#22530

Report on Focus Group Discussions of

THE MINISTRY OF HEALTH POLICY GUIDELINES: ACCESS TO CONTRACEPTION FOR MINORS

Conducted: March 2001

Conducted for: The National Family Planning Board

Conducted by : Hope Enterprises Ltd.
86 East Street, Kingston

INDEX

Report on Focus Groups Discussions on the Ministry of Health Policy Guidelines: Access to Contraception for Minors

Submitted by: Hope Enterprises Ltd.

1.0 INTRODUCTION:

The Ministry of Health, in its commitment to ensuring no child is deprived of his or her right to access health care is proposing a new policy guideline for minors. The policy will impact persons under the age of sixteen years and will ultimately allow health care professionals to attend to minors without parental consent and in appropriate cases, provide the minor with contraceptives.

This change in policy has the potential to create both negative and positive impacts. As a result the National Family Planning Board has commissioned Hope Enterprises Ltd to conduct a series of focus group discussions with the parents of children likely to be affected by the policy.

2.0 OBJECTIVE:

This project aims to gauge parental/public response to the policy in general and to its specific implications.

3.0 CONCLUSIONS

The proposed legislation was not endorsed as presented. Parents had concerns with unconditional doctor/patient confidentiality in cases where the minor does not agree to disclosure. It was universally felt that there were some instances, such as in 'serious cases' where notification of parents should be mandatory, whether the minor agreed or not. These were in the case of pregnancy, diseases including sexually transmitted infections and where the minor had been sexually assaulted.

Additionally, parents would only endorse the issuing of contraceptives to minors if the comprehensive counseling as outlined in the proposed legislation is followed.

The policy was also seen as having other implications which would need to be addressed in order to facilitate its successful implementation. These were:

1. Public education for parents prior to implementation of the legislation to facilitate their understanding of the comprehensive nature of the counseling which would be given to the minor before distribution of the contraceptives.

2. In cases where a parent is to be advised of a problem being faced by their minor, 'pre-disclosure' counseling of the parent was widely suggested. This was thought necessary to diffuse any potential angry reaction of the parent towards the minor.

3. Training health staff to be more 'adolescent friendly' so facilitating the environment in which the minor will feel welcomed and respected.

4. Re-training health staff to act as counselors, to fulfill the counseling requirement of the policy.

5. Having a system whereby health staff can be reported if their conduct was not in keeping with the requirement of respect for the minor.

6. Increasing the staff complement at clinics so ensuring that the healthcare provider will have the time to offer the counseling promised under the proposed legislation.

Overall the legislation was welcomed in terms of recognizing the right of the minor to health care, given with respect and dignity. However without mandatory

notification of "serious issues" the proposed legislation is not likely to have the full endorsement of parents.

4.0 METHODOLOGY:

A series of four focus groups were conducted with mothers and fathers who had at least one child between the ages of 10 and 16years old. Groups were conducted among both rural and urban residents who were all users of public sector clinics. Two groups were conducted in Kingston, a third group in May Pen and a fourth in St. Ann's Bay. A total of 28 persons participated in the project with groups ranging in size from 6-8 participants.

The policy was presented in 7 parts. The first part discussed the minor's right to health care. The second discussed the obligations of the health care professional. The third part discussed the child's right to confidentiality and the fourth part discussed the health care professional's responsibility to refer the case if they were unable to maintain the patient's right to confidentiality. The fifth section discussed the health care professional's obligation to counsel the adolescent and the type of counselling which should be given. The sixth section dealt with the criteria based on which the health care professional would decide to provide the minor with contraceptives. The final section explained the MOH's thoughts on parental responsibility to establish a good relationship with their child so as to ensure the child will confide in them.

Each section was presented on show cards, read aloud to the group and then discussed before moving on to the next section.

The groups were led by a trained Moderator, using a topic guide developed in collaboration with the National Family Planning Board. Groups were tape-recorded, the participants were refreshments provided with and reimbursed for transportation expenses.

5.0 DETAILED FINDINGS

The detailed findings are presented with the actual statements from the policy and the relevant responses to each.

Right to Health Care:

"Any individual regardless of age, gender or background who visits a health facility (public or private), whether they come with parents, by themselves, or were referred, should be registered and get to see a health care professional (doctor or nurse)."

Most participants expressed a favorable response to the concept of all persons regardless of age having a right to health care whether accompanied by a parent/guardian or not. Particularly in Kingston participants reasoned that this should always have been the case as children as old as 11 are often able to go to the doctor by themselves and explain their ailment. This is seen as a particular benefit when parents are too busy to accompany them:

"Sometimes you gone to work and the child is 13 years old and can go by herself"

"I would send my 7 year old daughter to the doctor alone....."

However, some parents, who prided themselves as being more traditional 'good parents', did have reservations about persons of any age seeing the doctor without them. This seemed to stem from the belief that a 'good parent' would not allow their young child to go alone and that a minor would need an adult to help explain their ailment. This trend was particularly evident in the group conducted in St. Ann's Bay:

"an adult should go with the child"

"I wouldn't send her alone now, not even at 14 years old"

Although most persons could cite numerous instances of the doctor/nurse refusing to see minors without an adult present, few seemed aware that administering to minors was illegal:

"most of the clinic now if you come without a parent them send you back for somebody big"

"parents have to come"

"doctors won't see the children if they are by themselves"

Obligation to Show Respect and Adolescent Right to Express Views Freely:

"The health professional has an obligation to:

- ***Show respect at all times and in all cases to adolescents (teenagers), including making sure to save their dignity (not embarrass them)***

- ***Assure them the right to express their views freely***

- ***Provide non-judgmental health care information and services in order to allow the adolescent to make informed decisions."***

Respondents were in strong agreement with this proposal and were able to cite numerous examples of teenage embarrassment and disrespect experienced at the hands of health care professionals:

"Mostly in the clinics the people them don't know how to talk to people"

"sometimes when the girls them get pregnant is not that they did not go to get it (family planning) but is how they were treated"

"the head nurse talks down to teenagers so most young girls don't go to the clinic when they get pregnant"

"they try to criticise them and embarrass them, they don't encourage them to use family planning, they talk down to them instead"

It was also felt that children would be more willing to talk to doctors/nurses than their parents:

"they will talk to the doctor and nurse"

"well I have a little one and I can't get to her whenever time anything is not working, but when I carry her to a doctor or a pastor they get things from her."

Some participants felt however, that it would take more than the passing of a policy to change the attitude of some health care professionals. It was felt the policy should be accompanied by special training for existing staff and the addition of other specially trained staff to some facilities. One respondent even suggested a kind of accountability system whereby if a client visited the clinic 3 times and the client is not treated with respect then they should be able to make a report to some higher power and appropriate action taken:

"If you go three times and the nurse rude you must can call a boss and tell"

"Need to council nurses on how to treat people"

"Nurses should be reported for breaching confidence"

Health Care Professional & Confidentiality:

"If the doctor or nurse's opinion on the situation in terms of confidentiality causes them to be unable to provide services, they should counsel the adolescent and refer them to someone who can provide them with service."

There was such clear agreement that the health care professional must act in a responsible and confidential manner (confidential re: not telling other person, excluding the parent) that it was a given that should a person feel unable to keep the confidence then the case must be referred.

Counselling

"first they should encourage abstinence (not having sex) and fully explain the benefits of abstinence for adolescents. If however the adolescent doesn't think abstinence is right for them and intends to start/continue having sex, then the doctor/nurse should give them contraceptive advice."

..."a wide range of information should be offered including all the different types of contraceptives available, relationships, mental health and sexual transmitted diseases (including HIV/AIDS)"

The mention of abstinence often received a resounding 'yes' from all groups. Additionally after discussing this portion of the policy, fears were often allayed, as it became evident that the doctor would counsel about all the other things that the parent would counsel. It was agreed that the child would be receiving informed advice on all possibilities. Important to parents was the fact that the health care professional would attempt to convince the child to delay sexual activity and that, only after clear refusal from the child would the doctor then advise them on contraceptives. It was also critical that contraception would be given to the child only as a last resort, if the child was insistent on being sexually active, with or without contraception, and refused to confide in their parents:

"yes they must talk out the first part then continue if the child insistent on sex"

"wide range yes...they must talk about everything and tell them everything"

"as long as they are sexually active they must give them information"

"talk to them about it regardless of if they are sexually active or not"

Doctors and nurses were generally trusted as counsellors and the givers of information. They were felt to be an appropriate substitute if the child did not want to talk to the parent.

Issuing contraceptives:

Now lets talk about how the doctor/nurse is to decide on whether to give them contraceptives. The policy states that they:

..."use their best judgement to decide if...

- ***the adolescent cannot be persuaded to confide in his/her parent/guardian or allow the doctor/nurse to persuade them;***

- ***if the adolescent is likely to start/continue having sex and other risky behavior with or without using protection;***

- ***if the adolescent has all the information, understands and has considered everything carefully;***

- ***if it is in the adolescent's best interest to have the doctor/nurse provide them with non-surgical contraceptives. (Any contraceptives that would require surgery would have to be approved by the parent first.)***

- ***at all times dual protection should be encouraged to reduce the risk of acquiring sexually transmitted infections.***

Furthermore any doctor/nurse who offer contraceptives to an adolescent should provide clear information of how to use them and any side-effects that may occur, and should check on the adolescent in the future to ensure they are practicing safe sex."

Most participants interpreted this section of the policy to mean that although health care professionals could now give a child contraceptives, this would only be done after much counselling and as 'a last resort' in cases where children were insistent upon having sex with or without contraception. This information would be kept confidential only at the child's insistence and the health care professional would attempt to convince the child otherwise. When considered in this light most respondents agreed with the policy and responded favourably to the idea of children being provided with contraceptives. Interestingly, even parents who initially disagreed with the policy now grudgingly supported the policy.

'if the doctor cannot convince the child, and the child insist that she going to have it (sex) same way, so it best to give it to them anyway'

'I won't trouble her because I know she taking something and she won't get pregnant'

"I don't have any problems with her having family planning because as long as she is having sex she should be on family planning"

"yes if after all that they still going to have sex then give them the contraceptive"

"If I find it (contraceptive) I would use it as a stepping stone to get involved" (this said by a parent who initial rejected the policy)

"Personally me no feel no way because me not taking up no more responsibility for no more baby"

"if I find the pill then I would say the child make a right decision"

"I may react a way but then me have to come to terms with reality"

"me would rather she is on the pill than get belly"

Advocating for dual method use was also seen as very important by most.

"also give them the condom"

Other Issues:

Parental counselling and an in-depth and comprehensive public education campaign were seen as key elements in the successful implementation of the policy. The suggestion was made for public education on the policy possibly, conducted through a variety of means including radio discussions, PTA meetings and posters in doctors' offices

When presented with the possible scenario of finding their 11 year old daughter with oral contraceptives, being taken without parental knowledge respondents explained that their may be initial anger. However, having been sensitised to the policy through public education and with the provision of parental counselling they would be able to realise the benefits of such actions and possibly help the child.

"counsel the children and the parents"
"call in parent alone or parent and child and counsel them"
"parents need to be counselled: on radio, at PTA meetings and so on..."
"have posters in doctors office"

It was agreed to by all that some parents may respond angrily and violently to the discovery of their child taking contraceptives. Proper education prior to the coming into effect of the policy and the provision of counselling would mitigate against and minimise the extent of such a response.

"at school you give them contraceptive but you don't let the parents know at first and they go home with it, then the parents going to say yes you turning man (or woman) and get angry, that is why the parents need counselling"

Perceived Advantages of the policy:

The policy was seen as having many possible benefits. These include the likelihood of reducing the spread of diseases including AIDS, reducing the incidence of pregnancy and improving the quality of lives for teenagers.

"less AIDS spreading"

"less pregnancy and AIDS"

They will get proper health care and understand themselves more"

"they will get counselling"

"helping to create a better society"

"stopping unwanted and early pregnancy"

"if teenagers have disease more likely to go for help if they have somebody who they can go and talk with and not just sit there and let it spread"

"help some children focus on career as they now delay sex"

The policy was generally thought to be clear and easily understood and well intentioned.

NFPB LEGISLATION

FOCUS GROUP DISCUSSION MODERATOR'S GUIDE

Introduction:

- *Moderator introduction*
- *Explain reason for meeting; the format of discussion/what a focus group is; that the discussion will be taped; that there are no right or wrong answers; and that everyone should feel free to express themselves honestly; and that we are all friends here and respect each other's opinions. [Refreshments to be served].*
- *Participant introduction:*

- Now I want each of you to introduce yourself to everyone so we can all be friends here. First tell us your first name.
- Tell me about your family? How many persons live in your household? - *children under 5? – children under 12? – teenagers? - Adults (counting yourself)?*
- *What is your one wish for Jamaica in 2001?* (ice breakers)

Discussion:

The Ministry of Health wants to ensure that no child is deprived of his/her right to access heath care, and that the best interest of the child should always be the first consideration. To ensure this they are thinking of introducing a new health policy that will affect those under 16, but before they do so they want to gain the opinion of Jamaican parents of it.

Lets take a look at the policy, step by step. Remember to stop me and ask questions if you don't understand anything, anything at all. It is very important you tell me, okay?

A. **First it says that:**

"Any individual regardless of age, gender or background who visits a health facility (public or private), whether they come with parents, by themselves, or were referred, should be registered and get to see a health care professional (doctor or nurse)."

In other words, if they are there about a sexual problem, the doctor or nurse must counsel them fully about not having sex until they are older. However if it is clear that they intend to continue/start, then the doctor or nurse must tell them about contraceptives/protection.

- As parents, how do you respond to that? What do you think about that?
- Do you have any concerns?
- Do you have any suggestions or changes you would like to make? What are they?

F. **Issuing contraceptives:** Now lets talk about how the doctor/nurse is to decide on whether to give them contraceptives. The policy states that they:

..."use their best judgement to decide if... **READ SHOW BOARD:**

- *the adolescent cannot be persuaded to confide in his/her parent/guardian or allow the doctor/nurse to persuade them;*
- *if the adolescent is likely to start/continue having sex and other risky behaviour with or without using protection;*
- *if the adolescent has all the information, understands and has considered everything carefully;*
- *if it is in the adolescent's best interest to have the doctor/nurse provide them with* ***non-surgical*** *contraceptives. (Any contraceptives that would require surgery would have to be approved by the parent first.)*

Furthermore any doctor/nurse who offer contraceptives to an adolescent should provide clear information of how to use them and any side-effects that may occur, and should check on the adolescent in the future to ensure they are practising safe sex."

- As parents, how do you respond to that? What do you think about that?
- Do you have any concerns?
- Do you have any suggestions or changes you would like to make? What are they?

G. The MOH's thinking is that :

"Adolescents should be strongly encouraged to involve parents or other trusted adults in their decisions regarding health care. However their decision to involve their parent(s) or not would be determined by their relationship and ***not*** *by law....it is the parent's responsibility to create an environment for adolescents to feel comfortable enough to talk to them. Remember that part of growing up is moving away from your parents, and adolescents may see a trained professional as being better able to counsel them, rather than parents. If adolescents are denied sexual and reproductive heath care or counselling because their parents don't agree this could put a larger barrier between the child and parent as well as possibly increase the risk of psychological harm to the adolescent."*

- Can someone try and put the whole policy in a nutshell/summarise for me?
- Are you comfortable with this proposed legislation overall?
- What kind of effect do you think this will have on the family? The parents? The child?
- Do you think it would be in the best interest of the youngster or improve health care? Why? How?
- What do you see as must important in it?
- What are the greatest benefits? /disadvantages?
- What are your greatest concerns?
- Should they go ahead and put it in place or would you change it before putting it in place? What would you change to make it better?

<u>Thank participants, give incentives and wrap up.</u>