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SUMMARY OF RESULTS

HEALTH REGION 1

HEALTH REGION 1

Introduction

The present report summarizes the findings for Health Region 1 of the Reproductive Health Survey (RHS) carried out in Jamaica in 1997. A contraceptive prevalence survey (CPS) of a similar type was carried out in Jamaica in 1993. The 1997 RHS, therefore, not only provides data on the current situation in Health Region 1 and Jamaica as a whole regarding reproductive health and contraceptive practices, but also permits an evaluation of changes since 1993. The 1997 RHS utilized an updated sampling frame based on the 1991 census which has been adopted for the Continuous Social and Demographic Surveys conducted by the Statistical Institute of Jamaica (STATIN).

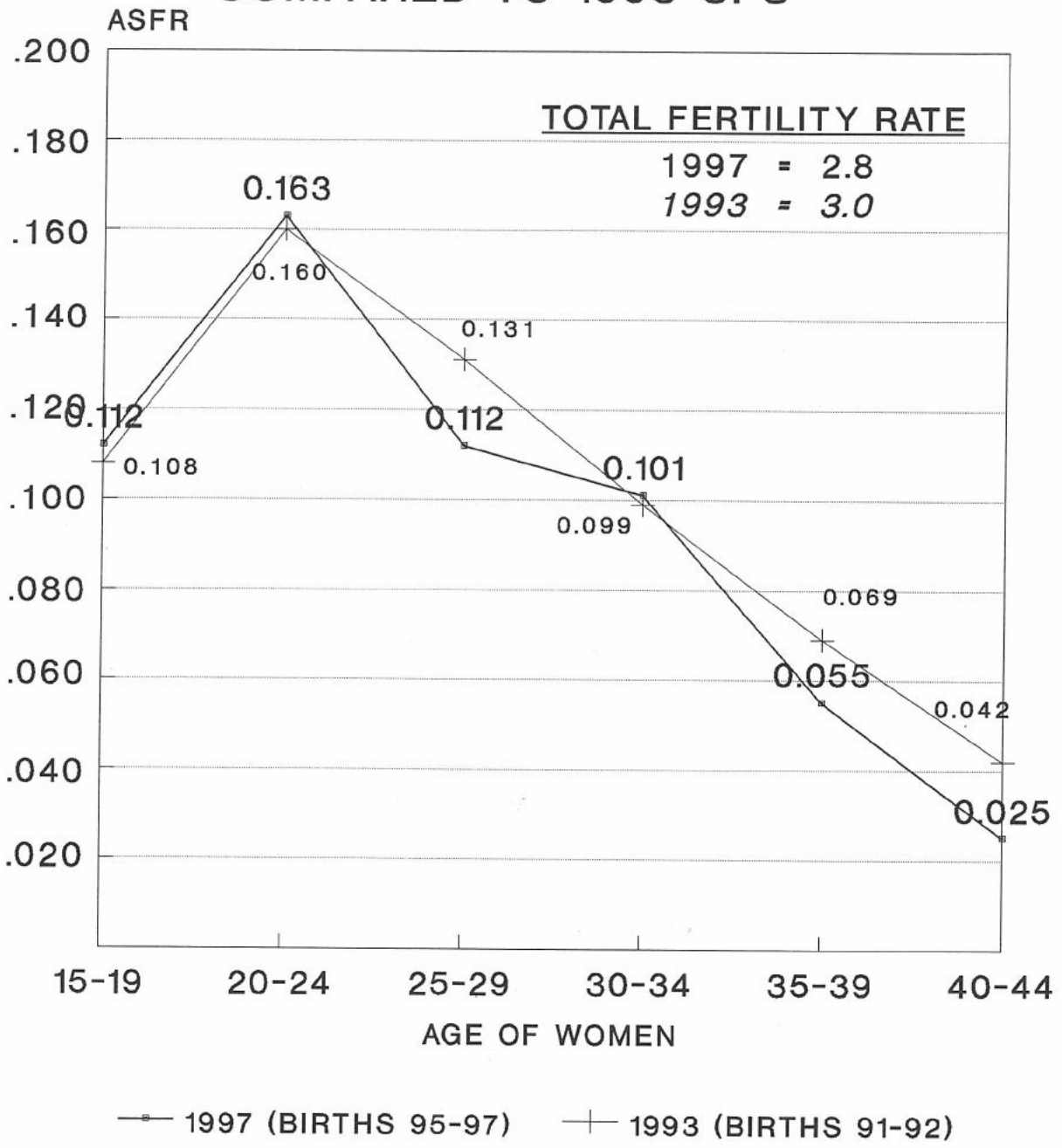
There are differences in the sampled population of the two surveys. Whereas in the 1993 CPS women aged 15 to 44 and men 15-54 were interviewed, the 1997 RHS included, in addition, women aged 45 to 49, but limited the coverage of men to an independent sample of young adults aged 15-24. The 1997 survey also had detailed questions in a special module addressed to young adult women aged 15 to 24, as well as questions on prenatal care and cancer screening, and questions on condom use, multiple sexual partners and attitudes toward contraception, which were addressed to all respondents.

Fertility

Fertility data for Jamaica as a whole and for Region 1 will be presented. The survey results show the total fertility rate (TFR) for the years 1995-1997 (i.e., the two years prior to interview) to be 2.8 births per woman (Figure 1). This represents a decrease from the TFR of 3.0 births per woman found in the 1993 survey. Age-specific fertility rates in the two surveys were similar for ages 15-19 and 20-24, indicating no recent decline in rates of early childbearing. Except among 30-34 year-olds, age-specific fertility rates fell substantially for all age groups from ages 25-29 to 40-44. The decline in fertility was particularly noteworthy at the oldest ages, with age-specific rates falling by 20 percent (14 births per 1000 women) at ages 35-39 and 40 percent (17 births per 1,000 women) at ages 40-44. The overall decline in the TFR of 0.2 births per woman between the 1993 and 1997 surveys follows a surprising failure to decline between the 1989 and 1993 surveys. Age-specific fertility rates were much higher at ages 20-24 than at any other ages, followed by similar levels at ages 15-19 and 25-29.

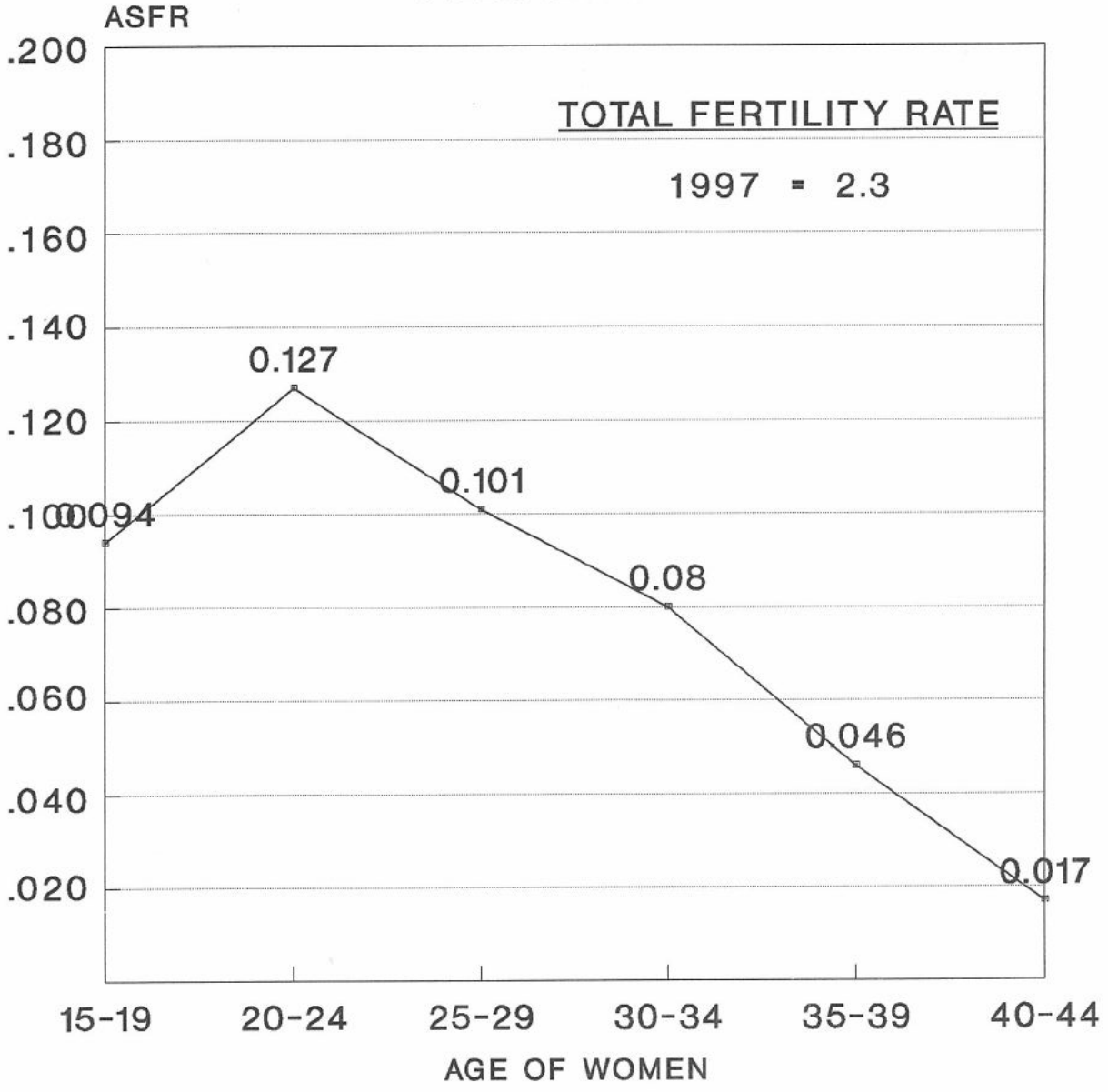
According to the 1997 survey, Region 1 had substantially lower fertility than the other three health regions of Jamaica. The TFR for the two years prior to the survey was 2.3 births per woman (Figure 2), compared to the island-wide rate of 2.8 births per woman. Each of the five-year age-specific fertility rates was also considerably lower in Region 1 than it was nationally.

FIGURE 1
AGE-SPECIFIC FERTILITY RATES
WOMEN AGED 15-44
COMPARED TO 1993 CPS



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 2
AGE-SPECIFIC FERTLITY RATES
WOMEN AGED 15-44
REGION 1



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

As in Jamaica as a whole, fertility rates were highest at ages 20-24, with 127 births per 1,000 women per year. This was followed by roughly equal rates at ages 15-19 and 25-29. Because of small regional sample sizes in the 1993 survey, it was not possible to examine changes in fertility within regions between 1993 and 1997.

Planning Status of the Last Pregnancy

Figure 3 shows the distribution of the planning status of the last pregnancy within the past 5 years for women aged 15-44 in Health Region 1 and Jamaica as a whole. A pregnancy is defined as "planned" if the woman wanted to become pregnant at the time she became pregnant. A pregnancy is "mistimed" if she wanted to become pregnant at a later date and is "unwanted" if she did not want to have any more children. These latter two categories together comprise "unintended" or unplanned pregnancies.

Overall, thirty-nine percent of pregnancies were reported by respondents in Health Region 1 to have been planned. Not shown in the graph is that this is an increase from 1993 when only 29 percent of pregnancies in Region 1 (and Jamaica as a whole) were planned. The majority of pregnancies in the region were unintended--including 41 percent mistimed and 17 percent unwanted. These percentages are similar to the country as a whole, where 42 percent of pregnancies were reported to be mistimed and 18 percent were unwanted.

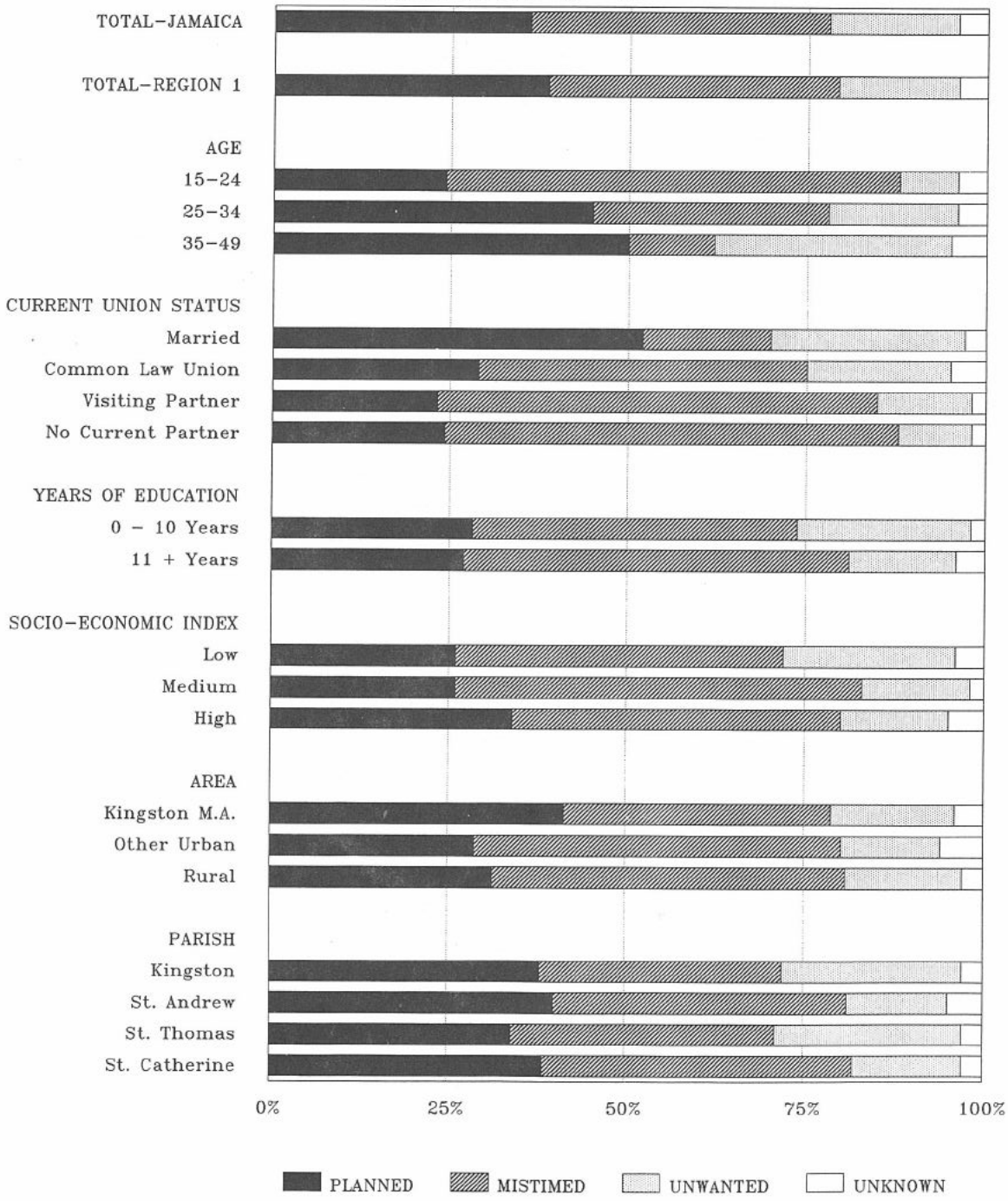
The proportion of unwanted pregnancies increases with age. Similarly, since Jamaican women tend to enter more stable unions as they age, the proportion of planned pregnancies is higher and the proportion of mistimed pregnancies is lower in the more stable unions. Conversely, mistimed pregnancies are concentrated among younger women in less stable unions who are more likely to have spacing of pregnancy failures. The percentage of planned pregnancies rises slightly with increases in the socio-economic index, but there is no discernable pattern by education.

Given the relatively high level of contraceptive use by women in union in Jamaica as a whole and in Health Region 1, the percentage of unintended pregnancies is still high. Two factors may be contributing to this: the less than optimum use of temporary methods resulting in contraceptive failure; and high levels of unprotected sexual activity by women who are not in union.

Knowledge of Contraceptives

Figure 4 shows "knowledge" of contraceptives among women. Knowledge here refers to the fact that the respondent has heard of a contraceptive method, not necessarily that she has enough knowledge of the method to be able to use it correctly.

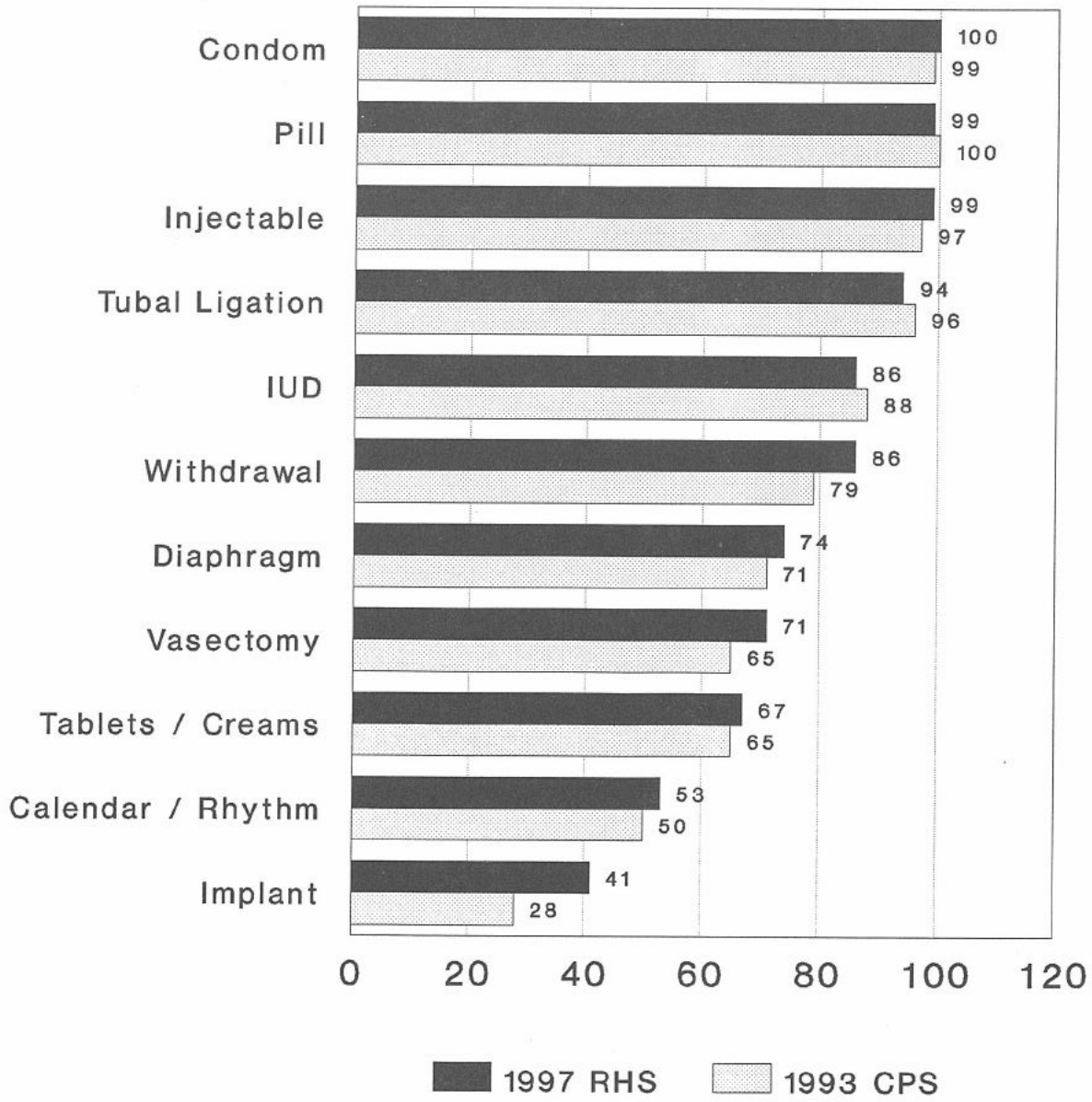
FIGURE 3
PLANNING STATUS OF LAST OR CURRENT PREGNANCY BY SELECTED CHARACTERISTICS (PERCENT DISTRIBUTION) WOMEN AGED 15-49



REGION 1

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 4
PERCENT OF WOMEN AGED 15-49
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 1
1997 JAMAICA
REPRODUCTIVE HEALTH SURVEY

Virtually all women in Region 1 have heard of the condom, pill, injectable and female sterilization, and almost 90 percent know of the IUD and withdrawal. The diaphragm, vaginal methods, natural methods and Norplant, which are little used in Jamaica, are less well known. While the informed choice of a contraceptive method must be left to userse, lack of knowledge of some of the more effective methods, particularly vasectomy and the implant (Norplant), reduces the choice and potential use of some available long-term methods. With the exception of withdrawal and the implant, knowledge of all methods is little changed from 1993 to 1997.

Figure 5 shows the level of women's knowledge of contraceptive methods in Region 1 by parish. There is little difference between parishes, except that fewer women in St. Thomas have heard of tubal ligation, withdrawal, vasectomy and the implant than women in the 3 other parishes.

Among young adult men (Figure 6), the best known methods are, as in the case of women, condoms, the pill, injectables, female sterilization and withdrawal. However, aside from condoms and the pill, all methods are less well known among men than among women.

Contraceptive Use

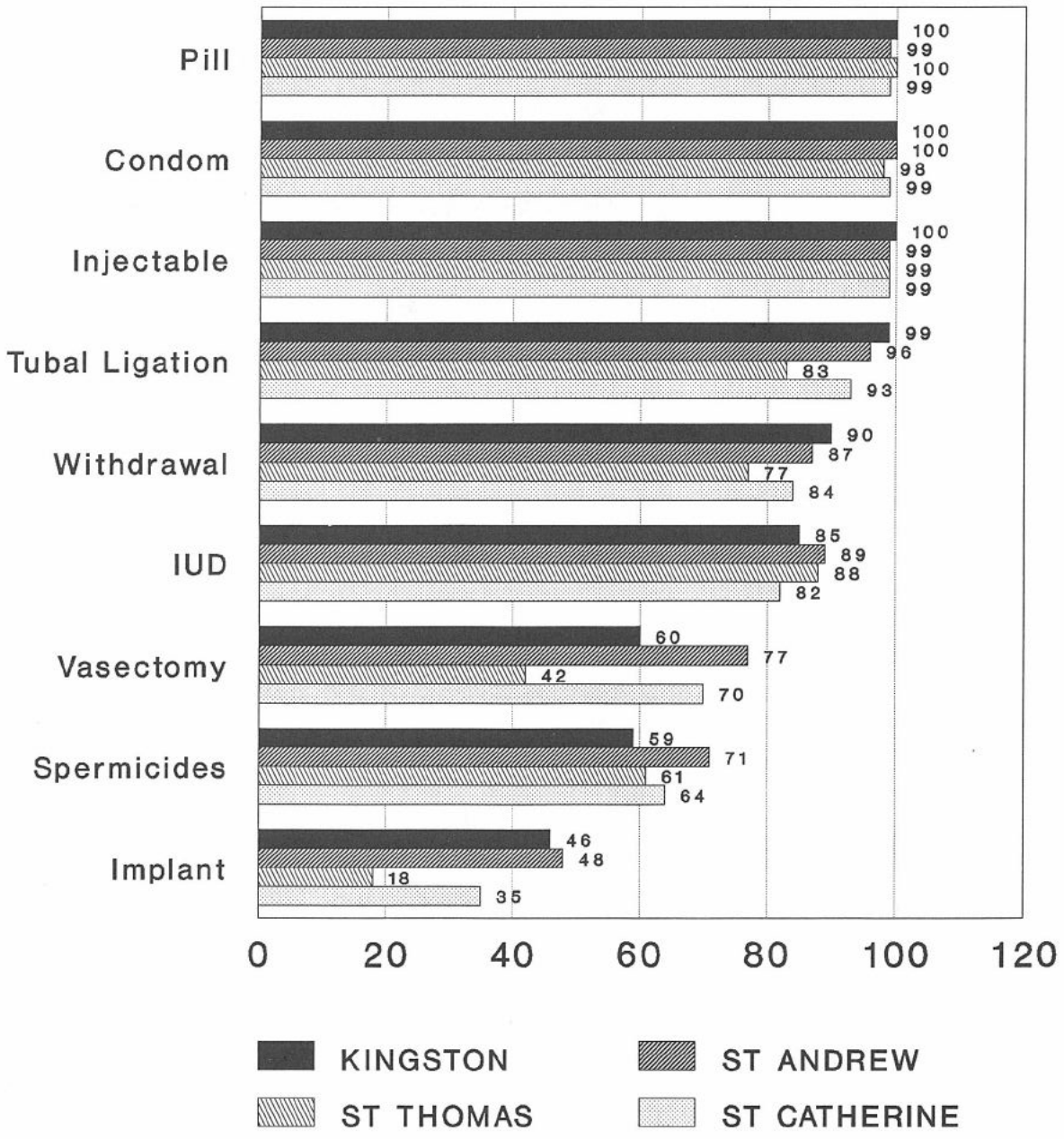
Figure 7 shows the prevalence of contraceptive use among women in union in Jamaica as a whole and Health Region 1 by principal type of method, comparing data for the region with the 1993 and 1989 surveys. The overall level of use in Region 1 at 66 percent of women in union is similar to the 65 percent for Jamaica and has only increased by one percentage point since 1993. This small increase since 1993 is accounted for by an increase in the use of injections. The level of condom use as a primary method has not changed since 1993.

Figure 8 is a pie chart showing additional data on specific contraceptive method use by all women (in union and not in union) as well as women in union in Health Region 1 in 1997. As seen in the upper pie, only 50 percent of all women are using a contraceptive method, with only 14 percent using the pill. The lower pie shows that oral contraceptives (21%) are the most prevalent method among women in union, followed by the condom (17%), female sterilization (12%) and injectables (11%). These are the same four leading methods as reported in 1993.

Figure 9 presents use of major contraceptive methods by women in union according to selected geographic and socio-demographic characteristics. In general, as age and increases, women tend to use more effective methods. While condom use predominates among women 24 and under, since almost half of these women using any method use the condom, the pill is the leading method between 25 and 34 years of age. The use of injections is also highest in this age group. After age 35 the pill is in turn eclipsed by female sterilization as the major method, as half of these older women using any method are using surgical contraception.

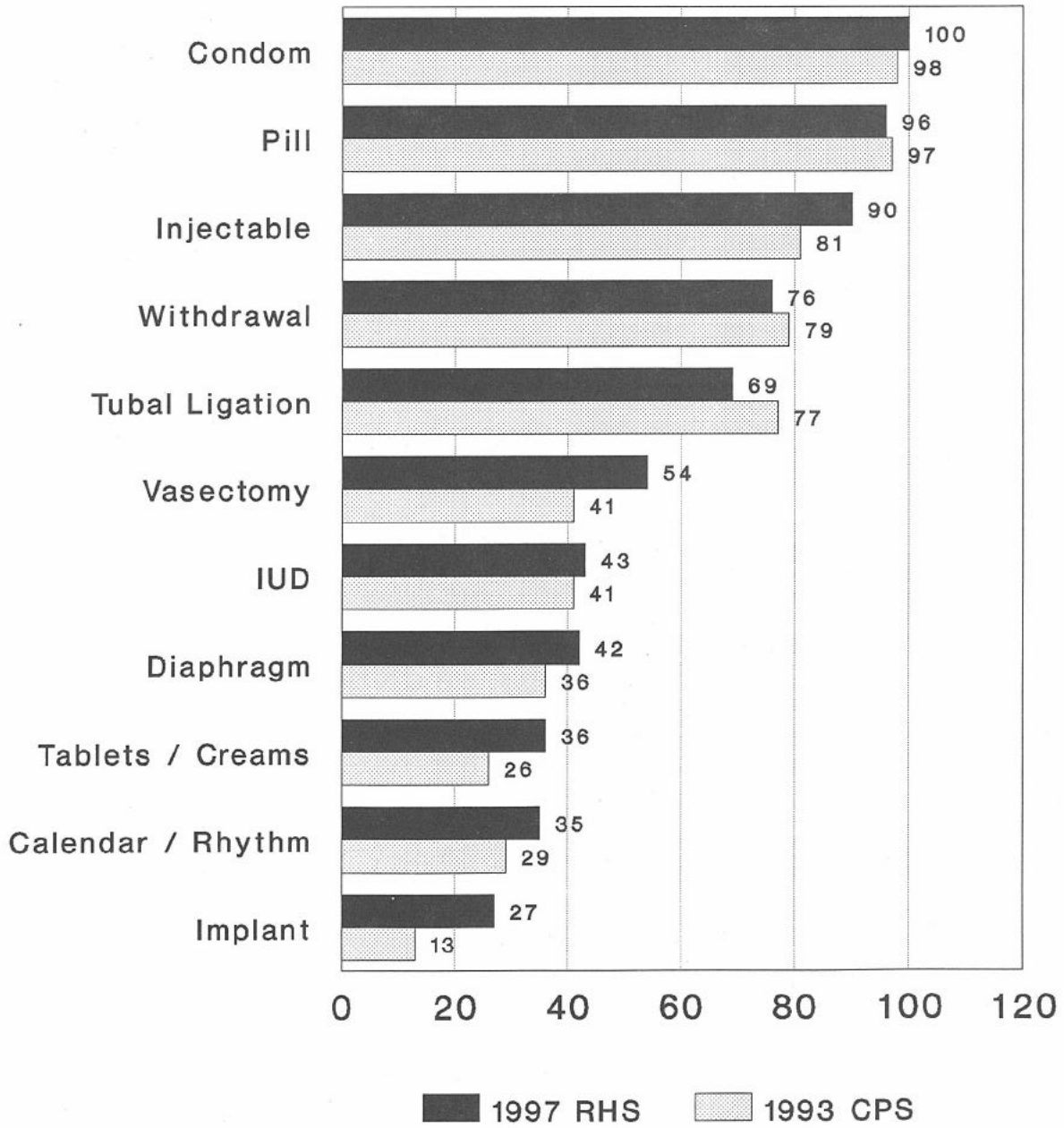
Overall use by women in a marital union is at about the same level as women in common-law or visiting unions, but there are differences in the methods used by these different groups. Almost

FIGURE 5
PERCENT OF WOMEN AGED 15-49 WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS BY PARISH



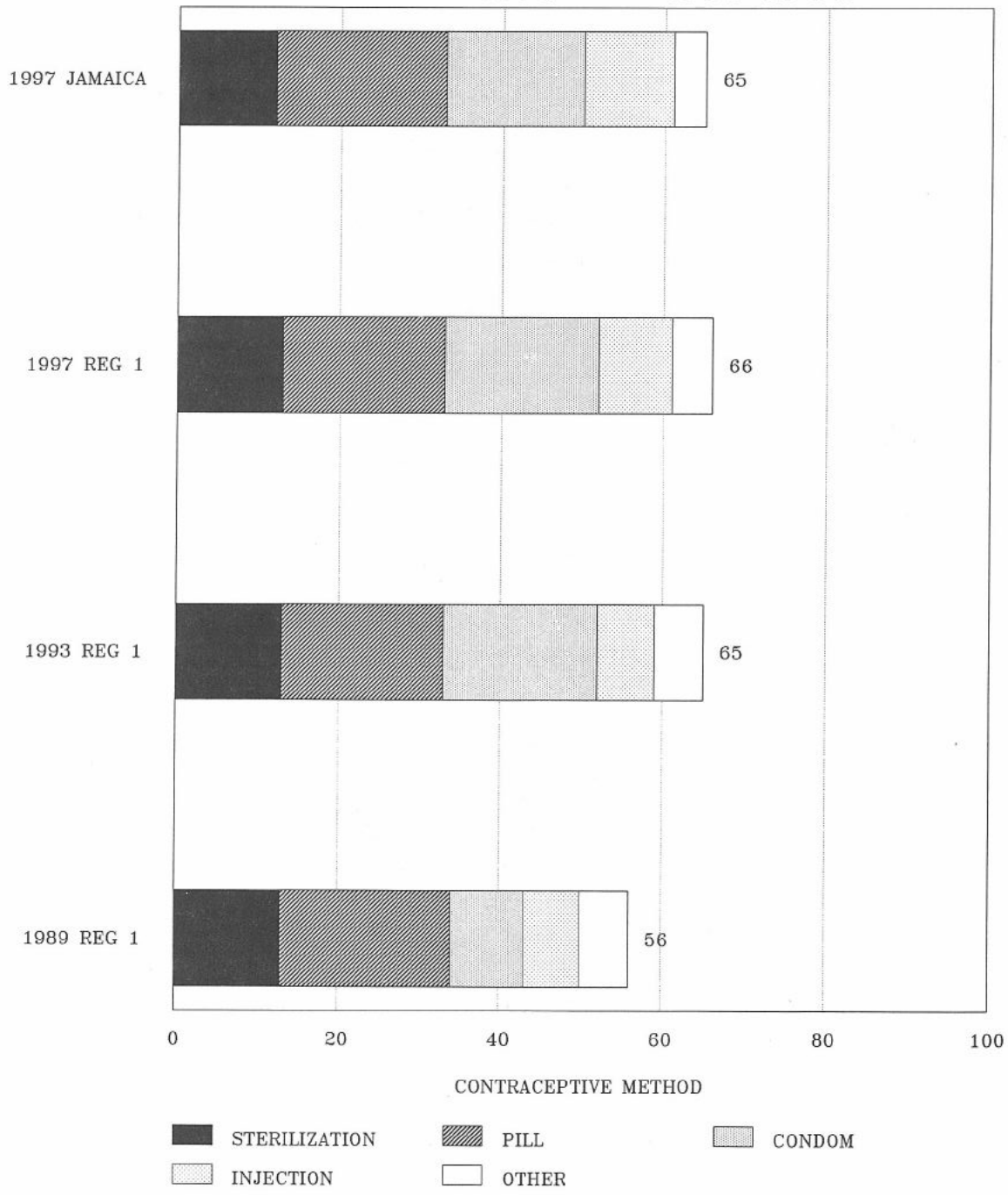
REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 6
PERCENT OF YOUNG ADULT MEN AGED 15-24
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



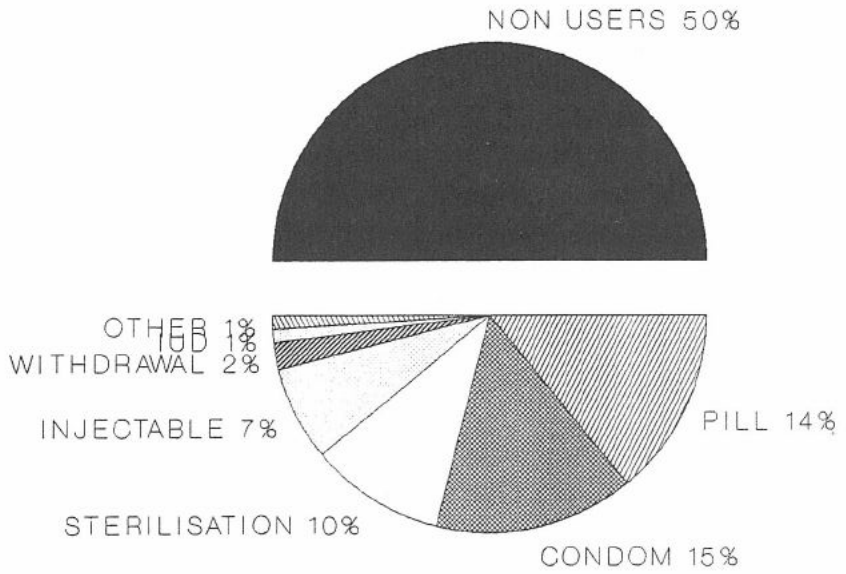
REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 7
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING CONTRACEPTION, BY METHOD COMPARED WITH 1993 AND 1989 CPSs

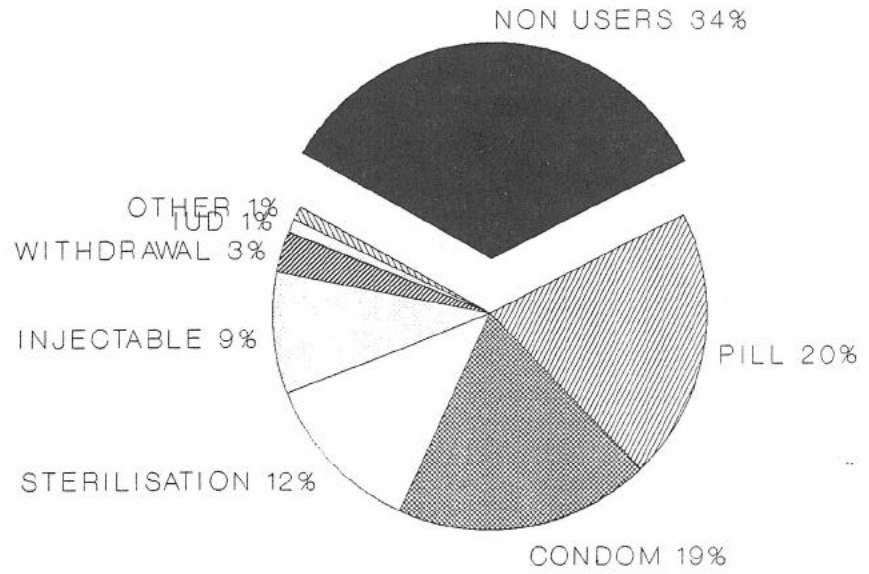


REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 8
PERCENTAGE OF ALL WOMEN AND WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD
REGION 1



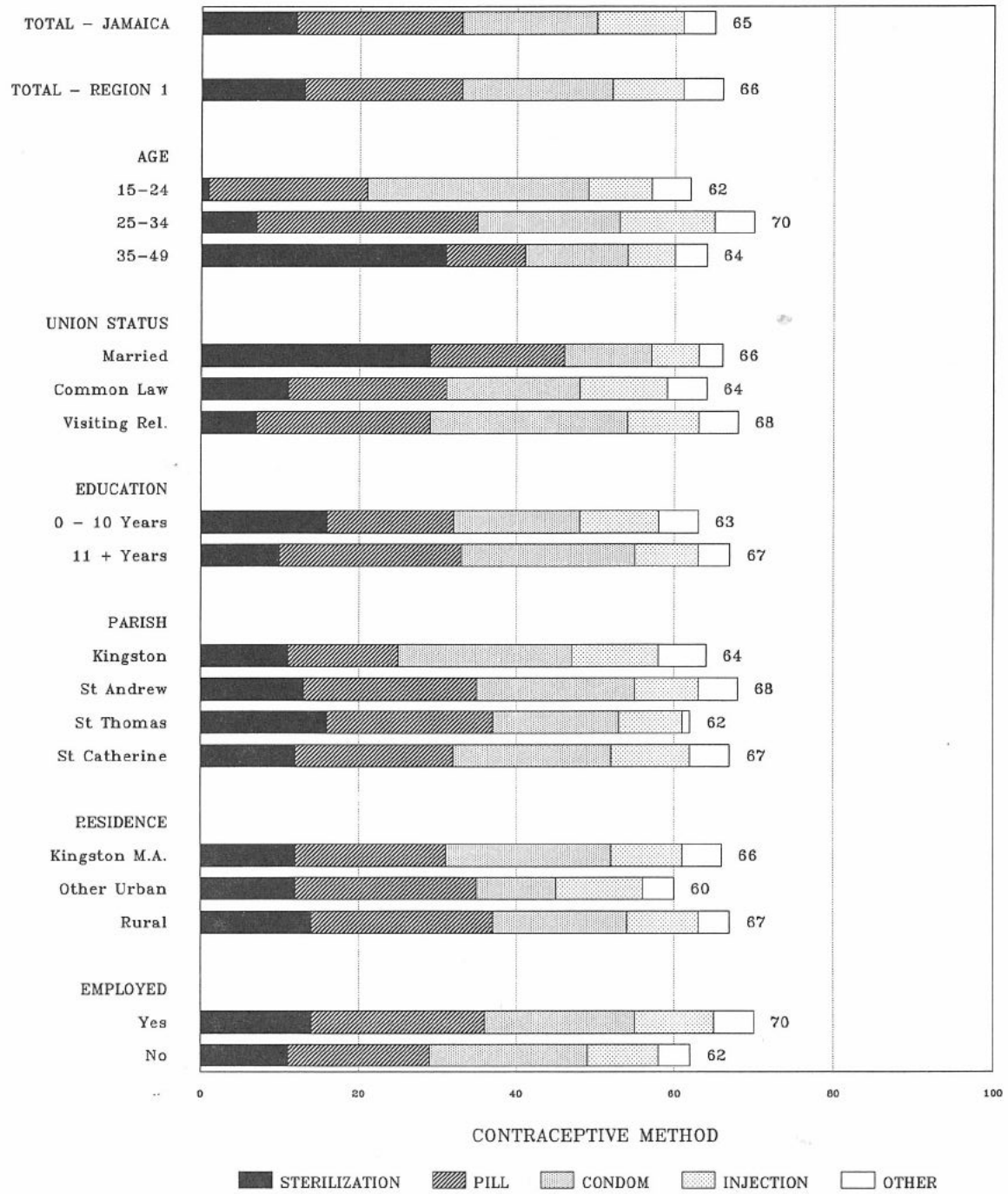
ALL WOMEN



WOMEN IN UNION

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 9
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD BY SELECTED CHARACTERISTICS



REGION 1
1993 JAMAICA CONTRACEPTIVE PREVALENCE SURVEY

half of married women using any method have been surgically sterilized. In contrast, relatively few women in a common-law union or in a visiting relationship have been sterilized. A factor not shown in this figure is that women who are married tend to be older than women in common law and visiting unions, which in turn is correlated with the number of living children. As mentioned above, with increasing age (and a greater number of children), a higher percentage of women choose this permanent method. Women who are in less stable unions and who are younger and have fewer children tend to use pills and condoms to a greater extent.

Overall contraceptive use is slightly higher among employed women than among others. There is little pattern to the overall use or method mix for any other variable including the parish of residence.

TABLE 1

Percentage Of Contraceptive Users In Health Region 1
Who Are Concurrently Using A Secondary Contraceptive Method
By Primary And Secondary Method Used
Women In Union Aged 15-49 Years
(Percent Distribution)
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

	Secondary Method Used						
	None	Condom	With-drawal	Natural Method	Other	Total	N
All Primary Methods	87.9	11.7	0.1	0.1	0.2	100.0	(1,405)*
Selected Primary Methods							
Pill	73.0	27.0	0.0	0.0	0.0	100.0	(332)
Injectable	83.9	16.1	0.0	0.0	0.0	100.0	(165)
Tubal Ligation	93.9	5.2	0.0	0.0	0.0	100.0	(208)
Condom	99.3	--	0.4	0.3	0.0	100.0	(293)
Withdrawal	100.0	0.0	--	0.0	0.0	100.0	(40)

* Number of cases for individual selected primary methods do not add up to number of cases for all primary methods because only those selected primary methods which had 25 or more users appear in this table.

Table 1 looks at the percentage of female first or primary contraceptive method users in Region 1 who concurrently use a secondary method. Overall, 12 percent of all users are also using a secondary method. Not shown in this table is that in 1993 only about half as many users (6%) were also using a secondary method.

Practically all secondary method use is the condom. This suggests that while data on primary method use alone do not show an increase in condom use from 1993 to 1997, by including secondary method condom use as part of this analysis, the use of condoms has increased in the four years since the 1993 survey. More than one-fourth of pill users and 16 percent of injectable users in Region 1 are concurrently using condoms.

To summarize the above findings, overall contraceptive use is high for all socio-demographic groups in Region 1 (and Jamaica) and is practically at the level of use of countries in Latin America where prevalence is considered to be high (70+ %), such as Costa Rica, Columbia and Brazil. While prevalence does not vary greatly by group, the choice of method does vary, with men and women moving from the condom to hormonal methods (pill and injections) and then to female sterilization as they get older.

Pill Use

A percent distribution of the brands of pills used is shown in Figure 10. The brand is important since each sector (government, social marketing and strictly commercial) has its own. The government programme distributes Lo-Femenal and Ovral, the 'Personal Choice' social marketing programme sells Perle and Minigynon, while the strictly commercial sector sells Nordette and a number of lesser-used brands categorized here as "other".

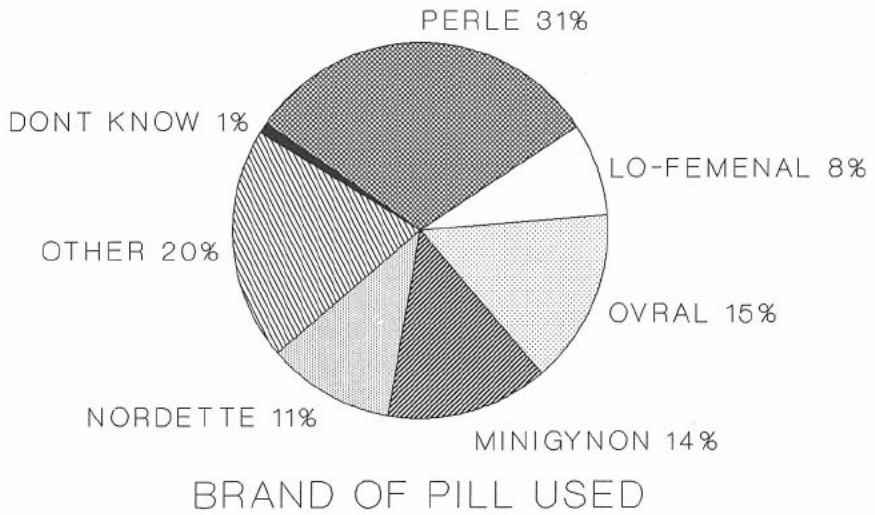
In Health Region 1 the leading pill brand is Perle, used by 31% of all pill user, while Minigynon is used by a further 14 percent. The Personal Choice programme, therefore, supplies almost half of all pill users in Region 1. The other major brands used in the region are Ovral, supplied by the public sector to 15 percent of pill users, and Nordette, sold in the private sector to 11 percent of users. However, when Nordette and the "other" category are taken together, the strictly commercial sector pills are used to a greater extent than Ovral and Lo-Femenal are distributed by the public sector.

Condom Use

Since condoms have been an important method in Jamaica for both men and women, a special series of questions on their use was addressed to all users of condoms, either as a primary or a secondary method, independent of their union status.

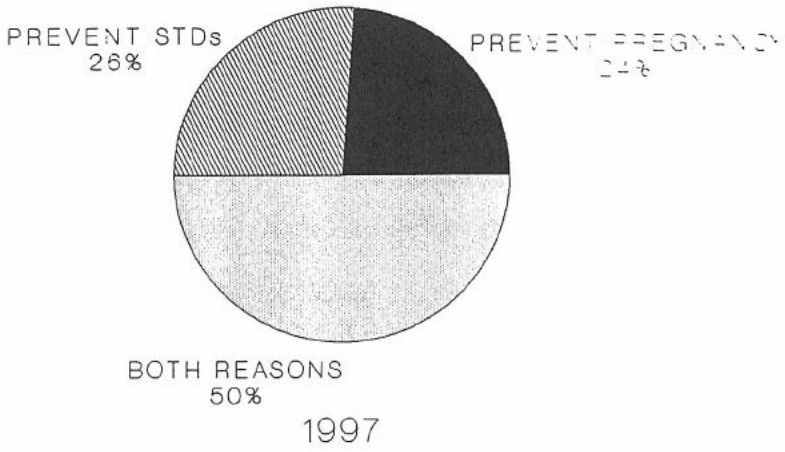
Figure 11 shows that while in Health Region 1 the majority of women who use condoms as a primary or secondary method do so both to prevent pregnancy and to protect themselves from sexually transmitted diseases, a large minority, 26 percent of all condom users, do so as a disease prevention measure only. This finding is important because, as seen in the lower part of Figure 11, the corresponding percentage in 1993 was only 7 percent of female condom users, which indicates that women's awareness of using

FIGURE 10
BRAND OF PILL CURRENTLY USED
WOMEN AGED 15-49
WHO ARE CURRENT PILL USERS
(PERCENT DISTRIBUTION)
REGION 1

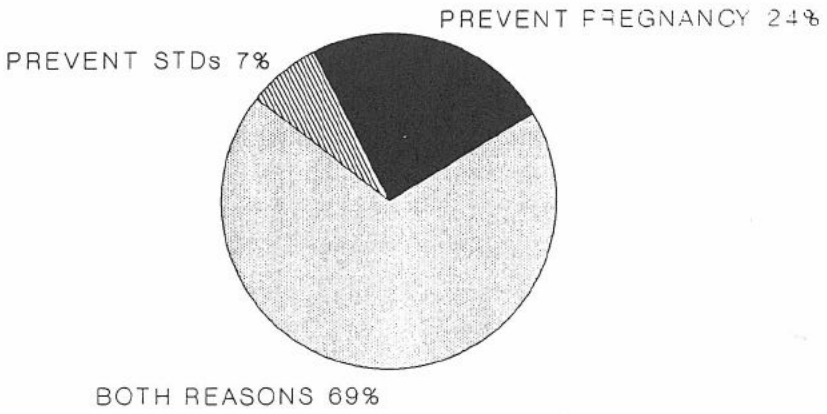


1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 11
REASONS FOR USING CONDOMS
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS
REGION 1



1997



1993

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

condoms to prevent disease is increasing.

In Region 1, 83 percent of women using condoms with a steady partner do so "always" or "most times", which is identical with the corresponding percentage for the country as a whole (Figure 12). The effectiveness of this or any method depends on correct and consistent use. Since the condom is being increasingly used as a disease prevention measure (See Figure 11), the effective percentage of condom users is diminished by those who are using condoms inconsistently.

Contraceptive Source

Figure 13 displays the relative importance of the various sources of the four most prevalent contraceptive methods for women in Region 1, and is compared with the 1993 CPS. There seems to have been a shift away from government health centers as a source for women using pills and condoms since 1993, which, in fact, continues a trend began in 1989. Most women buy their pills and condoms in pharmacies (69% and 60% of users of these methods, respectively). The other two major methods are still provided by the public sector, as almost all female sterilizations are performed in hospitals, while a similar proportion of injectable contraceptives are obtained in health centers.

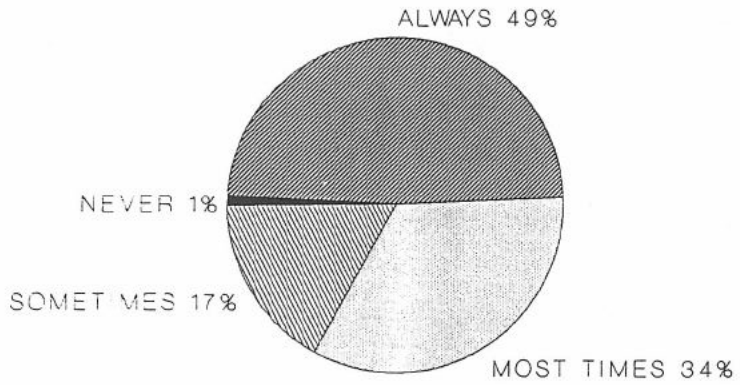
Prenatal Care and Women's Health

Not shown in a graph is that practically all women (99%) in Jamaica who had a pregnancy in the past five years had prenatal care during their last pregnancy. However, Figure 14 shows that only 59 percent of these women began their prenatal care during the first trimester of their pregnancy, which is relatively low. This percentage is slightly higher for Region 1, as 64 percent of women in the region began their prenatal care in the first trimester. There is some variation between parishes in the region as 70 percent of women in St. Andrew began their prenatal care in the first trimester of their pregnancy, while Kingston lags far behind, with only 45 percent.

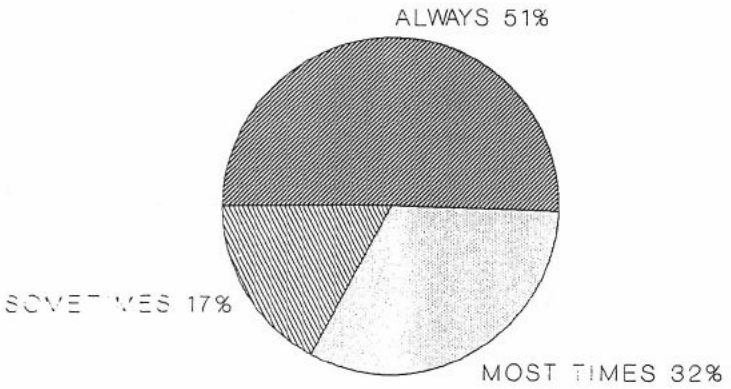
Pap Smears are an important means of early detection of cervical cancer. Only half of all Jamaican women have ever had a Pap Smear (51%) and only 15% had one in the past year (Figure 15). These figures are roughly the same for Region 1 as a whole and for the parishes in the region. (By contrast, in the United States almost all women have had a Pap Smear at least once and about two-thirds have had one in the past year.)

Monthly breast self-examinations are an effective way of detecting breast cancer at an

FIGURE 12
FREQUENCY OF CONDOM USE
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS
WITH A STEADY PARTNER



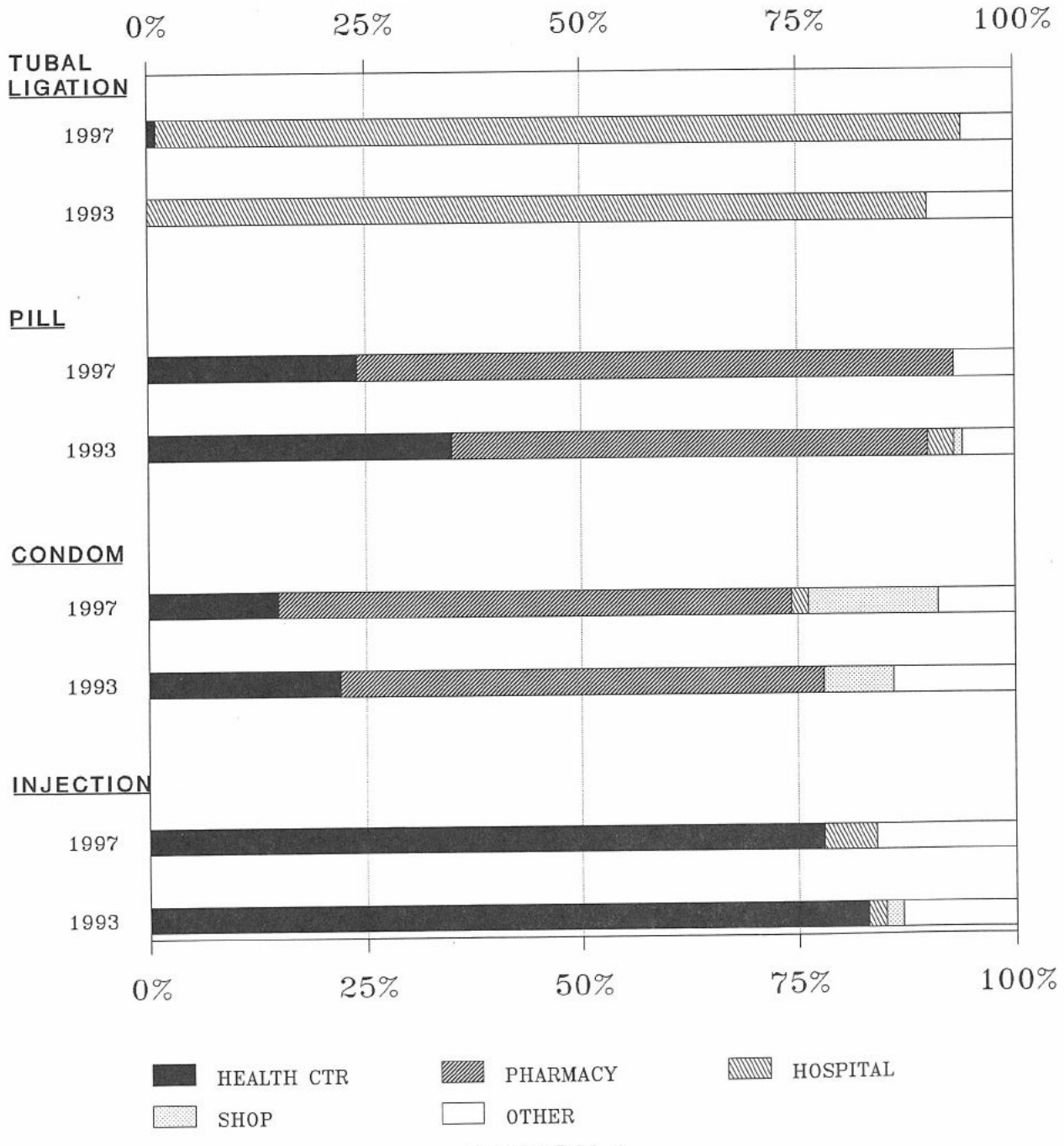
REGION 1



JAMAICA

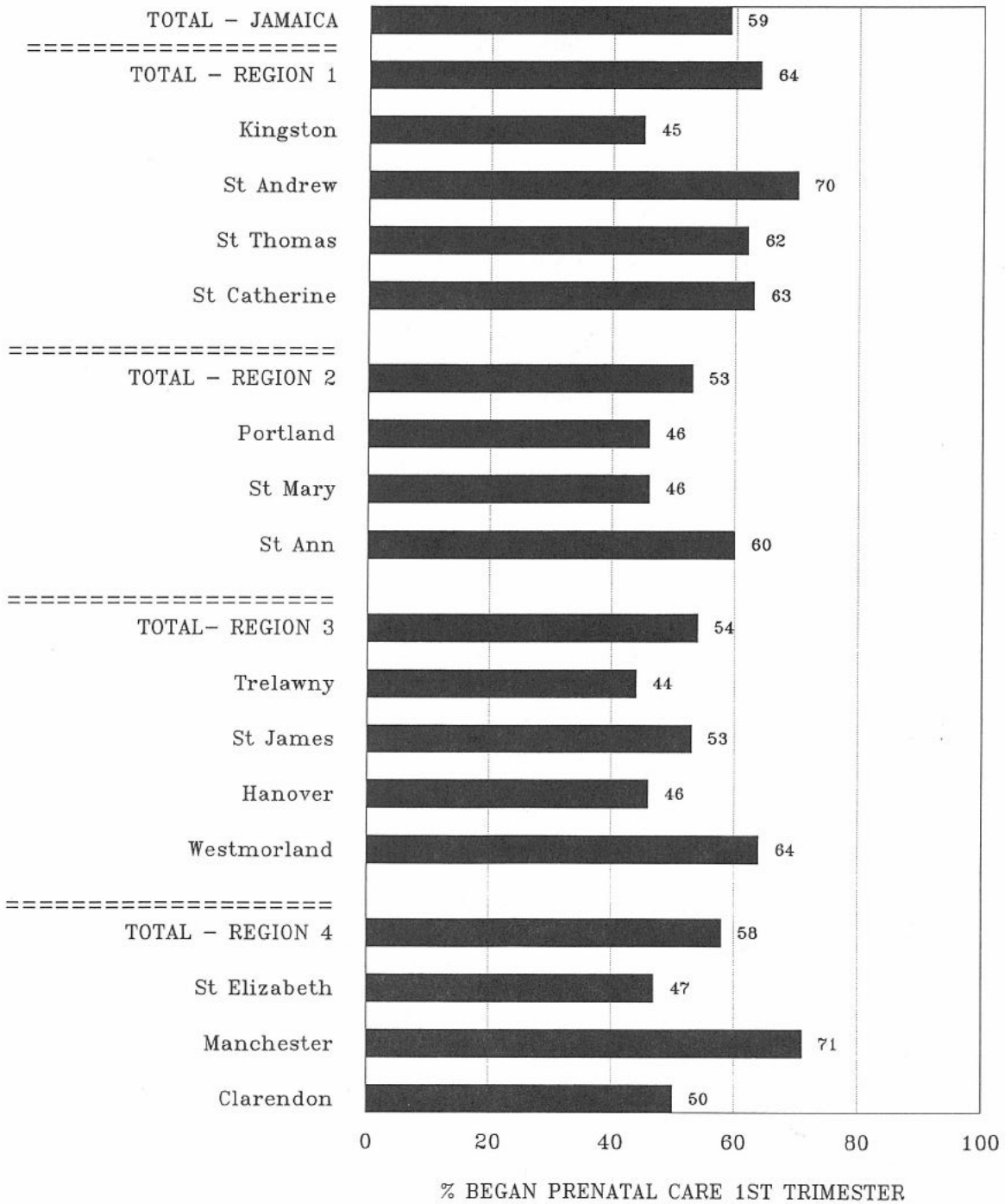
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 13
SOURCE OF CONTRACEPTION OF WOMEN IN UNION WHO ARE CURRENTLY USING MOST PREVALENT METHODS (PERCENT DISTRIBUTION) COMPARED TO 1993 CPS



REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 14
PERCENT WHO BEGAN PRENATAL CARE IN 1ST TRIMESTER AMONG WOMEN 15-49 PREGNANT IN THE PAST 5 YEARS BY REGION AND PARISH



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

early stage. Fifty-five percent of all Jamaican women ever do these examinations, but only 29 percent have done at least one in the past month (Figure 16). These percentages are similar for Region 1 as a whole and for the parishes in the region.

Young Adults

Concern about high levels of adolescent pregnancies and births led to a decision to carry out a special analysis of the situation. A young adult module was therefore included in the 1997 RHS.

In Health Region 1, a large majority of young women and men (women - 90%, men - 81%) have been exposed to family life / sex education in school, outside of school or both (Figure 17). These percentages are higher than the corresponding percentages in 1993. Most young adults reported having family life or sex education courses in school only. There was little difference according to age or parish.

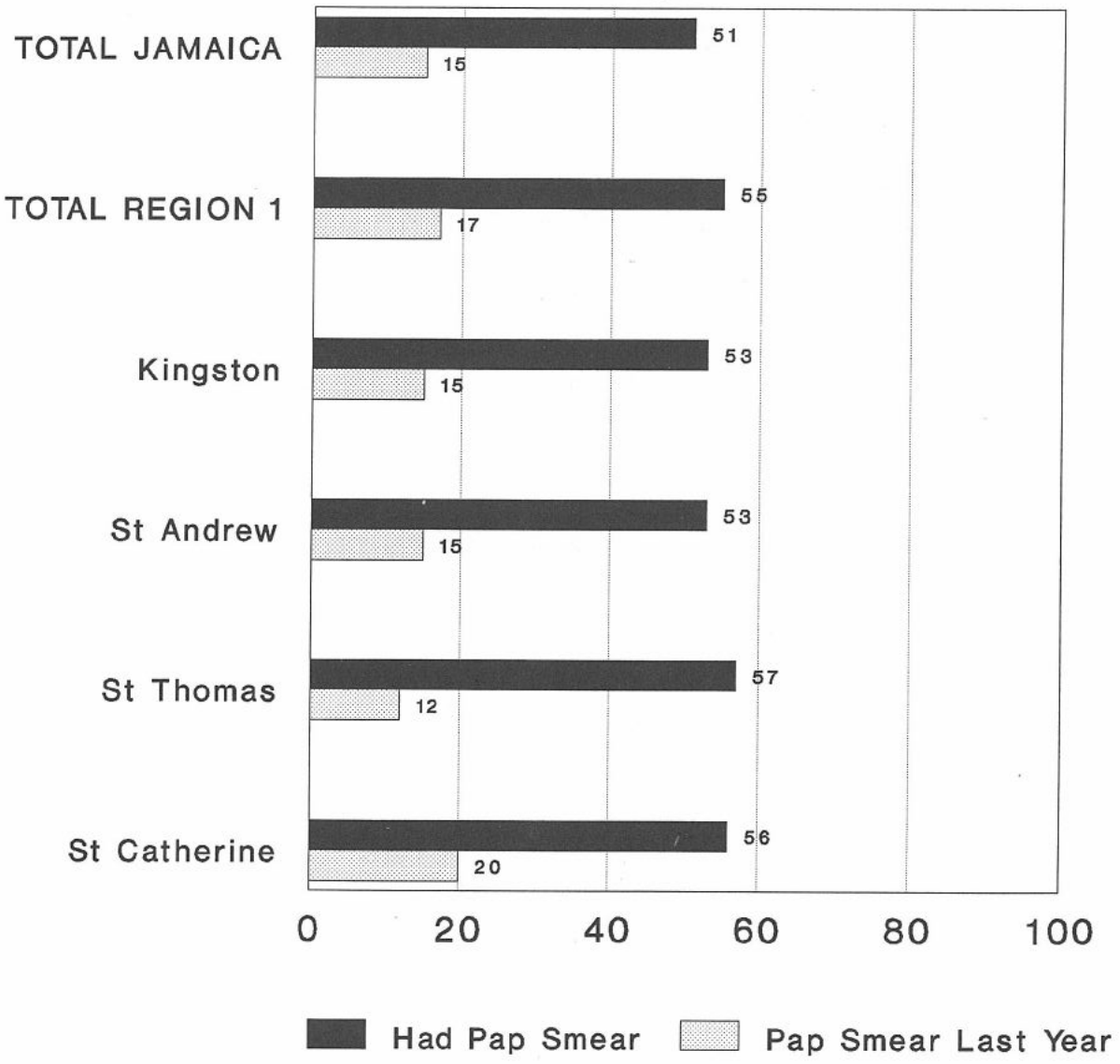
Sexual experience is defined as ever having had sexual intercourse. In this summary, we focus on the first sexual experience and contraceptive behavior. Current sexual activity (within the past month) and number of partners will be presented in detail in the full final report of the survey.

The proportion of young adults in Jamaica and Health Region 1 reporting sexual experience by age group is shown in Figure 18. Among the youngest females in both the country and the region there has been a decrease since 1993. For both sexes, as may be expected, sexual experience increases with age. The sexual experience rate for females in the country and region at ages 15-19 is 51 percent. In Region 1 this figure increases to 88 percent in the 20-24 age category. Three-fourths of males aged 15-19 report sexual experience, while sexual experience is essentially universal for older males.

In Health Region 1 the proportion of young men and women who used contraception at the time they first had sexual intercourse has increased since 1993 (Figure 19). Fifty-five percent of young women and 29 percent of young men used a contraceptive method at the time they first had sexual intercourse compared to the corresponding 1993 percentages of 44 percent and 16 percent for women and men, respectively. Use of contraception at first intercourse is lower in St. Thomas for both men and women.

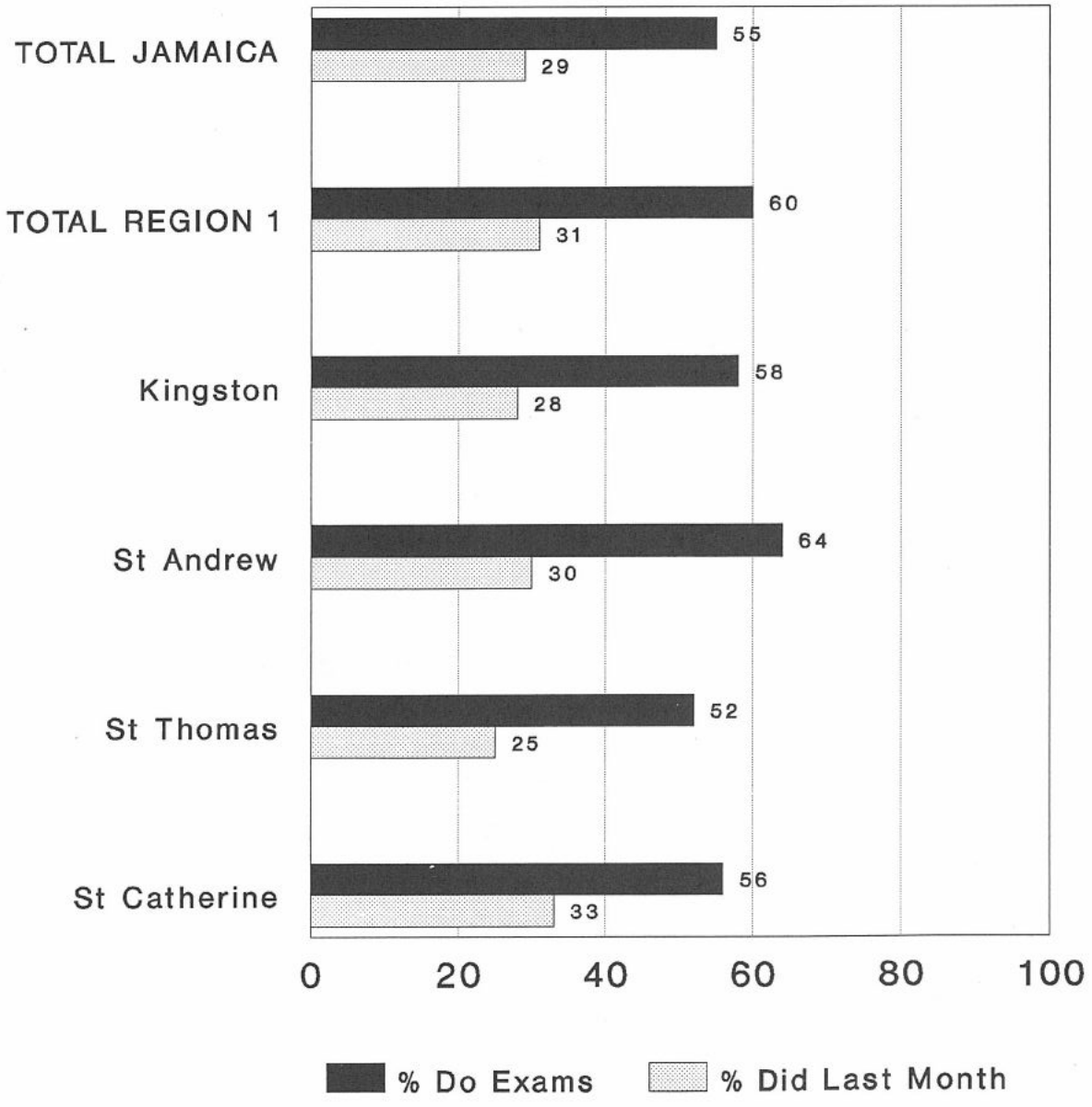
Not shown in a graph is that, similar to Health Region 1, for the nation as a whole approximately half of young women and about two-thirds of young men did not use

FIGURE 15
PERCENT OF WOMEN AGED 15-49
WHO HAVE EVER HAD A PAP SMEAR
AND HAVE HAD A PAP SMEAR IN THE LAST YEAR
BY PARISH



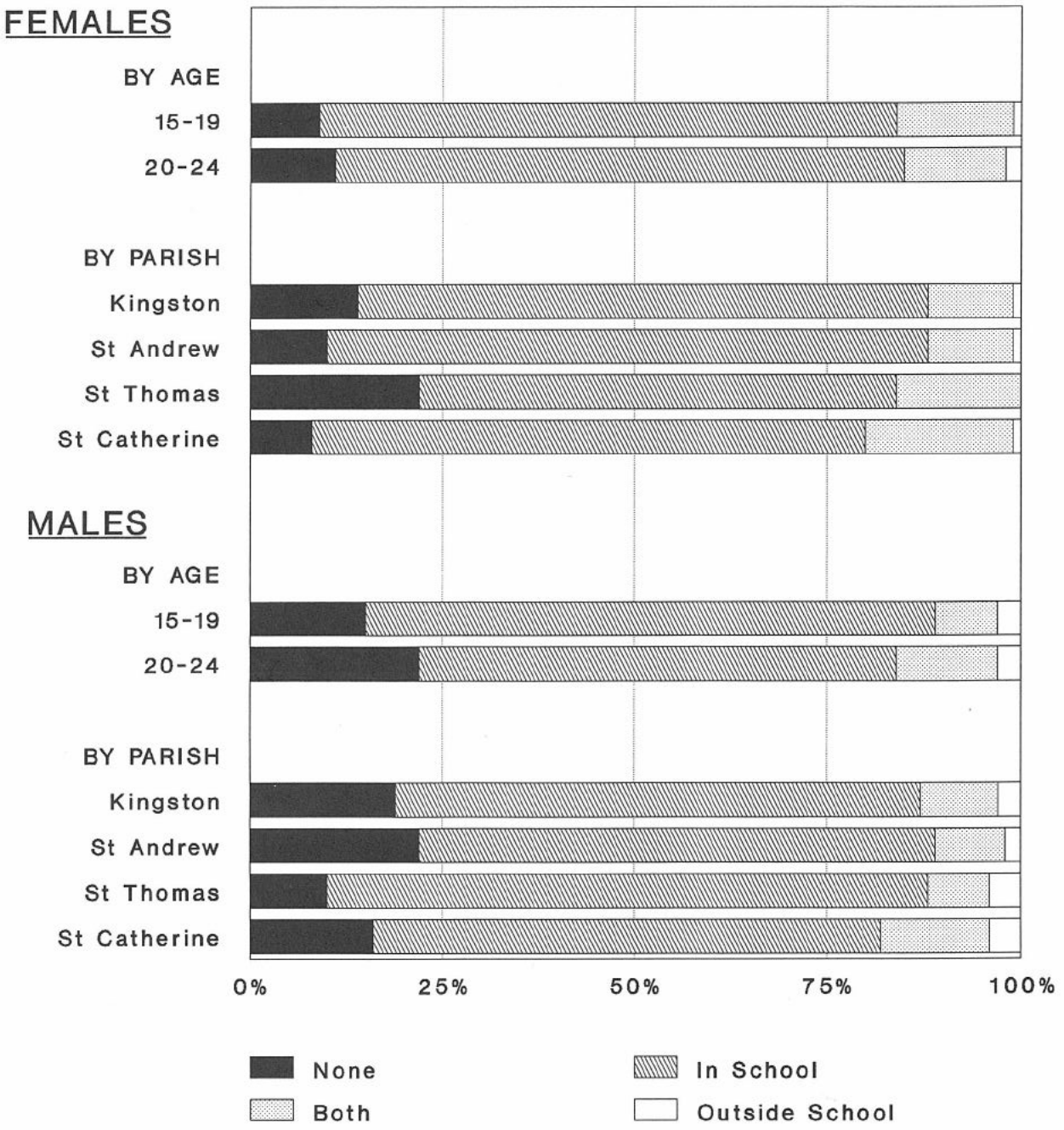
REGION 1
1997 JAMAICA
REPRODUCTIVE HEALTH SURVEY

FIGURE 16
PERCENT OF WOMEN AGED 15-49
WHO EVER DO A MONTHLY BREAST SELF-EXAMINATION
AND DID A BREAST SELF-EXAM IN THE LAST MONTH
BY PARISH



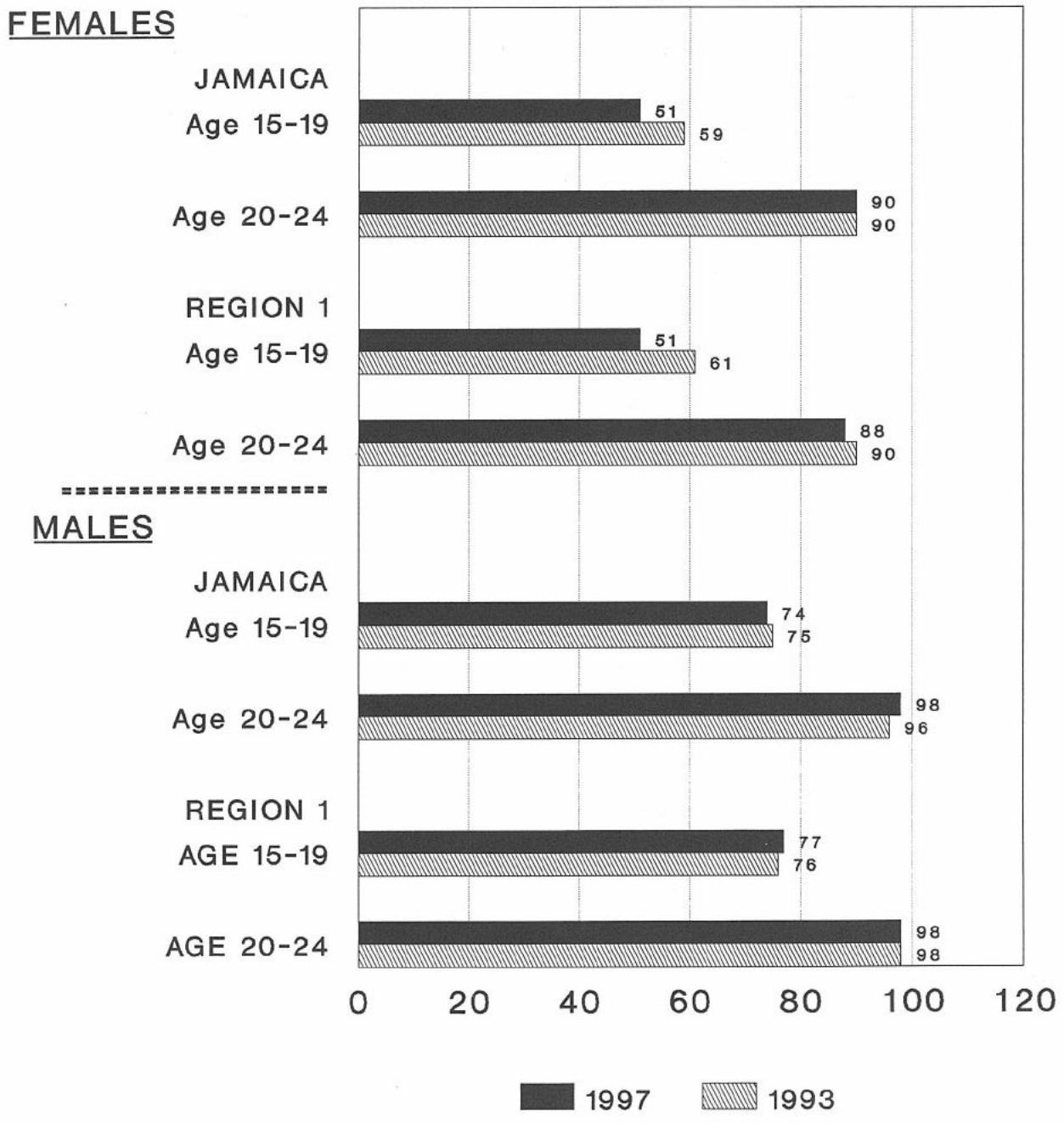
REGION 1
1997 JAMAICA
REPRODUCTIVE HEALTH SURVEY

FIGURE 17
FAMILY LIFE / SEX EDUCATION CLASS OR COURSE
IN SCHOOL AND / OR OUTSIDE OF SCHOOL
YOUNG ADULTS AGED 15-24
(PERCENT DISTRIBUTION)



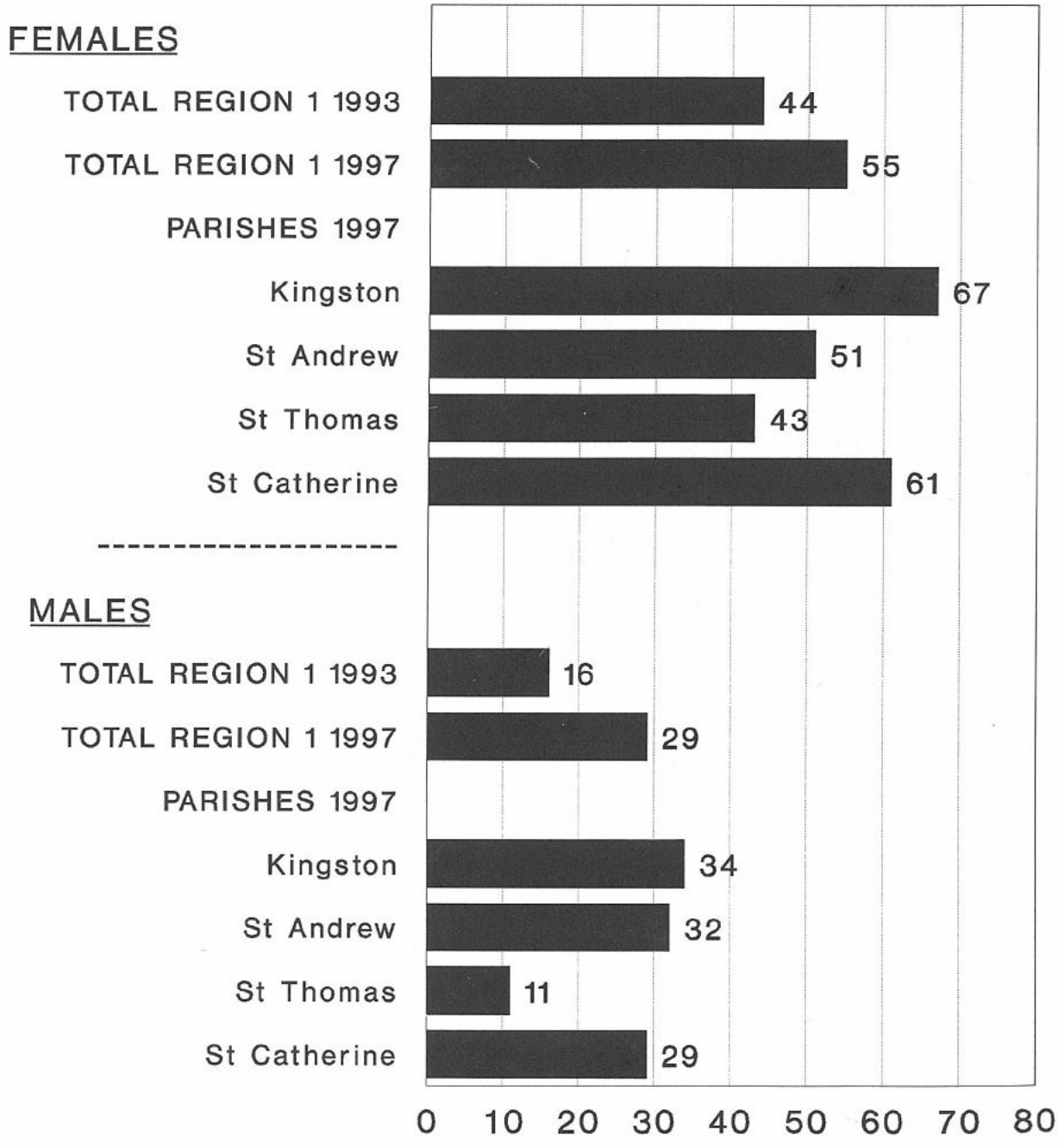
REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 18
PERCENT REPORTING SEXUAL EXPERIENCE
BY AGE GROUP
YOUNG ADULTS 15-24 YEARS OF AGE
COMPARED WITH 1993 CPS



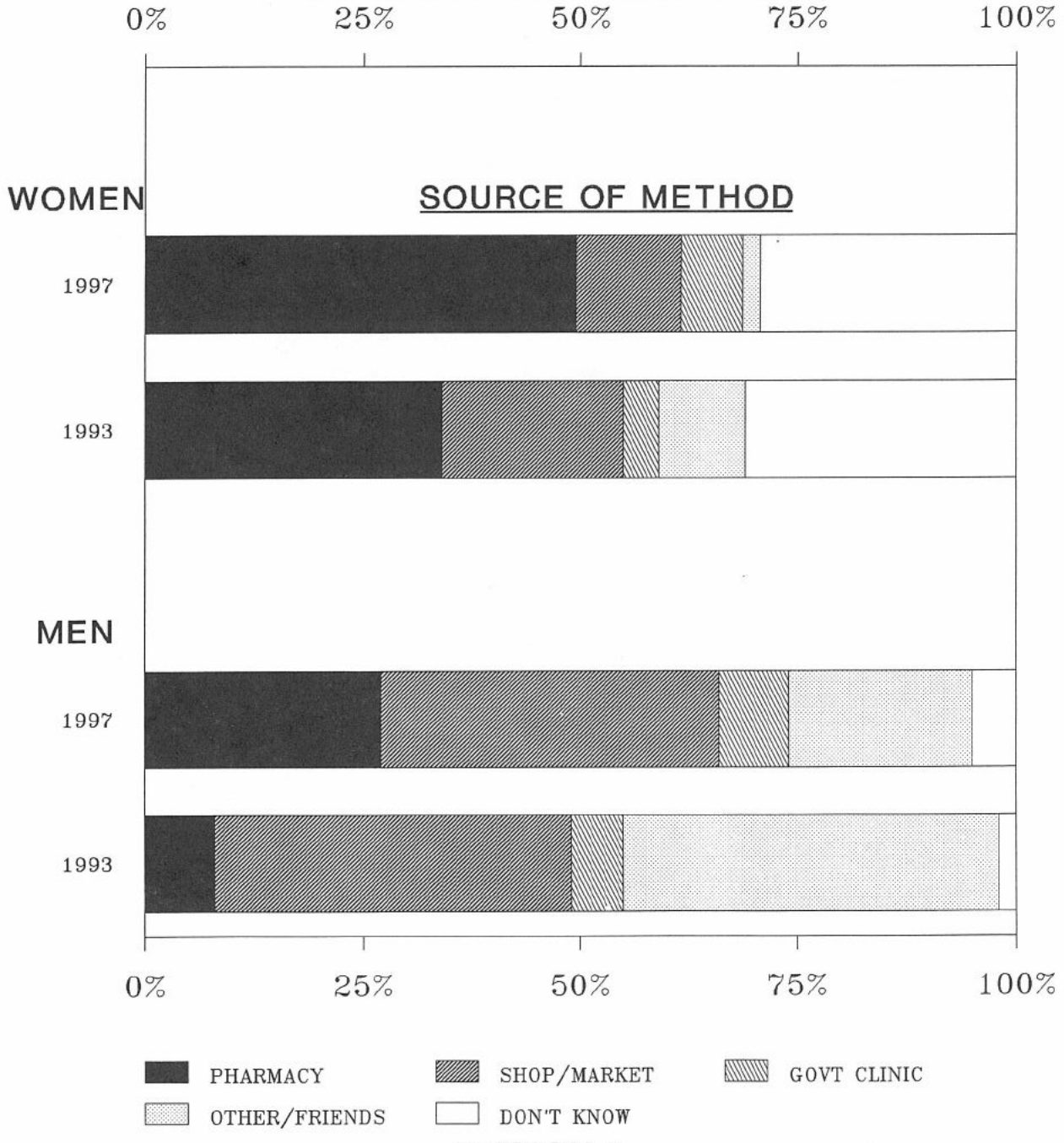
REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 19
% USING CONTRACEPTION AT 1ST SEXUAL INTERCOURSE
BY PARISH
YOUNG ADULTS 15-24 YEARS OF AGE
REGION 1



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 20
SOURCE OF CONTRACEPTIVE METHOD USED AT TIME OF FIRST SEXUAL INTERCOURSE
YOUNG ADULTS 15-24 YEARS OF AGE COMPARED WITH 1993 CPS



REGION 1
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

contraception at first sexual intercourse. When asked why they did not use, almost one-half of women and about 30 percent of men said that they did not expect to have sex at the time of first intercourse. Approximately 30 percent of young men said the reason was that they did not have knowledge of contraception at the time of their first sexual experience (data not shown).

Also not shown in a graph or table is that in Jamaica as a whole the condom was used by the great majority (about 90 percent) of men and women who used any method at the time of their first intercourse.

The source of contraception used at first intercourse in Health Region 1 differs somewhat for females and males (Figure 20). Women, who as mentioned above reported almost universally that their partner used a condom, gave the pharmacy as the primary source. Thirty-nine percent of men, who also largely used condoms at the time of their first intercourse, identified shops or markets as a primary source. Another 21 percent stated that they obtained their condom from other sources, mostly friends. Another difference is that 29 percent of females did not know where their partner obtained the condom.

SUMMARY OF RESULTS

HEALTH REGION 2

HEALTH REGION 2

Introduction

The present report summarizes the findings for Health Region 2 of the Reproductive Health Survey (RHS) carried out in Jamaica in 1997. A contraceptive prevalence survey (CPS) of a similar type was carried out in Jamaica in 1993. The 1997 RHS, therefore, not only provides data on the current situation in Health Region 2 and Jamaica as a whole regarding reproductive health and contraceptive practices, but also permits an evaluation of changes since 1993. The 1997 RHS utilized an updated sampling frame based on the 1991 census which has been adopted for the Continuous Social and Demographic Surveys conducted by the Statistical Institute of Jamaica.

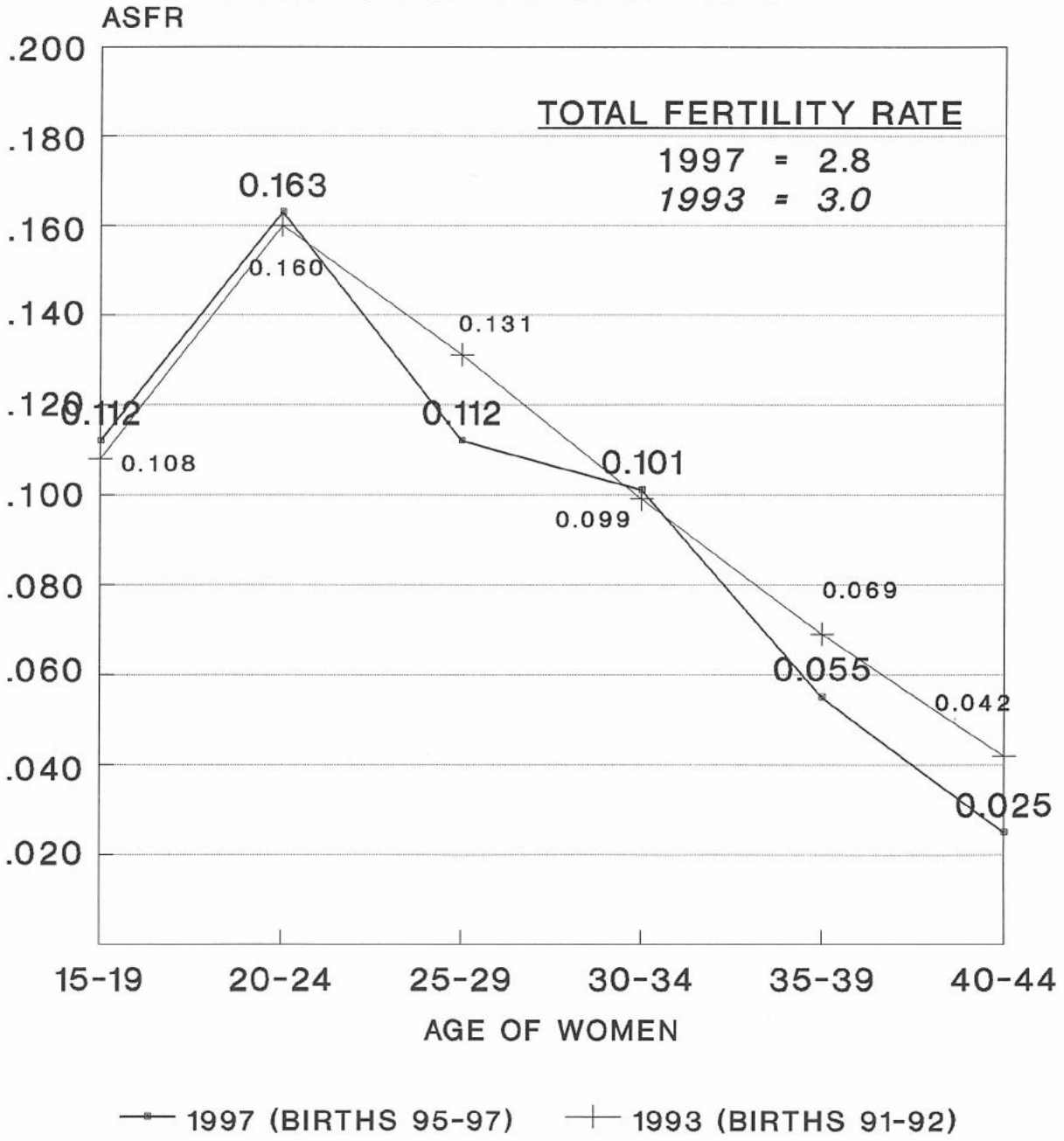
There are differences in the sampled population of the two surveys. Whereas in the 1993 CPS women aged 15 to 44 and men 15-54 were interviewed, the 1997 RHS included, in addition, women aged 45 to 49, but limited the coverage of men to an independent sample of young adults aged 15-24. The 1997 survey also had detailed questions in a special module addressed to young adult women aged 15 to 24, as well as questions on prenatal care and cancer screening, and questions on condom use, multiple sexual partners and attitudes toward contraception, which were addressed to all respondents.

Fertility

Fertility data for Jamaica as a whole and for Region 2 will be presented. The survey results show the total fertility rate (TFR) for the years 1995-1997 (i.e., the two years prior to interview) to be 2.8 births per woman (Figure 1). This represents a decrease from the TFR of 3.0 births per woman found in the 1993 survey. Age-specific fertility rates in the two surveys were similar for ages 15-19 and 20-24, indicating no recent decline in rates of early childbearing. Except among 30-34 year-olds, age-specific fertility rates fell substantially for all age groups from ages 25-29 to 40-44. The decline in fertility was particularly noteworthy at the oldest ages, with age-specific rates falling by 20 percent (14 births per 1000 women) at ages 35-39 and 40 percent (17 births per 1,000 women) at ages 40-44. The overall decline in the TFR of 0.2 births per woman between the 1993 and 1997 surveys follows a surprising failure to decline between the 1989 and 1993 surveys. Age-specific fertility rates were much higher at ages 20-24 than at any other ages, followed by similar levels at ages 15-19 and 25-29.

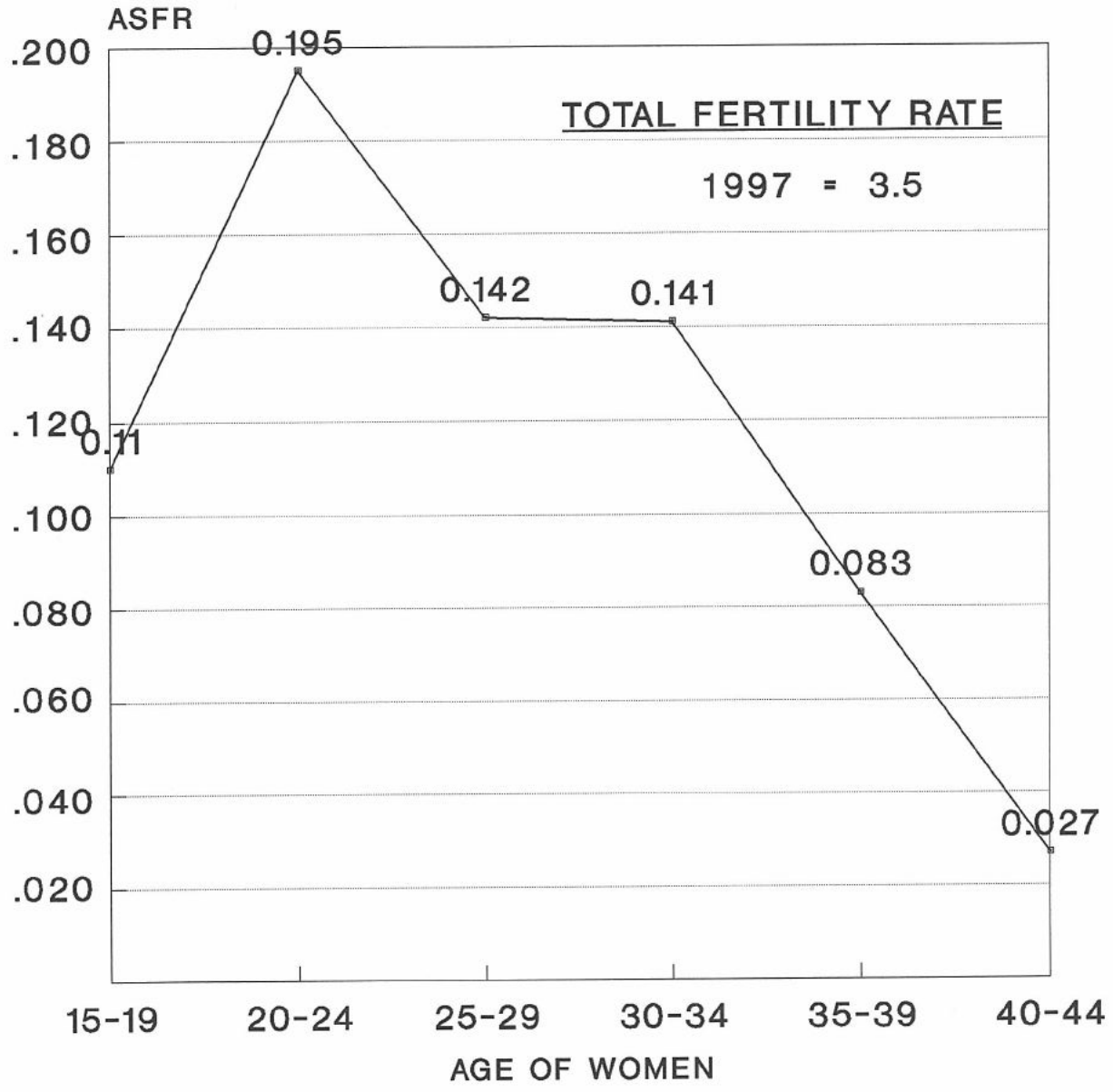
According to the 1997 survey, Region 2, along with Region 4 had the highest level of

FIGURE 1
AGE-SPECIFIC FERTILITY RATES
WOMEN AGED 15-44
COMPARED TO 1993 CPS



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 2
AGE-SPECIFIC FERTLITY RATES
WOMEN AGED 15-44
REGION 2



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

fertility of the four health regions of Jamaica. The TFR for the two years prior to the survey was 3.5 births per woman (Figure 2), compared to the island-wide rate of 2.8 births per woman. Except for ages 15-19, each of the five-year age-specific fertility rates was also considerably higher in Region 2 than it was nationally. As in Jamaica as a whole, fertility rates were highest at ages 20-24, with 195 births per 1,000 women per year. This was followed by roughly equal rates at ages 25-29 and 30-34. Because of small regional sample sizes in the 1993 survey, it was not possible to examine changes in fertility within regions between 1993 and 1997.

Planning Status of the Last Pregnancy

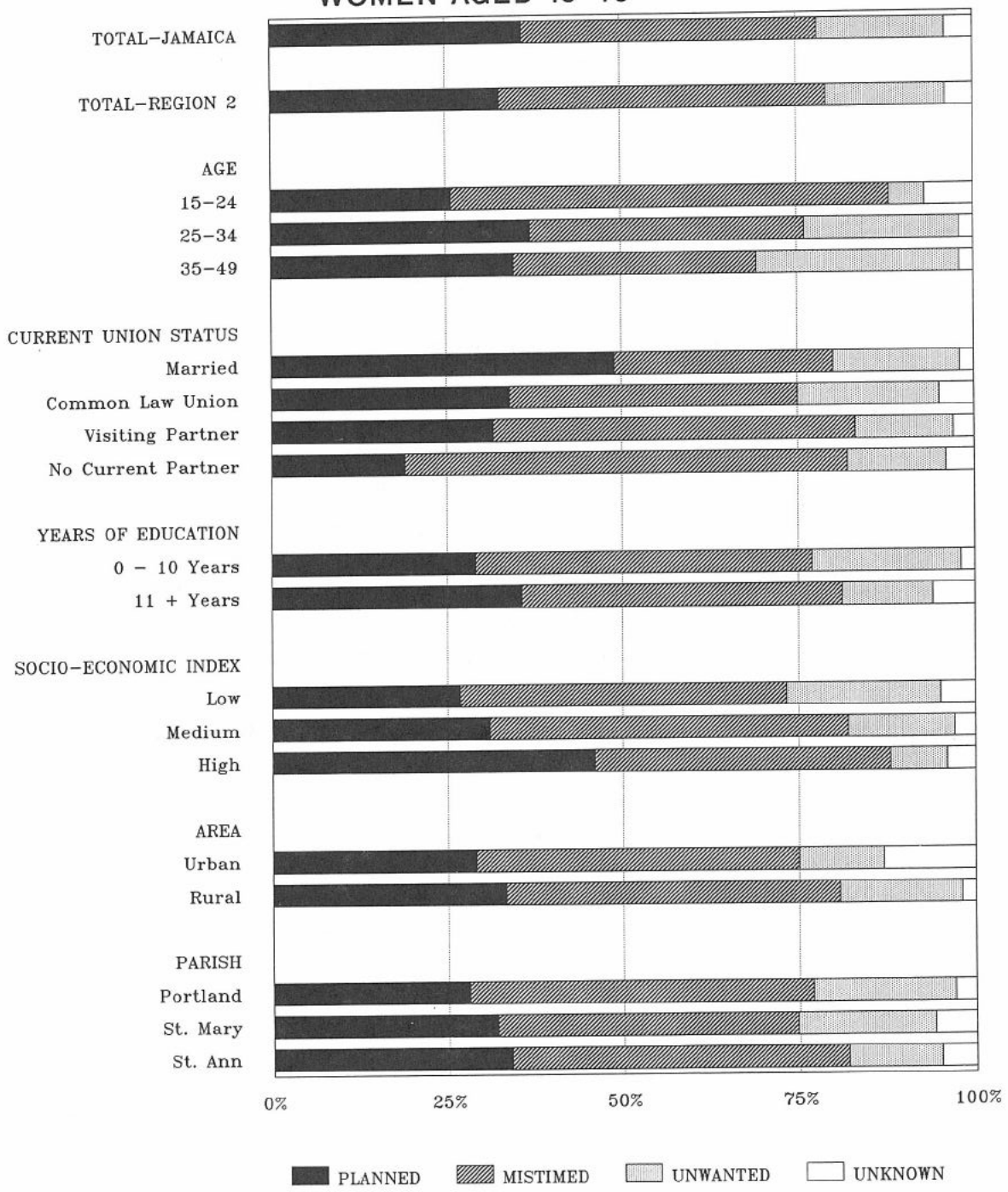
Figure 3 shows the distribution of the planning status of the last pregnancy within the past 5 years for women aged 15-44 in Health Region 2 and Jamaica as a whole. A pregnancy is defined as "planned" if the woman wanted to become pregnant at the time she became pregnant. A pregnancy is "mistimed" if she wanted to become pregnant at a later date and is "unwanted" if she did not want to have any more children. These latter two categories together comprise "unintended" or unplanned pregnancies.

Overall, thirty-three percent of pregnancies were reported by respondents in Health Region 2 to have been planned. Not shown in the graph is that this is a slight increase from 1993 when 30 percent of pregnancies in Region 2 were planned. The majority of pregnancies in the region were unintended--including 47 percent mistimed and 17 percent unwanted. These percentages are similar to the country as a whole, where 42 percent of pregnancies were reported to be mistimed and 18 percent were unwanted.

The proportion of unwanted pregnancies increases with age. Similarly, since Jamaican women tend to enter more stable unions as they age, the proportion of planned pregnancies is higher and the proportion of mistimed pregnancies is lower in the more stable unions. Conversely, mistimed pregnancies are concentrated among younger women in less stable unions who are more likely to have spacing of pregnancy failures. The percentage of planned pregnancies rises slightly with increases in the socio-economic index, but there is no discernable pattern by education.

Given the relatively high level of contraceptive use by women in union in Jamaica as a whole and in Health Region 2, the percentage of unintended pregnancies is still high. Two factors may be contributing to this: the less than optimum use of temporary methods resulting in contraceptive failure; and high levels of unprotected sexual activity by women who are not in union.

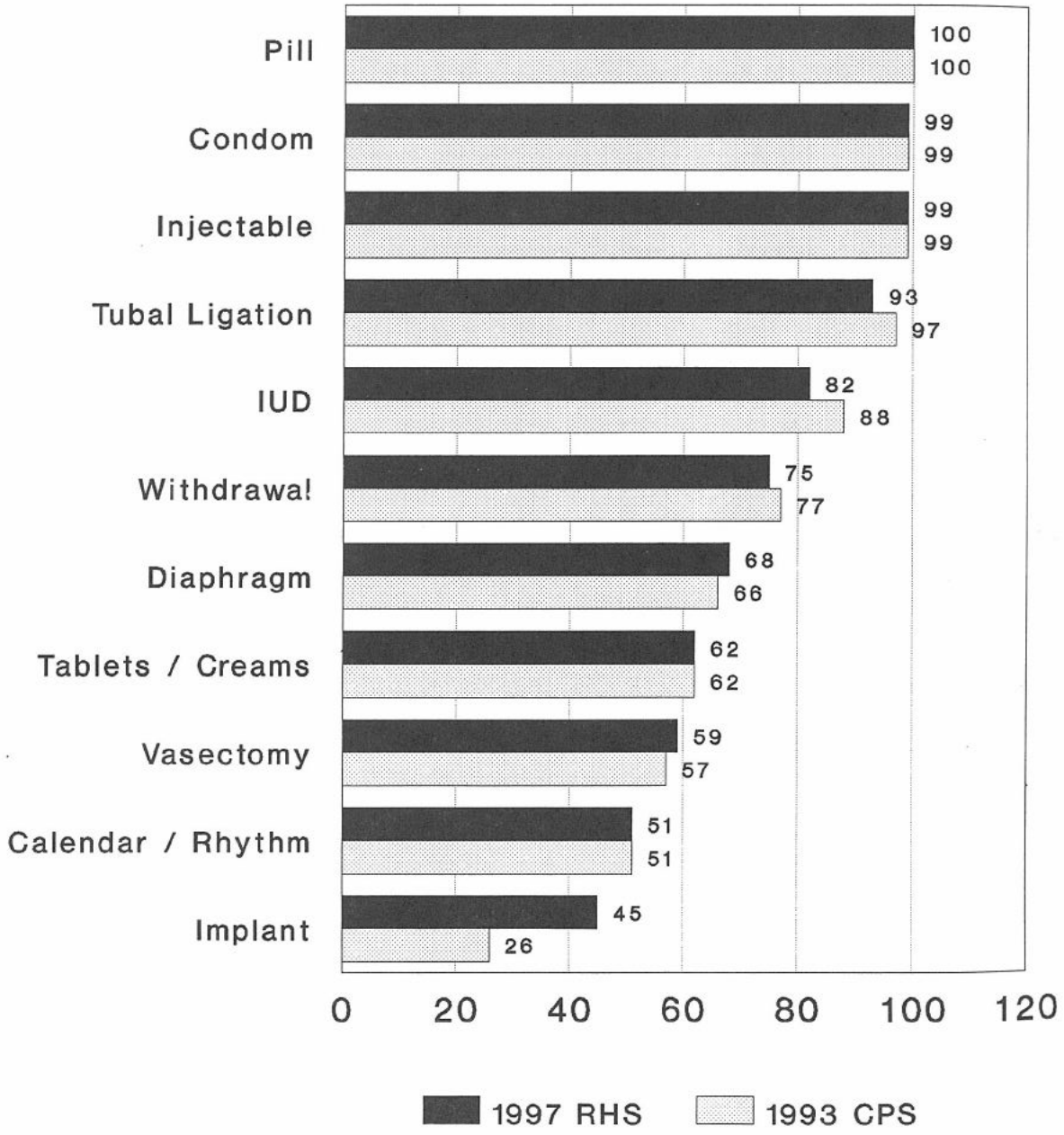
FIGURE 3
PLANNING STATUS OF LAST OR CURRENT PREGNANCY BY SELECTED CHARACTERISTICS (PERCENT DISTRIBUTION) WOMEN AGED 15-49



REGION 2

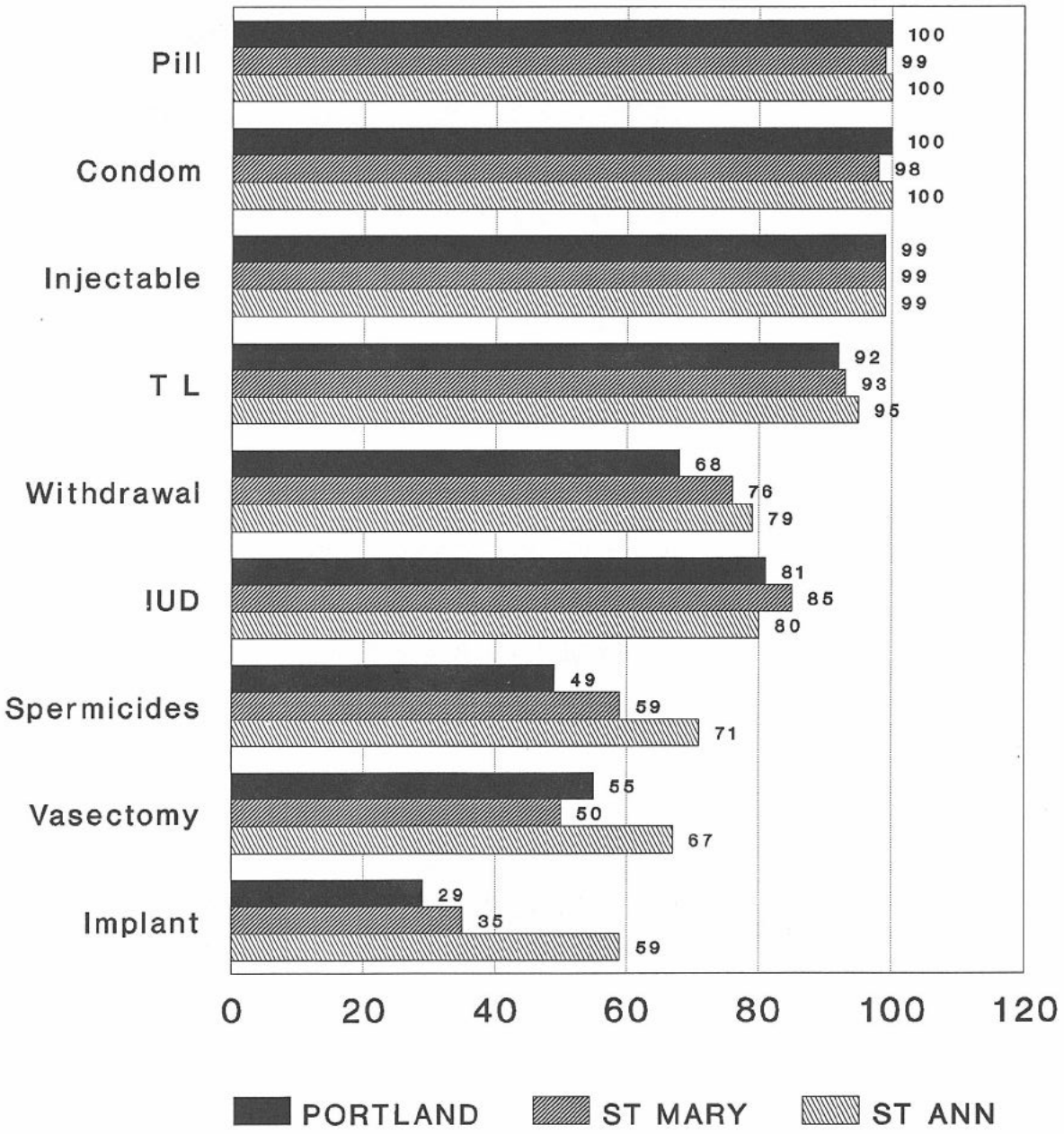
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 4
PERCENT OF WOMEN AGED 15-49
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 5
PERCENT OF WOMEN AGED 15-49 WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS BY PARISH



REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

Knowledge of Contraceptives

Figure 4 shows "knowledge" of contraceptives among women. Knowledge here refers to the fact that the respondent has heard of a contraceptive method, not necessarily that she has enough knowledge of the method to be able to use it correctly.

Virtually all women in Region 2 have heard of the condom, pill, injectables and female sterilization, and over 80 percent know of the IUD and three-fourths know of the withdrawal method. The diaphragm, vaginal methods, natural methods and Norplant, which are little used in Jamaica, are less well known. While the informed choice of a contraceptive method must be left to the couple, lack of knowledge of some of the more effective methods, particularly vasectomy and the implant (Norplant), reduces the choice and potential use of some available long-term methods. With the exception of the implant, knowledge of all methods is little changed from 1993 to 1997.

Figure 5 shows the level of women's knowledge of contraceptive methods in Region 2 by parish. There is little difference between parishes, except that more women in St. Ann have heard of withdrawal, spermicides, vasectomy and the implant than women in the two other parishes.

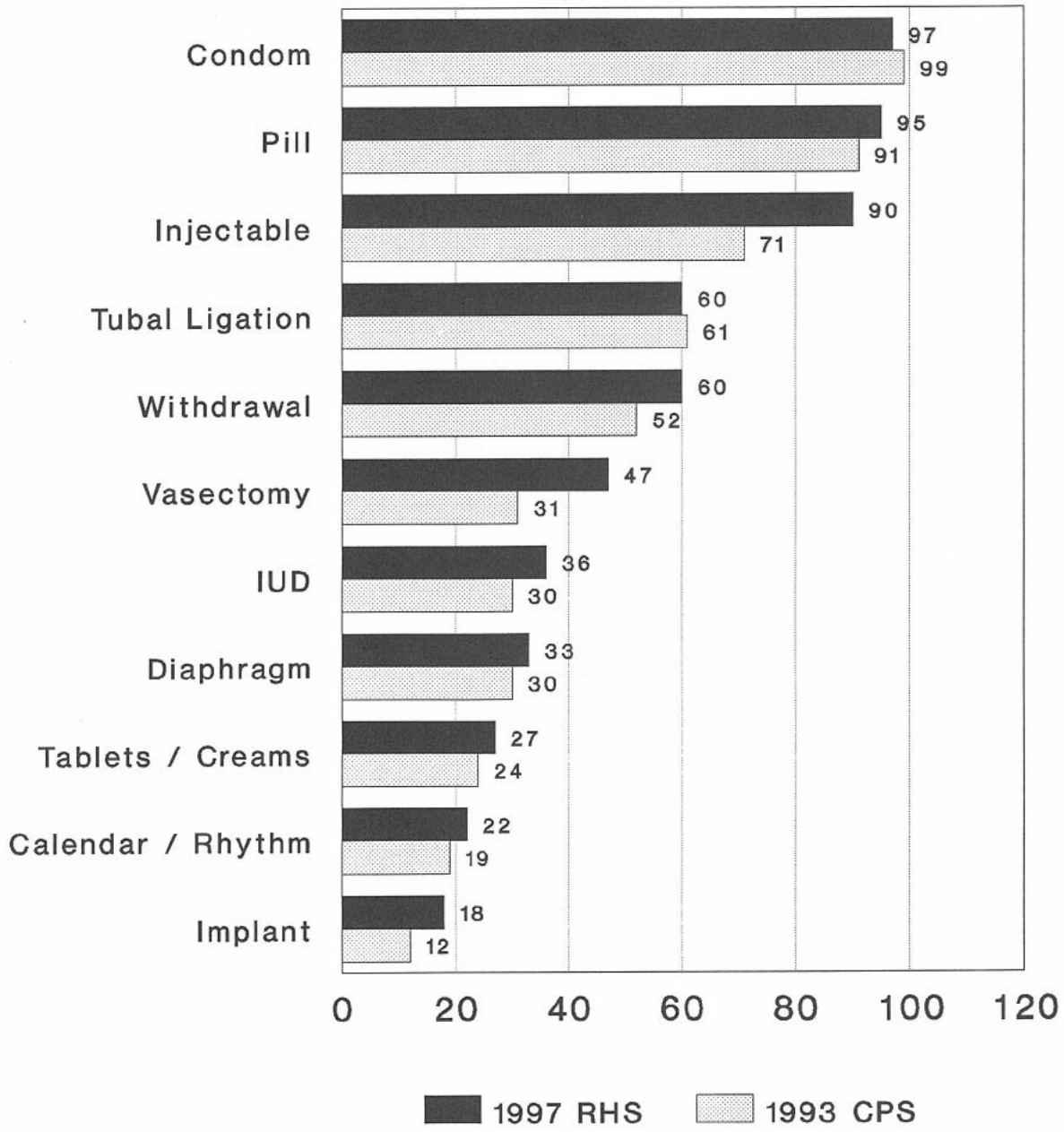
Among young adult men (Figure 6), the best known methods are, as in the case of women, condoms, the pill, injectables, female sterilization and withdrawal . However, aside from condoms and the pill, all methods are less well known among men than among women.

Contraceptive Use

Figure 7 shows the prevalence of contraceptive use among women in union in Jamaica as a whole and Health Region 2 by principal type of method, comparing data for the region with the 1993 and 1989 surveys. The overall level of use in Region 2 at 66 percent of women in union is similar to the 65 percent for Jamaica and has increased by three percentage points since 1993. This small increase since 1993 is accounted for by an increase in the use of the injection. The level of condom use as a primary method has dropped slightly since 1993.

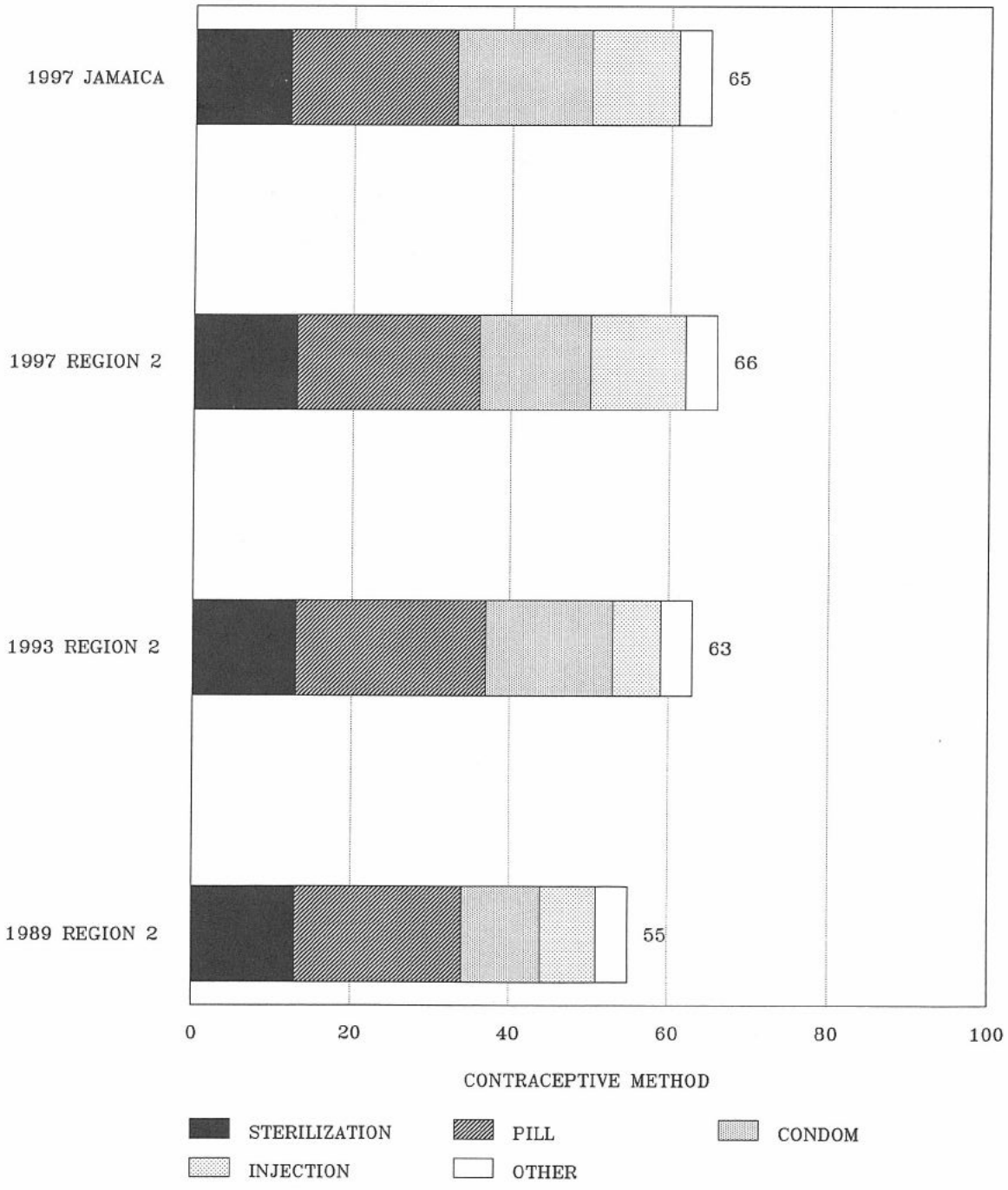
Figure 8 is a pie chart showing additional data on specific contraceptive method use by all women (in union and not in union) as well as women in union in Health Region 2 in 1997. As seen in the upper pie, only 52 percent of all women are using a contraceptive method, with only 18 percent using the pill. The lower pie shows that oral contraceptives

FIGURE 6
PERCENT OF YOUNG ADULT MEN AGED 15-24 WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS COMPARED WITH 1993 CPS



REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

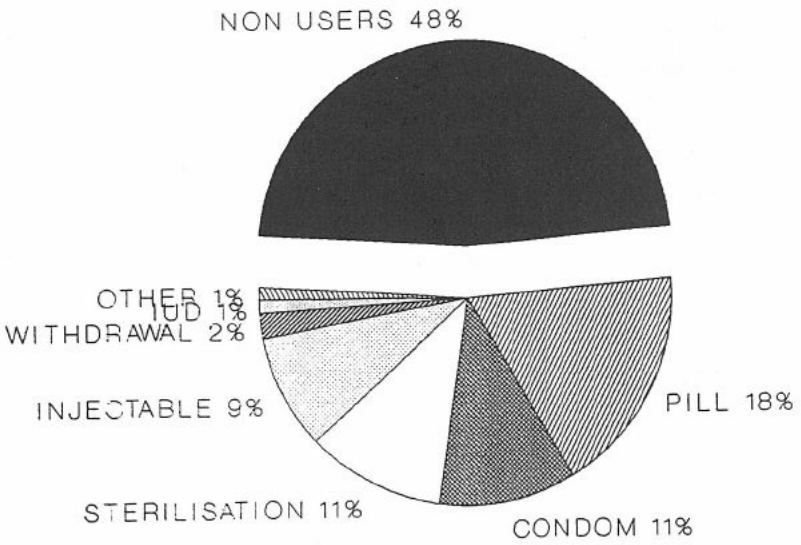
FIGURE 7
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING CONTRACEPTION, BY METHOD COMPARED WITH 1993 AND 1989 CPSs



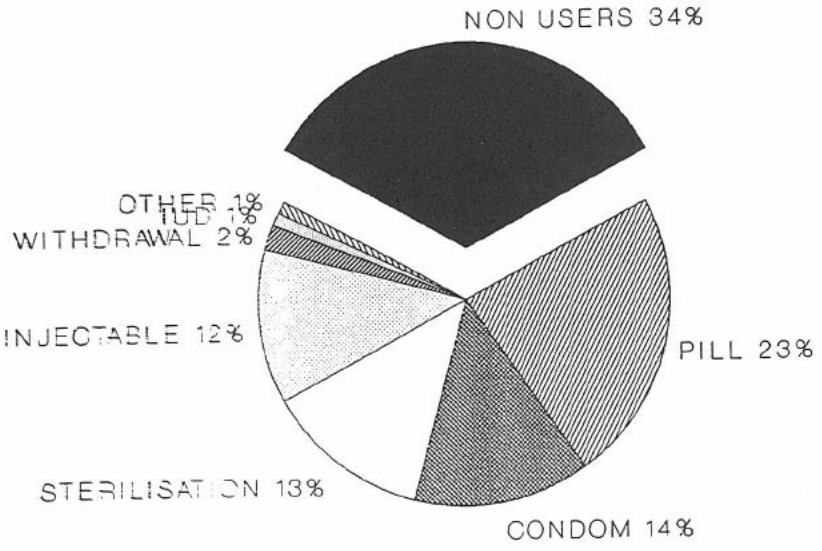
REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 8
PERCENTAGE OF ALL WOMEN AND WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD

REGION 2



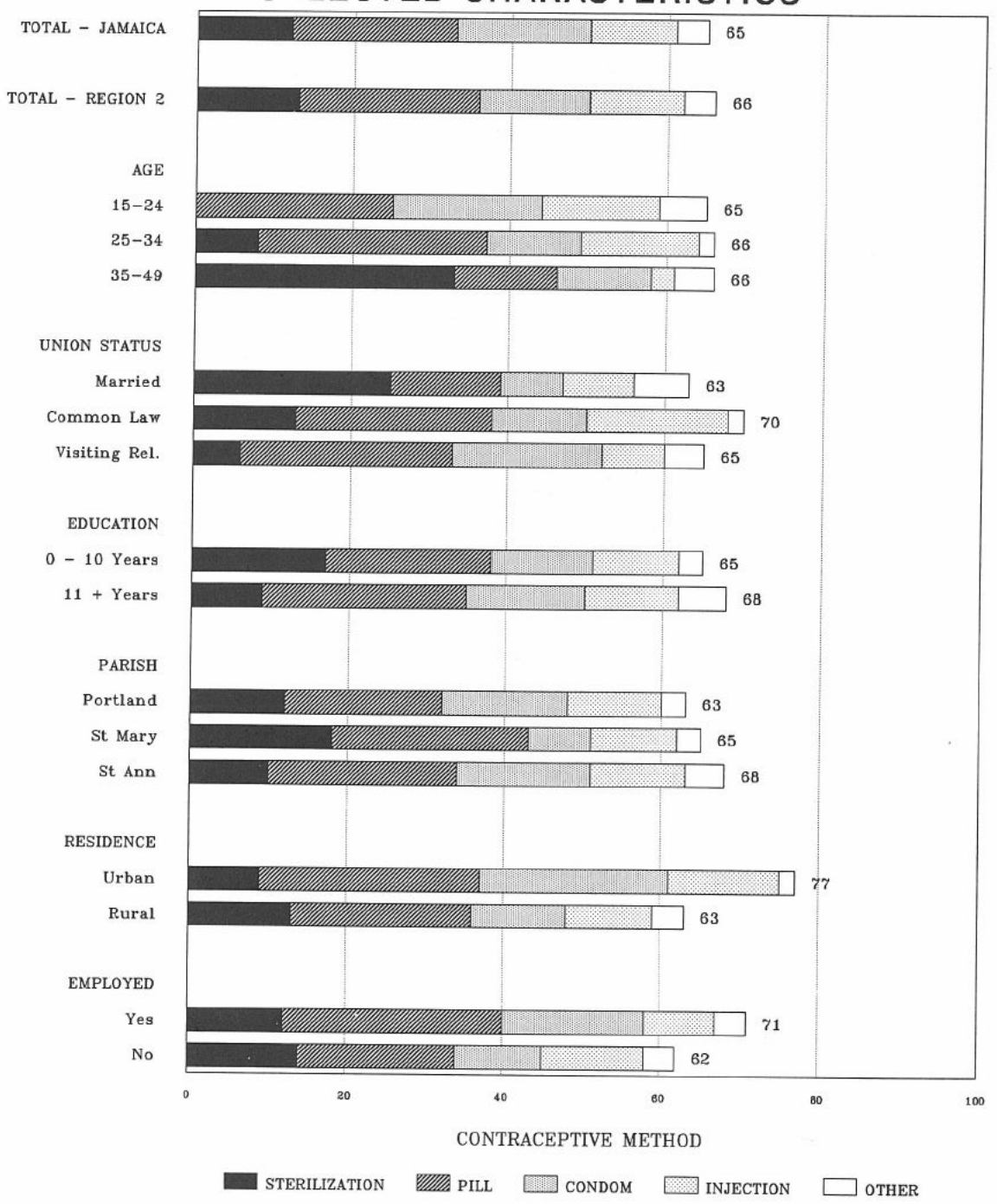
ALL WOMEN



WOMEN IN UNION

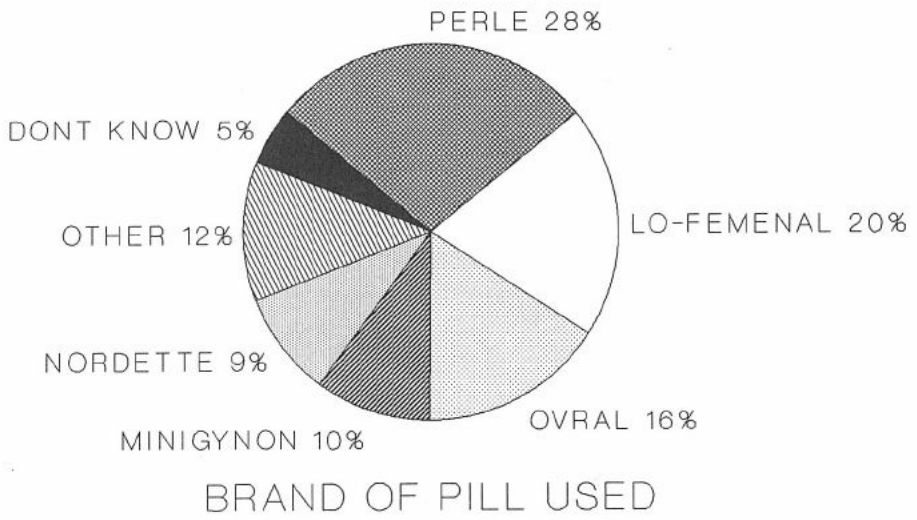
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 9
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD BY SELECTED CHARACTERISTICS



REGION 2
1993 JAMAICA CONTRACEPTIVE PREVALENCE SURVEY

FIGURE 10
BRAND OF PILL CURRENTLY USED
WOMEN AGED 15-49
WHO ARE CURRENT PILL USERS
(PERCENT DISTRIBUTION)
REGION 2



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

(23%) are the most prevalent method among women in union, followed by the condom (14%), female sterilization (13%) and injectables (12%). These are the same four leading methods that were reported in 1993.

Figure 9 presents use of major contraceptive methods by women in union according to selected geographic and socio-demographic characteristics. In general, as age and increases, women tend to use more effective methods. While pill and condom use predominates among women 24 and under, the pill and injection are the leading methods used between 25 and 34 years of age. After age 35 female sterilization is the major method, as half of these older women using any method are using surgical contraception.

Overall use by women in a marital union is only slightly less than women in common-law or visiting unions, but there are differences in the methods used by these different groups. Forty percent of married women using any method have been surgically sterilized. In contrast, relatively few women in a common-law union or in a visiting relationship (13% and 6 %, respectively) have been sterilized. A factor not shown in this figure is that women who are married tend to be older than women in common law and visiting unions, which in turn is correlated with the number of living children. As mentioned above, with increasing age (and a greater number of children), a higher percentage of women choose this permanent method. Women who are in less stable unions and who are younger and have fewer children tend to use pills and condoms to a greater extent.

Overall contraceptive use is slightly higher in urban areas and among employed women, but there is little pattern to the overall use or method mix for the remaining variables, with the exception of parish of residence. In St. Mary , the level of tubal ligation use is slightly higher (18%) than the other 2 parishes and condom use is half the level (16% vs. 8%) of the other parishes.

Table 1 looks at the percentage of female first or primary contraceptive method users in Region 2 who concurrently use a secondary method. Overall, 12 percent of all users are also using a secondary method. Not shown in this table is that for the country as a whole in 1993 only about half as many users (6%) were also using a secondary method.

Practically all secondary method use is the condom. This suggests that while data on primary method use alone do not show an increase in condom use from 1993 to 1997, by including secondary method condom use as part of this analysis, the use of condoms has increased in the four years since the 1993 survey. More than one-fourth of pill users and 12 percent of injectable users in Region 2 are concurrently using condoms.

To summarize the above findings, overall contraceptive use is high for all socio-demographic groups in Region 2 (and Jamaica) and is practically at the level of use of

TABLE 1

Percentage Of Contraceptive Users In Health Region 2 Who Are Concurrently Using A Secondary Contraceptive Method By Primary And Secondary Method Used Women In Union Aged 15-49 Years (Percent Distribution) 1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

	Secondary Method Used						
	None	Condom	With-drawal	Natural Method	Other	Total	N
All Primary Methods	87.8	11.4	0.8	0.0	0.0	100.0	(582)*
Selected Primary Methods							
Pill	74.2	25.3	0.5	0.0	0.0	100.0	(213)
Injectable	88.2	11.8	0.0	0.0	0.0	100.0	(106)
Tubal Ligation	98.7	1.4	0.0	0.0	0.0	100.0	(119)
Condom	96.9	--	3.1	0.0	0.0	100.0	(110)

* Number of cases for individual selected primary methods do not add up to number of cases for all primary methods because only those selected primary methods which had 25 or more users appear in this table.

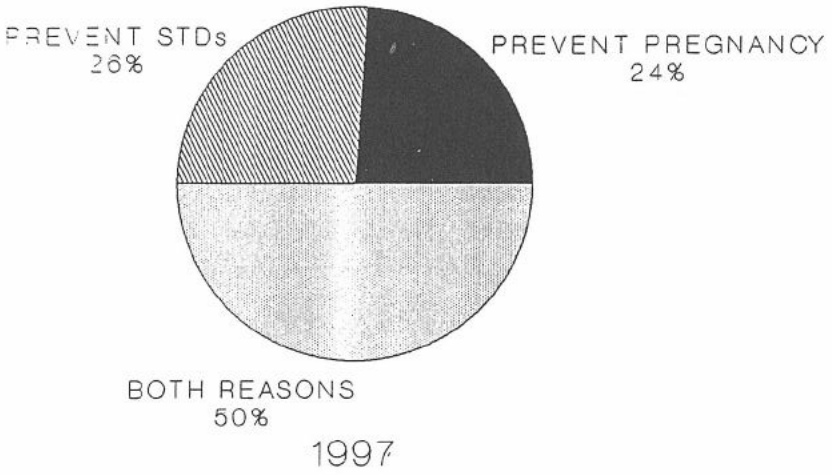
countries in Latin America where prevalence is considered to be high (70+ %), such as Costa Rica, Columbia and Brazil. While prevalence does not vary greatly by group, the choice of method does vary, with men and women moving from the condom to hormonal methods (pill and injections) and then to female sterilization as they get older.

Pill Use

A percent distribution of the brands of pills used is shown in Figure 10. The brand is important since each sector (government, social marketing and strictly commercial) has its own. The government programme distributes Lo-Femenal and Ovral, the 'Personal Choice' social marketing programme sells Perle and Minigynon, while the strictly commercial sector sells Nordette and a number of lesser-used brands categorized here as "other".

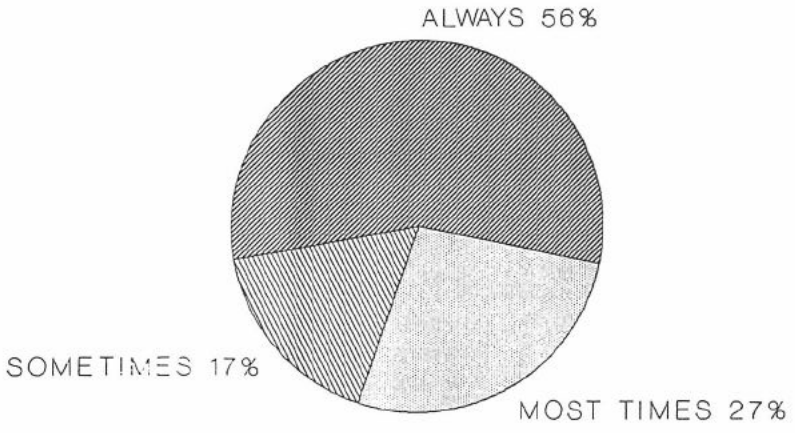
FIGURE 11
REASONS FOR USING CONDOMS
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS

REGION 2

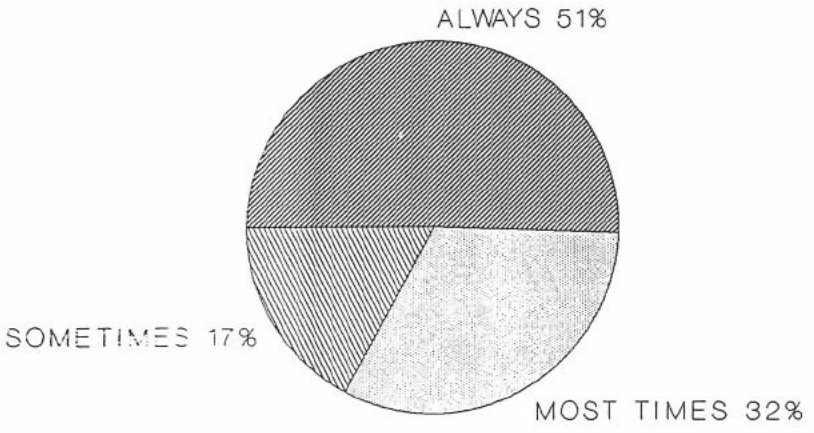


1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 12
FREQUENCY OF CONDOM USE
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS
WITH A STEADY PARTNER



REGION 2



JAMAICA

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

In Health Region 2 the leading pill brand is Perle, which is used by 28% of all pill users, while Minigynon is used by a further 10 percent. The Personal Choice programme, therefore, supplies 38 percent of all pill users in Region 2. However, public sector suppliers of oral contraceptives are equally important as Lo-Femenal and Ovral taken together are used by 36 percent of pill users. The strictly commercial sector in Region 2 is the least important as Nordette and the "other" category taken together are only bought by 21 percent of users in the region.

Condom Use

Since condoms have been an important method in Jamaica for both men and women, a special series of questions on their use was addressed to all users of condoms, either as a primary or a secondary method, independent of their union status.

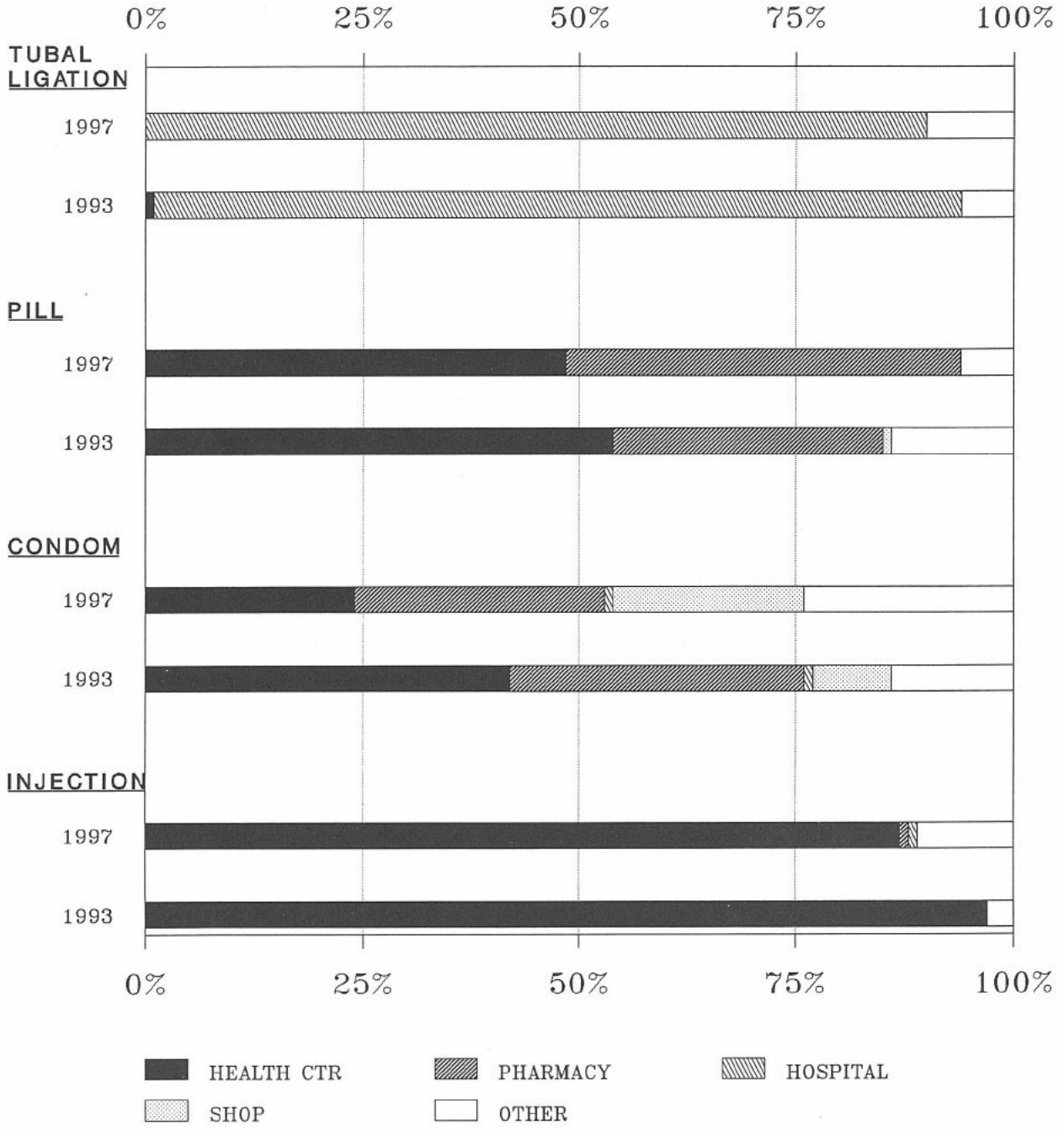
Figure 11 shows that while in Health Region 2 the majority of women who use condoms as a primary or secondary method do so both to prevent pregnancy and to protect themselves from sexually transmitted diseases, a large minority, 26 percent of all condom users, do so as a disease prevention measure only. This finding is important because, as seen in the lower part of Figure 11, the corresponding percentage in 1993 was only 2 percent of female condom users, which indicates that women's awareness of using condoms to prevent disease is increasing.

In Region 2, 83 percent of women using condoms with a steady partner do so "always" or "most times", which is identical with the corresponding figure for the country as a whole (Figure 12). The effectiveness of this or any method depends on correct and consistent use. Since the condom is being increasingly used as a disease prevention measure (See Figure 11), the effective percentage of condom users is diminished by those who are using condoms inconsistently.

Contraceptive Source

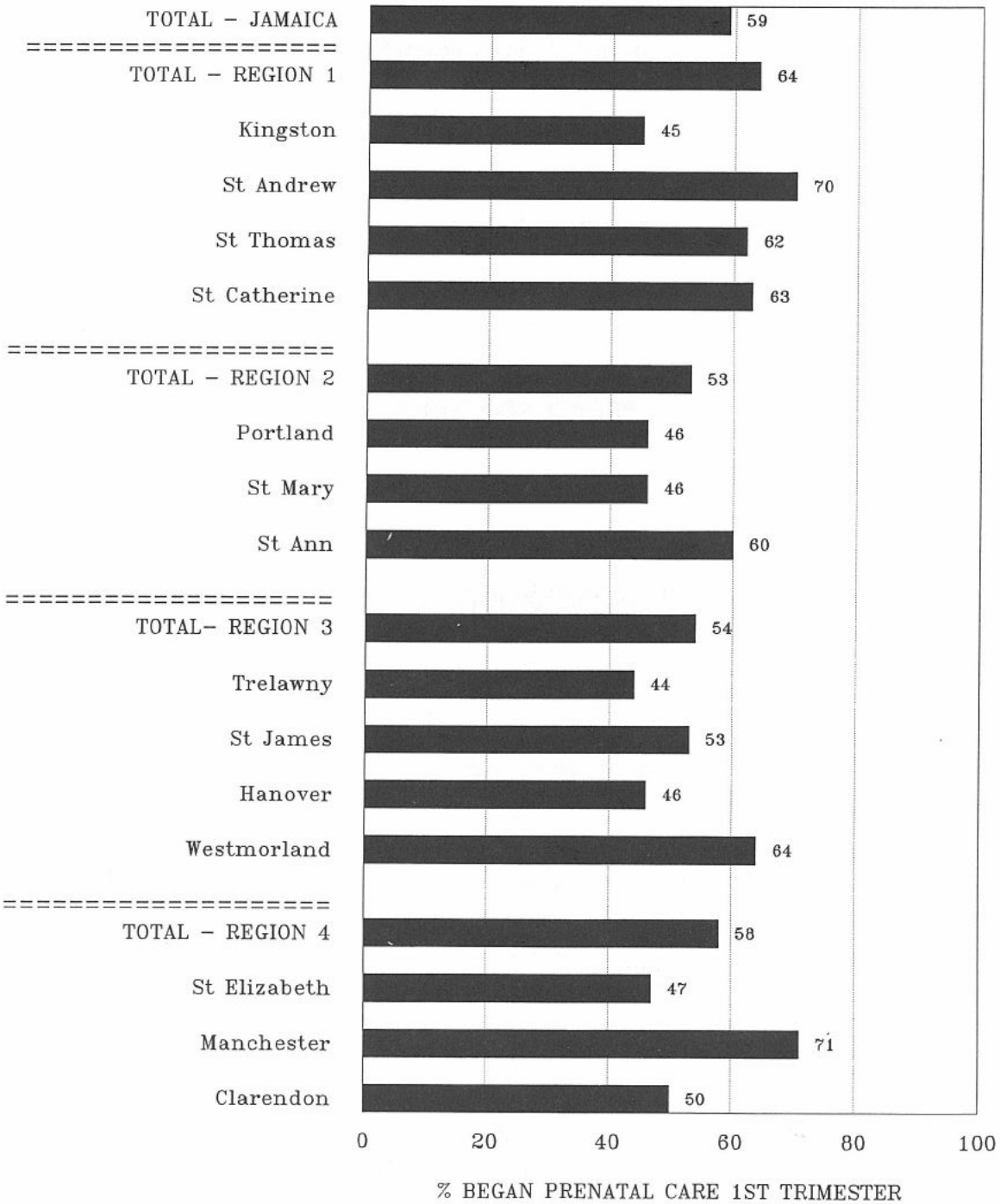
Figure 13 displays the relative importance of the various sources of the four most prevalent contraceptive methods for women in Region 2, and is compared with the 1993 CPS. There seems to have been a shift away from government health centers as a source for women using condoms since 1993, which, in fact, continues a trend began in 1989. Although many women in the region obtain their pills and condoms in government health centers, since 1993 an increasing percentage of women buy these in pharmacies and in the case of condoms, in shops. The other two major methods are still provided by the public sector, as almost all female sterilizations are performed in hospitals, while a

FIGURE 13
SOURCE OF CONTRACEPTION OF WOMEN IN UNION WHO ARE CURRENTLY USING MOST PREVALENT METHODS (PERCENT DISTRIBUTION) COMPARED TO 1993 CPS



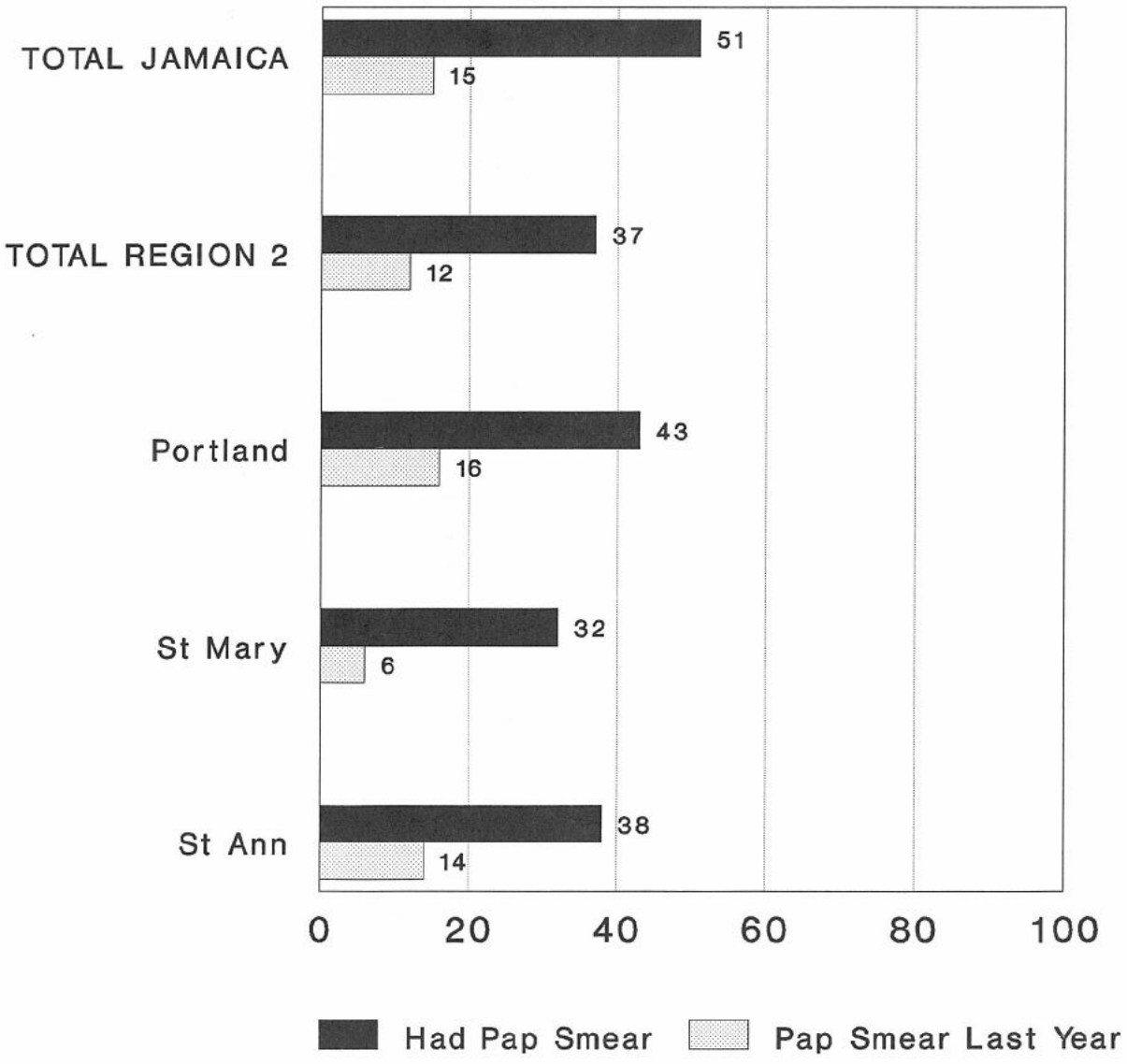
REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 14
PERCENT WHO BEGAN PRENATAL CARE IN 1ST TRIMESTER AMONG WOMEN 15-49 PREGNANT IN THE PAST 5 YEARS BY REGION AND PARISH



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 15
PERCENT OF WOMEN AGED 15-49
WHO HAVE EVER HAD A PAP SMEAR
AND HAVE HAD A PAP SMEAR IN THE LAST YEAR
BY PARISH



REGION 2
1997 JAMAICA
REPRODUCTIVE HEALTH SURVEY

similar proportion of injectable contraceptives are obtained in health centers.

Prenatal Care and Women's Health

Not shown in a graph is that practically all women (99%) in Jamaica who had a pregnancy in the past five years had prenatal care during their last pregnancy. However, Figure 14 shows that only 59 percent of these women began their prenatal care during the first trimester of their pregnancy, which is relatively low. This percentage is slightly lower in Region 2, as 53 percent of women in the region began their prenatal care in the first trimester. There is some variation between parishes in the region as 60 percent of women in St. Ann began their prenatal care in the first trimester of their pregnancy, compared to only 46 percent of women in Portland and St. Mary.

Pap Smears are an important means of early detection of cervical cancer. Only half of all Jamaican women have ever had a Pap Smear (51%) and only 15% had one in the past year (Figure 15). The corresponding percentages for Region 2 as a whole and for the parishes in the region are even lower. (By contrast, in the United States almost all women have had a Pap Smear at least once and about two-thirds have had one in the past year.)

Monthly breast self-examinations are an effective way of detecting breast cancer at an early stage. Fifty-five percent of all Jamaican women ever do these examinations, but only 29 percent have done at least one in the past month (Figure 16). These percentages are similar for Portland and St. Ann, but much lower in St. Mary.

Young Adults

Concern about high levels of adolescent pregnancies and births led to a decision to carry out some special analysis of the situation. A young adult module was therefore included in the 1997 RHS.

In Health Region 2, a large majority of young women and men (women - 80%, men - 74%) have been exposed to family life / sex education in school, outside of school or both (Figure 17). These percentages are about the same as the corresponding percentages in 1993. Most young adults reported having family life or sex education courses in school only. There was little difference according to age, but fewer young women had such training in St. Mary and less than half of young men in Portland had family life / sex education, compared to the other two parishes.

Sexual experience is defined as ever having had sexual intercourse. In this summary, we focus on the first sexual experience and contraceptive behavior. Current sexual activity

FIGURE 16
PERCENT OF WOMEN AGED 15-49
WHO EVER DO A MONTHLY BREAST SELF-EXAMINATION
AND DID A BREAST SELF-EXAM IN THE LAST MONTH
BY PARISH

REGION 2
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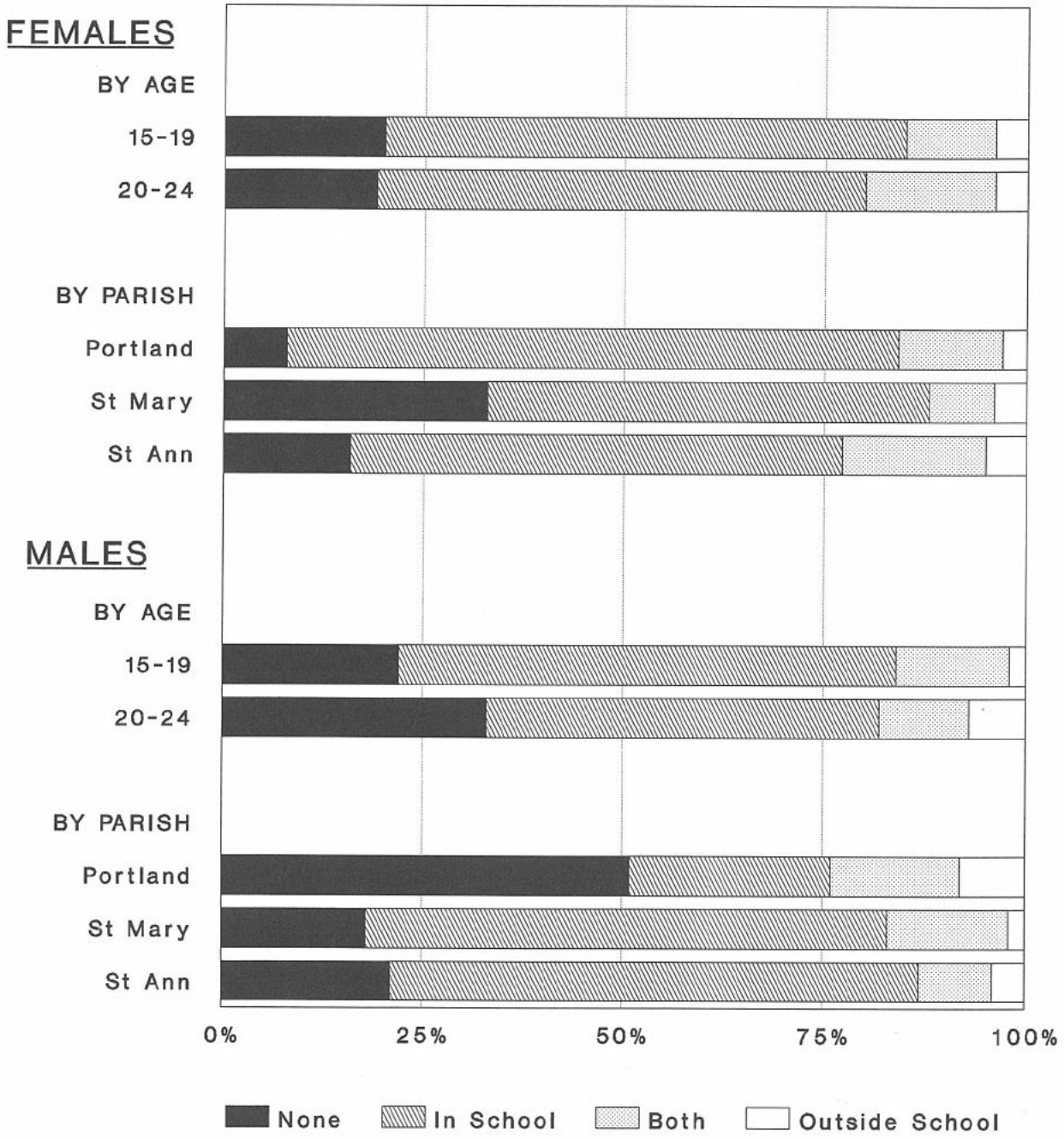
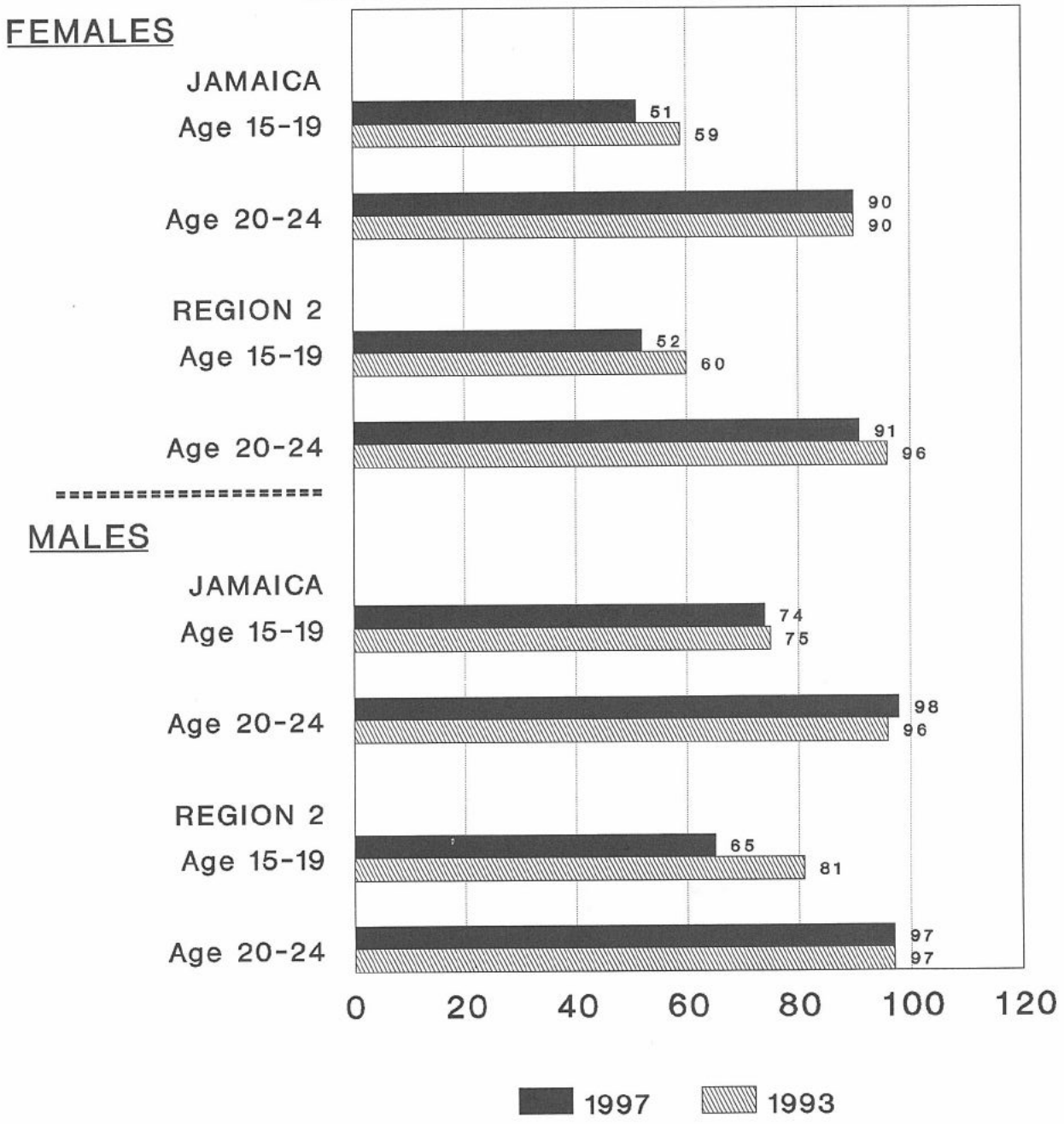
REPRODUCTIVE HEALTH SURVEY

FIGURE 17
FAMILY LIFE / SEX EDUCATION CLASS OR COURSE
IN SCHOOL AND / OR OUTSIDE OF SCHOOL
YOUNG ADULTS AGED 15-24
(PERCENT DISTRIBUTION)



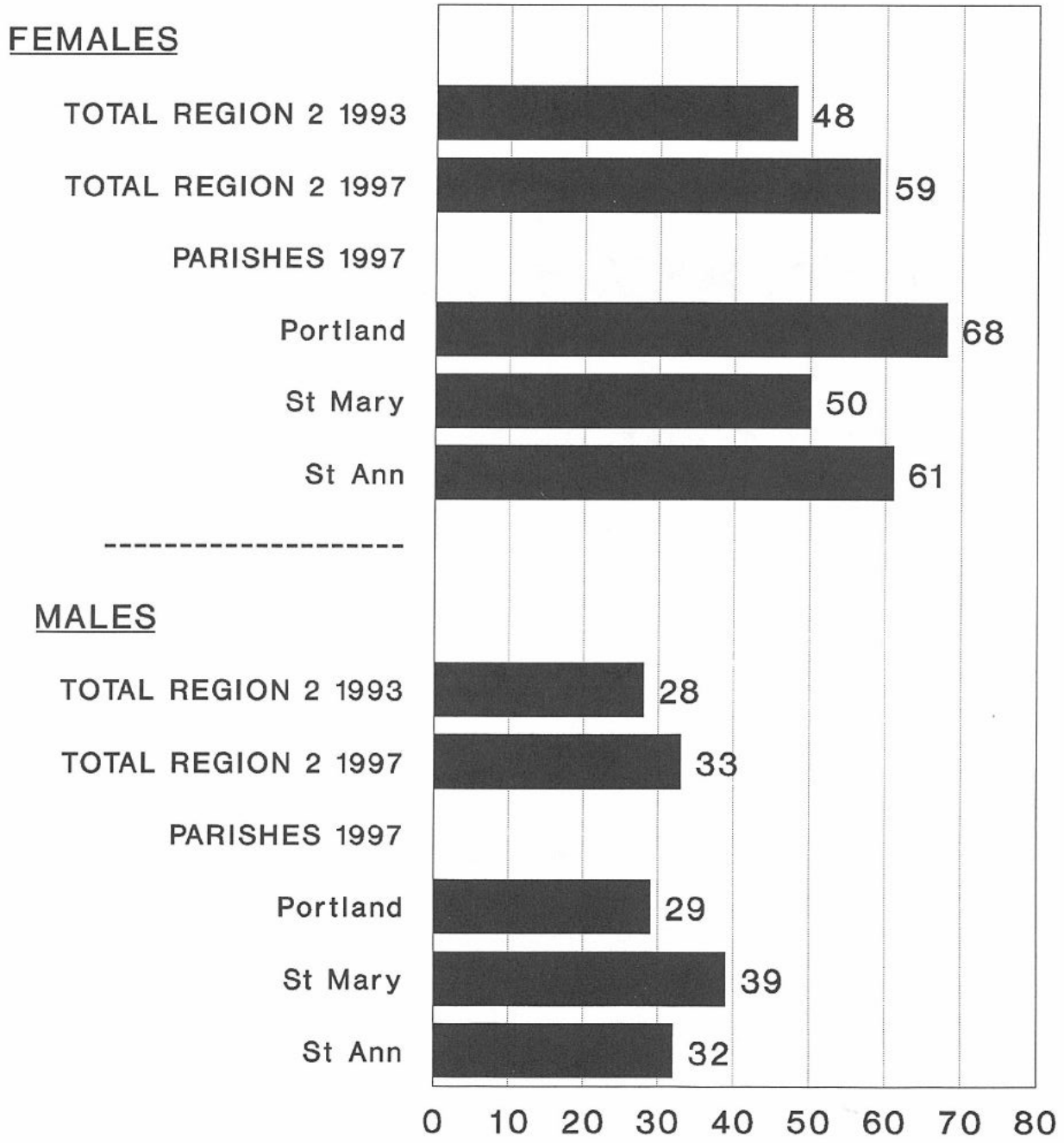
REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 18
PERCENT REPORTING SEXUAL EXPERIENCE
BY AGE GROUP
YOUNG ADULTS 15-24 YEARS OF AGE
COMPARED WITH 1993 CPS



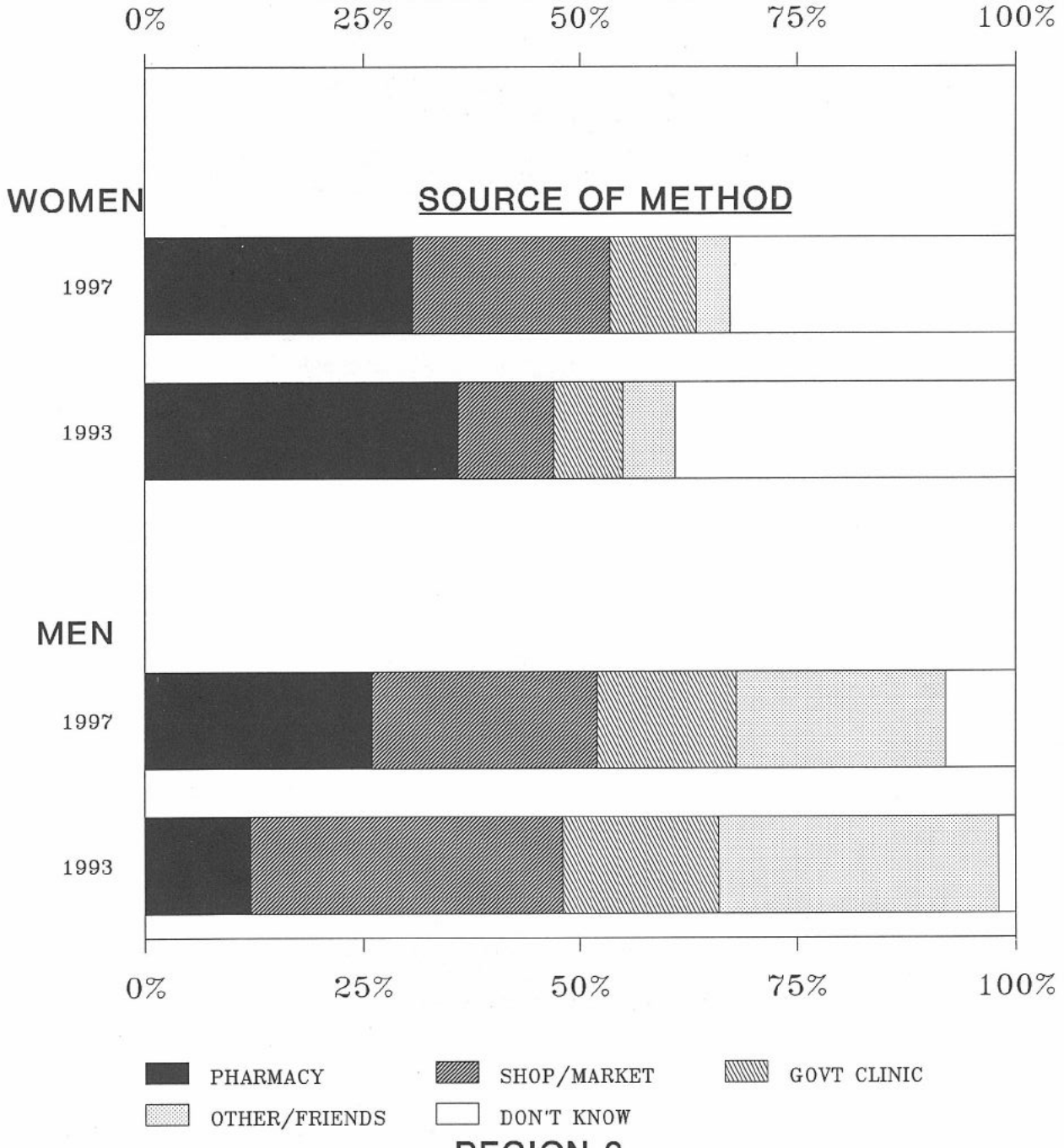
REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 19
% USING CONTRACEPTION AT 1ST SEXUAL INTERCOURSE
BY PARISH
YOUNG ADULTS 15-24 YEARS OF AGE
REGION 2



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 20
SOURCE OF CONTRACEPTIVE METHOD USED AT TIME OF FIRST SEXUAL INTERCOURSE
YOUNG ADULTS 15-24 YEARS OF AGE COMPARED WITH 1993 CPS



REGION 2
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

(within the past month) and number of partners will be presented in detail in the full final report of the survey.

The proportion of young adults in Jamaica and Health Region 2 reporting sexual experience by age group is shown in Figure 18. Among the youngest females in both the country and the region and young males in the region there has been a decrease since 1993. For both sexes, as may be expected, sexual experience increases with age. The sexual experience rate for females in the country and region at ages 15-19 is 51-52 percent. This figure increases to over 90 percent in the 20-24 age category. Sixty-five percent of males aged 15-19 in Region 2 report sexual experience, while sexual experience is essentially universal for older males.

In Health Region 2 the proportion of young men and women who used contraception at the time they first had sexual intercourse has increased since 1993 (Figure 19). Fifty-nine percent of young women and 33 percent of young men used a contraceptive method at the time of their first sexual intercourse, which represent increases from the corresponding 1993 percentages of 48 percent and 28 percent for women and men, respectively. Use of contraception at first intercourse is higher in Portland for men and in St. Mary for women.

Not shown in a graph is that, similar to Health Region 2, for the nation as a whole, approximately half of young women and about two-thirds of young men did not use contraception at first sexual intercourse. When asked why they did not use, almost one-half of women and about 30 percent of men said that they did not expect to have sex at the time of first intercourse. Approximately 30 percent of young men said the reason was that they did not have knowledge of contraception at the time of their first sexual experience (data not shown).

Also not shown in a graph or table is that in Jamaica as a whole the condom was used by the great majority (about 90 percent) of men and women who used any method at the time of their first intercourse.

The source of contraception used at first intercourse in Health Region 2 differs somewhat for females and males (Figure 20). Women, who as mentioned above reported almost universally that their partner used a condom, gave the pharmacy as the primary source. More than half of young men, who also largely used condoms at the time of their first intercourse, identified pharmacies, shops or markets as a primary source. Another 25 percent stated that they obtained their condom from other sources, mostly friends. Another difference is that one-third of young women did not know where their partner obtained the condom.

SUMMARY OF RESULTS

HEALTH REGION 3

HEALTH REGION 3

Introduction

The present report summarizes the findings for Health Region 3 of the Reproductive Health Survey (RHS) carried out in Jamaica in 1997. A contraceptive prevalence survey (CPS) of a similar type was carried out in Jamaica in 1993. The 1997 RHS, therefore, not only provides data on the current situation in Health Region 3 and Jamaica as a whole regarding reproductive health and contraceptive practices, but also permits an evaluation of changes since 1993. The 1997 RHS utilized an updated sampling frame based on the 1991 census which has been adopted for the Continuous Social and Demographic Surveys conducted by the Statistical Institute of Jamaica.

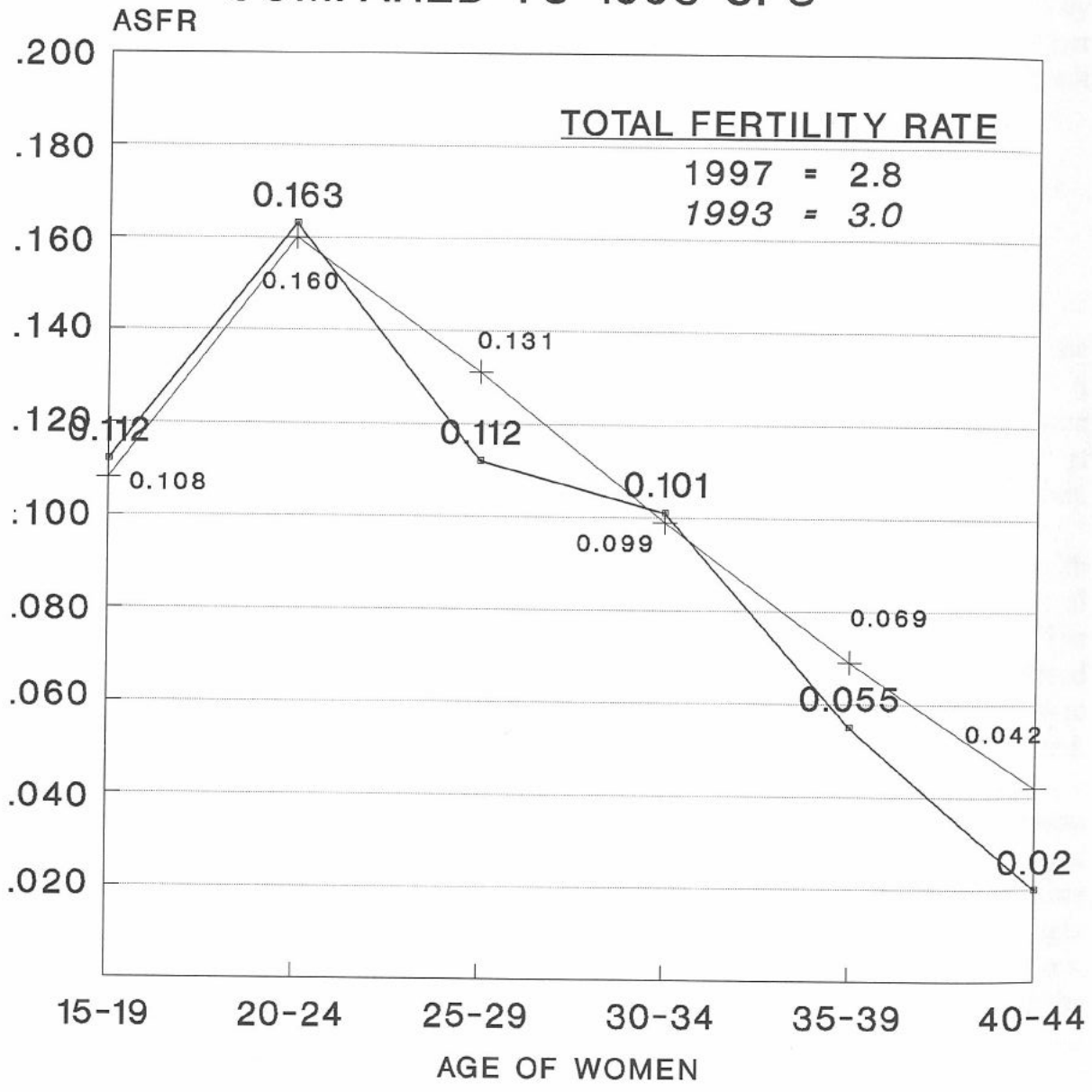
There are differences in the sampled population of the two surveys. Whereas in the 1993 CPS women aged 15 to 44 and men 15-54 were interviewed, the 1997 RHS included, in addition, women aged 45 to 49, but limited the coverage of men to an independent sample of young adults aged 15-24. The 1997 survey also had detailed questions in a special module addressed to young adult women aged 15 to 24, as well as questions on prenatal care and cancer screening, and questions on condom use, multiple sexual partners and attitudes toward contraception, which were addressed to all respondents.

Fertility

Fertility data for Jamaica as a whole and for Region 3 will be presented. The survey results show the total fertility rate (TFR) for the years 1995-1997 (i.e., the two years prior to interview) to be 2.8 births per woman (Figure 1). This represents a decrease from the TFR of 3.0 births per woman found in the 1993 survey. Age-specific fertility rates in the two surveys were similar for ages 15-19 and 20-24, indicating no recent decline in rates of early childbearing. Except among 30-34 year-olds, age-specific fertility rates fell substantially for all age groups from ages 25-29 to 40-44. The decline in fertility was particularly noteworthy at the oldest ages, with age-specific rates falling by 20 percent (14 births per 1000 women) at ages 35-39 and 40 percent (17 births per 1,000 women) at ages 40-44. The overall decline in the TFR of 0.2 births per woman between the 1993 and 1997 surveys follows a surprising failure to decline between the 1989 and 1993 surveys. Age-specific fertility rates were much higher at ages 20-24 than at any other ages, followed by similar levels at ages 15-19 and 25-29.

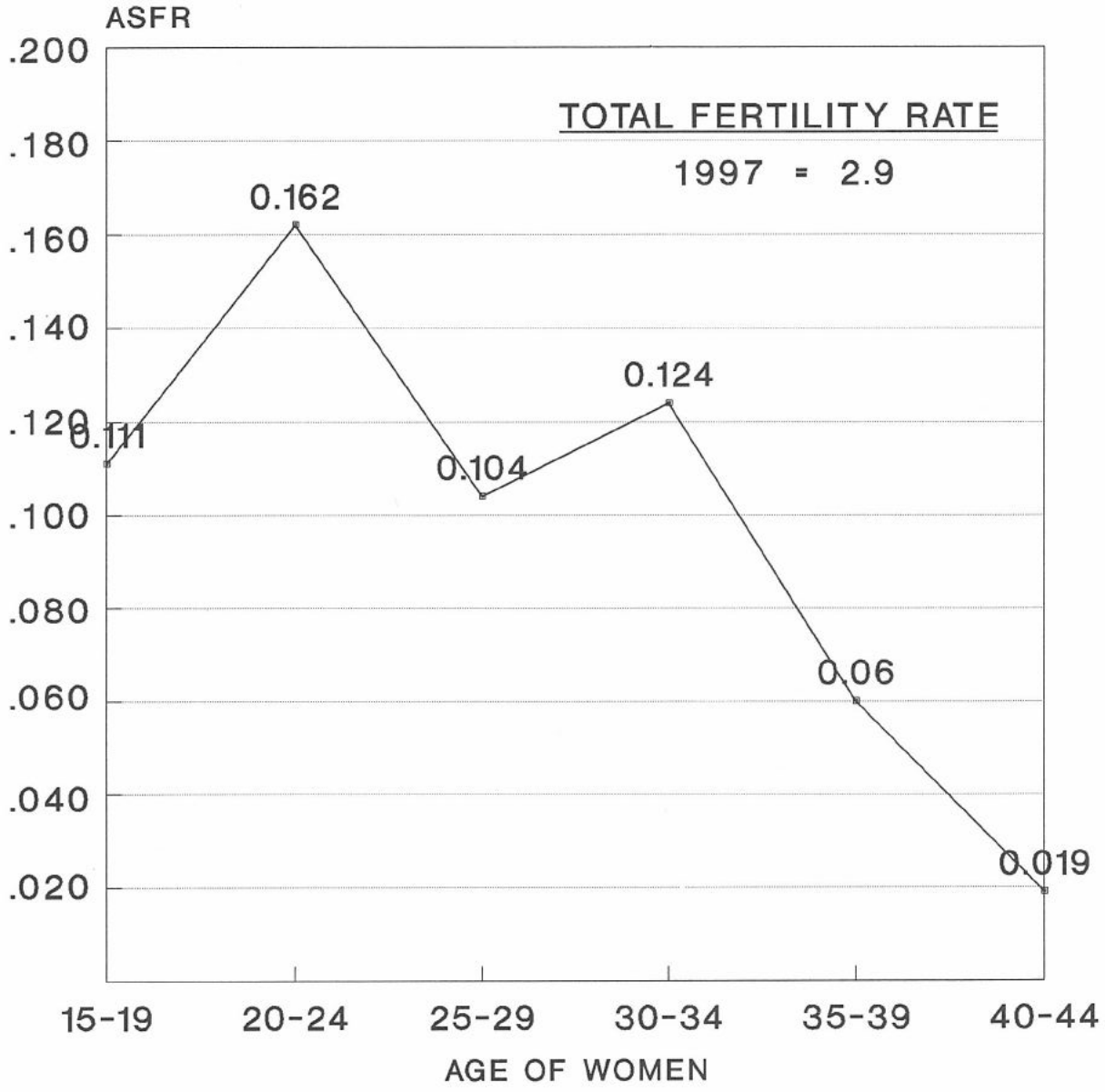
According to the 1997 survey, the fertility level in Region 3 was at an intermediate level,

FIGURE 1
AGE-SPECIFIC FERTILITY RATES
WOMEN AGED 15-44
COMPARED TO 1993 CPS



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 2
AGE-SPECIFIC FERTLITY RATES
WOMEN AGED 15-44
REGION 3



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

being very similar to the overall national level for Jamaica. The TFR for the two years prior to the survey was 2.9 births per woman (Figure 2), compared to the island-wide rate of 2.8 births per woman. Each of the five-year age-specific fertility rates was also very similar in Region 3 and island-wide, with the exception of ages 30-34, which had unexpectedly high fertility in Region 3. As in Jamaica as a whole, fertility rates were highest at ages 20-24, with 162 births per 1,000 women per year. This was followed by similar rates at ages 30-34, 15-19, and 25-29 (ranging between 104 and 124 births per 1,000 women). Because of small regional sample sizes in the 1993 survey, it was not possible to examine changes in fertility within regions between 1993 and 1997.

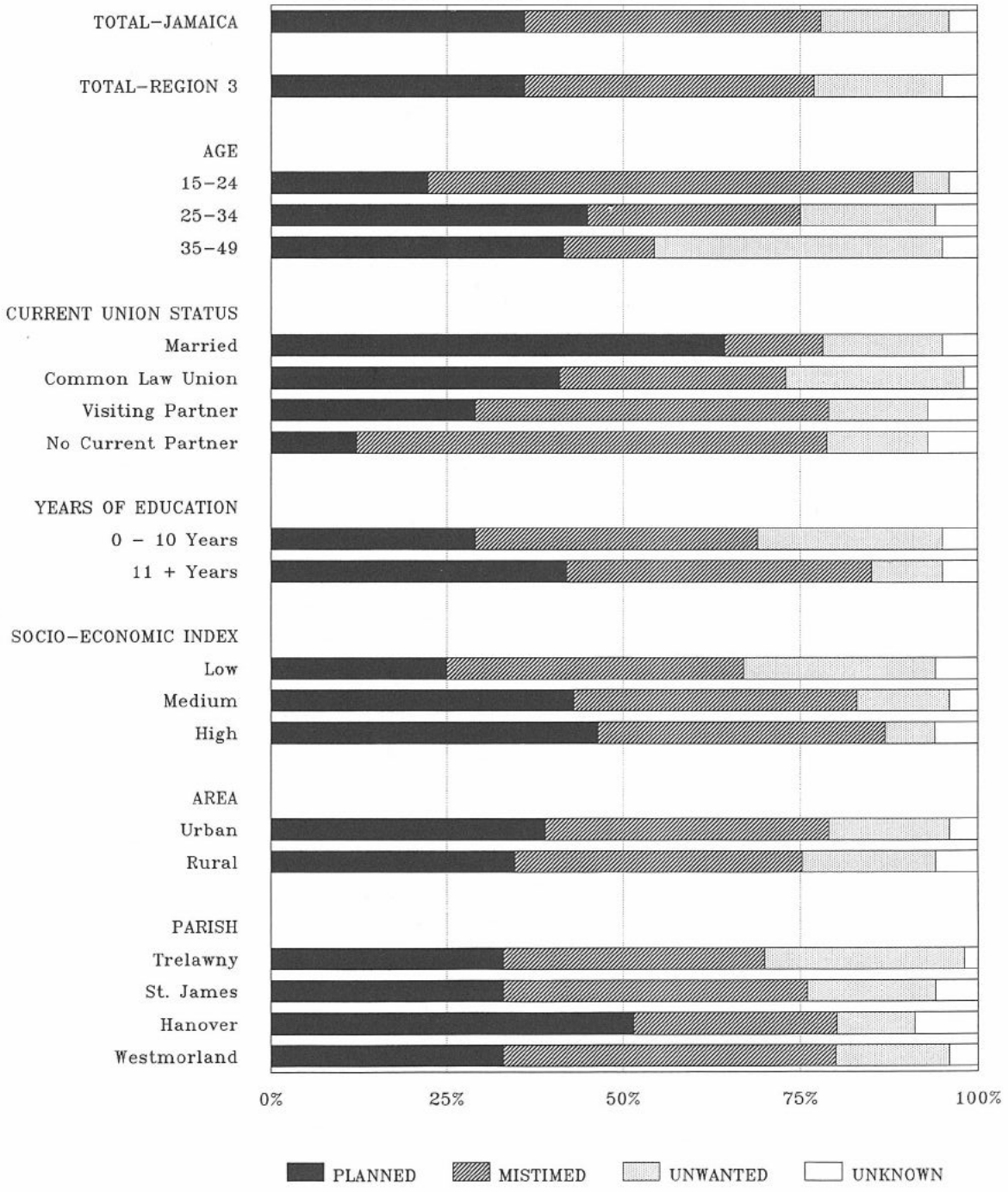
Planning Status of the Last Pregnancy

Figure 3 shows the distribution of the planning status of the last pregnancy within the past 5 years for women aged 15-44 in Health Region 3 and Jamaica as a whole. A pregnancy is defined as "planned" if the woman wanted to become pregnant at the time she became pregnant. A pregnancy is "mistimed" if she wanted to become pregnant at a later date and is "unwanted" if she did not want to have any more children. "Unintended" or unplanned pregnancies combine together these latter two categories. Overall, thirty-three percent of pregnancies were reported by respondents in Health Region 3 to have been planned. Not shown in the graph is that this is almost identical with the findings of 1993 when 32 percent of pregnancies in Region 3 were planned. The majority of pregnancies in the region were unintended--including 47 percent mistimed and 17 percent unwanted. These percentages are similar to the country as a whole, where 42 percent of pregnancies were reported to be mistimed and 18 percent were unwanted.

The proportion of unwanted pregnancies increases with age. Similarly, since Jamaican women tend to enter more stable unions as they age, the proportion of planned pregnancies is higher and the proportion of mistimed pregnancies is lower in the more stable unions. Conversely, mistimed pregnancies are concentrated among younger women in less stable unions who are more likely to have spacing of pregnancy failures. The percentage of planned pregnancies rises slightly with increases in education and the socio-economic index, and is higher in Hanover than the other three parishes.

Given the relatively high level of contraceptive use by women in union in Jamaica as a whole and in Health Region 3, the percentage of unintended pregnancies is still high. Two factors may be contributing to this: the less than optimum use of temporary methods resulting in contraceptive failure; and high levels of unprotected sexual activity by women who are not in union.

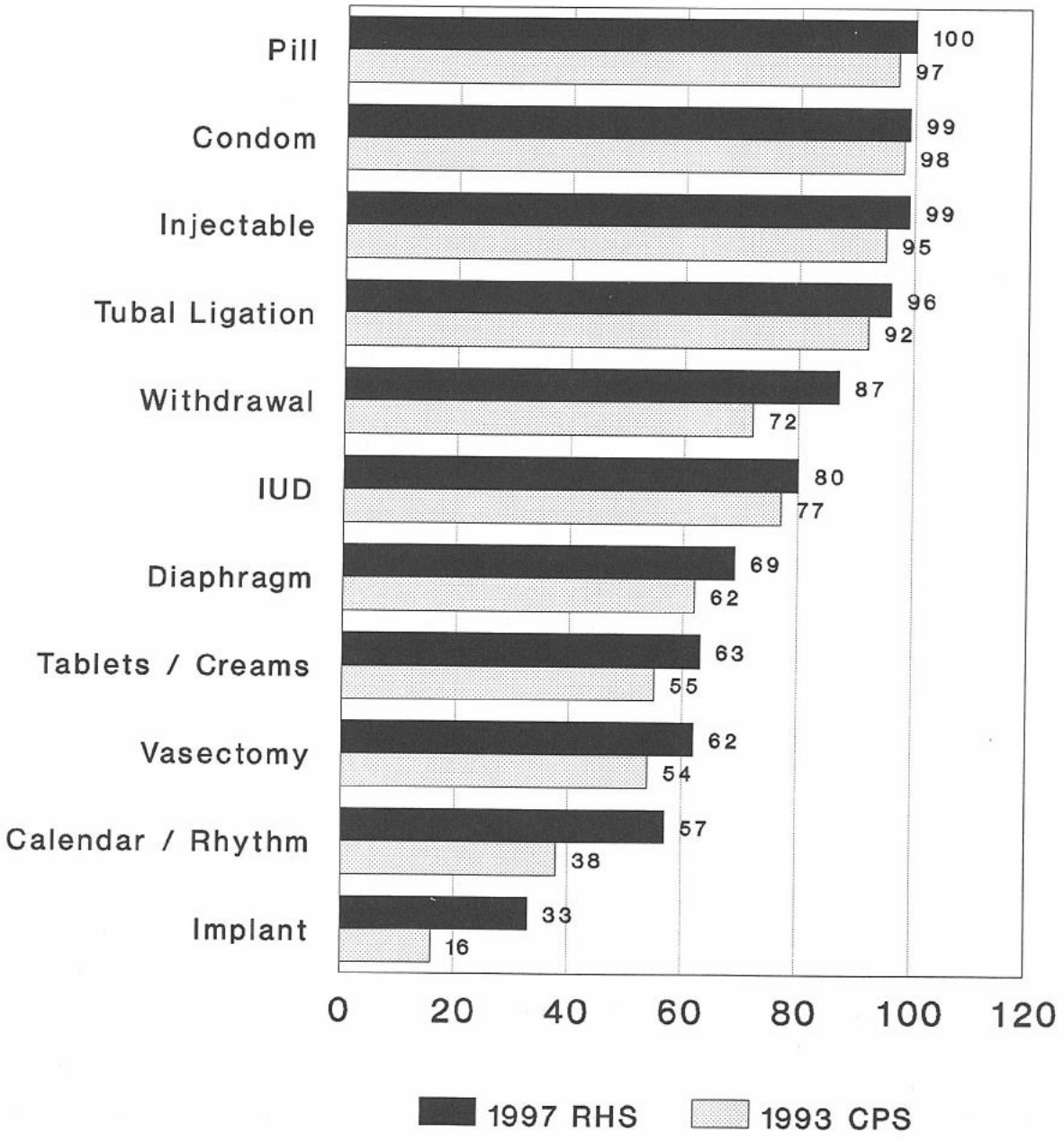
FIGURE 3
PLANNING STATUS OF LAST OR CURRENT PREGNANCY BY SELECTED CHARACTERISTICS (PERCENT DISTRIBUTION) WOMEN AGED 15-49



REGION 3

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 4
PERCENT OF WOMEN AGED 15-49
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 3
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

Knowledge of Contracetives

Figure 4 shows "knowledge" of contraceptives among women. Knowledge here refers to the fact that the respondent has heard of a contraceptive method, not necessarily that she has enough knowledge of the method to be able to use it correctly.

Virtually all women in Region 3 have heard of the condom, pill, injectables and female sterilization, and almost 90 percent know of the withdrawal method and 80 percent of the IUD. The diaphragm, vaginal methods, natural methods and Norplant, which are little used in Jamaica, are less well known. While the informed choice of a contraceptive method must be left to the couple, lack of knowledge of some of the more effective methods, particularly vasectomy and the implant (Norplant), reduces the choice and potential use of some available long-term methods. With the exception of withdrawal, calendar/rhythm and the implant, knowledge of all methods is little changed from 1993 to 1997.

Figure 5 shows the level of women's knowledge of contraceptive methods in Region 3 by parish. There is little difference between parishes, except that fewer women in Trelawney have heard of withdrawal, the IUD, spermicides and vasectomy, while fewer women in Westmoreland have heard of the implant.

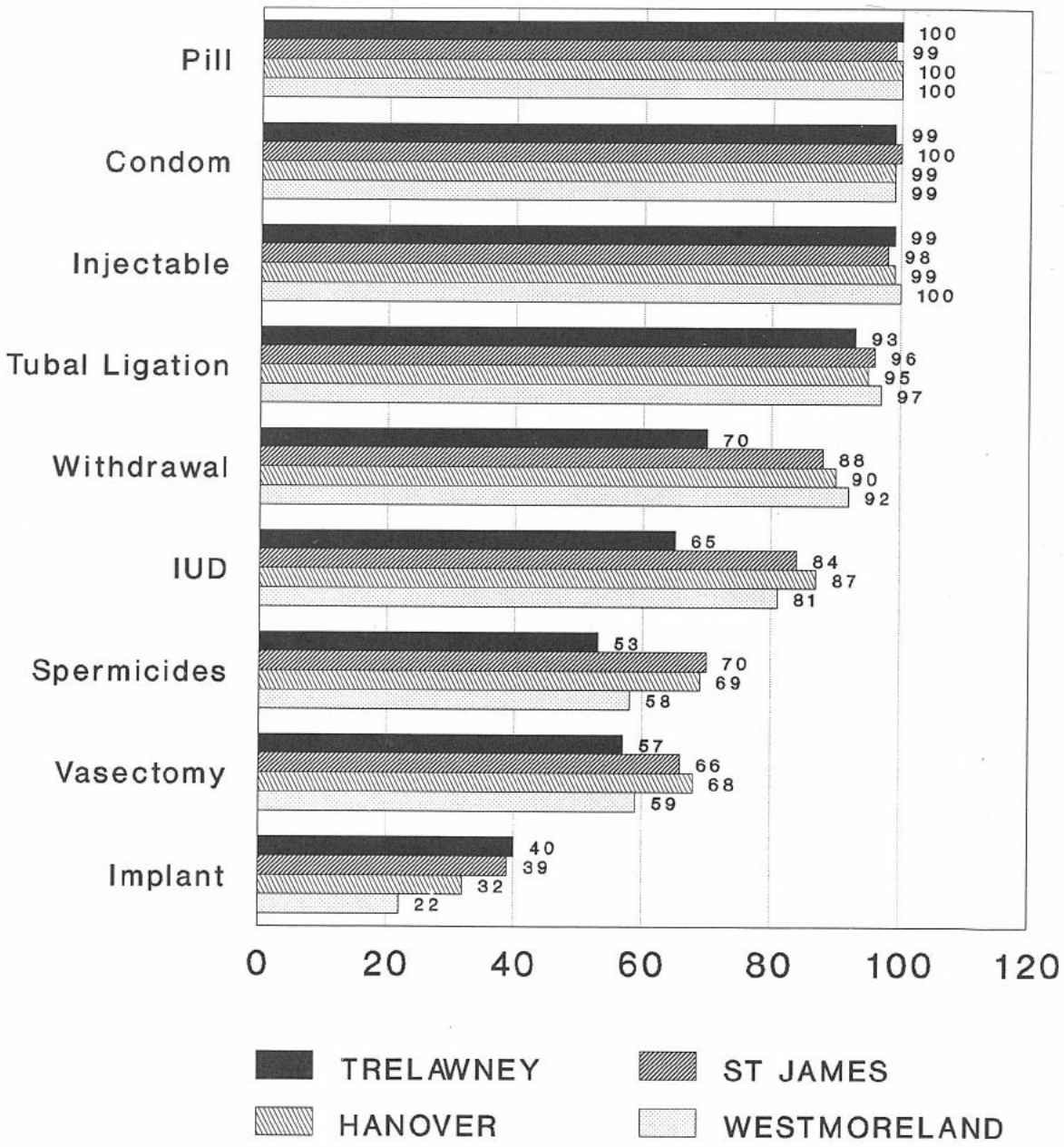
Among young adult men (Figure 6), the best known methods are, as in the case of women, condoms, the pill, injectables, female sterilization and withdrawal . However, aside from condoms, the pill and injectables all methods are less well known among men than among women.

Contraceptive Use

Figure 7 shows the prevalence of contraceptive use among women in union in Jamaica as a whole and Health Region 3 by principal type of method, comparing data for the region with the 1993 and 1989 surveys. The overall level of use in Region 3 at 63 percent of women in union is similar to the 65 percent for Jamaica and has increased by six percentage points since 1993. This increase since 1993 is accounted for by an increase in the use of condoms and injections.

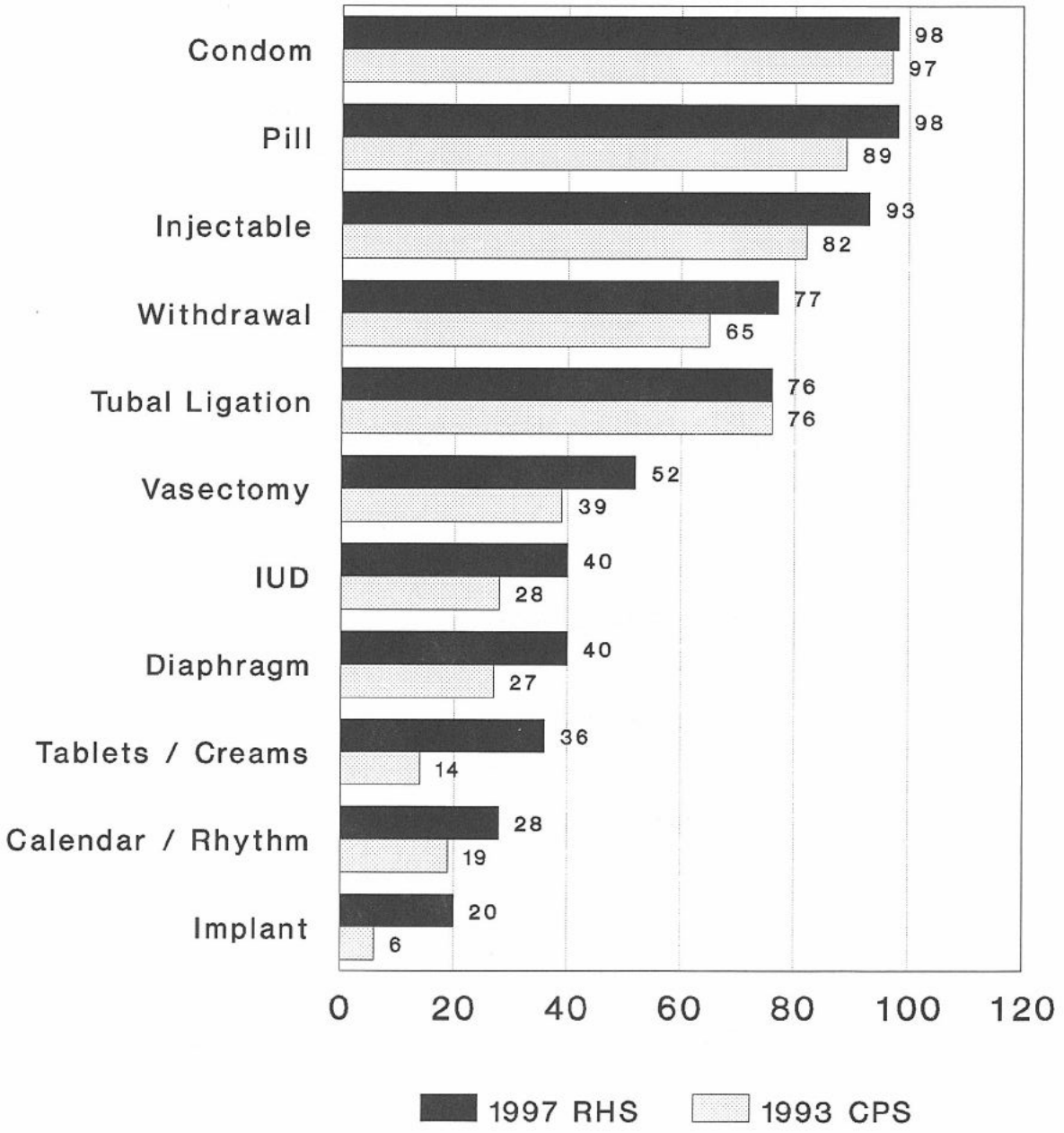
Figure 8 is a pie chart showing additional data on specific contraceptive method use by all women (in union and not in union) as well as women in union in Health Region 3 in 1997. As seen in the upper pie, only 49 percent of all women are using a contraceptive method, with only 15 percent using the pill. The lower pie shows that oral contraceptives (20%) are the most prevalent method among women in union, followed by the condom

FIGURE 5
PERCENT OF WOMEN AGED 15-49
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
BY PARISH



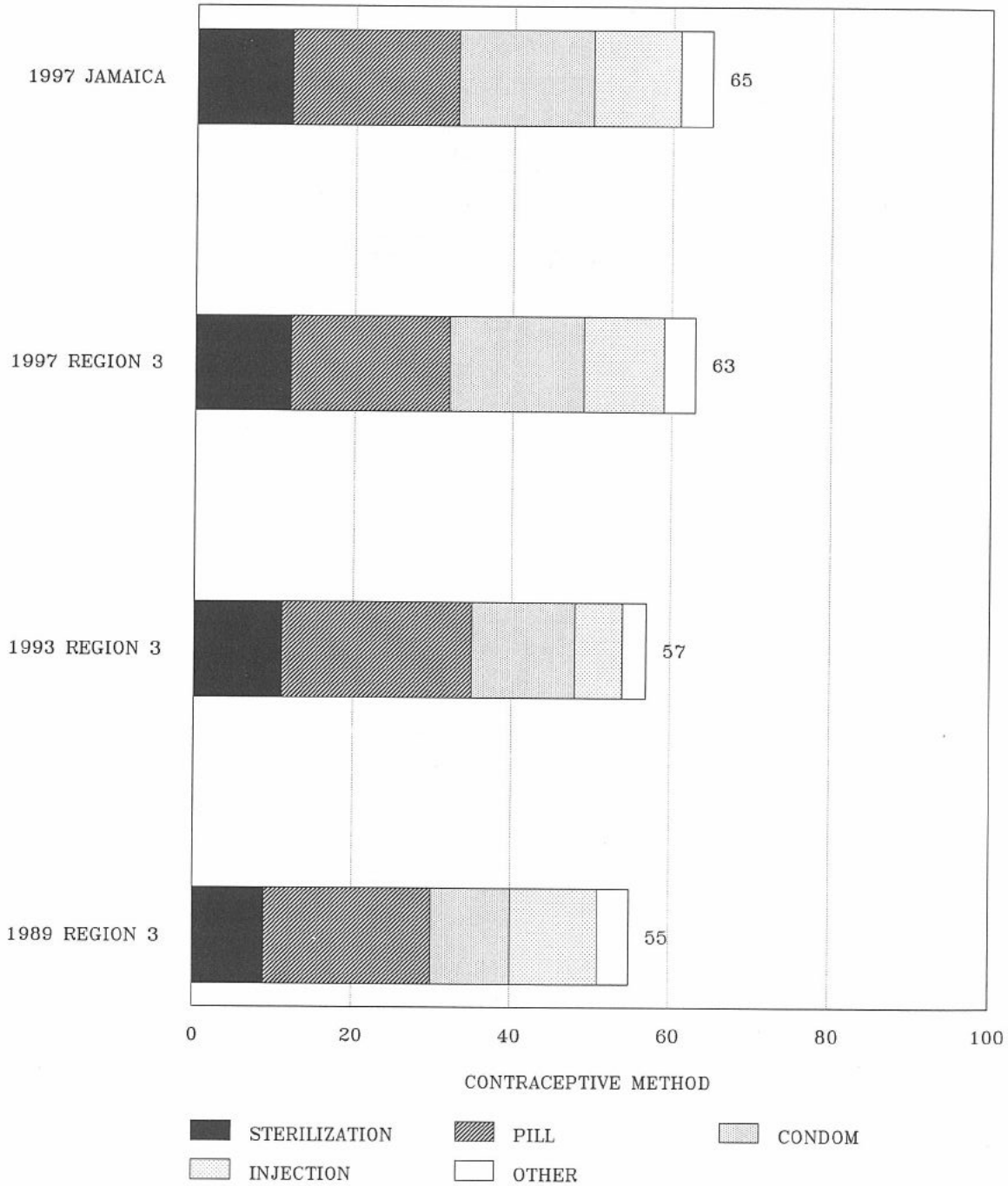
REGION 3
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 6
PERCENT OF YOUNG ADULT MEN AGED 15-24
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 3
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

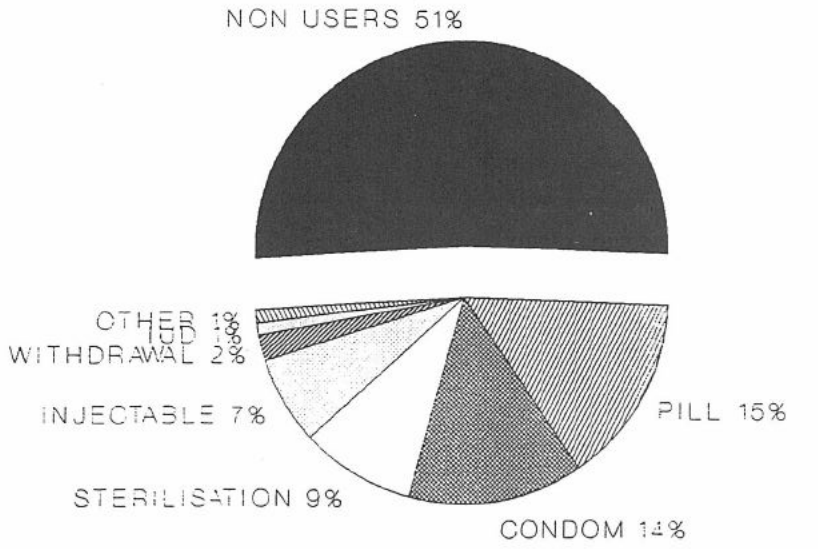
FIGURE 7
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING CONTRACEPTION, BY METHOD COMPARED WITH 1993 AND 1989 CPSs



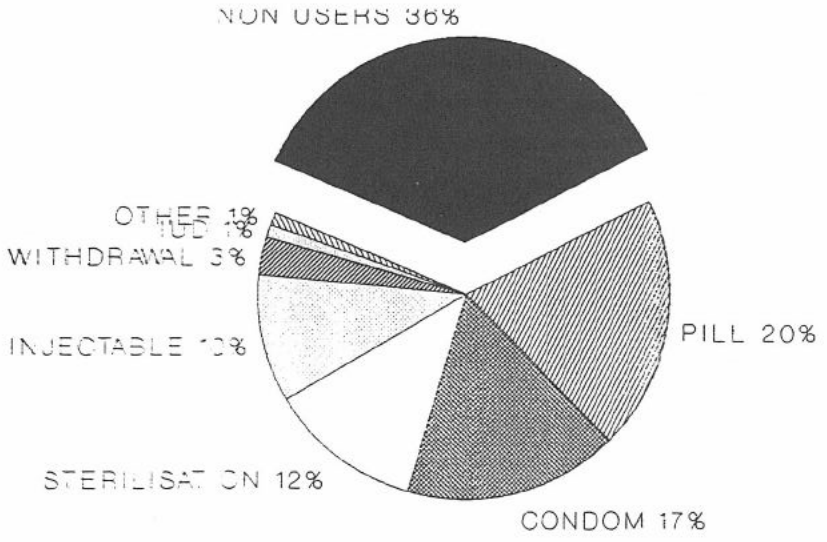
REGION 3
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 8
PERCENTAGE OF ALL WOMEN AND WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD

REGION 3



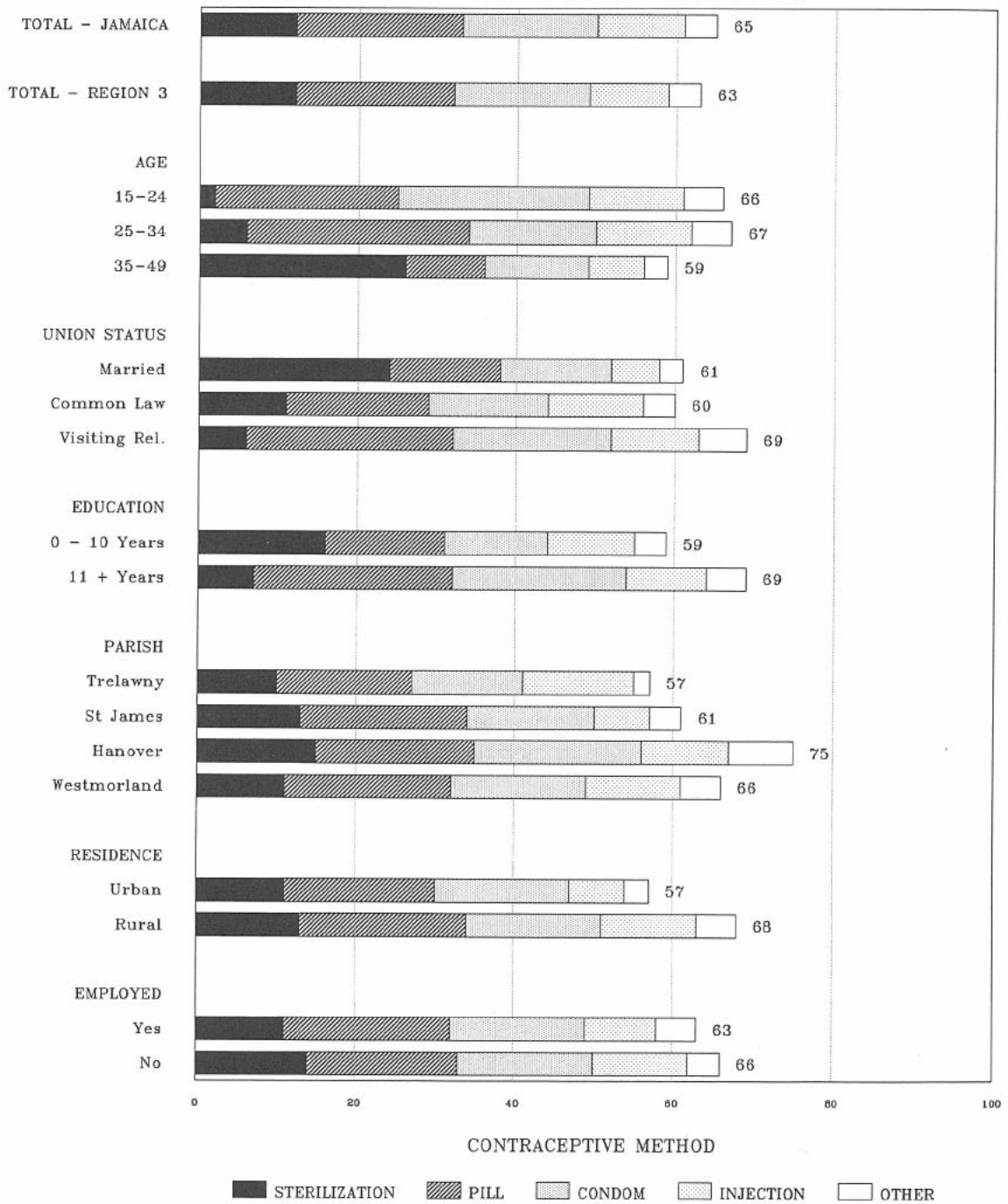
ALL WOMEN



WOMEN IN UNION

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 9
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD BY SELECTED CHARACTERISTICS



REGION 3
1993 JAMAICA CONTRACEPTIVE PREVALENCE SURVEY

(17%), female sterilization (12%) and injectables (10%). These are the same four leading methods as reported in 1993.

Figure 9 presents use of major contraceptive methods by women in union, according to selected geographic and socio-demographic characteristics. In general, as age and increases, women tend to use more effective methods. While pill and condom use predominates among women 24 and under, since most of these women using any method use these two methods, the pill is the leading method between 25 and 34 years of age. After age 35 the pill is in turn eclipsed by female sterilization as the major method, as almost half of these older women using any method have had a tubal ligation.

Overall use by women in a marital union is at about the same level as women in common-law or visiting unions, but there are differences in the methods used by these different groups. Forty percent of married women using any method have been surgically sterilized. In contrast, relatively few women in a common-law union or in a visiting relationship have been sterilized. A factor not shown in this figure is that women who are married tend to be older than women in common law and visiting unions, which in turn is correlated with the number of living children. As mentioned above, with increasing age (and a greater number of children), a higher percentage of women choose this permanent method. Women who are in less stable unions and who are younger and have fewer children tend to use pills and condoms to a greater extent.

Overall contraceptive use is slightly higher among women with more education and is higher in rural areas, including rural Hanover, but does not vary by employment.

Table 1 looks at the percentage of female primary or "first" contraceptive method users in Region 3 who concurrently use a secondary method. Overall, 13 percent of all primary method users are also using a secondary method. Not shown in this table is that in 1993 only about half as many users were also using a secondary method.

Practically all secondary method use is the condom. This suggests that while data on primary method use alone do not show much increase in condom use from 1993 to 1997, by including secondary method condom use as part of this analysis, the use of condoms has substantially increased in the four years since the 1993 survey. Almost 25 percent of pill users and 16 percent of injectable users in Region 3 are concurrently using condoms.

To summarize the above findings, overall contraceptive use is high for all socio-demographic groups in Region 3 (and Jamaica) and is practically at the level of use of countries in Latin America where prevalence is considered to be high (70+ %), such as Costa Rica, Columbia and Brazil. While prevalence does not vary greatly by group, the choice of method does vary, with men and women moving from the condom to hormonal

methods (pill and injection) and then to female sterilization as they get older.

TABLE 1

Percentage Of Contraceptive Users In Health Region 3
Who Are Concurrently Using A Secondary Contraceptive Method
By Primary And Secondary Method Used
Women In Union Aged 15-49 Years
(Percent Distribution)
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

	Secondary Method Used						
	None	Condom	With-drawal	Natural Method	Other	Total	N
All Primary Methods	87.0	11.7	0.2	0.1	0.1	100.0	(786)*
Selected Primary Methods							
Pill	75.4	24.3	0.4	0.0	0.0	100.0	(245)
Injectable	83.7	16.3	0.0	0.0	0.0	100.0	(165)
Tubal Ligation	88.1	11.6	0.0	0.0	0.3	100.0	(148)
Condom	99.5	--	0.2	0.2	0.0	100.0	(198)
Withdrawal	100.0	0.0	--	0.0	0.0	100.0	(35)

* Number of cases for individual selected primary methods do not add up to number of cases for all primary methods because only those selected primary methods which had 25 or more users appear in this table.

Pill Use

A percent distribution of the brands of pills used is shown in Figure 10. The brand is important since each sector (government, social marketing and strictly commercial) has its own. The government programme distributes Lo-Femenal and Ovral, the 'Personal Choice' social marketing programme sells Perle and Minigynon, while the strictly commercial sector sells Nordette and a number of lesser-used brands categorized here as "other".

In Health Region 3 the leading pill brand is Perle, which is used by 29% of all pill users, while Minigynon is used by a further 15 percent of pill users. The Personal Choice programme, therefore, supplies 44 percent of all pill users in Region 3. The other major

FIGURE 10
BRAND OF PILL CURRENTLY USED
WOMEN AGED 15-49
WHO ARE CURRENT PILL USERS
(PERCENT DISTRIBUTION)
REGION 3

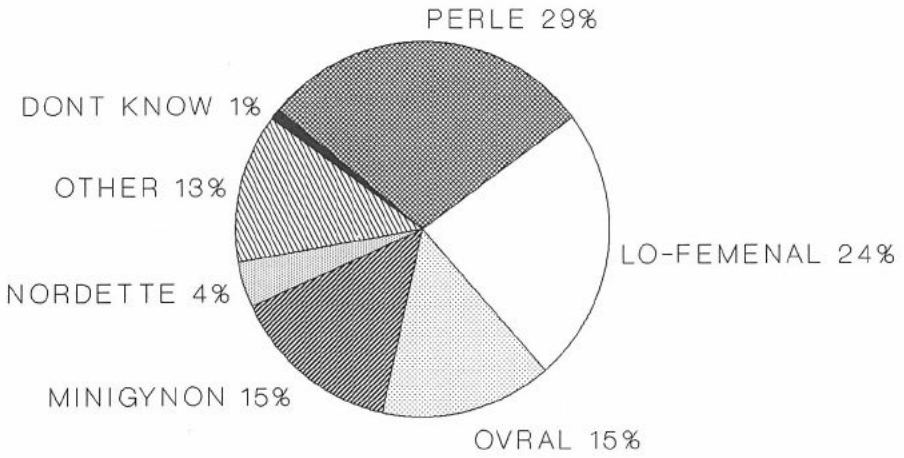
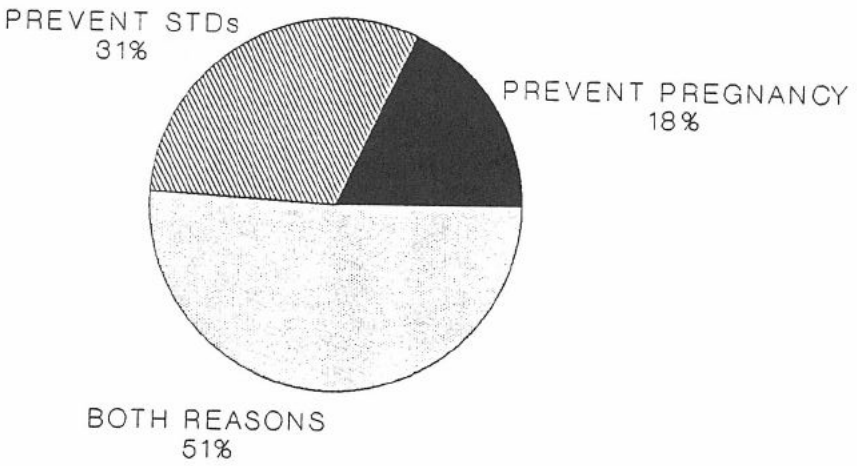
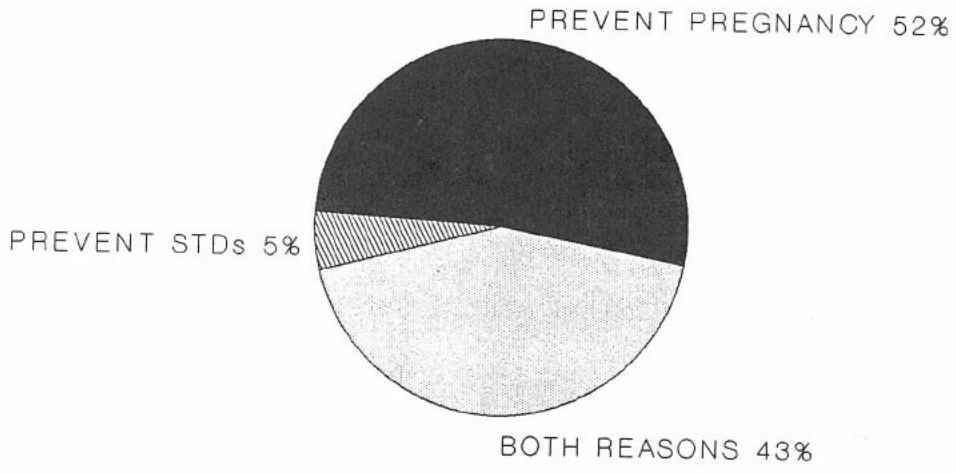


FIGURE 11
REASONS FOR USING CONDOMS
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS

REGION 3



1997



1993

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brands used in the region are Lo-Femenal and Ovral, supplied by the public sector to a total of 39 percent of pill users. Nordette and the "other" category taken together are sold in the strictly commercial sector to only 17 percent of pill users.

Condom Use

Since condoms have been an important method in Jamaica for both men and women, a special series of questions on their use was addressed to all users of condoms, either as a primary or a secondary method, independent of their union status.

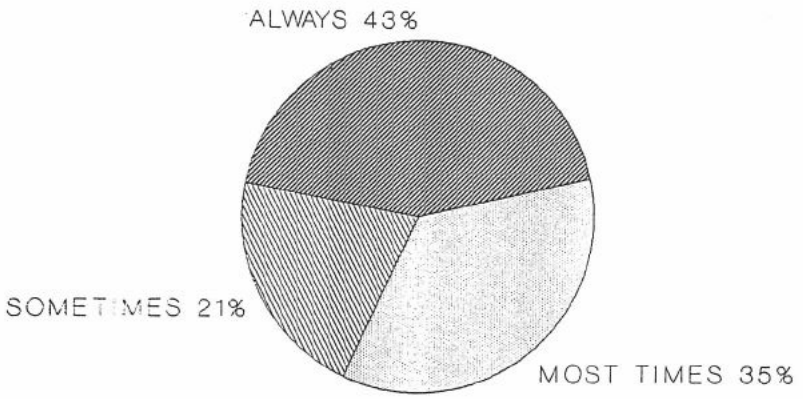
Figure 11 shows that while in Health Region 3 the majority of women who use condoms as a primary or secondary method do so both to prevent pregnancy and to protect themselves from sexually transmitted diseases, a large minority, 31 percent of all condom users, do so as a disease prevention measure only. This finding is important because, as seen in the lower part of Figure 11, the corresponding percentage in 1993 was only 5 percent of female condom users, which indicates that women's awareness of using condoms to prevent disease is increasing.

In Region 3 seventy-eight percent of women using condoms with a steady partner do so "always" or "most times" (Figure 12). This is similar to the figure of 83 percent for the country as a whole. The effectiveness of this or any method depends on correct and consistent use. Since the condom is being increasingly used as a disease prevention measure (See Figure 11), the effective percentage of condom users is diminished by those who are using condoms inconsistently.

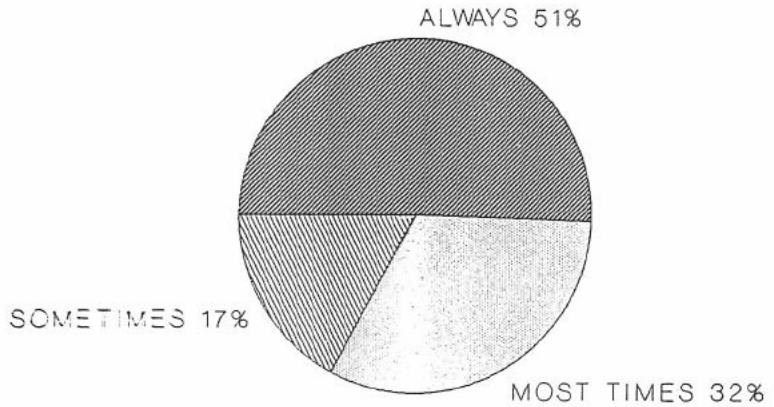
Contraceptive Source

Figure 13 displays the relative importance of the various sources of the four most prevalent contraceptive methods for women in Region 3, and is compared with the 1993 CPS. There seems to have been a shift away from government health centers as a source for women using pills and condoms since 1993, which, in fact, continues a trend began in 1989. Most women buy their pills and condoms in pharmacies (56% and 50% of users of these methods, respectively). The other two major methods are still provided by the public sector, as almost all female sterilizations are performed in hospitals and more than three-fourths of injectable contraceptive users obtain their supplies in health centers.

FIGURE 12
FREQUENCY OF CONDOM USE
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS
WITH A STEADY PARTNER



REGION 3



JAMAICA

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FIGURE 13
SOURCE OF CONTRACEPTION OF WOMEN IN UNION WHO ARE CURRENTLY USING MOST PREVALENT METHODS (PERCENT DISTRIBUTION) COMPARED TO 1993 CPS

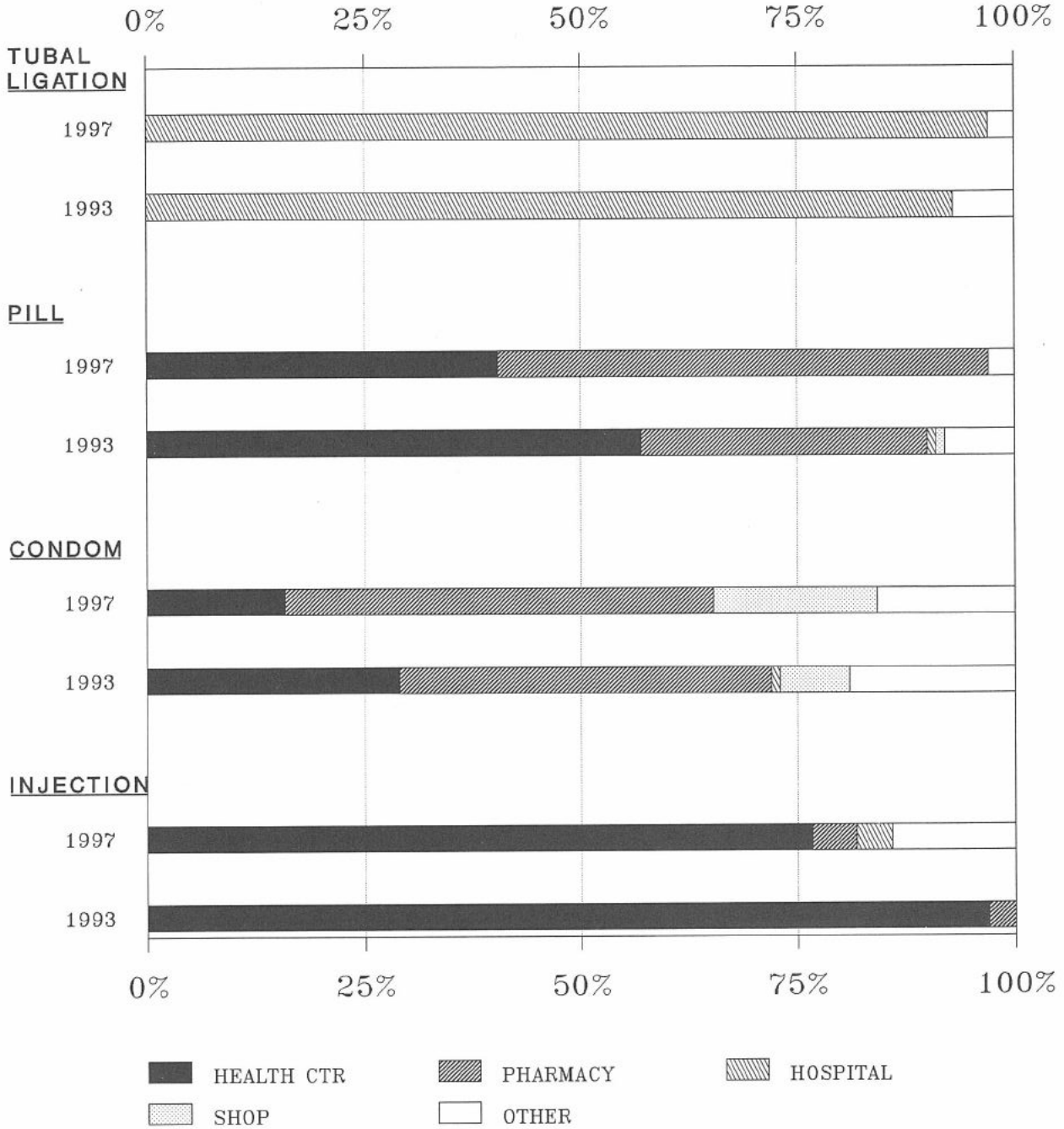

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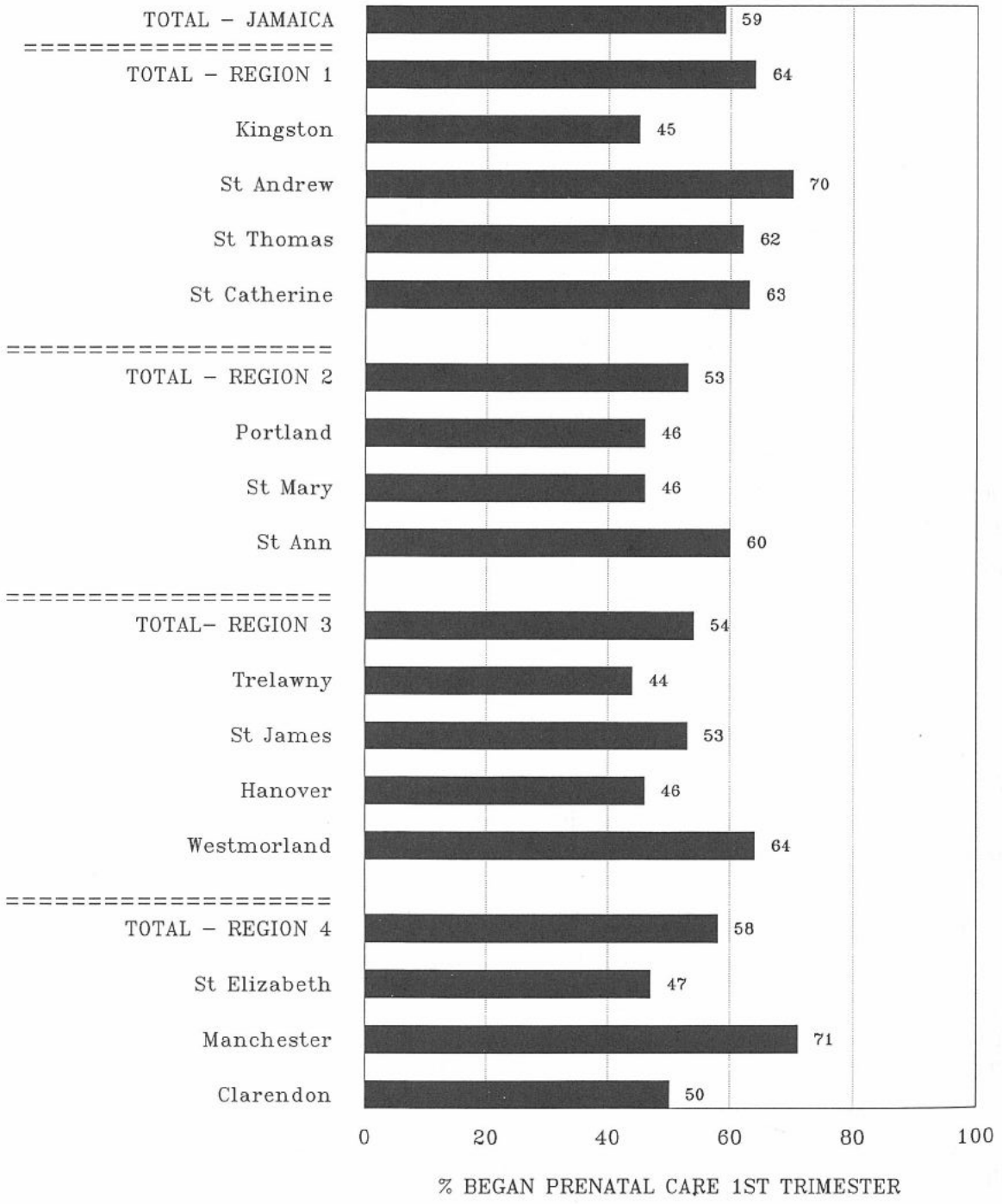
FIGURE 14
PERCENT WHO BEGAN PRENATAL CARE IN 1ST TRIMESTER AMONG WOMEN 15-49 PREGNANT IN THE PAST 5 YEARS BY REGION AND PARISH



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Prenatal Care and Women's Health

Not shown in a graph is that practically all women (99%) in Jamaica who had a pregnancy in the past five years had prenatal care during their last pregnancy. However, Figure 14 shows that only 59 percent of these women began their prenatal care during the first trimester of their pregnancy, which is relatively low. This percentage is slightly lower for Region 3, as 54 percent of women in the region began their prenatal care in the first trimester. There is some variation between parishes in the region as 64 percent of women in Westmoreland began their prenatal care in the first trimester of their pregnancy, compared to only 44 percent of women in Trelawney.

Pap Smears are an important means of early detection of cervical cancer. Only half of all Jamaican women have ever had a Pap Smear (51%) and only 15% had one in the past year (Figure 15). These figures are roughly the same for Region 3 as a whole, though there is some variation between the parishes in the region. Only 42 percent of women in Westmorland have ever had a Pap smear and only 9 percent of women in Trelawny had a Pap Smear in the last year.

Monthly breast self-examinations are an effective way of detecting breast cancer at an early stage. Fifty-five percent of all Jamaican women ever do these examinations, but only 29 percent have done at least one in the past month (Figure 16). These percentages are similar for Region 3 as a whole, while the data for the parishes varies. The percentage of women who do a monthly breast self-examination is higher than the island-wide figures in Trelawny and Hanover and lower in Westmoreland.

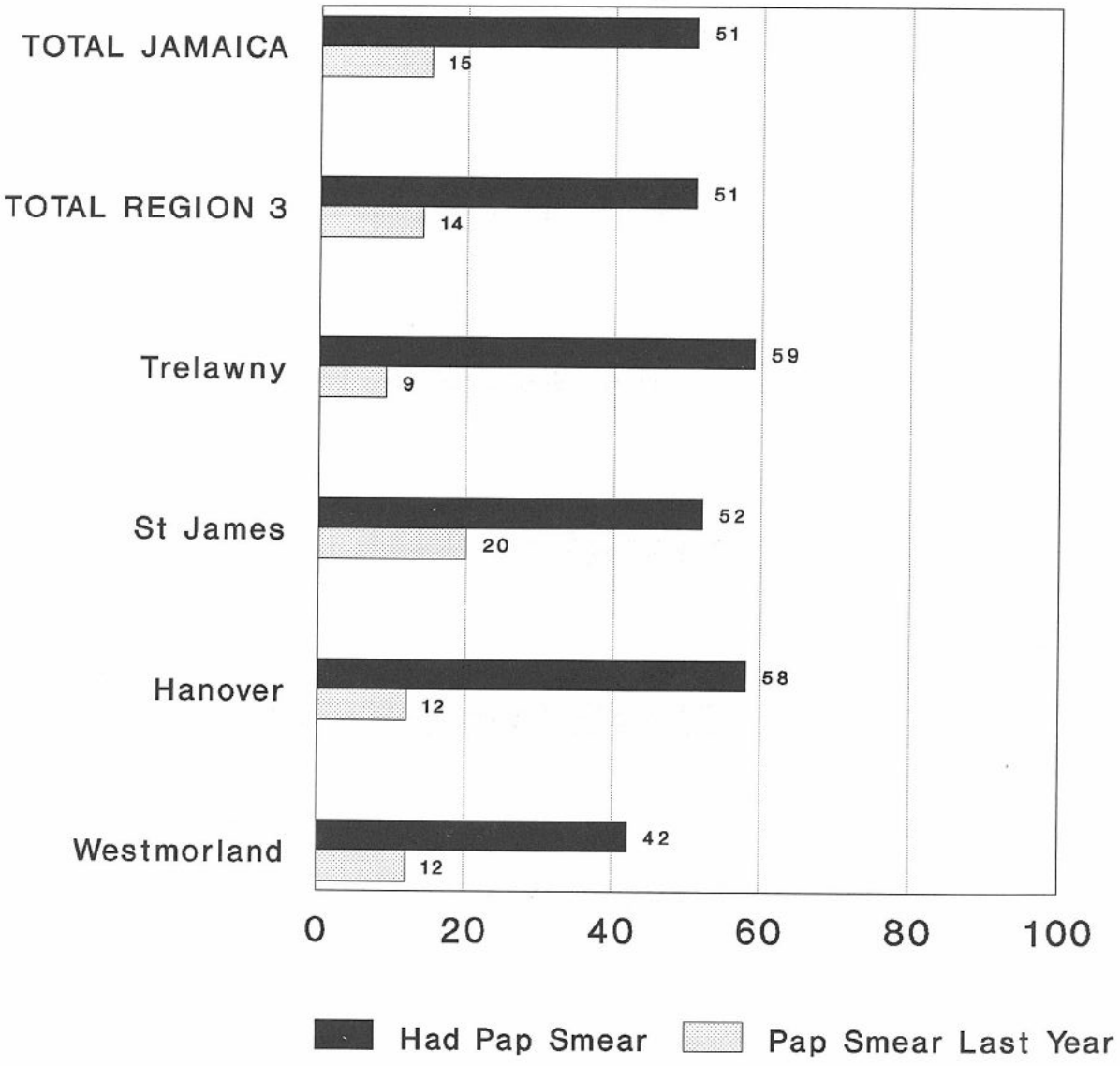
Young Adults

Concern about high levels of adolescent pregnancies and births led to a decision to carry out some special analysis of the situation. A young adult module was therefore included in the 1997 RHS.

In Health Region 3, a large majority of young women and men (women - 86%, men - 81%) have been exposed to family life / sex education in school, outside of school or both (Figure 17). These percentages are higher than the corresponding percentages in 1993. Most young adults reported having family life or sex education courses in school only. There was little difference according to age or parish.

Sexual experience is defined as ever having had sexual intercourse. In this summary, we focus on the first sexual experience and contraceptive behavior. Current sexual activity

FIGURE 15
PERCENT OF WOMEN AGED 15-49
WHO HAVE EVER HAD A PAP SMEAR
AND HAVE HAD A PAP SMEAR IN THE LAST YEAR
BY PARISH



REGION 3
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FIGURE 16
PERCENT OF WOMEN AGED 15-49
WHO DO A MONTHLY BREAST SELF-EXAMINATION
AND DID A BREAST SELF-EXAM IN THE LAST MONTH
BY PARISH

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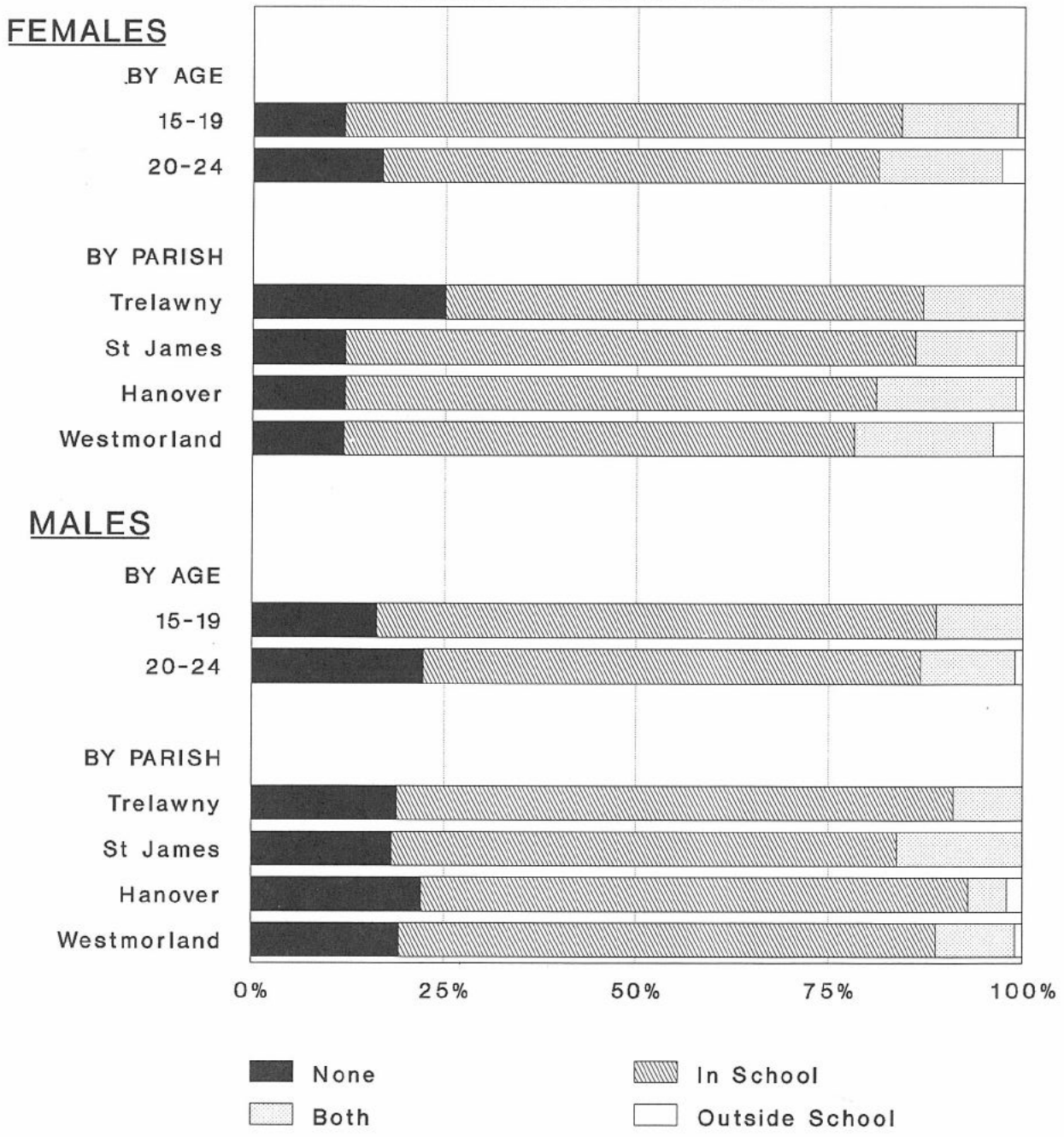
FIGURE 17
FAMILY LIFE / SEX EDUCATION CLASS OR COURSE
IN SCHOOL AND / OR OUTSIDE OF SCHOOL
YOUNG ADULTS AGED 15-24
(PERCENT DISTRIBUTION)



REGION 3
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FIGURE 18
PERCENT REPORTING SEXUAL EXPERIENCE
BY AGE GROUP
YOUNG ADULTS 15-24 YEARS OF AGE
COMPARED WITH 1993 CPS

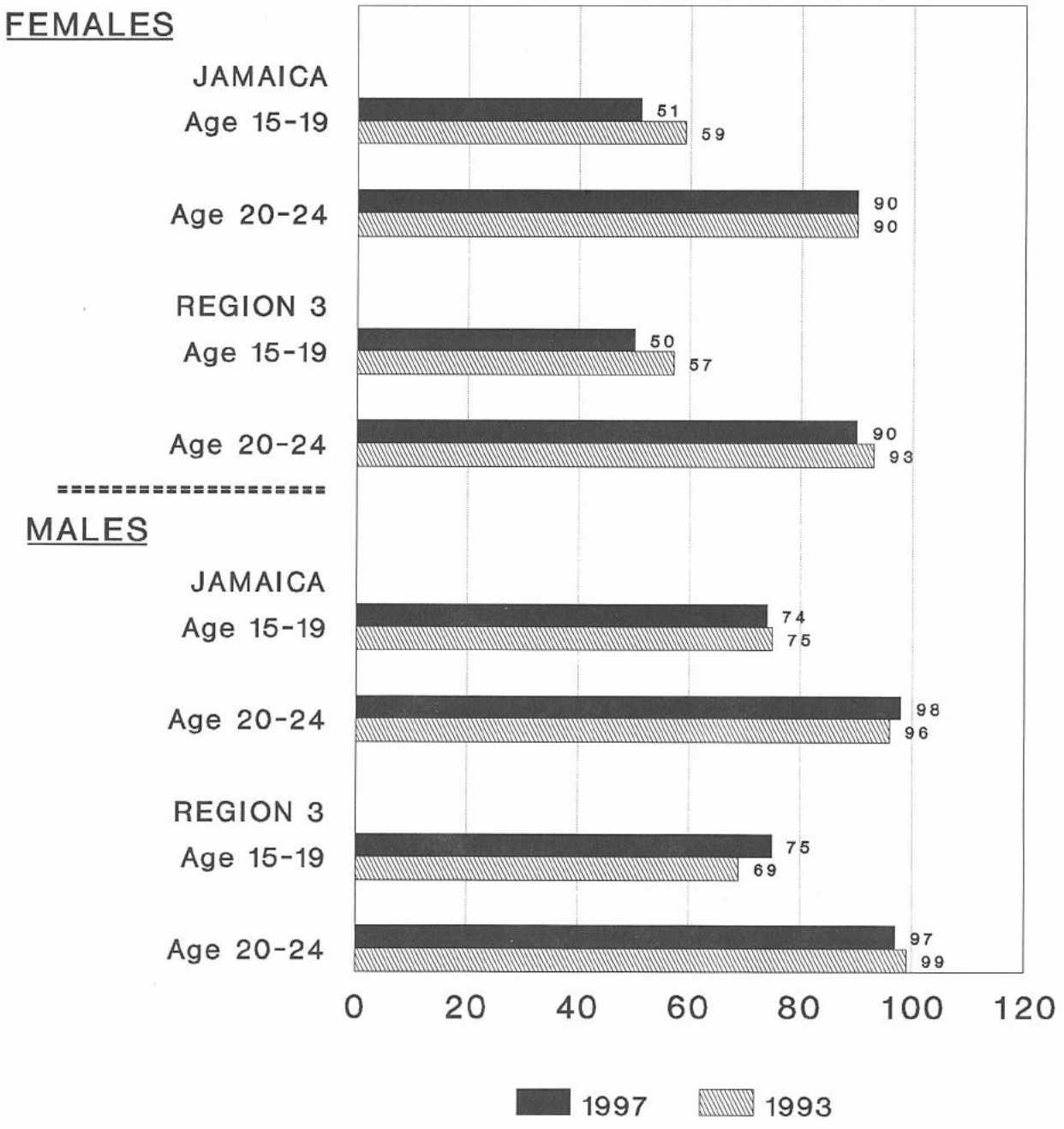

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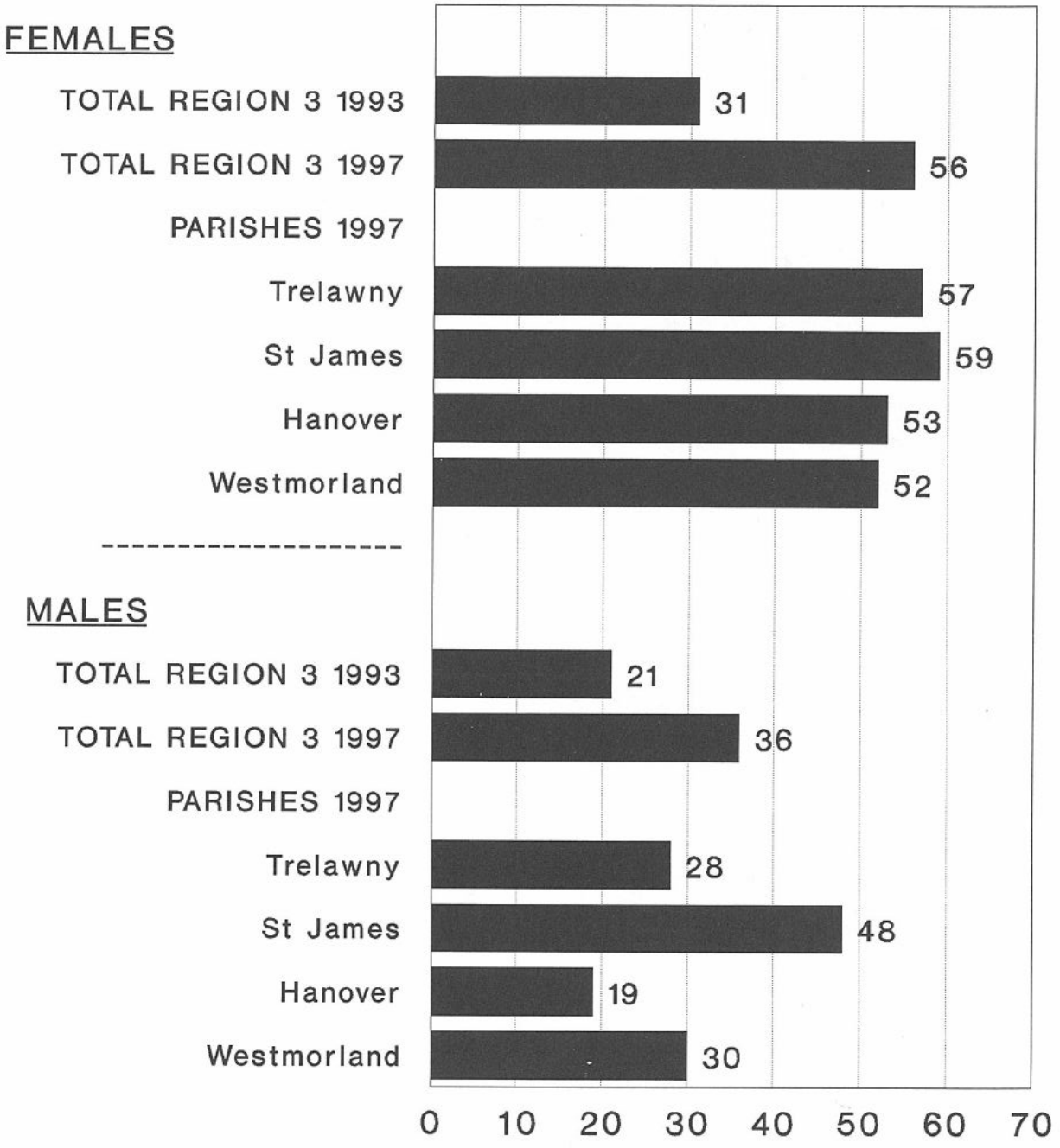
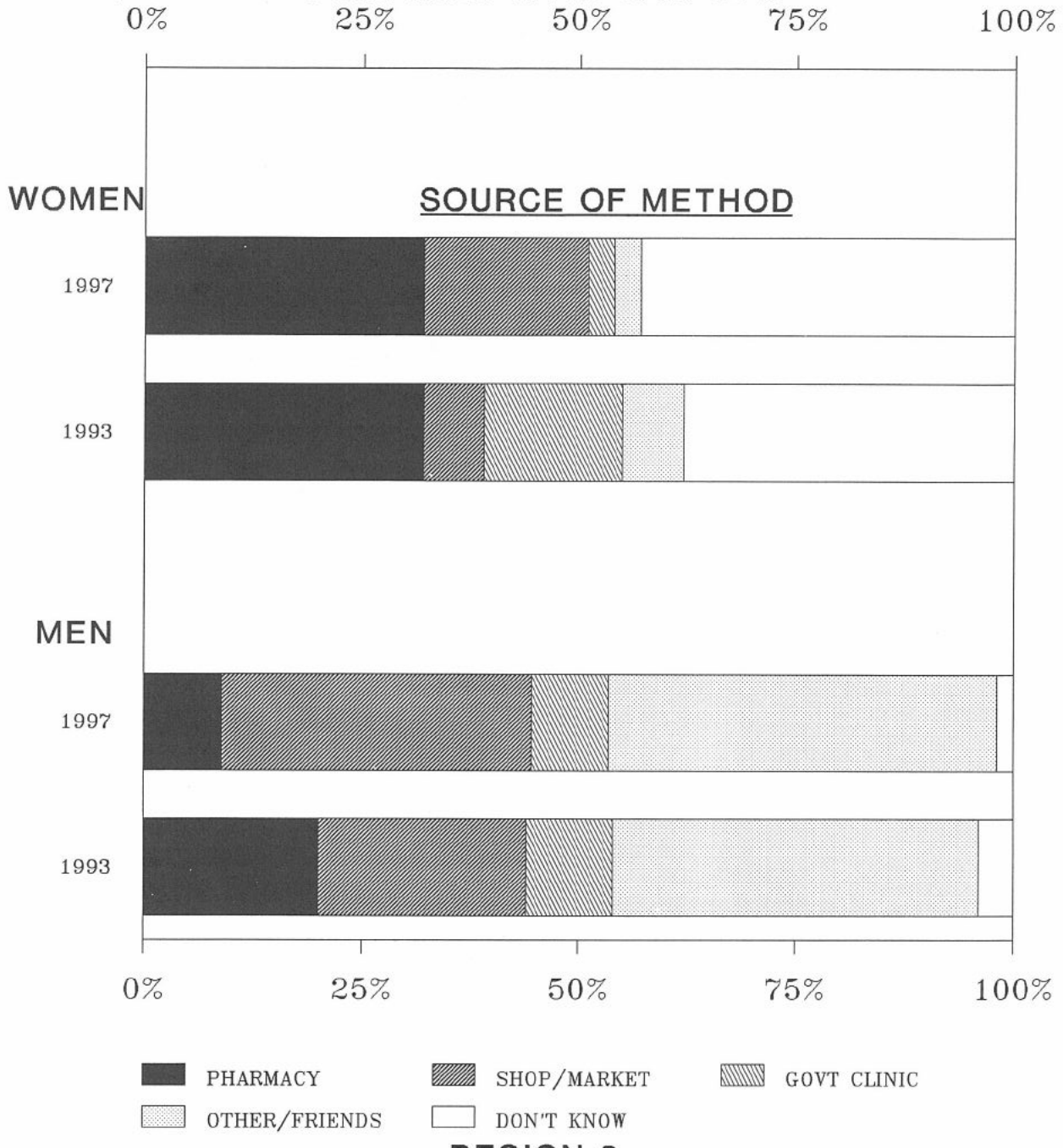
FIGURE 19
% USING CONTRACEPTION AT 1ST SEXUAL INTERCOURSE
BY PARISH
YOUNG ADULTS 15-24 YEARS OF AGE
REGION 3



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 20
SOURCE OF CONTRACEPTIVE METHOD USED
AT TIME OF FIRST SEXUAL INTERCOURSE
YOUNG ADULTS 15-24 YEARS OF AGE
COMPARED WITH 1993 CPS



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(within the past month) and number of partners will be presented in detail in the full final report of the survey.

The proportion of young adults in Jamaica and Health Region 3 reporting sexual experience by age group is shown in Figure 18. Among the youngest females in both the country and region there has been a decrease since 1993. For both sexes, as may be expected, sexual experience increases with age. The sexual experience rate for females in the country and region at ages 15-19 is 50-51 percent. This increases to 90 percent in the 20-24 age category. Three-fourths of males aged 15-19 report sexual experience, while sexual experience is essentially universal for older males.

In Health Region 3 the proportion of young men and women who used contraception at the time they first had sexual intercourse has increased since 1993 (Figure 19). Fifty-six percent of young women and 36 percent of young men used a contraceptive method at the time of their first sexual intercourse, which represent increases from the corresponding 1993 percentages of 31 percent and 21 percent for women and men, respectively. Use of contraception at first intercourse is lower in Hanover for men.

Not shown in a graph is that, similar to Health Region 3, for the nation as a whole approximately half of young women and about two-thirds of young men did not use contraception at first sexual intercourse. When asked why they did not use, almost one-half of women and about 30 percent of men said that they did not expect to have sex at the time of first intercourse. Approximately 30 percent of young men said the reason was that they did not have knowledge of contraception at the time of their first sexual experience (data not shown).

Also not shown in a graph or table is that in Jamaica as a whole the condom was used by the great majority (about 90 percent) of men and women who used any method at the time of their first intercourse.

The source of contraception used at first intercourse in Health Region 3 differs somewhat for females and males (Figure 20). Women, who as mentioned above reported almost universally that their partner used a condom, gave the pharmacy as the primary source. Thirty-six percent of men, who also largely used condoms at the time of their first intercourse, identified shops or markets as a primary source. Another 45 percent stated that they obtained their condom from other sources, mostly friends. Another difference is that 43 percent of females did not know where their partner obtained the condom.

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SUMMARY OF RESULTS HEALTH REGION 4

Introduction

The present report summarizes the findings for Health Region 4 of the Reproductive Health Survey (RHS) carried out in Jamaica in 1997. A contraceptive prevalence survey (CPS) of a similar type was carried out in Jamaica in 1993. The 1997 RHS, therefore, not only provides data on the current situation in Health Region 4 and Jamaica as a whole regarding reproductive health and contraceptive practices, but also permits an evaluation of changes since 1993. The 1997 RHS utilized an updated sampling frame based on the 1991 census which has been adopted for the Continuous Social and Demographic Surveys conducted by the Statistical Institute of Jamaica (STATIN).

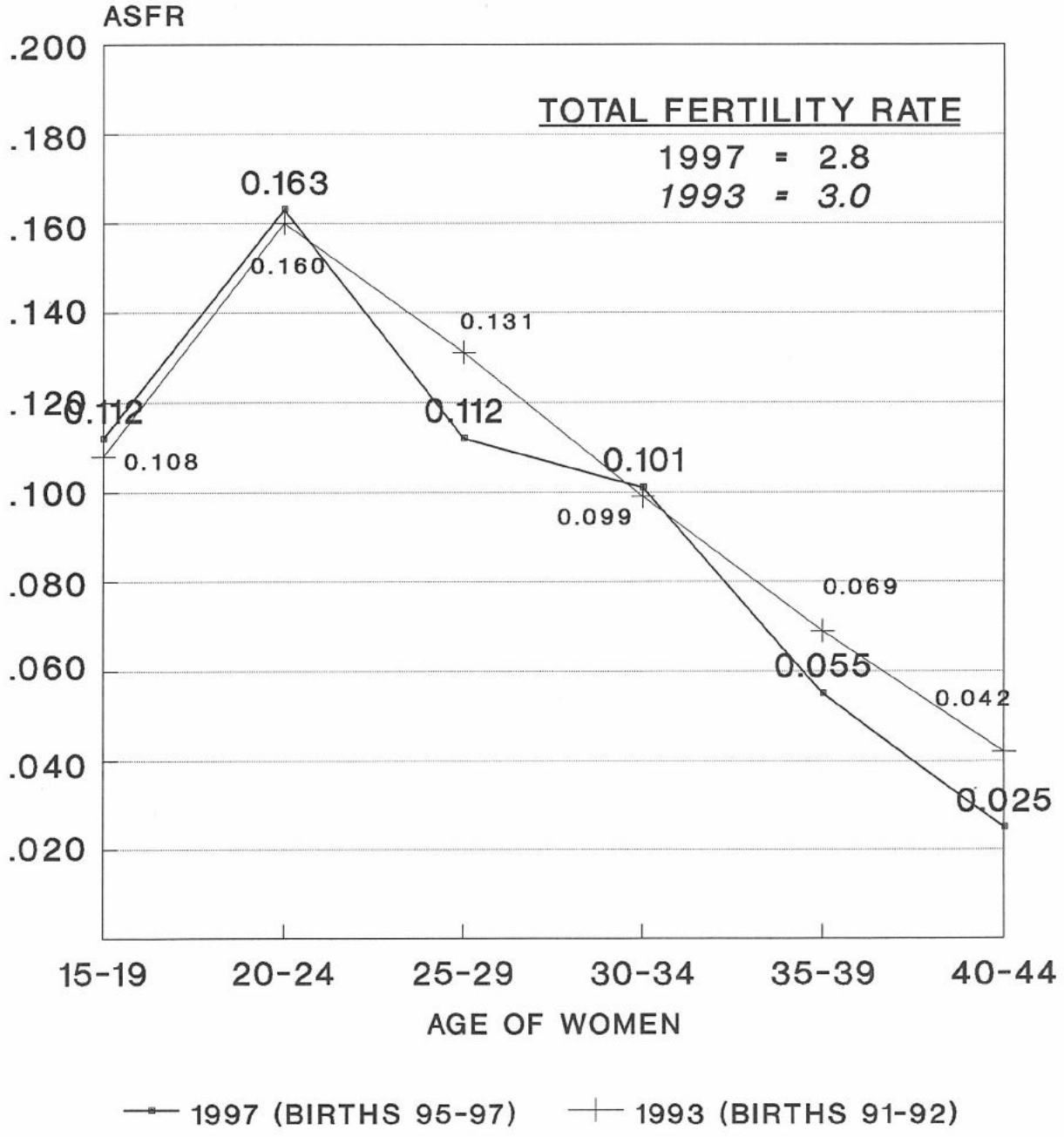
There are differences in the sampled population of the two surveys. Whereas in the 1993 CPS women aged 15 to 44 and men 15-54 were interviewed, the 1997 RHS included, in addition, women aged 45 to 49, but limited the coverage of men to an independent sample of young adults aged 15-24. The 1997 survey also had detailed questions in a special module addressed to young adult women aged 15 to 24, as well as questions on prenatal care and cancer screening, and questions on condom use, multiple sexual partners and attitudes toward contraception, which were addressed to all respondents.

Fertility

Fertility data for Jamaica as a whole and for Region 4 will be presented. The survey results show the total fertility rate (TFR) for the years 1995-1997 (i.e., the two years prior to interview) to be 2.8 births per woman (Figure 1). This represents a decrease from the TFR of 3.0 births per woman found in the 1993 survey. Age-specific fertility rates in the two surveys were similar for ages 15-19 and 20-24, indicating no recent decline in rates of early childbearing. Except among 30-34 year-olds, age-specific fertility rates fell substantially for all age groups from ages 25-29 to 40-44. The decline in fertility was particularly noteworthy at the oldest ages, with age-specific rates falling by 20 percent (14 births per 1000 women) at ages 35-39 and 40 percent (17 births per 1,000 women) at ages 40-44. The overall decline in the TFR of 0.2 births per woman between the 1993 and 1997 surveys follows a surprising failure to decline between the 1989 and 1993 surveys. Age-specific fertility rates were much higher at ages 20-24 than at any other ages, followed by similar levels at ages 15-19 and 25-29.

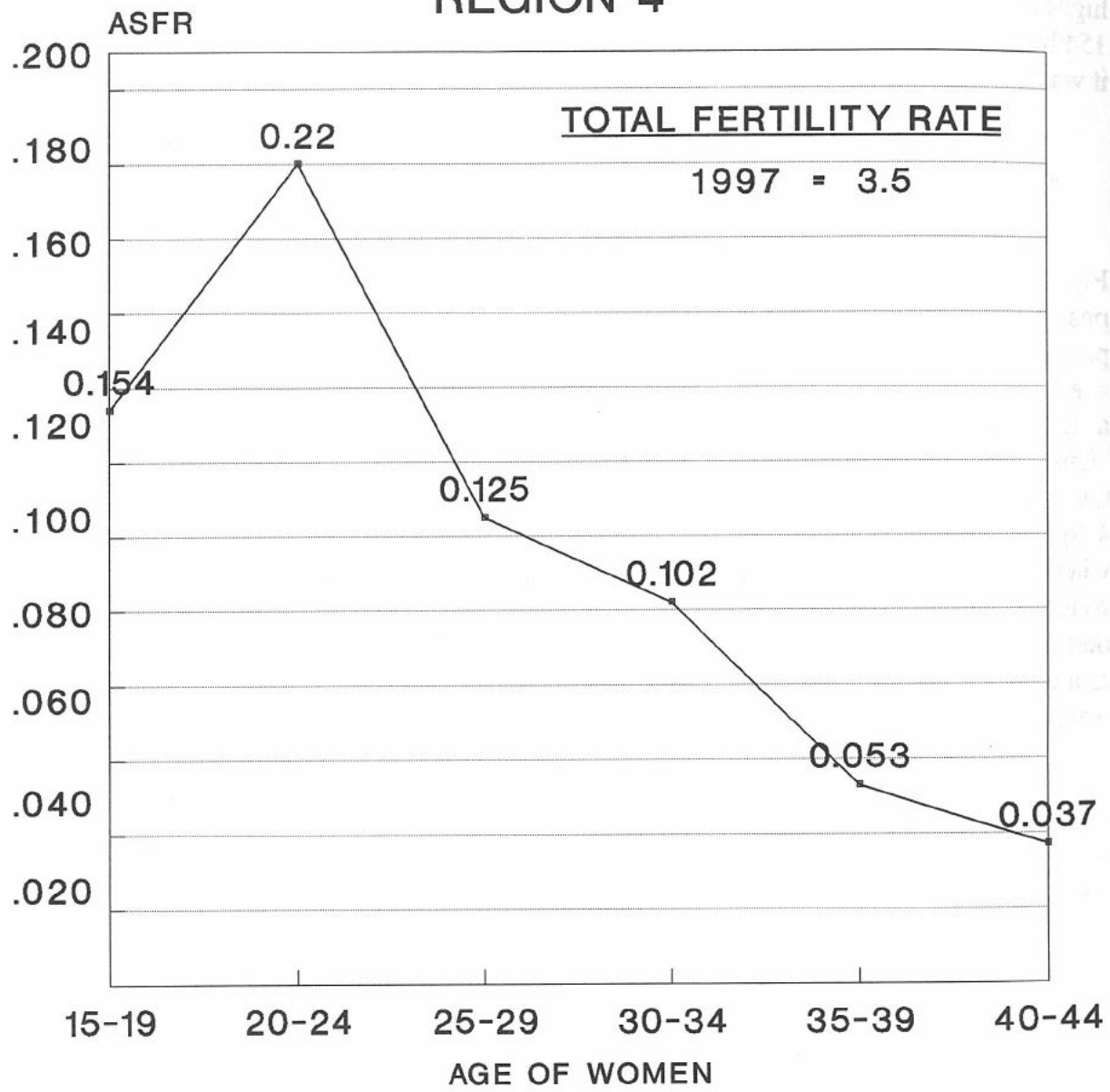
According to the 1997 survey, Region 4, along with Region 2, had the highest level of

FIGURE 1
AGE-SPECIFIC FERTILITY RATES
WOMEN AGED 15-44
COMPARED TO 1993 CPS



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 2
AGE-SPECIFIC FERTLITY RATES
WOMEN AGED 15-44
REGION 4



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fertility, of the four health regions in Jamaica. The TFR for the two years prior to the survey was 3.5 births per woman (Figure 2), compared to the island-wide rate of 2.8 births per woman. Age-specific fertility rates were particularly high in Region 4 for the youngest age groups, 15-19 and 20-24 years. At the older ages, fertility rates were very similar to the rates found island-wide. As in Jamaica as a whole, fertility rates were highest at ages 20-24, with 220 births per 1,000 women per year and at ages 15-19, with 154 births per 1,000 women. Because of small regional sample sizes in the 1993 survey, it was not possible to examine changes in fertility within regions between 1993 and 1997.

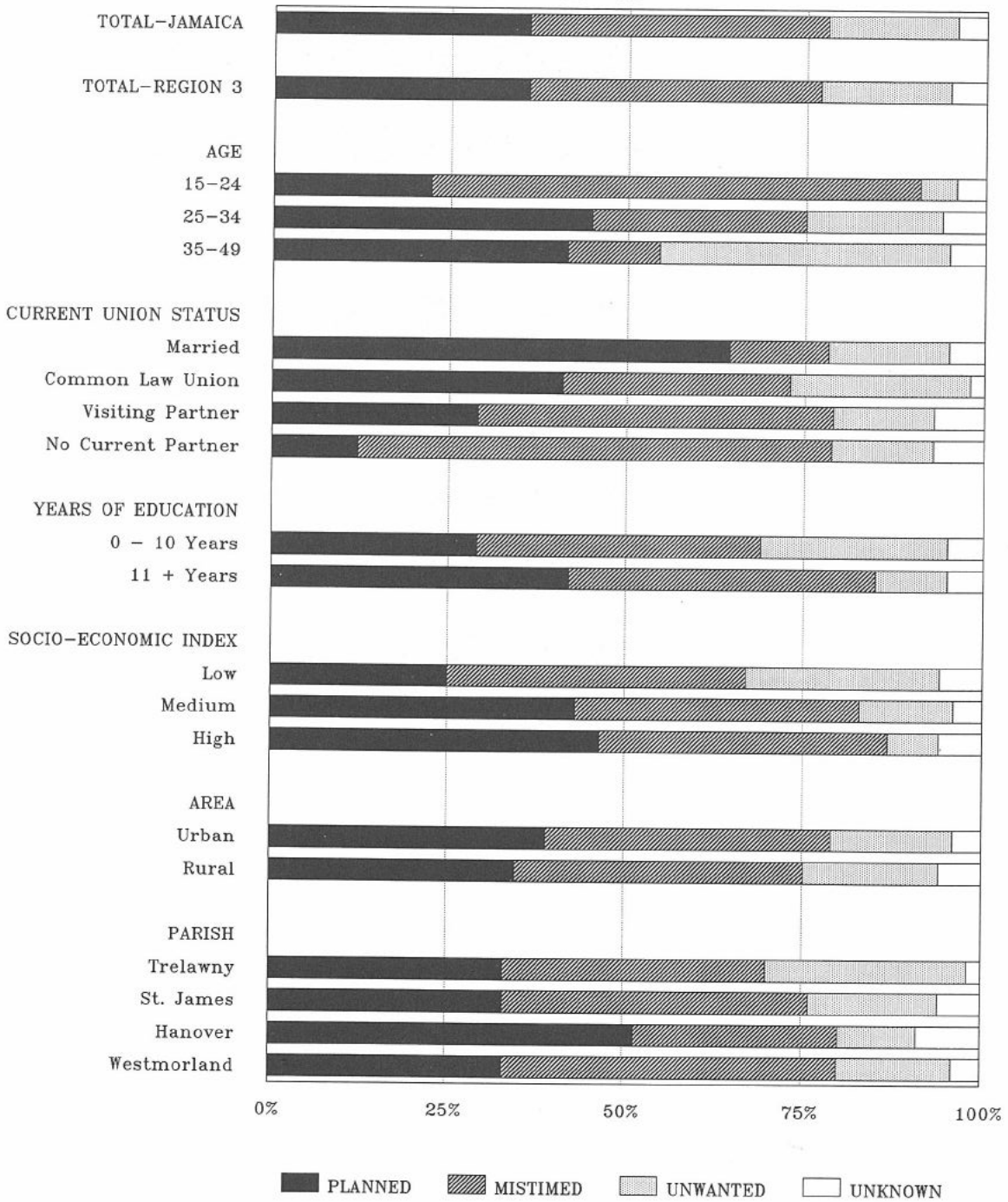
Planning Status Of The Last Pregnancy

Figure 3 shows the distribution of the planning status of the last pregnancy within the past 5 years for women aged 15-44 in Health Region 4 and Jamaica as a whole. A pregnancy is defined as "planned" if the woman wanted to become pregnant at the time she became pregnant. A pregnancy is "mistimed" if she wanted to become pregnant at a later date and is "unwanted" if she did not want to have any more children. "Unintended" or unplanned pregnancies combine together these latter two categories. Overall, thirty-five percent of pregnancies were reported by respondents in Health Region 4 to have been planned. Not shown in the graph is that this is an increase from 1993 when only 27 percent of pregnancies in Region 4 and 29 percent in Jamaica as a whole were planned. The majority of pregnancies in the region were unintended--including 40 percent mistimed and 21 percent unwanted. These percentages are similar to the country as a whole, where 42 percent of pregnancies were reported to be mistimed and 18 percent were unwanted.

The proportion of unwanted pregnancies increases with age. Similarly, since Jamaican women tend to enter more stable unions as they age, the proportion of planned pregnancies is higher and the proportion of mistimed pregnancies is lower in the more stable unions. Conversely, mistimed pregnancies are concentrated among younger women in less stable unions who are more likely to have spacing of pregnancy failures. The percentage of planned pregnancies rises with an increase in the socio-economic index, but there is no discernable pattern by education. In Manchester, the level of planned pregnancies is higher and the level of unwanted pregnancies is lower than in St. Elizabeth or Clarendon.

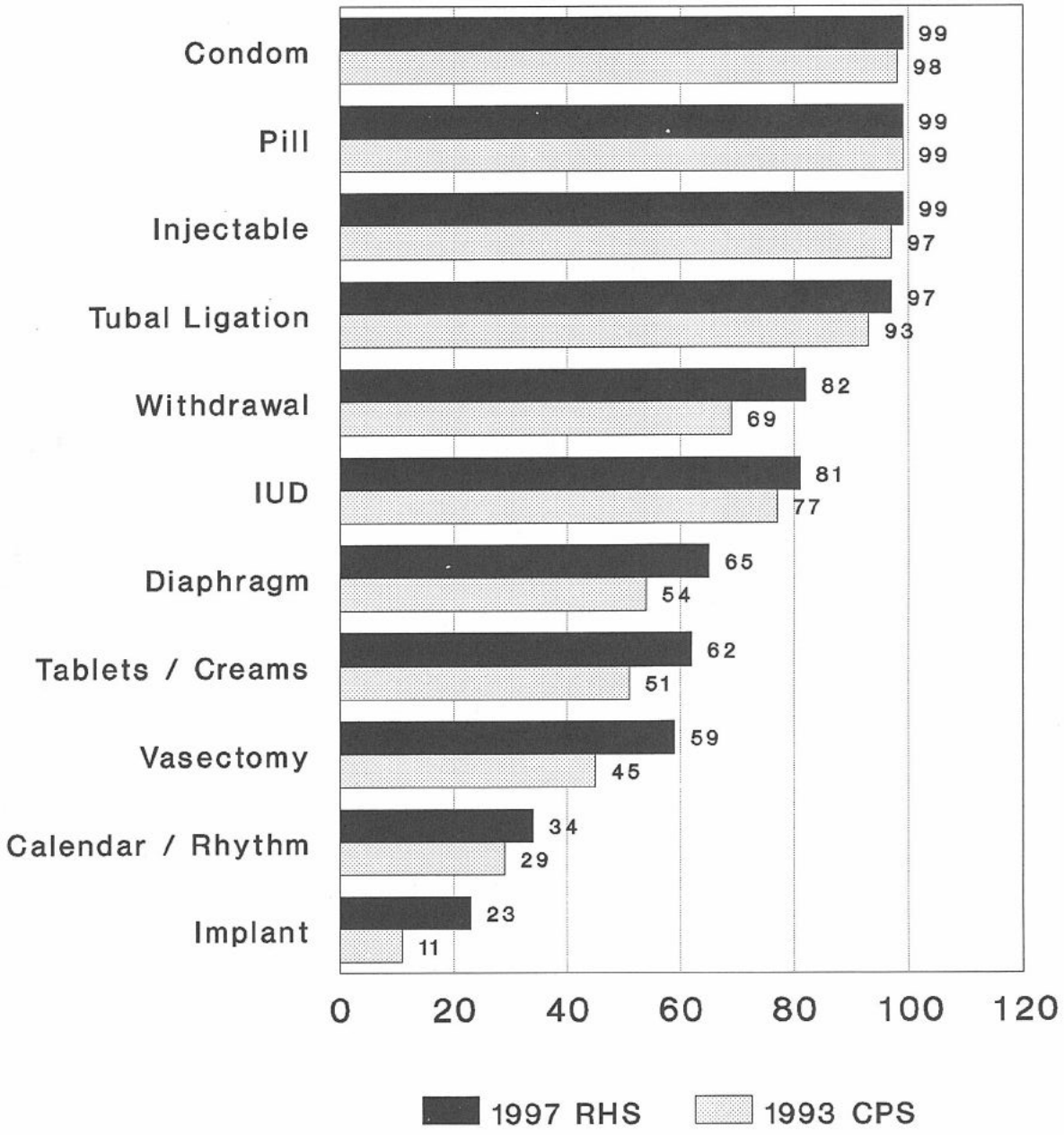
Given the relatively high level of contraceptive use by women in union in Jamaica as a whole and in Health Region 4, the percentage of unintended pregnancies is still high. Two factors may be contributing to this: the less than optimum use of temporary methods resulting in contraceptive failure; and high levels of unprotected sexual activity by women who are not in union.

FIGURE 3
PLANNING STATUS OF LAST OR CURRENT PREGNANCY BY SELECTED CHARACTERISTICS (PERCENT DISTRIBUTION) WOMEN AGED 15-49



REGION 3
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 4
PERCENT OF WOMEN AGED 15-49
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 4
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Knowledge of Contraceptives

Figure 4 shows "knowledge" of contraceptives among women. Knowledge here refers to the fact that the respondent has heard of a contraceptive method, not necessarily that she has enough knowledge of the method to be able to use it correctly.

Virtually all women in Region 4 have heard of the condom, pill, injectables and female sterilization, and over 80 percent know of the IUD and the withdrawal method. The diaphragm, vaginal methods, natural methods and Norplant, which are little used in Jamaica, are less well known. While the informed choice of a contraceptive method must be left to the couple, lack of knowledge of some of the more effective methods, particularly vasectomy and the implant (Norplant), reduces the choice and potential use of some available long-term methods. With the exception of withdrawal, the diaphragm, vasectomy and the implant, knowledge of all methods is little changed from 1993 to 1997.

Figure 5 shows the level of women's knowledge of contraceptive methods in Region 4 by parish. There is little difference between parishes, except that more women in Manchester have heard of withdrawal, the IUD, spermicides and vasectomy than women in the 2 other parishes.

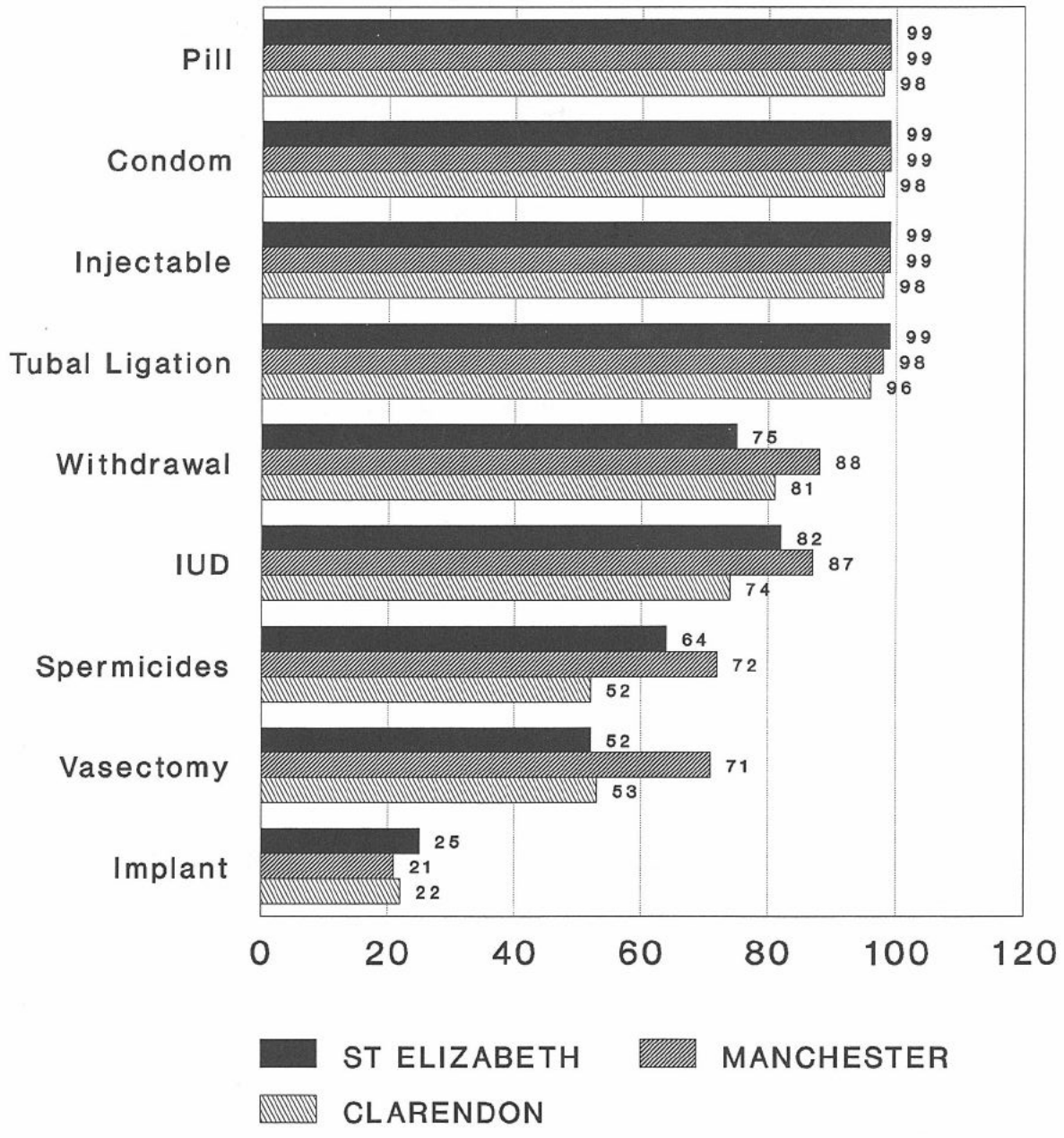
Among young adult men (Figure 6), the best known methods are, as in the case of women, condoms, the pill, injectables, female sterilization and withdrawal . However, aside from condoms, the pill and injectables, all methods are less well known among men than among women.

Contraceptive Use

Figure 7 shows the prevalence of contraceptive use among women in union in Jamaica as a whole and Health Region 4 by principal type of method, comparing data for the region with the 1993 and 1989 surveys. The overall level of use in Region 4 at 61 percent of women in union is lower than the 65 percent for Jamaica and has only increased by one percentage point since 1993. This small increase since 1993 is accounted for by an increase in the use of the injection. The level of condom use as a primary method has decreased slightly since 1993.

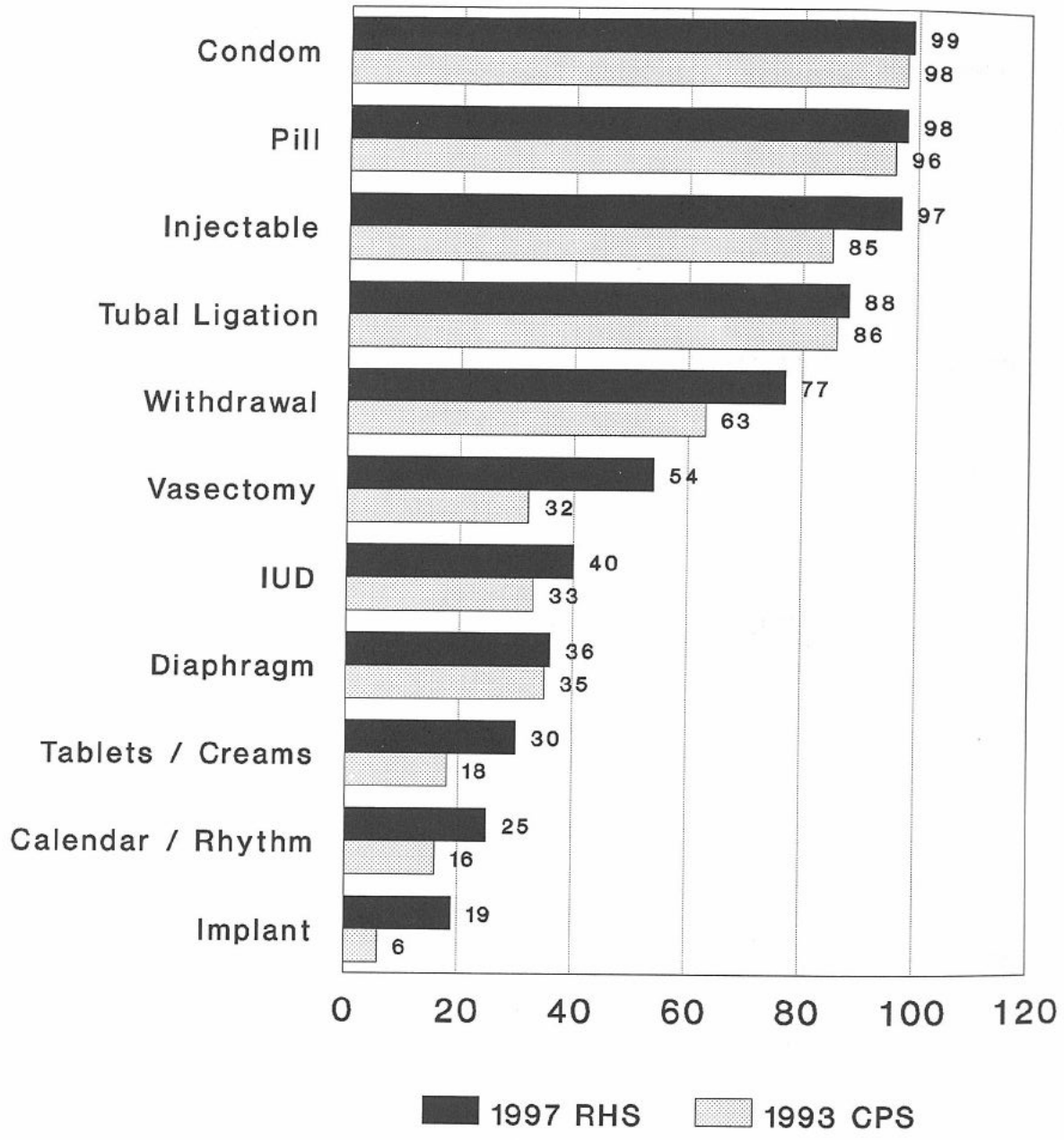
Figure 8 is a pie chart showing additional data on specific contraceptive method use by all women (in union and not in union) as well as women in union in Health Region 4 in 1997. As seen in the upper pie, only 49 percent of all women are using a contraceptive method, with only 15 percent using the pill. The lower pie shows that in 1997, as was

FIGURE 5
PERCENT OF WOMEN AGED 15-49 WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS BY PARISH



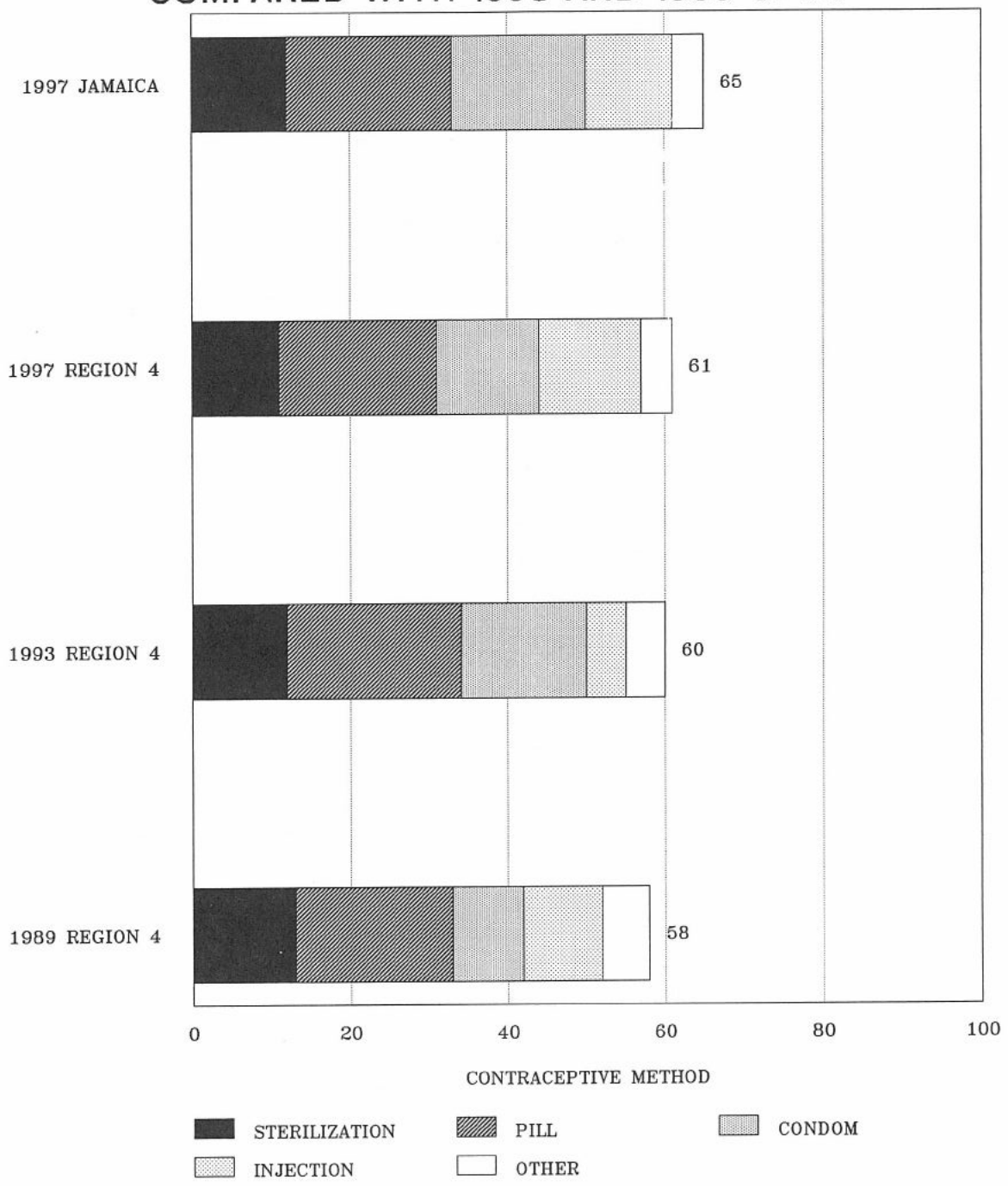
REGION 4
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 6
PERCENT OF YOUNG ADULT MEN AGED 15-24
WHO HEARD OF SPECIFIC CONTRACEPTIVE METHODS
COMPARED WITH 1993 CPS



REGION 4
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

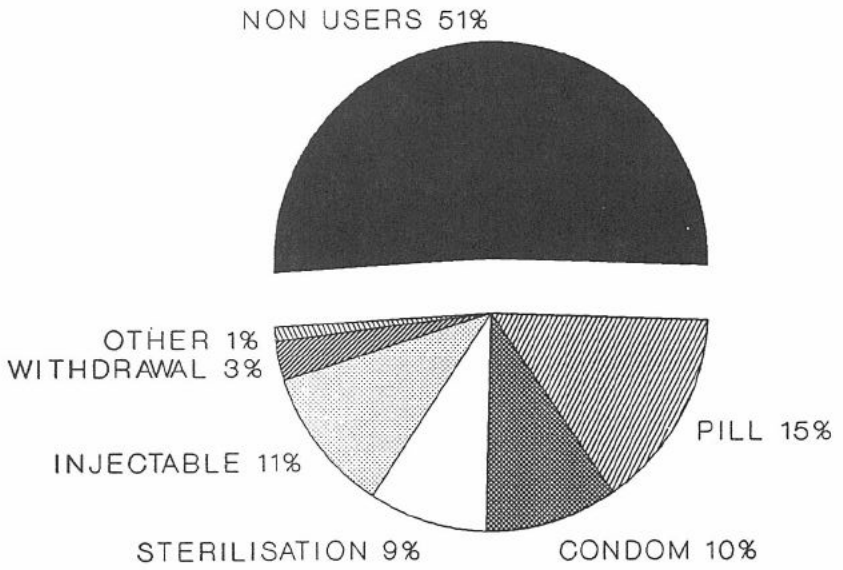
FIGURE 7
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING CONTRACEPTION, BY METHOD COMPARED WITH 1993 AND 1989 CPSs



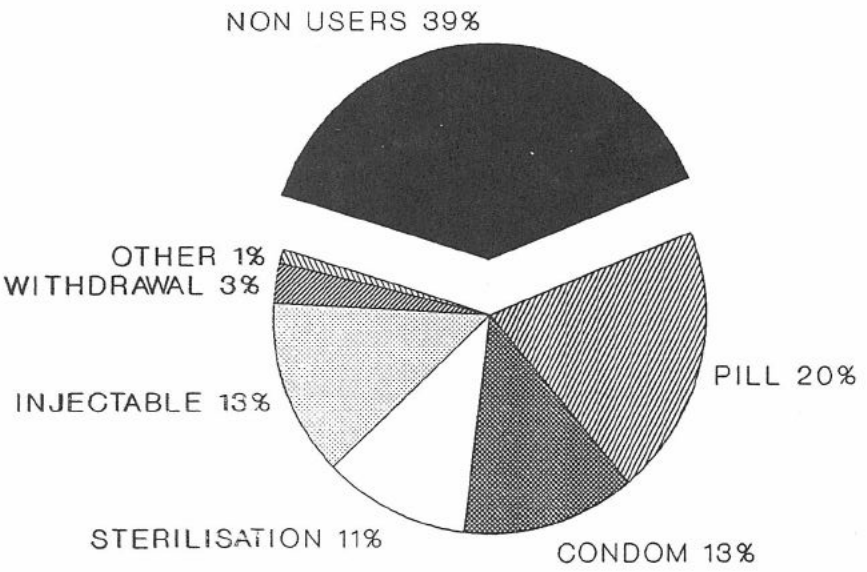
REGION 4
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 8
PERCENTAGE OF ALL WOMEN AND WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD

REGION 4

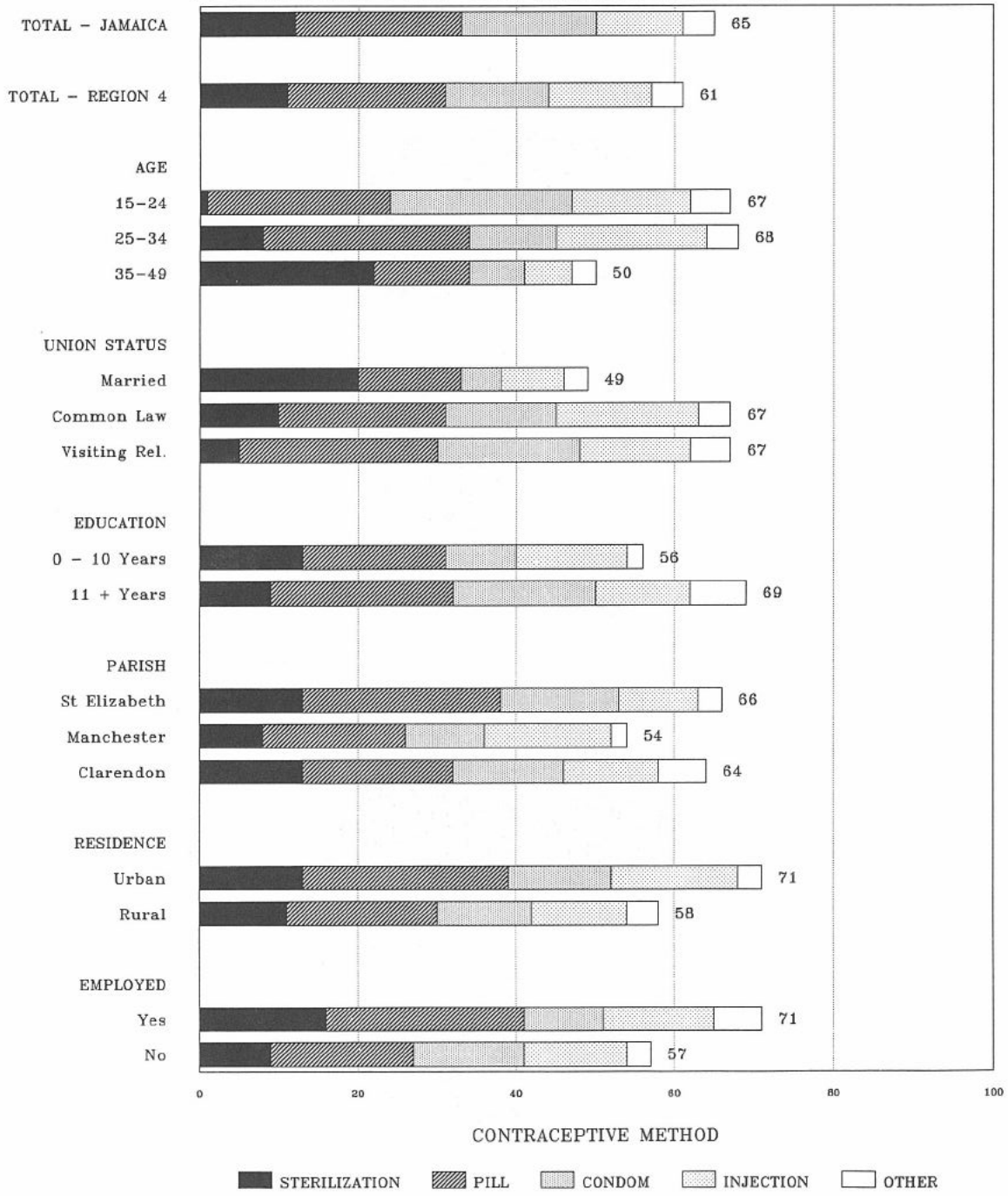


ALL WOMEN



WOMEN IN UNION

FIGURE 9
PERCENT OF WOMEN IN UNION AGED 15-49 CURRENTLY USING A CONTRACEPTIVE METHOD BY SELECTED CHARACTERISTICS



REGION 4
1993 JAMAICA CONTRACEPTIVE PREVALENCE SURVEY

the case in 1993, the pill is the most prevalent method among women in union, followed by the condom, injectables and female sterilization.

Figure 9 presents use of major contraceptive methods by women in union, according to selected geographic and socio-demographic characteristics. In general, as age and increases, women tend to use more effective methods. While pill and condom use predominate among women 24 and under, since more than half these women using any method use these two methods, the pill and the injection are the leading methods used between 25 and 34 years of age. After age 35 the pill and injection are in turn eclipsed by female sterilization as the major method, as almost half of these older women using any method have had a tubal ligation.

Overall use by women in a marital union is lower than women in common-law or visiting unions and there are differences in the methods used by these different groups. Almost half of married women using any method have been surgically sterilized. In contrast, relatively few women in a common-law union or in a visiting relationship have been sterilized. A factor not shown in this figure is that women who are married tend to be older than women in common law and visiting unions, which in turn is correlated with the number of living children. As mentioned above, with increasing age (and a greater number of children), a higher percentage of women choose this permanent method. Women who are in less stable unions and who are younger and have fewer children tend to use pills and condoms to a greater extent. Overall contraceptive use in the region is higher in urban areas and increases with education and employment. It is also lower in Manchester than in the other two parishes.

Table 1 looks at the percentage of female "first" or primary contraceptive method users in Region 4 who concurrently use a secondary method. Overall, 9 percent of all primary method users are also using a secondary method. Not shown in this table is that for the country as a whole in 1993 only about half as many users (6%) were also using a secondary method. Practically all secondary method use is the condom. This suggests that while data on primary method use alone do not show an increase in condom use from 1993 to 1997, by including secondary method condom use as part of this analysis, the use of condoms has increased in the four years since the 1993 survey. Seventeen percent of pill users and 12 percent of injectable users in Region 4 are concurrently using condoms.

To summarize the above findings, overall contraceptive use is high for all socio-demographic groups in Region 4 (and Jamaica) and is practically at the level of use of countries in Latin America where prevalence is considered to be high (70+ %), such as Costa Rica, Columbia and Brazil. While prevalence does not vary greatly by group, the choice of method does vary, with men and women moving from the condom to hormonal methods (pill and injection) and then to female sterilization as they get older.

TABLE 1

Percentage Of Contraceptive Users In Health Region 4
Who Are Concurrently Using A Secondary Contraceptive Method
By Primary And Secondary Method Used
Women In Union Aged 15-49 Years
(Percent Distribution)
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

	Secondary Method Used						
	None	Condom	With-drawal	Natural Method	Other	Total	N
All Primary Methods	90.7	9.2	0.0	0.0	0.1	100.0	(636)*
Selected Primary Methods							
Pill	82.8	17.3	0.0	0.0	0.0	100.0	(211)
Injectable	87.3	12.2	0.0	0.0	0.6	100.0	(143)
Tubal Ligation	96.0	4.0	0.0	0.0	0.0	100.0	(118)
Condom	100.0	--	0.0	0.0	0.0	100.0	(125)
Withdrawal	100.0	0.0	--	0.0	0.0	100.0	(31)

* Number of cases for individual selected primary methods do not add up to number of cases for all primary methods because only those selected primary methods which had 25 or more users appear in this table.

Pill Use

A percent distribution of the brands of pills used is shown in Figure 10. The brand is important since each sector (government, social marketing and strictly commercial) has its own. The government programme distributes Lo-Femenal and Ovral, the 'Personal Choice' social marketing programme sells Perle and Minigynon, while the strictly commercial sector sells Nordette and a number of lesser-used brands categorized here as "other".

In Health Region 4 the leading pill brand is Perle, used by 38% of all pill users, while Minigynon is used by a further 10 percent. The Personal Choice programme, therefore, supplies almost half of all pill users in Region 4. The other major brands used in the region are Lo-Femenal and Ovral, supplied by the public sector to a total of 41 percent of pill users. Nordette and "other" brands, sold in the private sector are only purchased by 8 percent of pill users.

FIGURE 10
BRAND OF PILL CURRENTLY USED
WOMEN AGED 15-49
WHO ARE CURRENT PILL USERS
(PERCENT DISTRIBUTION)
REGION 4

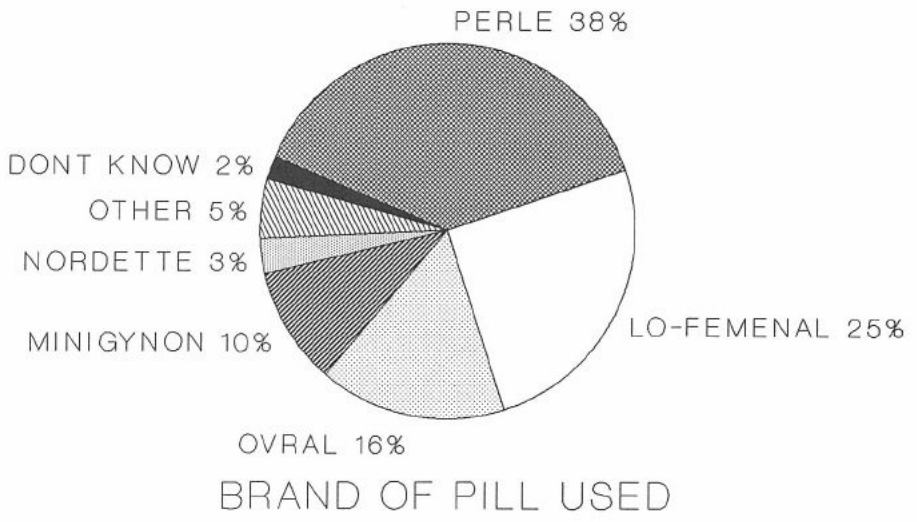
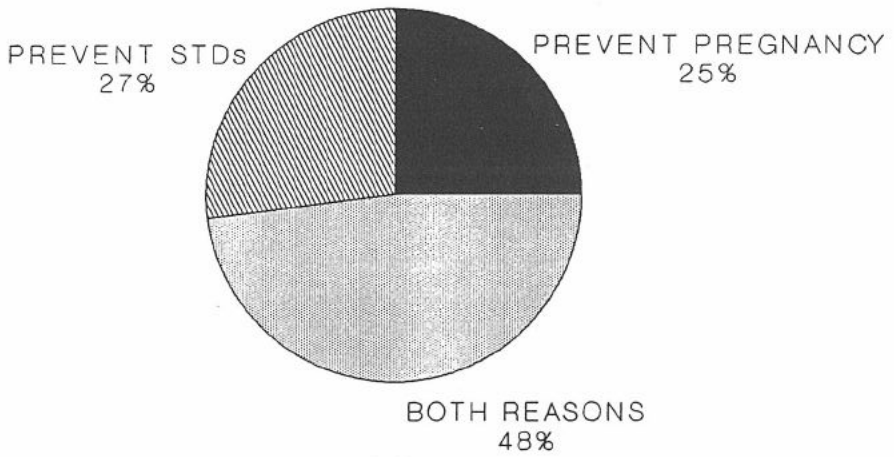
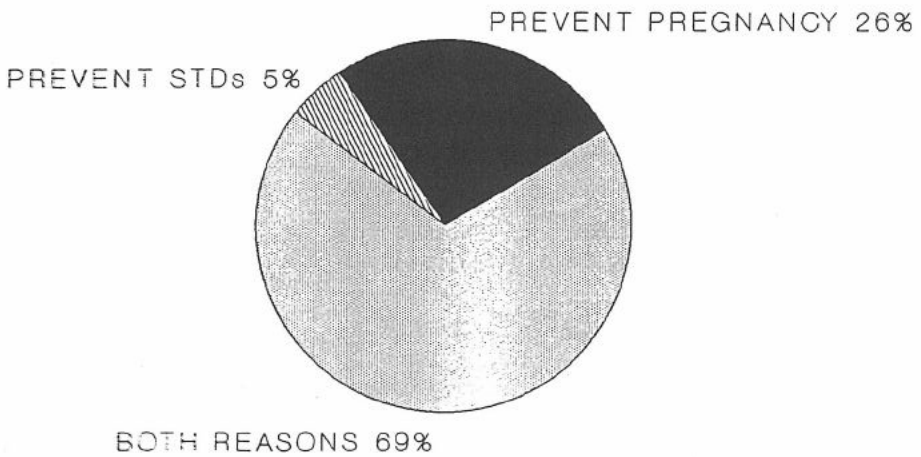


FIGURE 11
REASONS FOR USING CONDOMS
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS

REGION 4



1997



1993

1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

Condom Use

Since condoms have been an important method in Jamaica for both men and women, a special series of questions on their use was addressed to all users of condoms, either as a primary or a secondary method, independent of their union status.

Figure 11 shows that while in Health Region 4 the majority of women who use condoms as a primary or secondary method do so both to prevent pregnancy and to protect themselves from sexually transmitted diseases, a large minority, 27 percent of all condom users, do so as a disease prevention measure only. This finding is important because, as seen in the lower part of Figure 11, the corresponding percentage in 1993 was only 5 percent of female condom users, which indicates that women's awareness of using condoms to prevent disease is increasing.

In Region 4 eighty-five percent of women using condoms with a steady partner do so "always" or "most times" (Figure 12). This compares with only 81 percent for the country as a whole. The effectiveness of this or any method depends on correct and consistent use. Since the condom is being increasingly used as a disease prevention measure (See Figure 11), the effective percentage of condom users is diminished by those who are using condoms inconsistently.

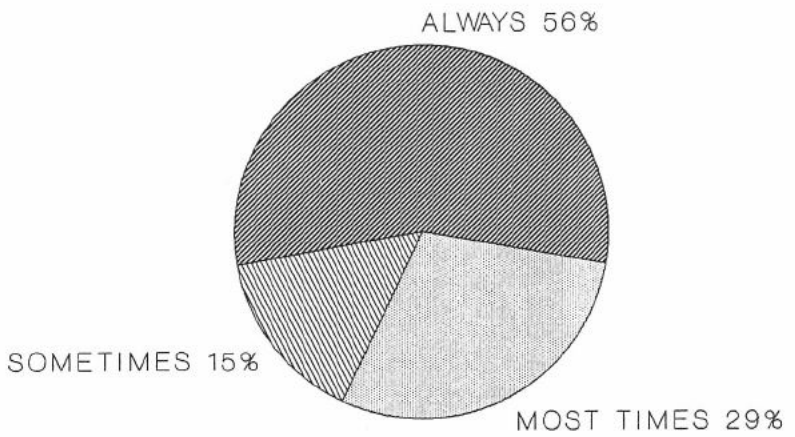
Contraceptive Source

Figure 13 displays the relative importance of the various sources of the four most prevalent contraceptive methods for women in Region 4, and is compared with the 1993 CPS. There seems to have been a shift away from government health centers as a source for women using pills and condoms since 1993, which, in fact, continues a trend began in 1989. Most women buy their pills and condoms in pharmacies (51% and 54% of users of these methods, respectively). The other two major methods are still provided by the public sector, as almost all female sterilizations are performed in hospitals, while a similar proportion of injectable contraceptives are obtained in health centers.

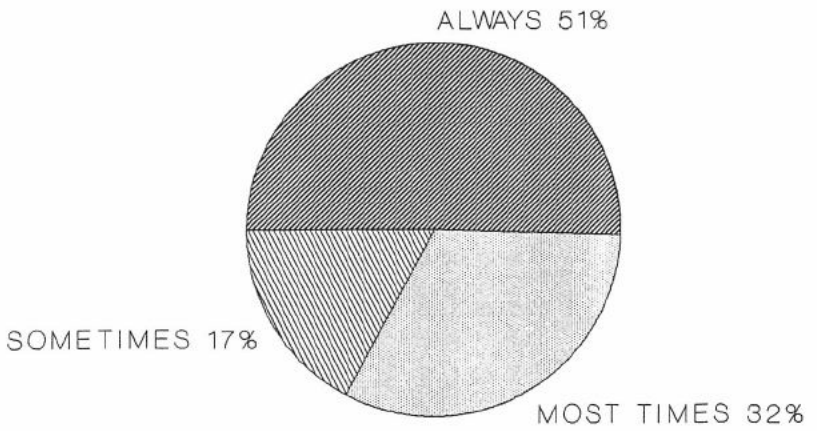
Prenatal Care and Women's Health

Not shown in a graph is that practically all women (99%) in Jamaica who had a pregnancy in the past five years had prenatal care during their last pregnancy. However, Figure 14 shows that only 59 percent of these women began their prenatal care during the first

FIGURE 12
FREQUENCY OF CONDOM USE
(PERCENT DISTRIBUTION)
WOMEN AGED 15-49
WHO ARE CURRENT USERS OF CONDOMS
WITH A STEADY PARTNER



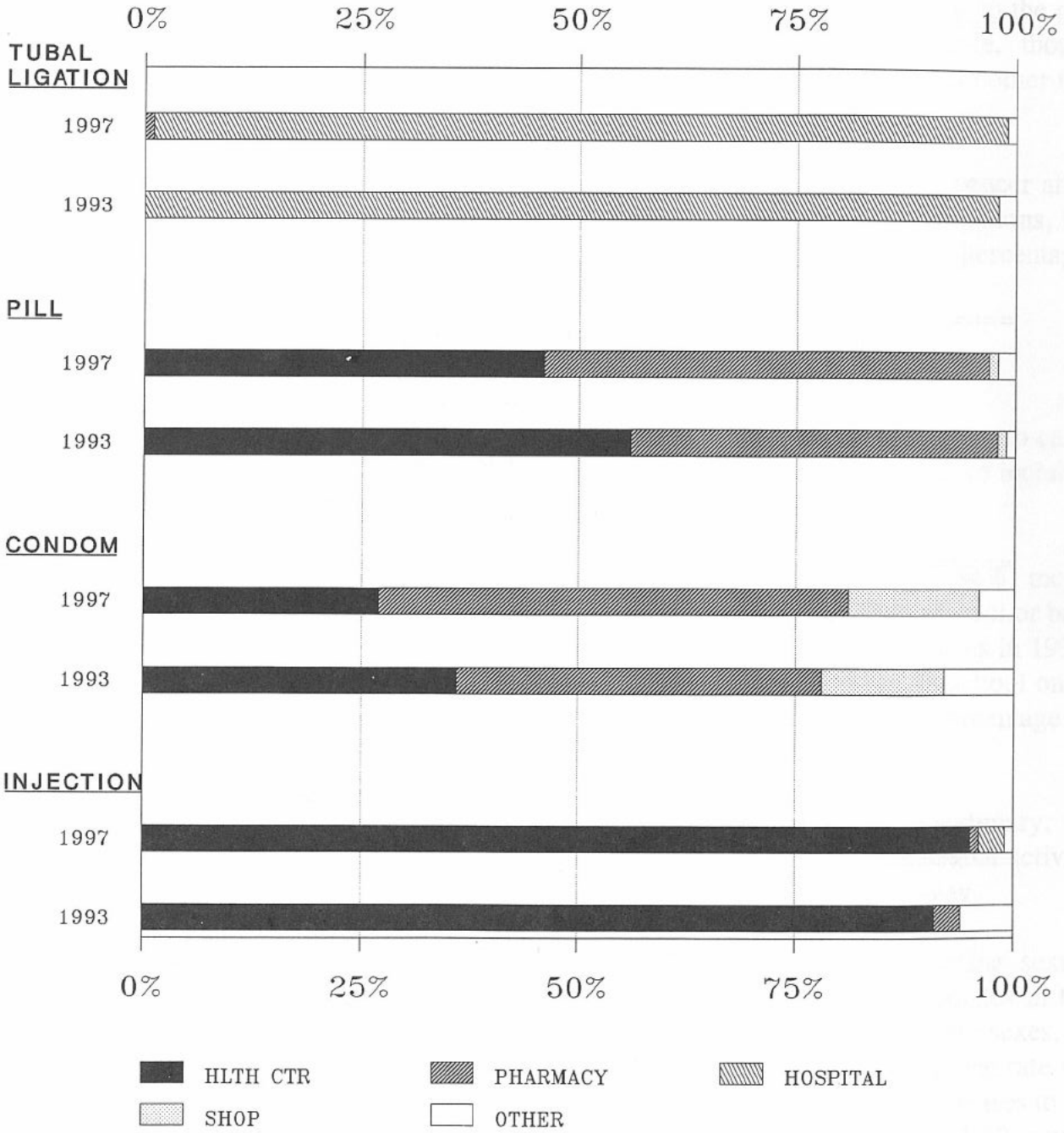
WITH STEADY PARTNER



JAMAICA

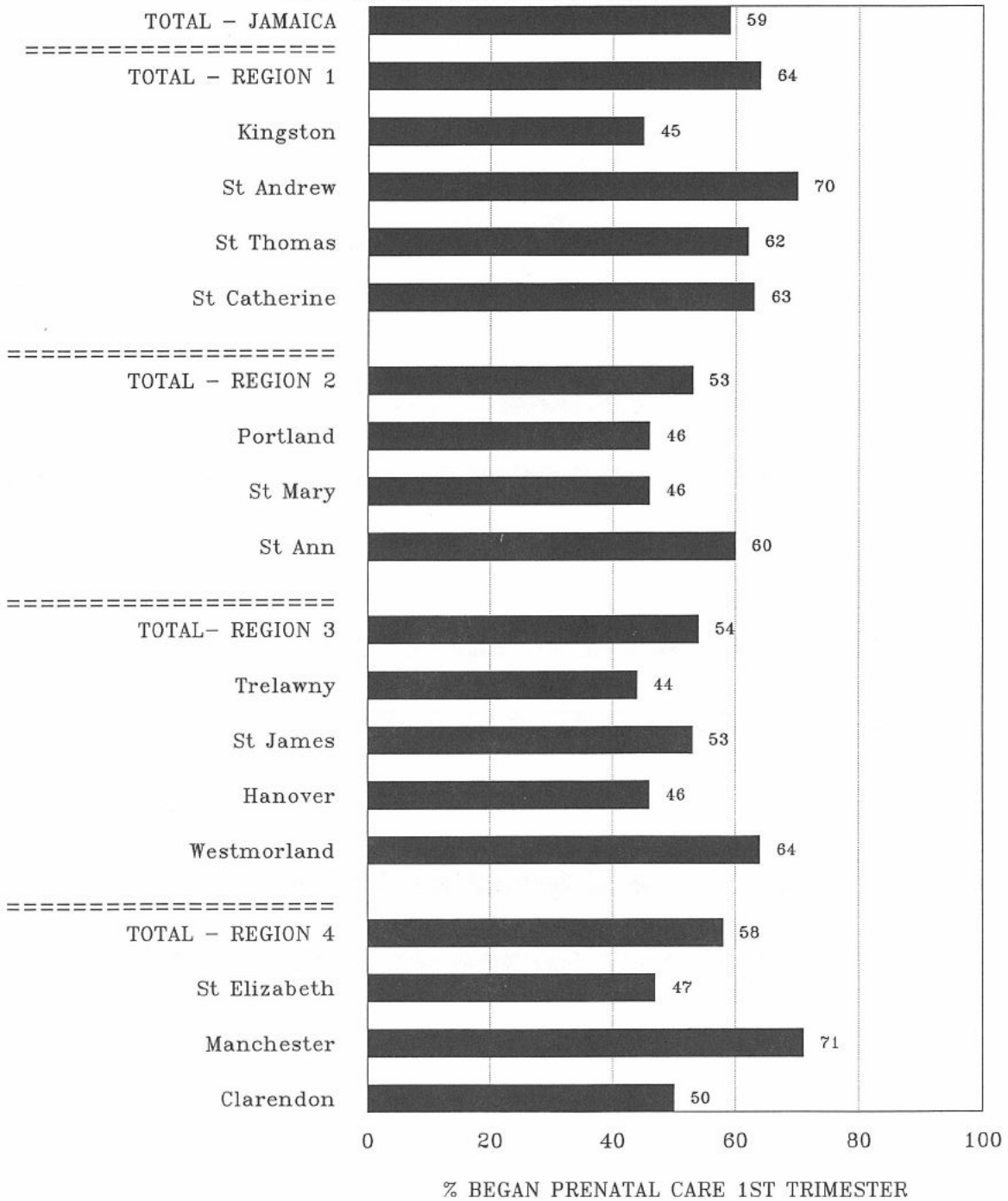
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 13
SOURCE OF CONTRACEPTION OF WOMEN IN UNION WHO ARE CURRENTLY USING MOST PREVALENT METHODS (PERCENT DISTRIBUTION) COMPARED TO 1993 CPS



REGION 4
1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

FIGURE 14
PERCENT WHO BEGAN PRENATAL CARE IN 1ST TRIMESTER AMONG WOMEN 15-49 PREGNANT IN THE PAST 5 YEARS BY REGION AND PARISH



1997 JAMAICA REPRODUCTIVE HEALTH SURVEY

trimester of their pregnancy, which is relatively low. This percentage is slightly higher for Region 4, as 58 percent of women in the region began their prenatal care in the first trimester. There is some variation between parishes in the region as 71 percent of women in Manchester began their prenatal care in the first trimester of their pregnancy, compared to only 47 percent of women in St. Elizabeth.

Pap Smears are an important means of early detection of cervical cancer. Only half of all Jamaican women have ever had a Pap Smear (51%) and only 15% had one in the past year (Figure 15). These figures are roughly the same for Region 4 as a whole, though more women in Clarendon have had a Pap Smear in the past year than in the other two parishes.

Monthly breast self-examinations are an effective way of detecting breast cancer at an early stage. Fifty-five percent of all Jamaican women ever do these examinations, but only 29 percent have done at least one in the past month (Figure 16). These percentages are similar for Region 4 as a whole and for the parishes in the region.

Young Adults

Concern about high levels of adolescent pregnancies and births led to a decision to carry out some special analysis of the situation. A young adult module was therefore included in the 1997 RHS.

In Health Region 4, a large majority of young women and men (women - 84%, men - 67%) have been exposed to family life / sex education in school, outside of school or both (Figure 17). These percentages are higher than the corresponding percentages in 1993. Most young adults reported having family life or sex education courses in school only. There was little difference according to age, though a relatively lower percentage of women have had this training in Manchester and men in St. Elizabeth.

Sexual experience is defined as ever having had sexual intercourse. In this summary, we focus on the first sexual experience and contraceptive behavior. Current sexual activity and number of partners will be presented in the full final report of the survey.

The proportion of young adults in Jamaica and Health Region 4 reporting sexual experience by age group is shown in Figure 18. Among the youngest females in the country but not in the region there has been a decrease since 1993. For both sexes, as may be expected, sexual experience increases with age. The sexual experience rate for females in the country and region at ages 15-19 is 51 percent. This figure increases to 92 percent in the 20-24 age category. Almost three-fourths of males aged 15-19 report sexual experience, while sexual experience is essentially universal for older males.

FIGURE 15
PERCENT OF WOMEN AGED 15-49
WHO HAVE EVER HAD A PAP SMEAR
AND HAVE HAD A PAP SMEAR IN THE LAST YEAR
BY PARISH

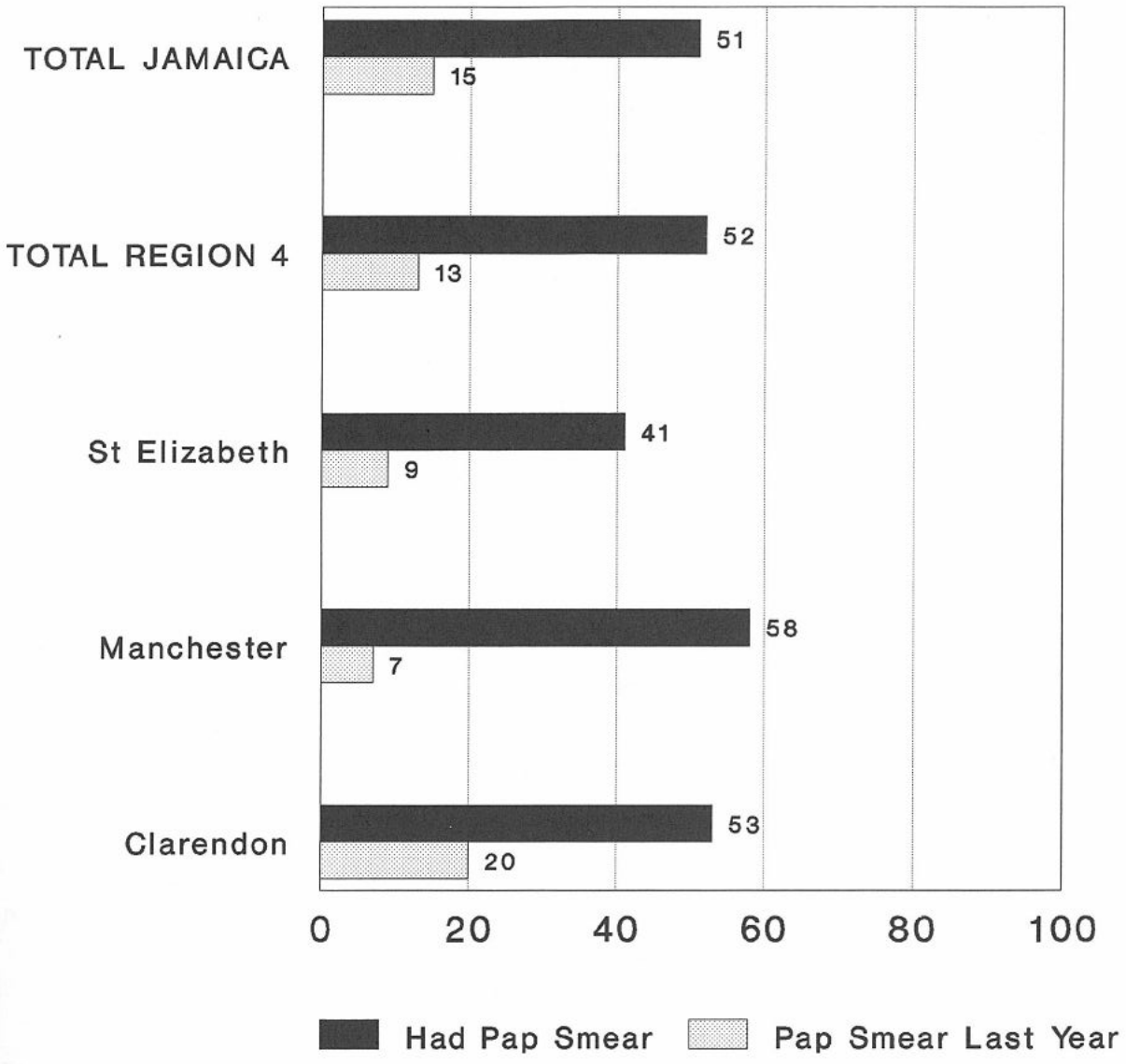


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FIGURE 16
PERCENT OF WOMEN AGED 15-49
WHO EVER DO A MONTHLY BREAST SELF-EXAMINATION
AND DID A BREAST SELF-EXAM IN THE LAST MONTH
BY PARISH

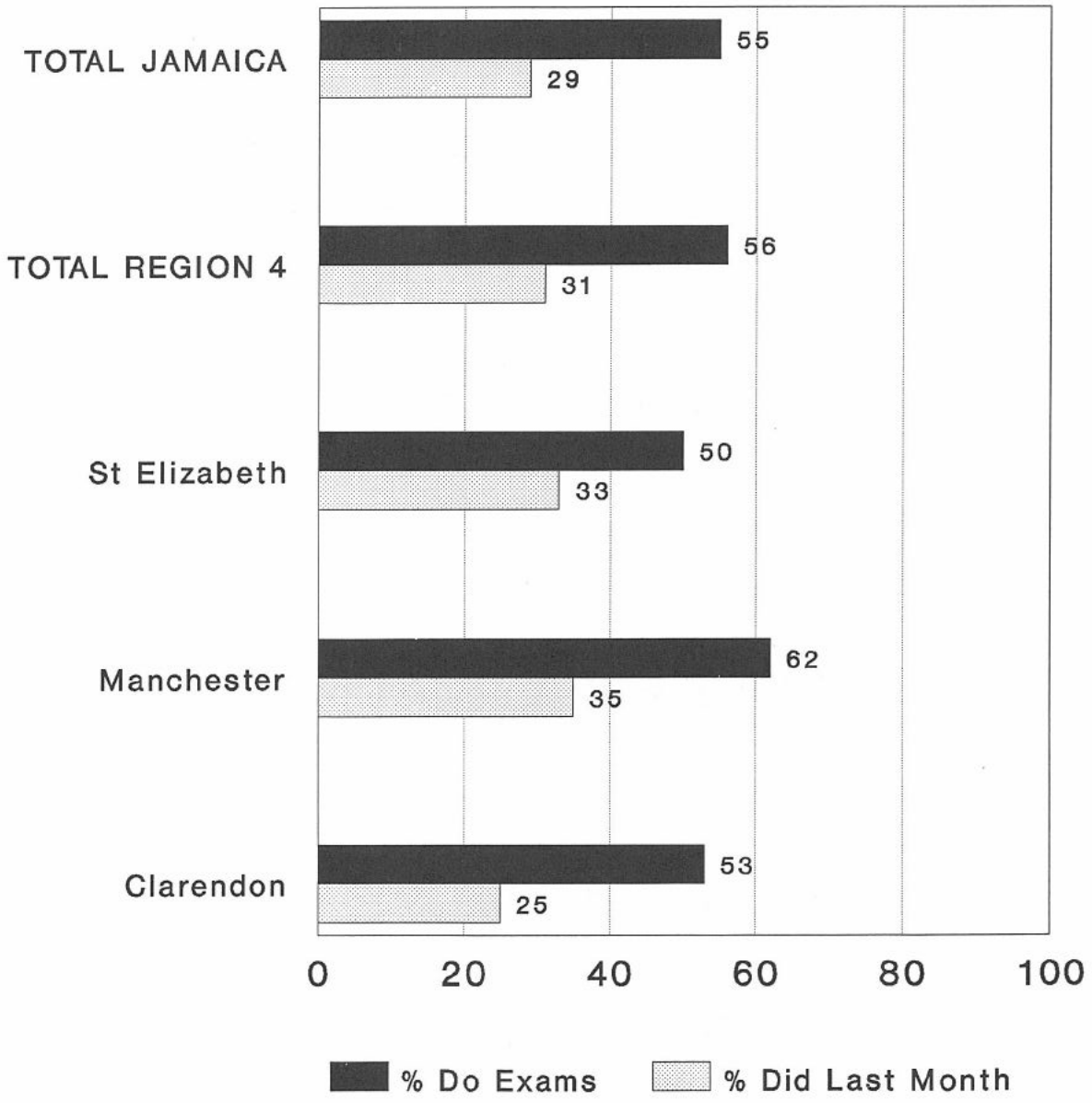

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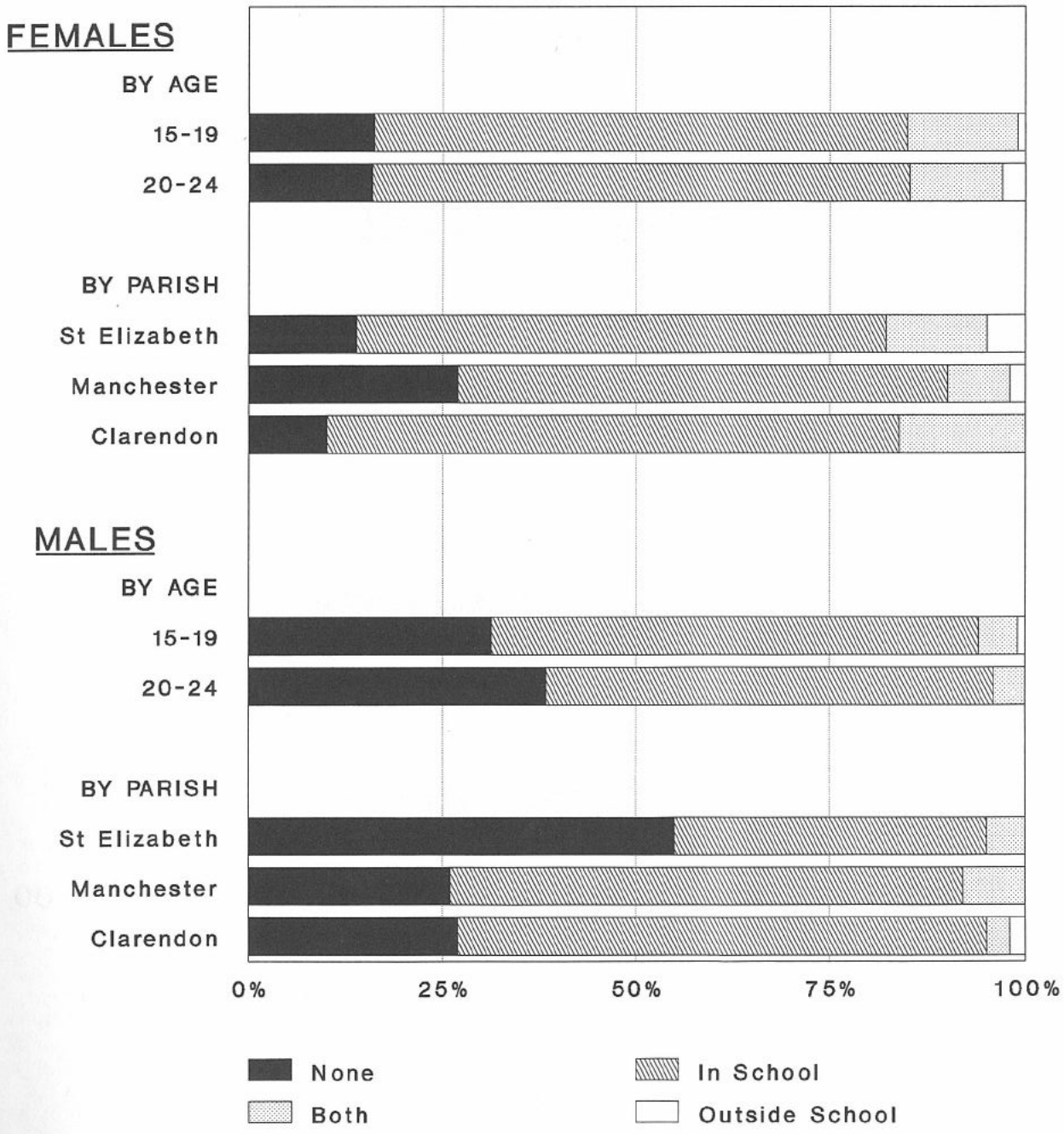
FIGURE 17
FAMILY LIFE / SEX EDUCATION CLASS OR COURSE
IN SCHOOL AND / OR OUTSIDE OF SCHOOL
YOUNG ADULTS AGED 15-24
(PERCENT DISTRIBUTION)



REGION 4
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FIGURE 18
PERCENT REPORTING SEXUAL EXPERIENCE
BY AGE GROUP
YOUNG ADULTS 15-24 YEARS OF AGE
COMPARED WITH 1993 CPS

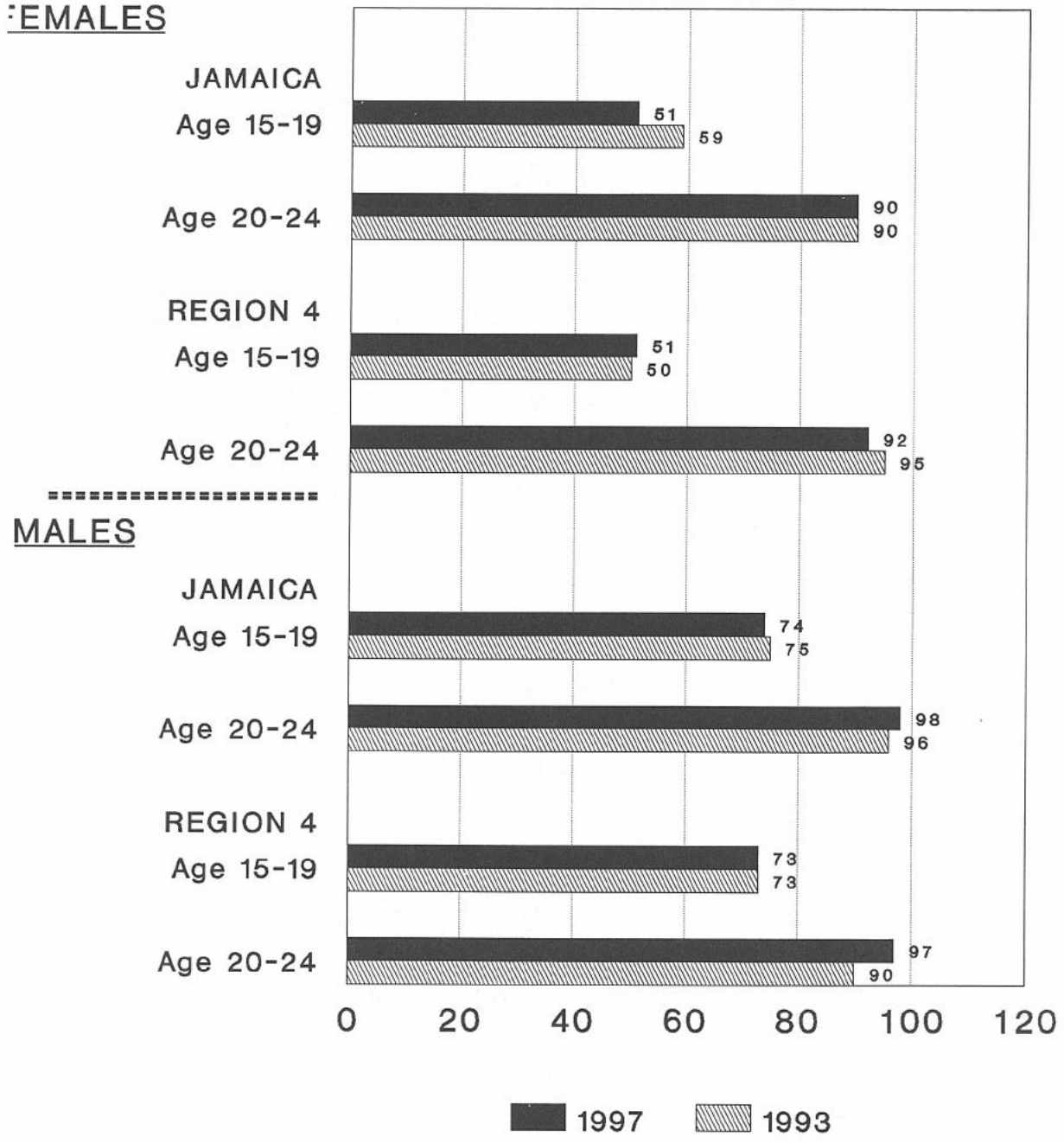

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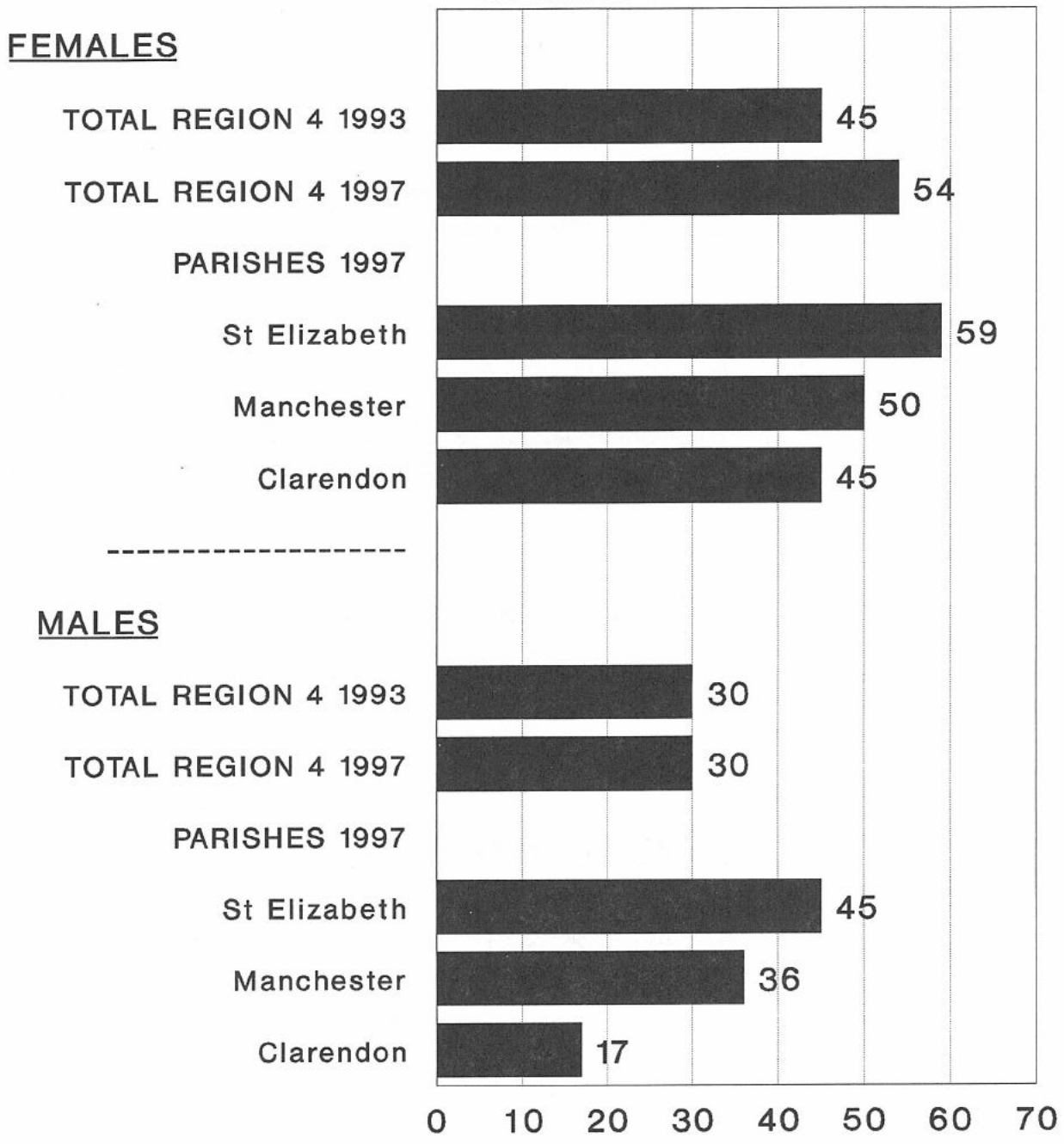
FIGURE 19
% USING CONTRACEPTION AT 1ST SEXUAL INTERCOURSE
BY PARISH
YOUNG ADULTS 15-24 YEARS OF AGE
REGION 4



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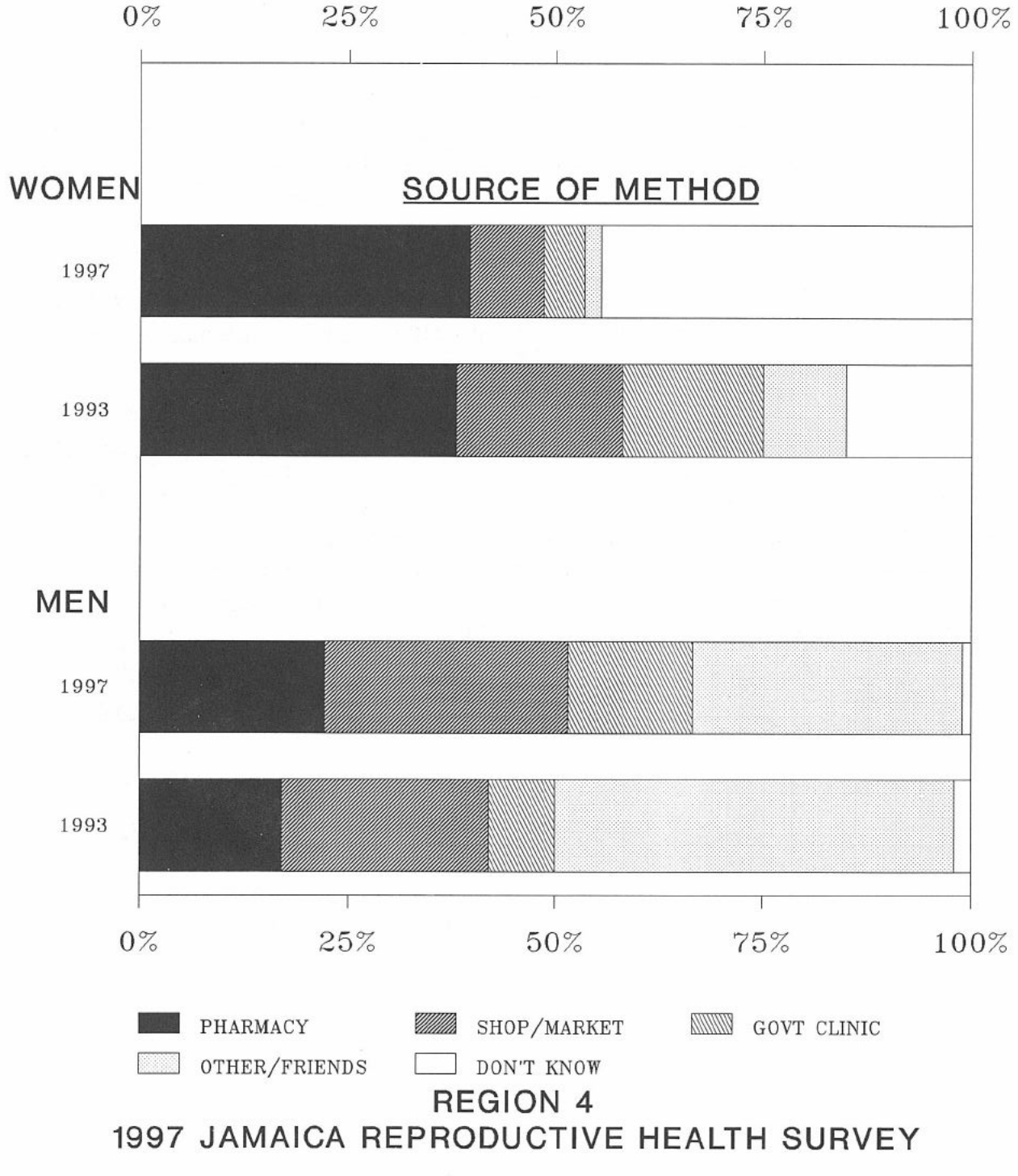
In Health Region 4 the proportion of young women who used contraception at the time they first had sexual intercourse has increased since 1993 (Figure 19). Fifty-four percent of young women and 30 percent of young men used a contraceptive method at the time of their first sexual intercourse which represent an increase for young women from the corresponding 1993 percentage of 45 percent. The corresponding percentage for young men has not changed since 1993. Use of contraception at first intercourse is highest in St. Elizabeth for both men and women.

Not shown in a graph is that, similar to Health Region 4, for the nation as a whole approximately half of young women and about two-thirds of young men did not use contraception at first sexual intercourse. When asked why they did not use, almost one-half of women and about 30 percent of men said that they did not expect to have sex at the time of first intercourse. Approximately 30 percent of young men said the reason was that they did not have knowledge of contraception at the time of their first sexual experience (data not shown).

Also not shown in a graph or table is that in Jamaica as a whole the condom was used by the great majority (about 90 percent) of men and women who used any method at the time of their first intercourse.

The source of contraception used at first intercourse in Health Region 4 differs for females and males (Figure 20). Women, who as mentioned above reported almost universal use of condoms at first intercourse, gave the pharmacy as the principal source. Thirty percent of men, who also largely used condoms at the time of their first intercourse, identified shops or markets as the primary source. Another 32 percent stated they obtained them from other sources, mostly friends. Another difference is that 45 percent of women did not know where their partner obtained the condom.

FIGURE 20
SOURCE OF CONTRACEPTIVE METHOD USED AT TIME OF FIRST SEXUAL INTERCOURSE
YOUNG ADULTS 15-24 YEARS OF AGE COMPARED WITH 1993 CPS



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APPENDIX

REPORT OF THE REGIONAL DISSEMINATION SEMINARS
REPORT ON THE REGIONAL DISSEMINATION SEMINARS ON THE 1997 REPRODUCTIVE HEALTH SURVEY
April 20 - 24, 1998

Introduction

The National Family Planning Board (NFPB) in collaboration with the Ministry of Health (MOH), with funds provided by the United States Agency for International Development (USAID) under the Family Planning Initiative Project (FPIP), conducted four regional dissemination seminars.

These seminars were being held for the first time prior to the National Dissemination Seminar and are based on preliminary findings. The findings were being discussed with health personnel within each health region providing reproductive health services in the public and private sectors.

1. Seminar Objective

The seminars were being presented to discuss the findings of the 1997 Reproductive Health Survey (RHS) so as to develop a better understanding among health service workers of the implications of the findings in order to improve the delivery of the family planning services.

2. Specific Objectives

Participants were to use the data to:

- identify trends in family planning.
- discuss and report on family planning activities and conditions among women and men in the age group surveyed.
- identify changes that could be made to improve the programme.

These seminars were held in each region as shown where the participants were selected by the Senior Medical Officer of Health and the Health Management Team.

At the seminar in Region 1, the Executive Director of NFPB, Mrs. Beryl Chevannes, extended greetings on behalf of the Chairman, Board of Directors and staff of NFPB and MOH. At the seminars in Regions 2 and 3, the Executive Director's message was read by Mrs. J. Davis, Director, Information, Education and Communication, NFPB, and by Mr. E. Radlein, Director,

Projects, Research and Statistics, NFPB at Region 4.

3. Number of Participants

The following participants attended at each of the four regions:

Venue	Date	Region	Parishes	Participants		
				M	F	T
Wyndham New Kingston Hotel	April 20, 1998	South- East - Region 1	Kingston, St. Andrew, St. Thomas, St. Catherine	4	56	60
Mandeville Hotel, Mandeville	April 21, 1998	Southern - Region 4	St. Elizabeth, Manchester, Clarendon	7	36	43
Club Jamaica, Ocho Rios	April 23, 1998	North-East - Region 2	Portland, St. Mary, St. Ann	10	56	66
Wexford Court Hotel, Montego Bay	April 24, 1998	Cornwall - Region 3	Trelawny, St. James, Hanover, Westmoreland	6	50	56

At each seminar, the main presenters were Mrs. Carmen McFarlane, Project Director for the Reproductive Health Survey and Mr. Jay Friedman, Consultant from the Division of Reproductive Health, Centers for Disease Control and Prevention (CDC). Mrs. McFarlane dealt mainly with the presentation of the findings at the national level while Mr. Friedman was responsible for the presentation at the regional level.

Ms. Julia Beamish and Mr. Karl Haub from the Population Reference Bureau in Washington D.C. were in attendance at all the sites as technical consultants of the Measures Communication Project. This project uses an audience-centered approach to plan and implement dissemination and data use by key audiences. Technical assistance will be provided under Measures at the National Dissemination Seminar.

A resource team from the NFPB assisted the main presenters at each seminar and was comprised of:

Mrs. E. McFarquhar	Family Planning Coordinator (Chairman, All Four Seminars).
Mrs. E. Radlein	Director, Projects, Research and Statistics (Regions 1 and 4).
Mrs. J. Davis	Director, Information, Education and Communication Department (Region 3 and 4).
Mrs. R. Jones	Training Officer (Regions 2, 3 and 4).

Ms. E. Richards	Statistical Officer (Region 1).
Mrs. B. Stephenson,	Statistical Officer (Regions 1 and 4).
Mrs. V. Soares	Statistical Clerk (Regions 1 and 4).
Ms. P. Baxter	Statistical Clerk (Regions 1, 2 and 3).
Mrs. A. McDonald	Secretary (Regions 1, 2, 3 and 4).
Mr. L. Davidson	Driver (Regions 1, 2, 3 and 4).

Senior Medical Officers (SMOs) Drs. J. Guerney (South-east), M. Coombs (Southern), J. Kirlew (North-east) and A. Konstantinoff (Cornwall) reported on the family planning activities within their region.

Presentations

1. National

Some thirteen topics were covered in the presentation on the main findings at the national level. The objectives of the Survey were to:

1. obtain a wide range of information on the reproductive health of women and young adult men in Jamaica;
2. look at the knowledge and practices of women and young men;
3. extend the scope of information available from earlier studies;
4. further provide information which could contribute to an effective family life education programme within and outside the formal education system.

The coverage and sample designs were also addressed in the presentation. Emphasis, however, was on thirteen topics, with the use of transparencies, charts and graphs. The topics presented were:

1. Age Distribution of the Population
2. Relationship Status
3. Fertility
4. Family Preferences
5. Prenatal Care and Women's Health
6. Pap Smears
7. Breast Self-Examination
8. Blood Pressure Checks
9. Fertility Regulation
10. Source of Contraception

11. Planning Status
12. Family Life Education
13. Sexual Activity among Adults.

The two main performance indicators of the programme are: the Total Fertility Rate (TFR) and the Contraceptive Prevalence Rate (CPR). The TFR has been declining over the years but within regions, there are rates that are above average, as in Regions 2 and 3, and in Region 1, the rate is well below the national figure. Despite the overall decline in the TFR, teenage fertility is increasing and is of concern if the overall objective of replacement level fertility is to be realized.

On the other hand, the CPR is increasing, from 62 percent in the previous survey to 64.4 percent in the 1997 survey. The CPR by age group, by method and region, was also addressed.

2. Regional

A summary of the results of each health region was distributed to all participants at each seminar, and, with the use of transparencies, the presenter highlighted the findings for the region and the parishes within the region. Comparisons were made of each region's performance in relation to the national findings and the extent of changes occurring since 1993. The participants were invited to express their views on the trends occurring in their region and to indicate their comments or queries on the findings. Topics covered included:

1. Fertility
2. Planning Status
3. Contraceptives - Knowledge and Use
4. Sources of Contraception
5. Prenatal Care and Women's Health
6. Pap Smears
7. Breast Self-Examination
8. Young Adults
9. Family Life Education
10. Sexual Experience.

A session for questions and answers on the two presentations completed this segment on the preliminary findings at both levels.

3. Family Planning Activities Within The Regions

Demographic and reproductive health data were presented by the SMOs for the region to inform participants of the level of family planning activities in the region. Each SMO outlined the objectives, activities, strategies and facilitating factors which pertained to the region, with recommendations to improve services therein. Dr. Guerney made a number of comparisons in the southern region with the results of the 1993 Contraceptive Prevalence Survey and drew

attention to changes occurring within the parishes on the main indicators such as teenage recruitment, new acceptors and contraceptive use. A situation analysis in response to the findings was presented by Dr. Coombs, with the use of 1997 service data on the low level of recruitment within the southern region. This region had a higher TFR than the national level and his presentation addressed the unsatisfactory method mix and the low acceptance rate as a contributor to the higher level. In her presentation. Dr. Kirlew outlined the manner in which the region functioned, utilizing the National Family Planning Programme Policy and Guidelines. In the Cornwall Region, Dr. Konstantinoff expressed similar sentiments and outline the objectives with respect to recruitment, pap smears and contraceptive use. In all regions, their achievements and constraints were discussed in support of their performance, as suggested in the preliminary findings of the RHS and a number of recommendations for improving the programmes in their region were made.

Recommendations

At each seminar, participants were placed in groups to discuss the implications of the findings. The following represents a composite of the recommendations made:

1. New guidelines should be developed and made available to health workers. These should include directions on the inclusion of girls under 16 years of age in the programme, after an indepth examination of the legal implications. If it is considered important enough to the programme, then an amendment to the existing laws concerning girls at the age of consent may have to be recommended. Based on the outcome of such recommendations, guidelines should be established and communicated to all service providers.

2. Measures should be put in place to decrease the waiting time in clinics.

3. At least two evening clinics should be established in each parish.

4. Parish budgets should be increased to provide the financing of extra hours spent by service providers in evening clinics.

5. Males should be trained to deal with male reproductive issues.

6. Vasectomy should be promoted as an alternative method among males.

7. Vasectomy services should be provided in each parish.

8. Ministers of religion should be targeted through the Jamaica Council of Churches.

9. All clinics offering family planning services should be provided with pelvic models for use in the programme.

10. Measures to institute policy to reduce the final cost for tubal ligation to those who cannot afford the present cost should be implemented.

11. The central office of the Ministry of Health should notify hospitals that tubal ligation should be free in cases where affordability is a factor.

12. Clients could be referred to the Spaldings Hospital for tubal ligation.

13. Staff should be trained or where necessary, retrained in the insertion of the Intra-Uterine Device (IUCD).

14. IUCD equipment should be provided to increase acceptance.

15. IUCD support groups including general practitioners should be established.

16. At least two adolescent clinics should be established in each parish within the four regions.

17. An aggressive health education programme should be introduced in primary schools. targeting both boys and girls.

18. There should be involvement of teacher representatives, for example, school nurses, guidance counsellors, the Parent/Teachers Associations (PTAs), etc., in all matters relating to adolescents.

19. Parent education classes/workshops should be conducted in each parish.

20. The advantage of Planned Parenthood should be promoted at postnatal clinics in the Cornwall Region.

21. Family life education in schools and among youth groups should be intensified.

22. A Pap Smear programme should be reintroduced in Types 2 and 3 Health Centres in conjunction with Cancer Screening and National Health Laboratory.

23. Educational materials on breast self-examination, importance of pap smears, etc. should be available in health clinics and other service centres for distribution to clients.

24. Adjustments should be made to the present system of data collection aimed at capturing data on clients visiting post partum clinics for antenatal care in the first trimester.

25. A system for the recording of dual methods as part of the data capture programme should be established.