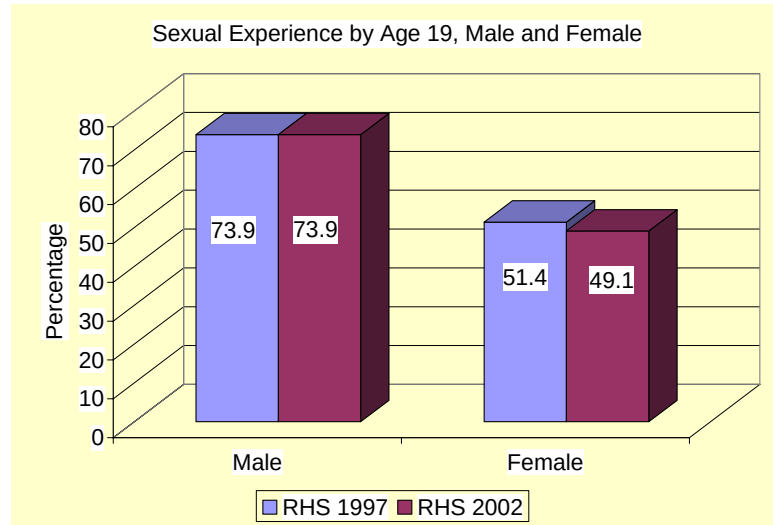
The proportion of unplanned pregnancies among adolescents, particularly the younger adolescents (aged 15-17 years), remains high.

There has been little change in the mean age at first sexual intercourse among young adult women 15-24 which remains at around 15.8.

The mean age at first sexual intercourse for young adult men 15-24 has increased to 14.5, an indication that young men on average are delaying their sexual debut. Notwithstanding this, males continue to enter their sexual debut at an earlier age compared to their female counterparts.



The proportion of female adolescents who are sexually experienced by age 19 years was however reduced from 51.4% in 1997 to 49.1% in 2002. For male adolescents however, the situation remained unchanged.



Contraceptive prevalence among adolescents (15 – 19) who are in union has also seen a significant increase from 58.6% in 1997 to 69.8% in 2002.

The condom remains the most prevalent contraceptive method used by adolescents in union and there has been a significant increase in condom use among this group. Condom use increased from 26.9% in 1997 to **43% in 2002**. Condoms are also the contraceptive first used by adolescents in their sexual debut. Approximately 96.4% of adolescent females and 97.9% of adolescent males used a condom at first sex. (Other methods also used at first sex included withdrawal and pills).

Approximately 67.4% of sexually experienced young adult women used contraception at first sexual intercourse compared to 55.6% in 1997. Among females aged 15 - 19, the proportion who used a contraceptive at first intercourse was 70.0%. For males aged 15 - 19 however, the proportion who used a contraceptive at first intercourse is a disappointing 44.9%

Adolescents who did not use a contraceptive at first intercourse cited as the main reason that they “didn’t expect to have sex”(females 50.2%, males 35.0%). The second reason for non-use among females was that they “couldn’t get method at that time” (15.0%). For adolescent males, however, the second key reason for non-use of contraceptives was that they “didn’t know of any method” (29.2%).

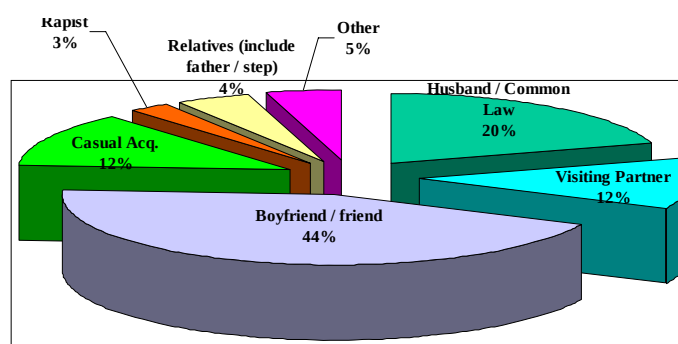
There was also a decline in the proportion of young adult women (15 – 24) who reported ever being pregnant from 43.2% to 37.4%. Approximately 19.1% of adolescents 15 - 19 reported ever being pregnant, with the lowest incidence of pregnancy occurring among the age group 15 – 17 years (7.3% in 2002).

Consequently the proportion of adolescents reporting ever having a live birth was also reduced (from 11.2% in 1997 to 5.9% in 2002 among the 15 – 17 age group and from 34.4% to 29.0% among the 18 – 19 age group).

There was an increase in **pregnancies among adolescents who are still in school**, particularly among those enrolled in secondary and post secondary institutions (from 42.2% to 48.3% and from 6.5% to 11.1% respectively). Only one in three women (36.6%) who got pregnant while in secondary schools will return, while more than half or 58% who got pregnant while at post secondary institutions will return.

Perpetrators of Forced Sex

- **Forced sex perpetrated mainly by persons intimate / known to the victim.**



Approximately 3.8% of women in the 15 – 19 age group had exchanged sex for money or goods. The youngest adolescents under age 17 (ranging from 4.0% among 17 year olds to 9.3% among 15 year olds), women in rural areas (3.3%) those from the lowest socio-economic status (4.2%) who have little education (13.3%) are most vulnerable to this.

The percentage of adolescent females who reported to have experienced forced sexual intercourse was reduced from 25.9% to 20.1% in 2002. Again, the youngest age groups – 15 year-olds (21.3%), and 16 year-olds (25.8%) appear to be most vulnerable to forced intercourse. **Findings also show that boyfriends or other steady partners were the main perpetrators of forced sex.**

Young adult women (regardless of age), as well as men, shared the view that a woman is responsible enough to have her first child between the ages of 20 – 24. Unlike their female counterparts, however, the majority of men are of the view that younger women (aged 24 years and under) are also responsible enough to begin childbearing. This situation was not much different in 1997.

EXPAND ACCESS TO REPRODUCTIVE HEALTH TO MEN

RHS 2002 findings indicate a decline in the proportion of young men **who know** where to go for information on sexual relations or contraceptives. Approximately 69.5% of men aged 15-24 know where to go for information on these matters compared to 82.8% in 1997. This finding is influenced by the low level of knowledge among males in the youngest age group (15 – 17) of which only 52.1% know where to go for information.

The situation is the same for male knowledge of where to go for treatment for STIs. Only 78.3% know where to go for this (compared to 94.8% in 1997). Again, only 57.3% of the 15 – 17 year olds know where to go for treatment of STIs.

There was however an increase in the proportion of sexually experienced young adult men who used contraception at first intercourse. Approximately 42.9% of sexually experienced young adult men used contraception at first intercourse compared to 31% in 1997. In addition, approximately 82.6% of young adult men who had sexual relations in the last 30 days³ used contraception compared to 79.6% in 1997.

Contraceptive (condom) use among young men is however inconsistent. While “ever use” among adolescent males 15 - 19 increased from 83.8% to 93.6%, few reported using a condom with their last partner (60.5% compared to 66.4% in 1997). Fewer use a condom consistently with their non-steady partner (57.3% compared to 62.4% in 1997). Fewer still, use a condom at every intercourse (24.2% compared to 35.6% in 1997).

Coupled with inconsistent contraceptive use is promiscuous / risky behaviour among young males. There was an increase in the proportion of young adult males who reported having two or more sexual partners during the past three months from 34.7% in 1997 to 44.4% in 2002. (Whereas the pattern for females has not changed with approximately 97% of women reporting having only one sexual partner during the past three months).

While the proportion of young adult males aged 15 – 24 who reported ever fathering a child declined from 10.0% in 1997 to 8.4% in 2002, fatherhood among adolescent males 15 – 19 **increased**. Among males aged 15 – 17 the proportion of fathers increased from 0.1% in 1997 to 0.4%, while among the 18 – 19 age group, there was a marginal increase from 3.5% to 3.8%.

³ Prior to the survey.

