

**Analysis of the Legal, Regulatory,  
and Policy Environment for  
Adolescent Reproductive Health in  
Jamaica**

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September 2001



**Youth.now**

**Brigette McDonald Levy  
Karen Hardee  
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## List of Abbreviations

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AIDS	acquired immune deficiency syndrome
CPS	Contraceptive Prevalence Survey
FLE	family life education
GOJ	Government of Jamaica
HIV	human immune deficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IUD	intrauterine device
JRHS	Jamaica Reproductive Health Survey
MAJ	Medical Association of Jamaica
MOH	Ministry of Health
NAC	National AIDS Committee
NAJ	Nurses Association of Jamaica
NFPB	National Family Planning Board
NGO	nongovernmental organization
OB/GYN	Obstetricians/Gynecologists
PIOJ	Planning Institute of Jamaica
PPCC	Population Policy Coordinating Committee
RH	reproductive health
STD	sexually transmitted disease
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWI	University of the West Indies
WHO	World Health Organization

## Acknowledgments

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## I. Introduction

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### A. Adolescent Reproductive Health

Adolescents represent the future of Jamaica and yet their passage through the years 10 to 19 are challenging – to adolescents themselves as they go through numerous physical and psychological changes, to their families and communities as they help adolescents grow, and to the government as it attempts to help young people stay healthy and gain the skills they need to move from childhood to adulthood and become productive members of society.

Jamaican youth live in a challenging environment. School enrollment is unacceptably low. In 1998, fully 22 percent of adolescents in ages 12-18 were not enrolled in the formal school system (PIOJ, 1999). Even children who are in school worry about their economic and job prospects. In 1998, the unemployment rate of young people ages 14-19 was 55 percent. For young people ages 20-24, the unemployment rate was still high, at 27 percent (compared with an unemployment rate of 8 percent among the 35-44 year age group).

While adolescents are generally healthy, many engage in health behaviors that place them at risk, such as early and unprotected sex, substance use and abuse, and activities that lead to intentional or unintentional injuries (Campbell-Forrester, 2000). Adolescent pregnancy represents a serious, yet preventable, social and health problem. Before Jamaican women reach the age of 20, 40 percent have been pregnant at least once, with more than 80 percent of the pregnancies unplanned (McFarlane et al., 1999). Young women in rural areas are more likely to have been pregnant by age 20 than are women living in urban areas.

Sexual activity begins in an environment that sends mixed messages to girls and boys about sex. Boys “perceive social encouragement and pressure to be sexually active, while girls who have sex, particularly if a pregnancy reveals their sexual activity, are labeled as having poor moral character” (Eggleston, Jackson and Hardee, 1999). Sexual activity begins at an early age, although the view that a girl should have a baby when she is a teenager to prove that she is not a “mule” weakens with age. (in one study, 28 percent of girls and 40 percent of boys roughly ages 11 to 12 held that view, compared to 12 percent of girls and 21 percent of boys approximately ages 14 to 15 (Jackson et al., 1998). Among young adults ages 15-17 surveyed in the 1997 Reproductive Health Survey (the youngest group studied), 38 percent of females and 64 percent of males reported having had sexual intercourse. Unintended pregnancy disrupts the lives of young

girls who are less likely to return to school once they become mothers. The younger they begin sexual activity, the less likely young people are to use contraception, increasing the risk of pregnancy and disease. Of the women who first had sex at age 13, 41 percent used contraception at first sex, compared to 67 percent of women who first had sex at age 18-24. Use of contraception at first sex was slightly more common among urban than rural women (57 percent compared to 54 percent). Still, among women in union ages 15–19 in 1997, slightly less than 60 percent were currently using contraception.

Young people are at risk of contracting sexually transmitted diseases, including HIV/AIDS. The next five years will bring over 4,000 AIDS deaths in Jamaica, primarily of young people (Gebre, 2001).

Most adolescents receive inadequate information, guidance and services to help them safely negotiate through the teen years, either from schools or from parents/guardians. Young people have many misconceptions about sex, pregnancy and sexually transmitted diseases (e.g. timing during the menstrual cycle when pregnancy is most likely to occur, that pregnancy is possible at first intercourse, that sex with a virgin will cure an STD, that drinking Coke or Pepsi after sex prevents pregnancy) (Jackson et al., 1998). Many young people start having sex before they receive any family life education (FLE). About 86 percent of young women (ages 15 to 24) and 76 percent of young men said they had received some type of FLE (McFarlane et al., 1999). Yet, 17 percent of girls who get pregnant in school are at the primary level. The mean age for first sex for girls ages 15-17 is 14.7, yet only 35 percent of girls had their first FLE class before the age of 13. The mean age for first sex for boys ages 15 to 17 is 12.4, yet by age 13, only 30 percent have had a course in FLE (McDonald, 1999; McLain, Hardee and Levy, 1999).

FLE begins too late and that topics covered are too general to have much impact on sexual behavior, contraceptive use, and disease prevention. Among girls ages 15 to 24 that receive information from parents or guardians, 35 percent did not receive information on pregnancy before their first menarche, and 38 percent did not receive information on pregnancy before their first sex (McDonald 1999). Peer education programs have not received sufficient attention. Adolescents rarely access reproductive health services, in part due to negative attitudes of providers towards young people who are sexually active and because of the age of consent, which has made providers fearful of serving adolescents.

Adolescent sexual and reproductive health remains a sensitive topic in the country, but the government has acknowledged that it must be addressed. In early 2000, the Prime Minister of Jamaica, the Honorable P.J. Patterson, launched the USAID-funded bilateral adolescent reproductive health project, signaling high-level support for improving the reproductive health of adolescents. A recent analysis conducted for the Ministry of Health proposed a number of recommendations to strengthen reproductive health information and services programs for adolescents (McLain, Hardee and Levy, 1999). An important step in doing so is to ensure that the legal and policy environment

supports the development and implementation of reproductive health programs of information and services for adolescents.

## B. The Policy Environment in Jamaica

The policy environment for reproductive health in Jamaica is generally positive. A Policy Environment Score (PES) study in 1999, however, found that the environment for adolescent reproductive health is the weakest among four components of reproductive health, including family planning, safe pregnancy, STI/HIV/Aids in addition to adolescent reproductive health (Strachan, Hardee and Grey, 2001). Table 1 shows that the policy environment for adolescent reproductive health has considerable room for improvement.

**Table 1. Policy Environment Scores by Component and Program for 2000**

Component	Average	Political support	Policy Formulation	Organization	Legal and regulatory	Resources	Program components	Evaluation and research
Family planning	71	76	72	62	79	57	70	79
Safe pregnancy	62	71	63	60	68	57	75	69
Adolescents	60	74	72	46	60	52	56	62
STDs/AIDS	74	71	73	72	81	64	71	74

Note: Values can range from 0 to 100.

A 1995 Analysis of the Legal and Regulatory Environment for Family Planning (Ravenholt and Clyde, 1995) concluded that the overall environment for family planning in Jamaica was good. It noted, however, that some laws, regulations and operational policies constrain the ability of the national family planning programme to meet national population goals, especially with regard to sexually active adolescents. The report noted that adolescents' access to information and contraceptive services were impeded, due to:

- The law regarding age of consent for medical services
- Provider biases
- The Ministry of Education and Culture's need to develop and implement effective FLE

## C. Purpose of the Review

The review examines the legal and regulatory environment within which the government can expand the provision of reproductive health information and services to adolescents. It provides an assessment of the laws, regulations and service guidelines that impede or favor the ability of public sector and nongovernmental organizations to deliver such programs to adolescents in Jamaica.

This review builds upon and updates the 1995 Legal and Regulatory Analysis for Family Planning, with a more specific focus on adolescents. The review examines other laws, regulation and practices that were not specifically addressed in the 1995 analysis that affect adolescents' reproductive health.

#### **D. Methodology**

The review examined and analyzed the legal, regulatory and policy environment, which included:

- The acts and regulations that govern all aspects of reproductive health information and services for adolescents, such as standards, guidelines and practices developed by the Ministry of Health and the National Family Planning Board for service delivery; and the codes of ethics of relevant professional associations and councils. A list of the relevant acts and regulations appears in Appendix 1.
- Published and unpublished studies and analyses, including the 1995 Legal and Regulatory Analysis for Family Planning;
- Discussions among members of an adolescent policy working group (APWG) constituted by the Ministry of Health to guide its work on adolescent health, including reproductive health.

## **II. Findings**

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#### **A. Definitions of Adolescence and the Adolescent**

Adolescence is the process whereby an individual makes a gradual transition from childhood to adulthood. It has been defined by the World Health Organization (WHO), as “those years between 10 and 19” based on:

- *Health considerations:* the onset of puberty and the development of secondary sexual characteristics;
- *Sociological conditions:* moving from a position of socio-economic dependence to one of relative independence; and
- *Psychological criteria:* where the thinking and reasoning process and patterns develop from those of a child to those of an adult.

In Jamaican law, the term adolescent or adolescence is not used in legal language. This age cohort is captured in the terms “minor,” “juvenile” and “youth,” which are defined by various ages.

The Age of Majority (which is the age at which adulthood is generally accepted to have commenced) is 18, according to the 1989 Law Reform. This is the age at which individuals are regarded as competent to handle their own affairs, have voting rights, enter into binding contracts and assume responsibility for their behavior, including accepting criminal responsibility.

Other legislation that defines childhood and adulthood includes:

- The Adoption of Children Act and The Children (Guardian and Custody) Act, which define child as a person less than 18 years of age who has never been married.
- The Juvenile Act (1951) related to the protection of children, states that:
  - A child is a person under 14
  - A juvenile is a person under 17 years of age
  - A young person is a person that has attained the age of 14, but is less than 17 years of age.
- The Marriage Act (1887) says that anyone having achieved the age of 18 may marry without the consent of others, and a minor between the ages of 16 and 18 may marry with the prior approval of a parent of legal guardian. Marriage below the age of 16 is prohibited; however, exceptions can be made under the Hindu Marriage Act (1957) and the Muslim Marriage Act.
- The Offences Against the Person Act (1864), defines the age of consent to sexual intercourse as 16 years for young persons of both sexes.
- The Education Act (1965) defines a child as a person who has not attained the age of 15 years.
- The Labour Act states that an individual must attain 17 years of age before he or she can enter into full time employment in the labour force.

There are a number of contradictions in these age definitions and stipulations based on age in the various laws and acts. For example, an adolescent can enter into sexual union at 16, but cannot get married without prior consent until age 18; and can marry at 16, but cannot support family/ be employed until age 17.

In their review of the draft Child Care and Protection Act, the Round Table of Jurists recommended that the discrepancies in these age definitions need to be addressed.

## **B. International and Jamaican Definition of Reproductive Health**

Until 1995, government policies on population focused on population size, fertility, mortality, external migration, and internal migration. In 1989, the Population Policy Coordinating Committee (PPCC) began a process to revise the existing policy (last revised in 1983). According to a government representative who participated in the policy revision process, “Revisions of the population policy started as a part of the Cairo process, including discussions of gender, the aged, children and the environment and development.” (Hardee, 1998). The 1995 revised population policy, however, did not make explicit reference to reproductive health (PIOJ, 1995a).

At the same time it was revising the population policy, the PPCC developed the 1995–2015 *National Plan of Action on Population and Development*, which was designed to implement the objectives and recommendations of the 1995 (revised) *National Population Policy* and the International Conference on Population and Development (ICPD) *Programme of Action* (PIOJ, 1995b). The plan includes a chapter on reproductive rights and reproductive health (including the verbatim definition of reproductive health from the ICPD). Responsibility for implementing the national plan of action does not rest with any particular government ministry.

The Ministry of Health (which is a member of the PPCCC) also subscribes to the ICPD definition of reproductive health:

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." (ICPD *Programme of Action*, Paragraph 7.2).

In its Strategic Framework for Reproductive Health, 2000-2005 (MOH, 2000), the MOH recognizes the linkages between reproductive health and other factors within the individual's environment.

### **C. International Policies and Conventions Related to Adolescent Reproductive Health to Which Jamaica is a Signatory**

Internationally, progress is being made in the areas of sexual and reproductive health for adolescents. Key international conventions that affect adolescent reproductive health include the 1982 Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), the 1990 Convention on the Rights of the Child, the Programme of Action of the 1994 ICPD, and the follow-up to ICPD 5 years later (Cairo +5, held in 1999), and the Fourth World Conference on Women (FWCW) in Beijing in 1995 (and its five year follow-up in 2000). Jamaica ratified the Convention on the Rights of the Child in 1991. This Convention says that nations must take appropriate legal, administrative, and educational measures to protect children from mistreatment, exploitation and sexual abuse. The Convention promotes the development of preventive measures for child survival, the promotion of other health issues, including reproductive health issues. The Convention also supports development of a supportive and protective environment that will prepare children and adolescents to be responsible and to live in a free society, with values of tolerance, peace and equity.

CEDAW requires nations to eliminate discrimination against women (including adolescents) in their access to health care services throughout the life cycle, particularly in the areas of family planning, pregnancy and delivery, and postpartum care.

ICPD and the FWCW promoted the view that reproductive health – not merely family planning – is a health issue as well as a development issue. The ICPD Programme of Action devoted a section to adolescents. This group was identified as group at high risk for negative reproductive health outcomes, and adolescence was identified as a critical time in the life cycle where patterns of behavior are formed that has consequences for the rest of life. The ICPD Programme Action noted that adolescents must be served according to their needs.

The 1999 Cairo +5 Conference stated that adolescents should enjoy the highest attainable standards of health through the provision of high quality, user-friendly, adolescent-appropriate services. These should include reproductive health counseling, education, information and health promotion strategies in addition to clinical services. The services should be private, confidential and non-judgmental, and provided in a manner appropriate to the culture, values and beliefs of the society.

### **D. National Policies Pertaining to Adolescent Reproductive Health**

Adolescent reproductive health in Jamaica is not addressed through one policy, but is covered in different policies, laws and regulations. These are summarized below in rough chronological order are discussed in more detail.

- The NFPB and the MOH are developing a policy on *Providing Effective Contraceptives to Minors* (2000, draft).
- MOH and NFPB *Family Planning Service Delivery Guidelines* (1999) includes a chapter on contraception for adolescents and an appendix that explains the Gillick Law from the United Kingdom and its protection for health care workers to serve adolescents.
- The MOH *Strategic Framework for Reproductive Health (2000-2005)* includes objectives for family planning, safe motherhood and STI/HIV prevention and treatment. Adolescents are noted as a key target group and are mentioned explicitly in a number of places in the document.
- *National Policy for Family Life Education* (1994–1995). Revised in 1999). Provides guidance on conceptualizing, standardizing, and developing health and FLE materials.
- *Child Care and Protection Act* (1999, proposed). Seeks to bring all legal issues that affect children and their care and protection rights under one overarching piece of legislation. It deals with children in the care of the state, children who are in conflict with the law, and children who are victims of crime and violence. Of note is the prosecution of perpetrators of incest and statutory rape, the age of consent, and treatment of victims of abuse.
- *National HIV/STD Control Programme Medium Term Plan* (1997-2001) has a strategic focus on young people
- *National Population Policy* (1995, revised). Includes a policy goal to promote the well being of children (ages 0-18). Notes teen pregnancy as an issue.
- *National Plan of Action on Population and Development* (1995-2015). Addresses the rights of children to standards of living adequate for their well being, the right to good health and education and the right to be free from all types of abuse, including sexual abuse.
- *National Youth Policy* (1995). Considers youth as the future for achieving national development. Covers proper health care for youth and (generally) reproductive health information and awareness for responsible parenthood, breastfeeding, sex education, STD/AIDS.
- *National Plan of Action for Children* (1995) and the *National Policy for Children* (1997) address child development issues (within the context

of the Convention on the Rights of the Child) and the special needs of adolescents, including the right to health care, and opportunities for participation in articulating their needs and planning for appropriate programs and services.

***Other related laws and acts:***

- The National Family Planning Act (1970): established the National Family Planning Board with the function to carry out the National Family Planning and Population Programme in Jamaica.
- The Pharmacy Act (1960) governs the registration of trained professionals and students by the Pharmacy Council.
- The Venereal Disease Act (1957) established the framework for notification to the Chief Medical Officer for syphilis, gonorrhoea or soft chancre. Notification for HIV/AIDS was added in 1985.
- The Offences Against the Person Act (1864) defines the punishments for rape (section 44), and attaches certain criteria, such as committing rape when armed carries greater punishment. Intercourse under false pretenses, and intercourse with a person with a disability or a person under the age of consent is also a punishable offence. While abortion is generally illegal, section 72 governs limited circumstances under which to procure or administer an abortion.

**E. National Policy Initiatives on Adolescent Reproductive Health**

A number of initiatives are underway in Jamaica to improve the policy environment for adolescent reproductive health.

In late 2000, the MOH instituted an **Adolescent Policy Working Group**, comprising representatives of the government, nongovernmental organizations and donors. The terms of reference for the group are to examine and address legal and policy barriers to improving adolescent health, including reproductive health. The MOH has also instituted a **Youth Friendly Services Working Group**.

UNFPA is supporting a sitting **parliamentary sub-committee** (2000) to examine adolescent sexual and reproductive health in the context of adolescent health and national development. A special group of the subcommittee is examining issues of importance to adolescent sexual and reproductive health and will bring policy recommendations to parliament.

**National AIDS Committee** seeks to prevent the transmission of HIV/AIDS, and to promote the appropriate care for people living with AIDS. Adolescents are an important target group for HIV/AIDS prevention messages and care.

To implement the 1995 Youth Policy, the Ministry of Local Government, Youth, and Community Development is formulating a **National Youth Development Strategy** for 2000 and beyond. This strategy is also being developed in response to the government labeling youth development as one of its two highest priorities over the short and medium term. As part of the National Youth Development Strategy, the **National Youth Development Centre** will become an executive agency of the Ministry of Local Government, Youth and Community Development. The centre, while recognizing the importance of reproductive health issues, will focus primarily on education, skills training and employment.

The **Office of the Ambassador for Children** (1997) in the MOH is charged with ensuring the rights of children ages 0-18. The office is currently focusing on young children and children in need of special care and protection.

UNICEF has supported the development of a policy on children.

The **Womens' Centre of Jamaica Foundation**, has been instrumental in ensuring that pregnant girls who give birth to children are able to remain in school.

## F. The Age of Consent to Medical Services in Jamaica

### 1. *Legal Perspectives on Age of Consent for Medical Care*

The age of majority for most purposes is 18, however for any surgical or medical treatment the consent of the minor who has attained age of 16 shall be as effective as it would be if he were 18, according to the Law Reform. Thus, it has been necessary for health care personnel to obtain parental consent before providing medical care to anyone younger than 16 years.

The age of consent refers to the legal capacity of minors and to their ability to give consent. The law has taken a protective stance to insulate minors from the consequences of their own decisions and from outside pressures or coercion. The rationale is that minors lack the capacity to give legally valid consent where such is required, because their physical, mental and moral development is incomplete and they are vulnerable to exploitation.

Implicit in the age of consent is the fact that the consent must be:

- for what is actually done;
- voluntary;
- given by a person legally and mentally competent to do so;
- based on possession of adequate information about the process.

This includes an explanation of the nature of the medical procedure to be used,

the risks of the suggested procedure, their seriousness and probability of their occurrence, the potential benefits of the treatment, the need for any post treatment supervision or continue treatment as well as alternatives to the treatment suggested and their relative risks and benefits also be explained (Paxman and Zuckerman, 1987).

Adolescents do not have the same basic legal rights as adults, and have not been able to avail themselves without parental consent of certain services, including medical treatment and in the case of reproductive health, for clinical care and family planning services. In practice, however, providers will treat a minor with an STD, although providers may face prosecution for doing so.

This perspective on the age of consent fails to take into account, however, the process of intellectual development that may be occurring in the developing child and limits the options for reproductive health care to adolescents. The legal approach supports the supremacy of parental rights, in view of their responsibilities for the minor.

Exceptions to the requirement of consent are:

- Provision of **emergency care** – the necessity of parental consent is waived if procedure is critical to saving the life of the young person
- In the case of the **emancipated minor**, that is one who is not subject to parental control or regulation. These include those who:
  - Live apart from their parents;
  - Are self-supporting at any age;
  - Presently give service in the armed forces;
  - Are, or have been, pregnant (Paxman, 1987).

## ***2. Ministry of Health Position on Providing Health Care to Adolescents***

The MOH and the NFPB have long recognized that the age of consent presents a barrier to access to reproductive health services by adolescents. This stems not only from the fear of litigation, but also from attitudes among providers about adolescent sexual activity, particularly by girls. When revising the family planning service delivery guidelines, the MOH and the NFPB recognized that they must address the issue of serving adolescents. After much discussion, the group developing the guidelines added a chapter on adolescents and an appendix on the legal basis for serving adolescents.

Appendix E in the *Family Planning Service Delivery Guidelines* presents the Gillick

case from the United Kingdom as a precedent for Jamaican providers being protected in their provision of reproductive health care to adolescents. In the Gillick case, the House of Lords found that a doctor, who, in the exercise of his clinical judgment, gave contraceptive advice and treatment to a girl under 16 without her parents' consent, did not commit an offence under the Offences Against the Person Act. It was held by the House of Lords that the Law did not recognize any rule of absolute parental authority until a fixed age. Instead, parental rights were recognized by the law only as long as they were needed for the protection of the child and, such rights yielded to the child's rights to make his own decisions when he reached a sufficient understanding and intelligence to be capable of making up his own mind. This case is important in the English-speaking Caribbean because English common law is of "persuasive" (as opposed to binding) authority in the region and will normally be adopted by Caribbean courts.

The 1999 *Family Planning Service Delivery Guidelines* states that, "The Ministry of Health's policy on this issue is consistent with the approach adopted in the Gillick case." (MOH and NFPB, 1999: 143). This statement from the MOH offers some protection to providers. A legal opinion from Margaret May Macaulay (2000), based on a review of the Gillick case, supported the MOH's position. She wrote, "It is my considered opinion that under the laws of Jamaica, there is no legal impediment whatsoever to medical professionals giving advice and treatment to under the age of consent teenagers regarding sexual and reproductive health matters without parents knowledge and consent.... In the absence of any legislative provision to the contrary in Jamaica, Doctors are therefore, I opine, in law entitled to give advise and treatment on sexual and reproductive health matters to under age of consent teenagers" (p. 23). She noted that it would be advisable, "to have the matter clarified by codifying legislative provisions in the Medical Act for the avoidance of all doubt" (p. 24).

The MOH, in collaboration with the NFPB and the PIOJ, are have developed policy guidelines for health personnel on Access to Contraception for Persons Under 16 Years. The guidelines have been tested with groups of parents in focus group discussions to determine their suitability and acceptability. The guidelines, in draft as of April 2001, refer to international conventions and agreements to which Jamaica is a signatory obligating governments to ensure the right of adolescents to health care. The guidelines encourage parental participation in an adolescent's health care, while also encouraging abstinence. Only surgical procedures are not permitted under law without parental consent. The guidelines state:

1. "Any individual regardless of age, gender, or parity who visits a health facility, whether accompanied by parent(s) or legal guardian; on individual volition, or through any form of referral must be registered and directed for care to a health professional.
2. The health professional has an ethical obligation to:

- Show respect at all times and in all circumstances to adolescents, including preservation of their dignity.
  - Observe strict confidentiality unless there are clear and compelling reasons for the contrary; and in such cases health professionals should always inform the adolescent that they intend to disclose the information and the consequences of such disclosure.
  - Provide non-judgmental health information and services to allow for informed consent and choice.
3. The health professional should encourage abstinence with full explanation of the mental, physical and social reasons for voluntary abstinence for adolescents.
  4. If abstinence is not received as an appropriate message, and the minor intends to continue to have sexual activity, contraceptive advice is in her/his best interest.
  5. The health professional should exercise his/her best judgment in determining that:
    - The minor cannot be persuaded to confide in his/her parent/guardian or allow the health professional to inform them;
    - The minor is likely to begin or to continue having sexual intercourse and related risky behavior with or without the use of contraception;
    - The minor has full information, has given careful consideration to the issues involved, and understands the advice of the health professional.
    - The minor's best interests require that the health professional provide a **medical** contraceptive.

The term medical contraceptive is emphasized to indicate that a minor's right to surgical procedures without parental notification or consent is statutorily restricted.

6. The contraceptive services where so determined, should be offered whenever possible, in a broad spectrum counseling context, which should include interpersonal relations, mental health and sexually transmitted infections, including HIV/AIDS (on-site or through supervised referral).
7. Health professionals offering contraceptives to minors should provide clear information on the method, (including information on any side effects) and appropriate follow-up to ensure compliance.
8. When deciding whether or not to accept a minor as a patient, the nurse or physician should evaluate his/her personal view. If a provider's view on confidentiality restricts the provision of services to a minor, the patient should be counseled and referred to another provider.

9. Providers should be aware that the low dose combined oral contraceptive pill and condoms are available without prescription.”

## **G. Adolescents’ Access to Reproductive Health Care**

### **1. *Public, Private and Commercial Sectors***

Reproductive health services are accessed through public health care system and private physicians. Contraceptive care in the public system is guided by the 1999 *Service Delivery Guidelines for Family Planning* in Jamaica, discussed above. The service delivery guidelines and the policy on providing contraceptives to minors also apply to the private sector.

The Pharmacy Act regulates the place of sale and distribution of drugs and devices. Some over-the-counter contraceptives are available to adolescents, including condoms and low-dose oral contraceptives, if adolescents can overcome other barriers (e.g. cost, psychological) to access.

### **2. *Health services in schools***

Schools are an appropriate point to supply mainly preventive services for adolescents. The services currently provided in schools include medical dental, vaccines, and immunization, with limited curative services.

Access to health care through schools is governed by school policies that state accidents and illnesses must be reported to the school authorities and to health authorities if they include reportable diseases. In addition, a student may be barred from attending school under the Communicable Diseases Act. In certain situations, the school nurses and authorities will refer the adolescent to the public health system for curative and specialist services. At this time, no reproductive health services are provided through school-based health services.

Guidance and counseling is offered to all students in schools. Each school is authorized to have a Guidance Counselor. Given funding limitations, however, not all schools have guidance counselors. Guidance and counseling covers a wide range of topics, from family dysfunction, abusive situations and sexual concerns affecting adolescents, among others.

### **3. *Abortion***

Abortion is illegal in Jamaica under the Offenses Against the Person Act. The person seeking the abortion is punishable as well as the person who performs the abortion. In Statute Law, which codifies the law of the land by Parliament, there is nothing to indicate that an abortion may be performed legally. Medical practitioners, under special circumstances may perform abortions, provided that a second officer agrees that the procedure is necessary. In such a circumstance if a case of abortion is brought before the courts, the judge uses his discretionary

powers, informed by precedent to make a decision in the case before him. The criteria for an abortion by a medical practitioner are that:

- There is grave and immediate risk to the health of the woman - physical or mental - from continuation of the pregnancy;
- The child is like to suffer from some degree of physical or mental impairment;
- the pregnancy is a result of incest or rape or other forms of criminal intercourse;
- childbirth is like to have an adverse effect on family health and well-being;
- routinely employ contraceptive methods failed.

The complications of abortion performed by non-medical personnel seen at Victoria Jubilee Hospital and other hospitals (such as perforation of the uterus) may result in hysterectomy or even death of the adolescent. This indicates that adolescents are seeking and obtaining abortions. This is an area that requires urgent attention.

#### **4. *STI/HIV/AIDS***

While adolescents have access to services for treatment for sexually transmitted infections and HIV/AIDS, barriers exist to adolescents accessing the services. In addition, the MOH notes the need for legislation on HIV/AIDS, including in the area of denial from health services. The MOH's National HIV/STD Control Programme (NHCP) Medium Term Plan 1997-2001 specifically notes the need to reach youth, including through marketing of condoms to adolescents (MOH, 1997).

### **G. Access to Information**

#### **1. *Health education***

Adolescents need the opportunity to access information on the biological and psychosocial characteristics of adolescence and the changes associated with this time, nutrition, disease prevention, and fertility regulation. Schools are uniquely placed to convey this information to students. Indeed, health education is an essential feature of school curricula.

Jamaica has had a family life programme for over 25 years, with mixed results. Most experts believe that FLE starts too late and that topics covered are too general to have much impact on sexual behavior, contraceptive use and disease prevention. Also, the curricula do not address gender, which is very influential on sexual behavior. General family life education begins in schools at age six, and progresses to another level of specificity of information at age nine.

The most recent policy on FLE is contained in the 1999 [A Statement of National Policy for Health and Family Life Education in Jamaica](#) from the Ministry of

Education and Culture. (The 1999 policy statement is a partial revision of the previous policy promulgated in 1994.) The 1999 policy states that, “Health and Family Life Education, because of its emphasis on the promotion of appropriate value systems and desirable attitudes and the imparting of relevant skills, is a useful vehicle for furthering national goals. HFLE should, therefore, encompass the life span of the individual to include young children, students, out-of-school youths and adults” (MOEC, 1999: 4). While the 1999 policy statement does not delve into the specifics of curricula, it does mention sexual health. One of the objectives of HFLE is to “enable persons to understand themselves as socially and sexually responsible beings” (p. 7). In its definition of HFLE, the policy “recognizes the importance of human sexuality and incorporates the importance of reproductive health education” (p. 7). Further objectives of the policy are to: “provide guidelines for the standard delivery of HFLE in the formal system” and “provide guidelines for the revision and development of HFLE materials for the formal and non-formal sectors” (p. 10). This policy objective paves the way to incorporating new perspectives in promoting adolescent reproductive health into HFLE. The policy lists a number of governmental and non-governmental organizations charged with working with the MOEC to develop and implement HFLE in Jamaican schools. The MOEC’s primary partner in this endeavor is the NFPB.

HFLE efforts in Jamaica have been influenced by the Standing Committee of Ministers of Education (SCME) in the Caribbean Community (CARICOM), in place since 1986. At that time CARICOM mandated its Secretariat to implement a strategy designed to broaden the scope of HFLE in the Region, to strengthen the teachers’ capacity to deliver HFLE programmes and to establish requisite home-school community linkages.

There is no universal approach to reproductive health education, but as far as the law is concerned the following issues are pertinent: what reproductive health education courses should be permitted within the school curriculum; should they be obligatory or elective; what the content of the courses should be; whether the curriculum is separate or integrated; at what age should it begin and what should be the duration; should the sexes be separate or together for instruction; what is the role of the parents; should their consent be required; and should they be permitted to screen the materials used in courses. These issues are not addressed fully in the HFLE policy (Brisset, 2000; HFLE Seminar, 2000).

A Guidance and Counseling degree is offered at all the teacher training colleges in Jamaica, for example at Mico Teacher Training College, Sam Sharpe Teachers’ College, Shortwood Training College and the United Theological College. These teacher’s training colleges offer certified courses. Other Universities with headquarters overseas and affiliates in Jamaica also offer certified guidance and counseling degrees.

Access to health education outside of the school environment is generally through public and private health care providers. The age of consent issues previously discussed apply.

## **2. Counseling**

No laws exist on counseling in Jamaica. In practice, physicians, social workers or nurses provide counseling, in the public health system. Most workers feel that the main responsibility of counselors is to provide accurate information to the client to assist them in decision-making (McFarlane et al., 1996). NGOs and private providers also provide counseling, but laws regarding counseling do not govern their activities.

Counselors in Jamaican schools have to have a teacher's training certificate, but not necessarily related to counseling.

## **3. Public Information on Contraception and Reproductive Health**

There is no restriction on dissemination of unbranded information about contraceptives, for example, through social marketing. Branded consumer advertising is allowed for all reclassified pills of doses less than 750 mg of Levenorestrel, but only with application to and approval from the MOH. The MOH must approve each ad.

Advertising, including for social marketing, needs to take the Obscene Publication Act of 1927 into account, that seeks to suppress obscenities in publications that are produced for public consumption.

## **H. Partner Notification and Testing**

Adolescents are covered by the MOH's guidelines on partner notification and contact investigation. Proposed AIDS legislation, prepared by the Legal and Ethical Sub-Committee of the National AIDS Committee, states that "where the PWA [person living with AIDS] is a minor...the Health Care Provider should be able to disclose to the PWA parent or guardian" (NAC, 2000: 6).

For testing, the proposed legislation states that, "All HIV testing should be undertaken under considerations that ensure confidentiality, informed consent and pre and post-test counseling. Consideration should be given to providing for HIV testing without the permission in the following situations: rape (including buggery), incest.... Provision should be made for allowing parent or guardian to give consent for testing in respect of children who are under the age of legal consent" (NAS, 2000: 11).

There is no legislation on schools' rights to require HIV tests of students. This issue has arisen due to a student being told he could return to school until he had had an HIV test (his mother is HIV positive). The proposed AIDS legislation also states that, "institutions of Learning should not refuse to admit students infected by HIV/AIDS. Persons with HIV/AIDS should not be expelled or suspended due to their HIV/AIDS status or that of their relatives" (NAC, 2000:

10).

### III. Gaps in the Policy Environment For Adolescent Reproductive Health

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Jamaica is making great strides in ensuring adolescent access to quality reproductive health services. Abstinence is always first promoted as the best method to avoid negative outcomes. However, the reality in Jamaica is clear: unprotected sexual activity is widespread and begins early. The legal, regulatory, and policy environment is improving but work must continue to codify the rights of adolescents to reproductive health information and services. A number of challenges remain, including the need to:

- Complete the guidelines on providing contraceptives to minors, and revise the Medical Act to reflect this policy.
- Ensure the rights of adolescents to access reproductive health services, including STD/HIV services and all contraceptive methods, through dissemination of the MOH *Strategic Framework for Reproductive Health*, the *Family Planning Service Delivery Guidelines* and the guidelines on serving minors. Clear guidelines for service providers could help eliminate some of attitudinal and gender-based barriers.
- Ensure that providers are free from legal liability in giving sexual and reproductive health care to sexually active adolescents below the age of consent (through the adoption of the UK Gillick law).
- Institutionalize and strengthen Health and Family Life Education (HFLE) in the school system (including evaluation of HFLE). Implement an HFLE policy that requires teaching effective, youth-informed HFLE curriculum in all schools before age 10 and implement youth-friendly counseling/teaching techniques as part of pre-service training for all potential school counselors and HFLE teachers.
- Ensure the right of re-enrollment of adolescent mothers to the formal school system. A legal opinion written by Macaulay (2000) found no reason for girls not to be allowed to return to school. She urged “that the Minister of Education, in the first and immediate instance be formally invited to exercise his discretion under Regulation 31(2) to permit the continuance in school of pregnant teenage mothers as has happened in other Caribbean countries by the formulation of policies in this regard. If the invitation is refused, then lobbying for the passage of legislative provisions ought to be

undertaken.” A law exists that gives adolescents the right to enrollment after having a child. However, that law is not usually enforced.

- Pass the proposed AIDS legislation to ensure that students are not denied access to education due to their HIV status or that of family members.
- Successful elsewhere, peer education programs are an effective mechanism for young people to work together to address ARH on their own terms. Peer education programs should be expanded.
- Institute a system of referrals from school-based health services to reproductive health services.
- Reexamine the law stating that men who have consensual sex with girls under 16 face criminal prosecution<sup>1</sup>. This situation makes it difficult to get young baby-fathers to come forward and accept responsibility without facing jail time.
- Protect boys and girls through enforcement of laws related to sexual exploitation, including incest and rape.
- Provide clear guidelines on what constitutes forced sex/rape.
- Legally obligate health care staff to inform relevant authorities on all cases of violence and abuse against adolescents.
- Develop a national youth STI/HIV prevention policy, with decentralized goals and objectives.
- Develop a policy for diagnosis and treatment of infected adolescents for more effective STI/HIV/AIDS prevention and control response.
- Develop a policy and protocol for treatment of high-risk pregnancies, which include all adolescent pregnancies.
- Develop the existing youth policy to include ARH issues.

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<sup>1</sup> The Adolescent Policy Working Group is recommending that the team drafting the Child Care and Protection Act consider this issue in their deliberations.

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### List of Legislation and Policies included in this review:

#### *Legislation*

The Adoption of Children Act  
Child Care and Protection Act (1999, proposed)  
The Children (Guardian and Custody) Act  
The Education Act (1965).  
The Juvenile Act (1951)  
The Labour Act  
Law Reform (age at majority) (1989)  
Hindu Marriage Act (1957)  
The Marriage Act (1887)  
Muslim Marriage Act.  
The Offences Against the Person Act (1964)  
The Pharmacy Act (1960)  
The Venereal Disease Act (1957).

#### *Policies:*

Family Planning Service Delivery Guidelines (1999), MOH and NFPB  
Providing Effective Contraceptives to Minors, 2000, draft, MOH and NFPB  
Strategic Framework for Reproductive Health, 2000-2005, MOH  
National Policy for Family Life Education (1994–1995. Revised in 1999)  
National HIV/STD Control Programme Medium Term Plan (1997-2001), MOH  
National Plan of Action for Children (1995)  
National Plan of Action on Population and Development (1995-2015), PIOJ  
National Policy for Children (1997)  
National Population Policy (1995, revised), PIOJ  
National Youth Policy (1995)