

PN-ABM-200

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**BACKGROUND BRIEFING BOOK  
FOR FAMILY PLANNING INITIATIVES PROJECT  
IN JAMAICA**

**Based on a Review of Secondary Research**

**DRAFT**

Prepared for

National Family Planning Board  
and  
Family Planning Initiatives Project Participants

Prepared by

The Futures Group  
One Thomas Circle NW, 6th Floor  
Washington, DC, USA 20005-5608  
(202) 775-9680

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## **INTRODUCTION**

**The purpose of this briefing book is to summarize key information that will be useful to USAID/Kingston, the Jamaican National Family Planning Board (NFPB), and other participants involved in the Family Planning Initiatives Project (FPIP). The information presented here was selectively chosen from data available from existing research reports and records and with the strategic direction of the new FPI project in mind. It is hoped that this information will be valuable to project participants as they proceed with various planning and implementation activities. For more detailed information about any particular topic, refer to the bibliography or summary of research studies reviewed in Appendices A and B.**

**All the materials collected as a part of this effort will be made available to NFPB. It is hoped that this will help to initiate the beginning of a family planning resource center at NFPB. It is also hoped that as other materials are identified or prepared that they too will be added to the collection.**

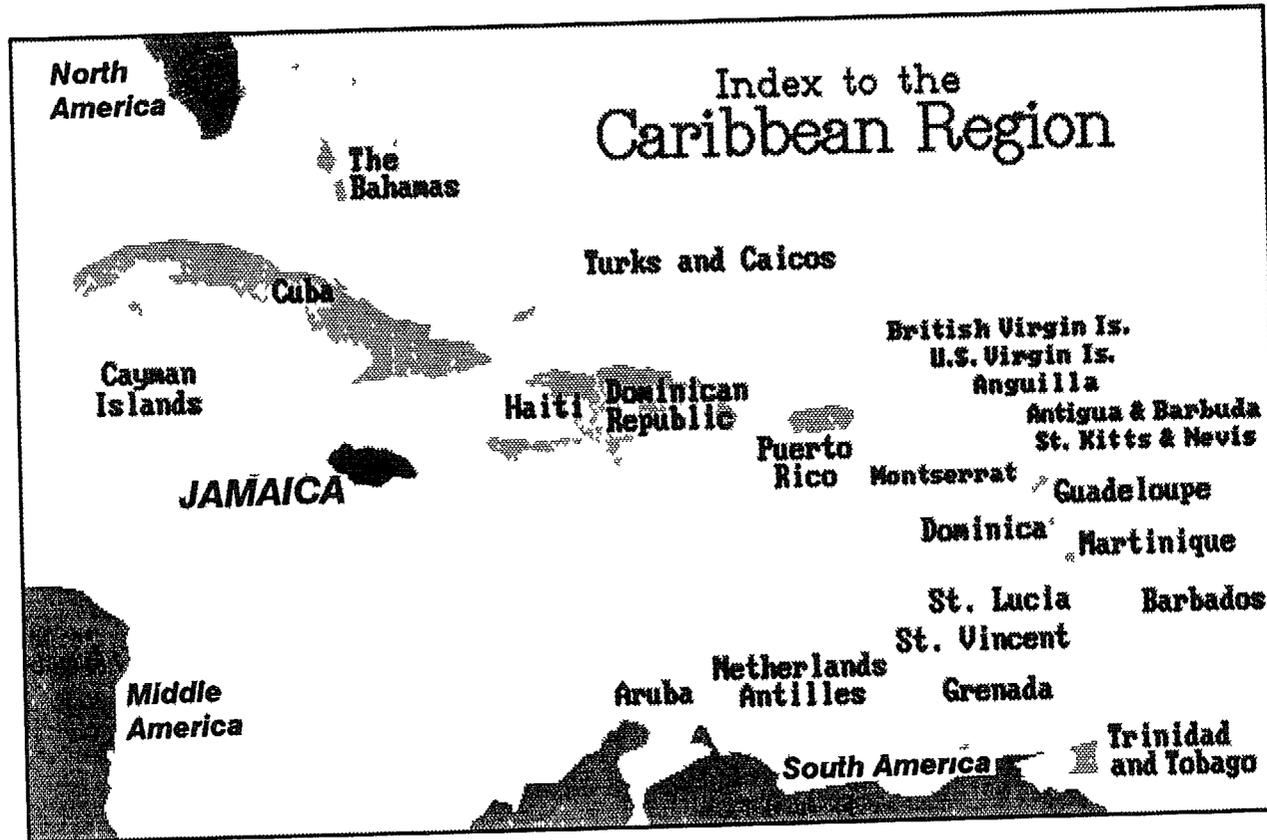
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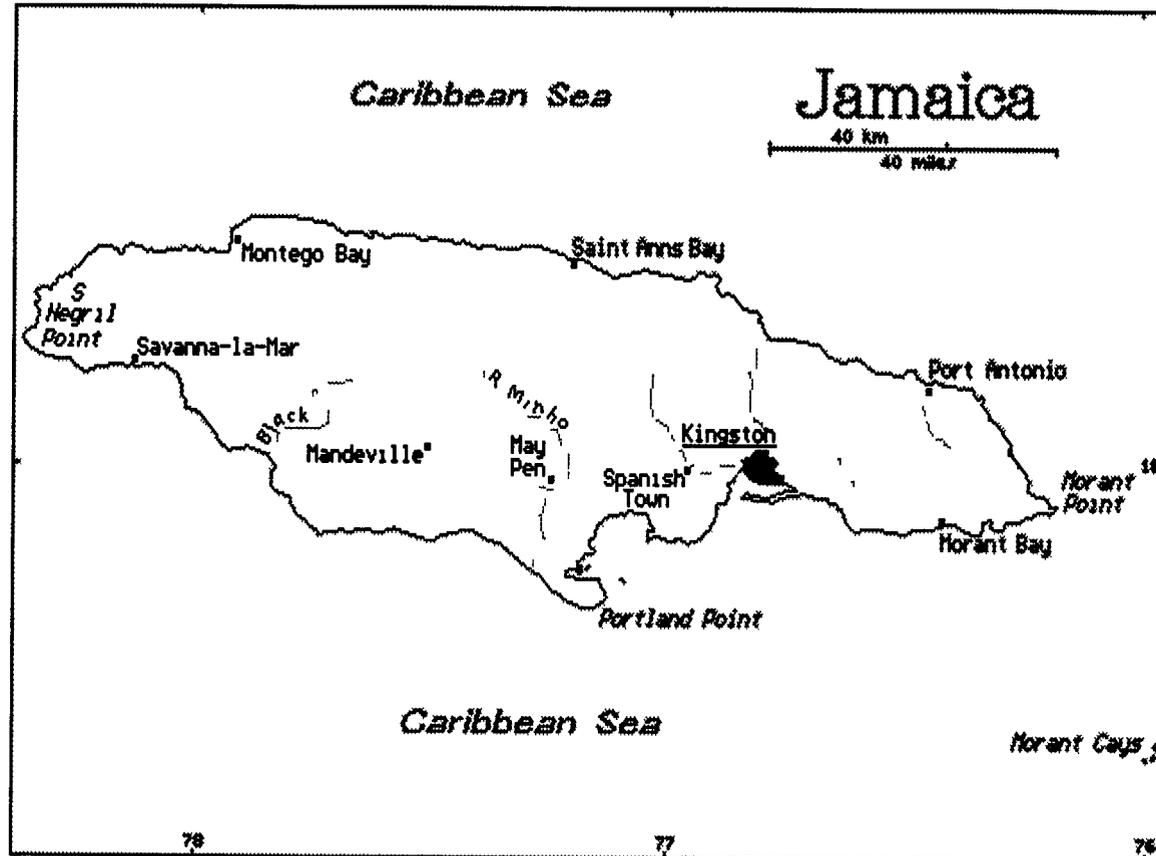
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## **I COUNTRY SITUATION**

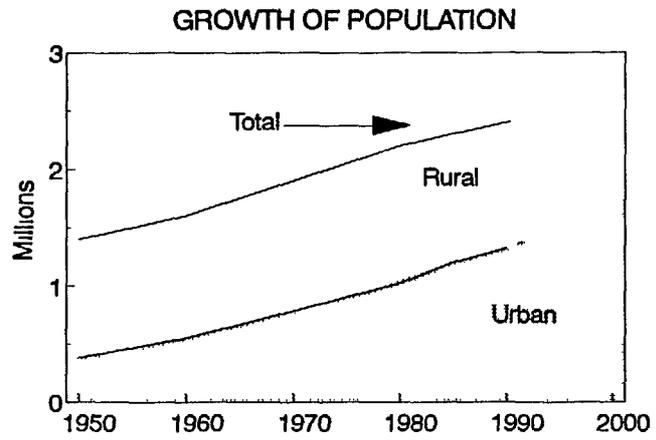
# MAP OF CARIBBEAN REGION



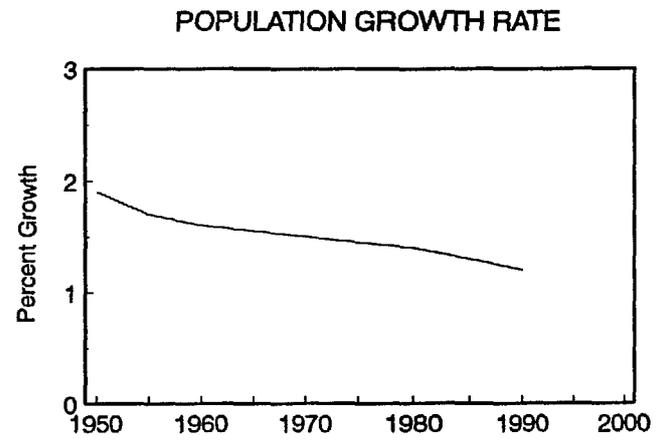
# MAP OF JAMAICA



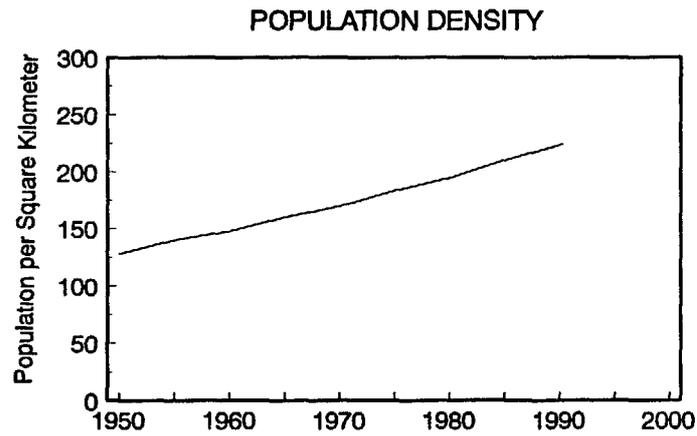
## DEMOGRAPHIC TRENDS



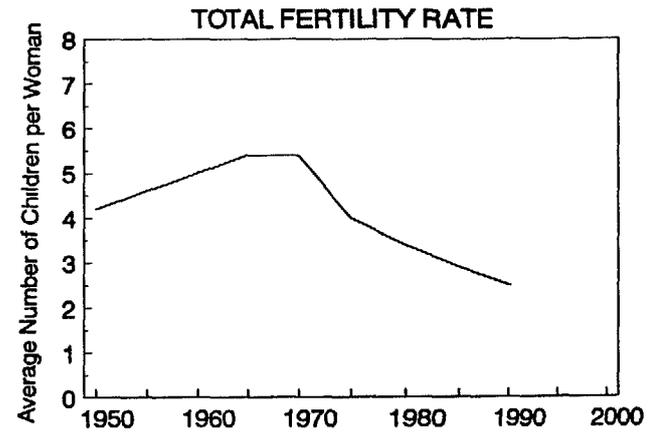
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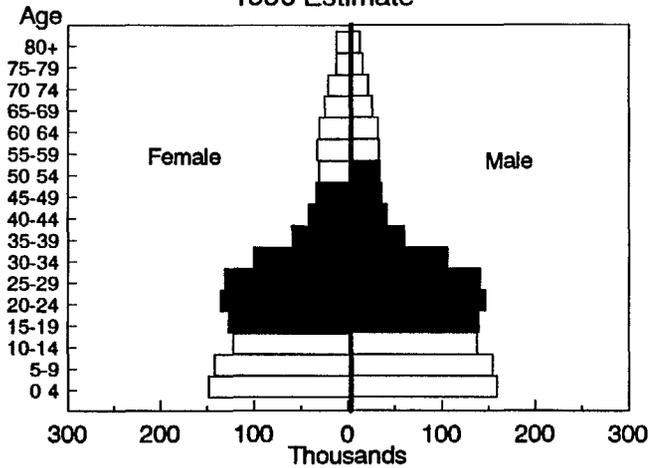
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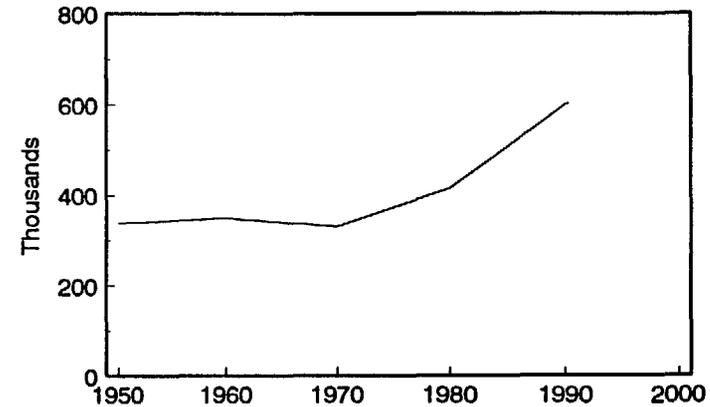
## DEMOGRAPHIC TRENDS

**AGE STRUCTURE OF POPULATION**  
1990 Estimate



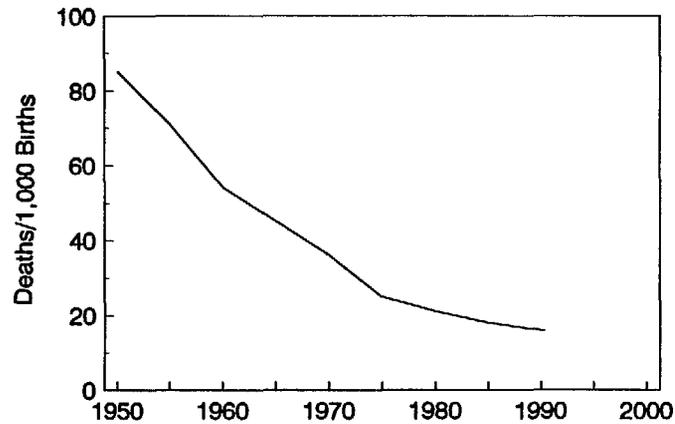
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**WOMEN OF CHILDBEARING AGE**  
(15-45)



Source 12

**INFANT MORTALITY RATE**



Source 12

**MATERNAL MORTALITY**

■ Most recent estimate is 115 deaths per 100,000 women (1984)

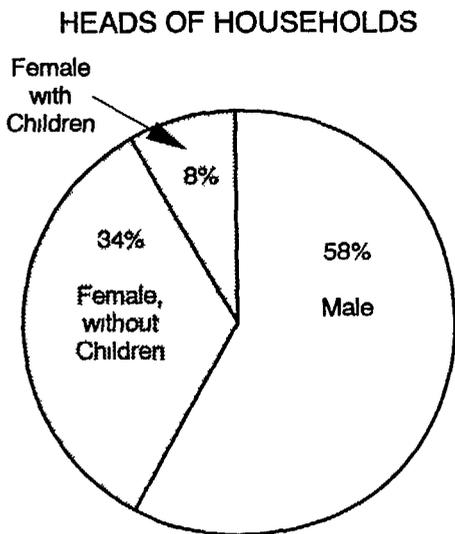
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## **DEMOGRAPHIC CHARACTERISTICS OF POPULATION**

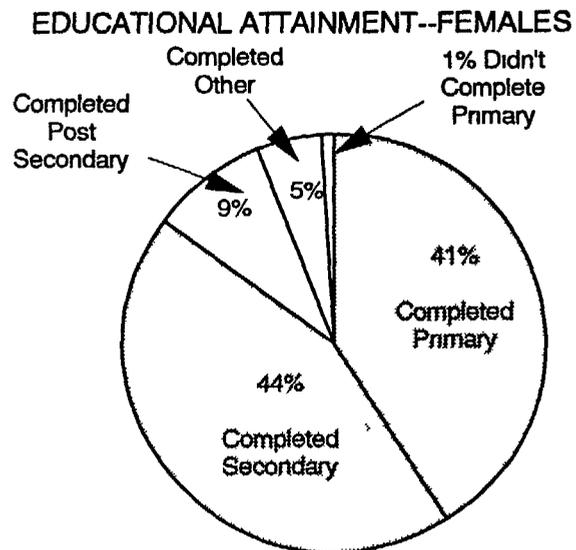
- **The Jamaican population was estimated to be 2.4 million in 1991. The population is growing at an annual rate of 1.1% and is projected to double to 4.8 million by 2026. Jamaica is ranked as the 33rd most densely populated country (33/160), with population density of 587 people per square mile. (Actual density is higher because of sizeable under-inhabited mountainous interior.)**
- **Internal migration and the rate of urban growth is occurring at a moderately high rate of 2.5% per year. The present urban/rural split is 52% to 48%, in favor urban areas — with over one-third of the total population residing in the Kingston metropolitan area.**
- **Net external migration (i.e., difference between immigration and emigration) has been continuing at a high rate. Between 1980 and 1990, official estimates show that the country has lost 193,000 people or an average of 17,000 persons per year. This net loss has helped to reduce the overall growth of the population. (One analyst has estimated that, between 1960 and 2000, 1.8 million births will be averted due to emigration and 2 million births averted due to reductions in fertility.) In addition, there is a sizeable group of migrant farm workers that seasonally seeks work abroad.**
- **There are approximately 600,000 women (or 52% of all women) who are of reproductive age (i.e., 15-45). Because the age structure of Jamaica is fairly young, this number is expected to grow to slightly over 700,000 by the year 2000.**
- **Total fertility rate has steadily declined from approximately 6 in the late 1960s to 2.9 in 1989. Jamaica's index of fertility transition (IFT), which is a measure of how far a country has come between a maximum rate of 8.5 and a replacement level of 2.1, is 88%. This means that Jamaica has completed 88% of the move from a high fertility country to one with replacement fertility.**
- **Health indicators show major improvements — increases in life expectancy and reductions in infant and maternal mortality.**

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### SOCIAL SITUATION

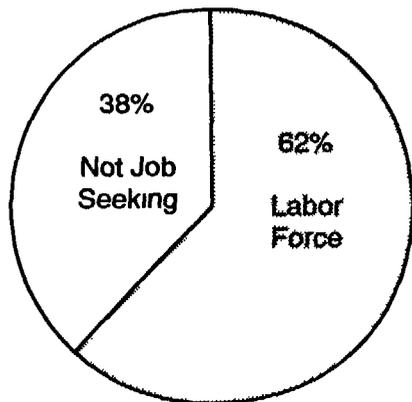


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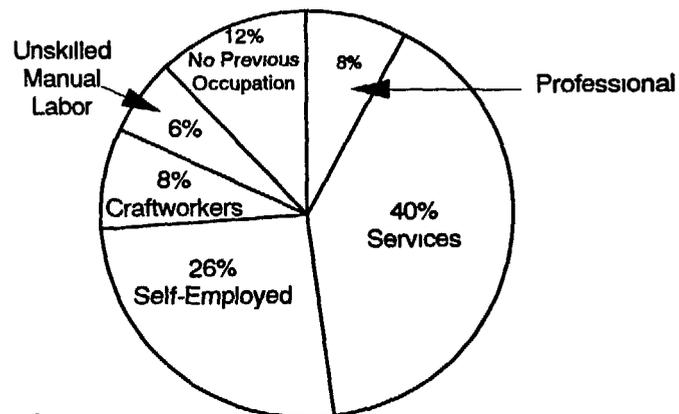
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#### LABOR FORCE PARTICIPATION RATES -- FEMALES



Source 9

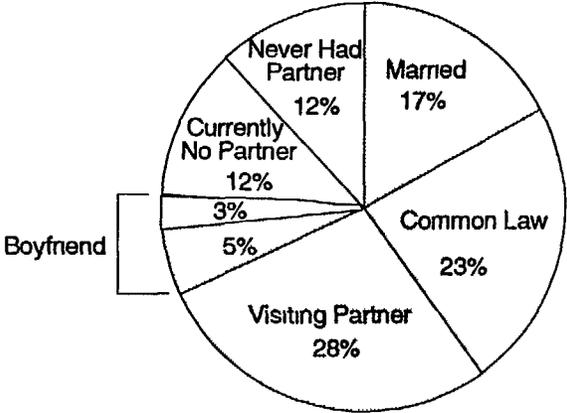
#### LABOR FORCE BY OCCUPATION -- FEMALES



Source 9

# SOCIAL SITUATION

**TYPE OF UNIONS--FEMALES**



**LENGTH OF UNIONS--FEMALES**

Union Status \ Length of Union	<1 Years	1-2 Years	3-4 Years	>5 Years
Married	5	4	6	85
Common Law	6	18	17	59
Visiting Relationship	19	33	20	28
Boyfriend	25	43	13	19

Approximately half the women have been in their current union less than five years

**NUMBER OF SEXUAL PARTNERS**

<i>Females</i>				
Age	14-19	20-29	30-39	40-49
Avg # of Partners	1.5	2.0	2.3	2.4
% Having Had a Partner	54%	94%	96%	99%

Note: Sexual partner does not necessarily equate with sexual relationships

**AGE AT FIRST INTERCOURSE--FEMALES**

Age	14-19	20-29	30-39	40-49
Average Age	14.8	16.6	17.0	17.5
% Having Had Sex	50%	94%	99%	100%

**AGE AT FIRST BIRTH--FEMALES**

Age	14-19	20-29	30-39	40-49
Average Age	16	18	21	23
% Having Given Birth	17%	71%	91%	92%

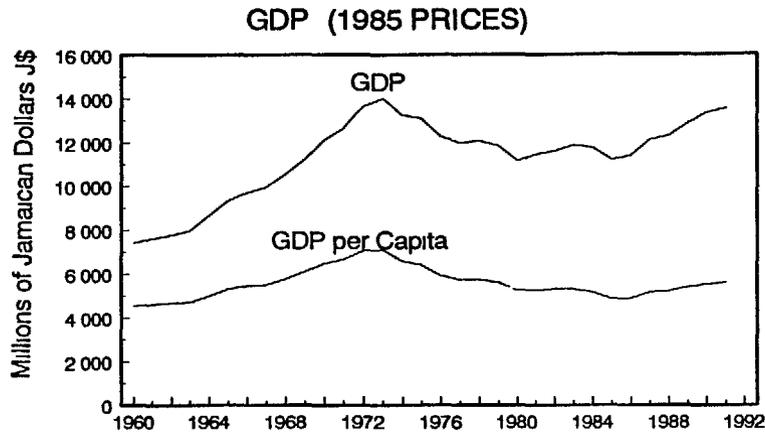
Sources 48, 77

## **SOCIAL SITUATION**

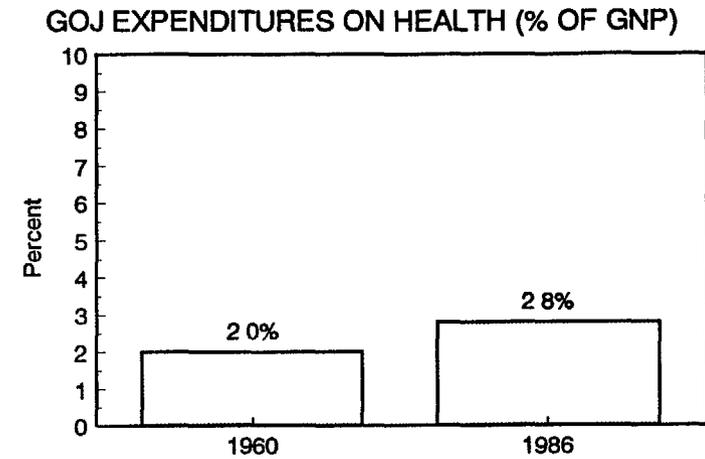
- **Jamaica is a relatively homogeneous society, which has been shaped both by the African slave plantation culture and later British colonial rule**
- **Social structure**      **Tends to be a matriarchal society characterized by early sexual activity, unstable unions, and the taking of casual or "outside" partners. Mating tends to begin in unstable relationships and move toward more stable unions. Much child birth occurs outside of legal unions. Child birth signifies a rite of passage for young women. A social stereotype of male sexual prowess exists. Recent studies suggest that as many as half the men take outside partners. Age at first intercourse appears to be decreasing from 18 to 16 years old, while age at first birth shows signs of increasing from 18.8 to 20.2 years old.**
- **Status of women**      **Signs of improvement — 88% of women are literate, 67% of girls are enrolled in secondary school, 68% of women are employed as wage earners, 42% of households are headed by women, equal pay and child support laws exist. Still women earn a fraction of what men do and many still end up as the sole supporter of their children.**
- **Ethnic groups**      **76% African, 15% Afro-European, 9% East Indian, 3% White, 1% other**
- **Religions**      **41% established Protestant (Jamaica Council of Churches), 30% Evangelical, 5% Roman Catholic, 4% other (including Rastafarian), 20% no religion**
- **Language**      **Official language English, Creole English (patois)**
- **STDs and AIDS**      **The incidence of STDs has declined from a high in the late 1960s and early 1970s of approximately 5% of the adult population to less than 1% in 1990. The number of AIDS cases, although still small, has been steadily increasing. As of September 1991, 268 AIDS cases have been reported.**

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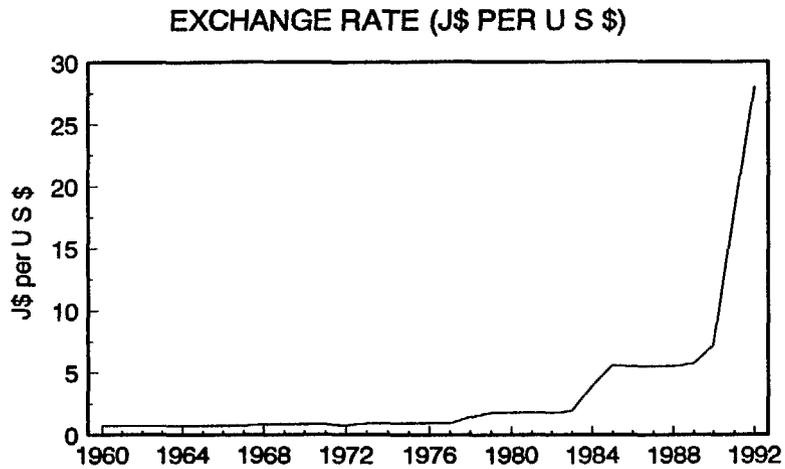
### ECONOMIC ENVIRONMENT



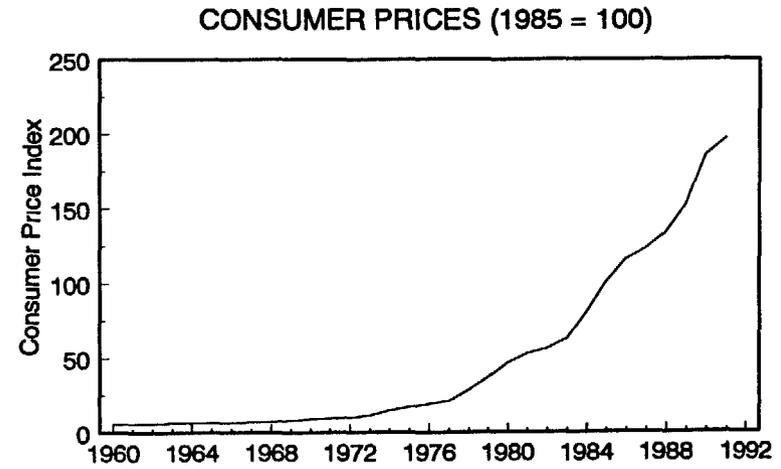
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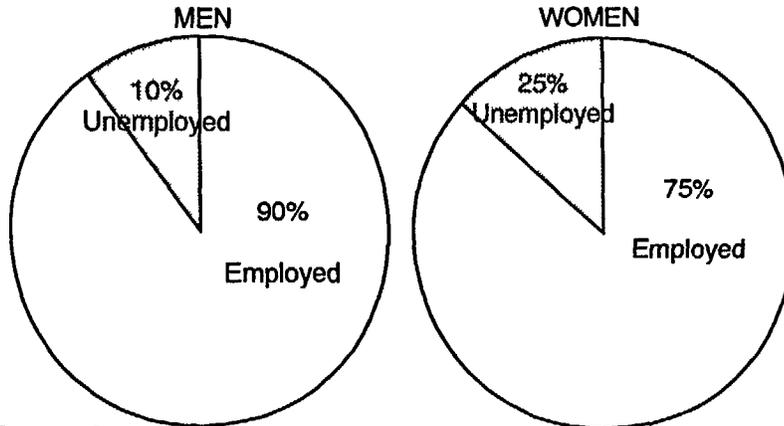
Sources 2, 4



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## ECONOMIC ENVIRONMENT

### UNEMPLOYMENT RATES



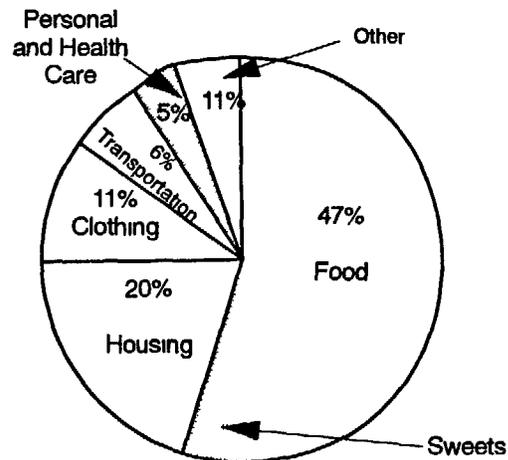
Source 9

### AVERAGE HOUSEHOLD INCOME (1989 - J\$)

Population Quintile	Average Household Income
1	7 115
2	13 340
3	19,910
4	30 630
5	68 570

Source 16

### CONSUMPTION PATTERNS



Source 16

### CONSUMPTION EXPENDITURES

Population Quintile	% of National Consumption
1	5
2	10
3	14
4	22
5	49
Total	100

■ Mean per capita consumption J\$5 581

Source 16

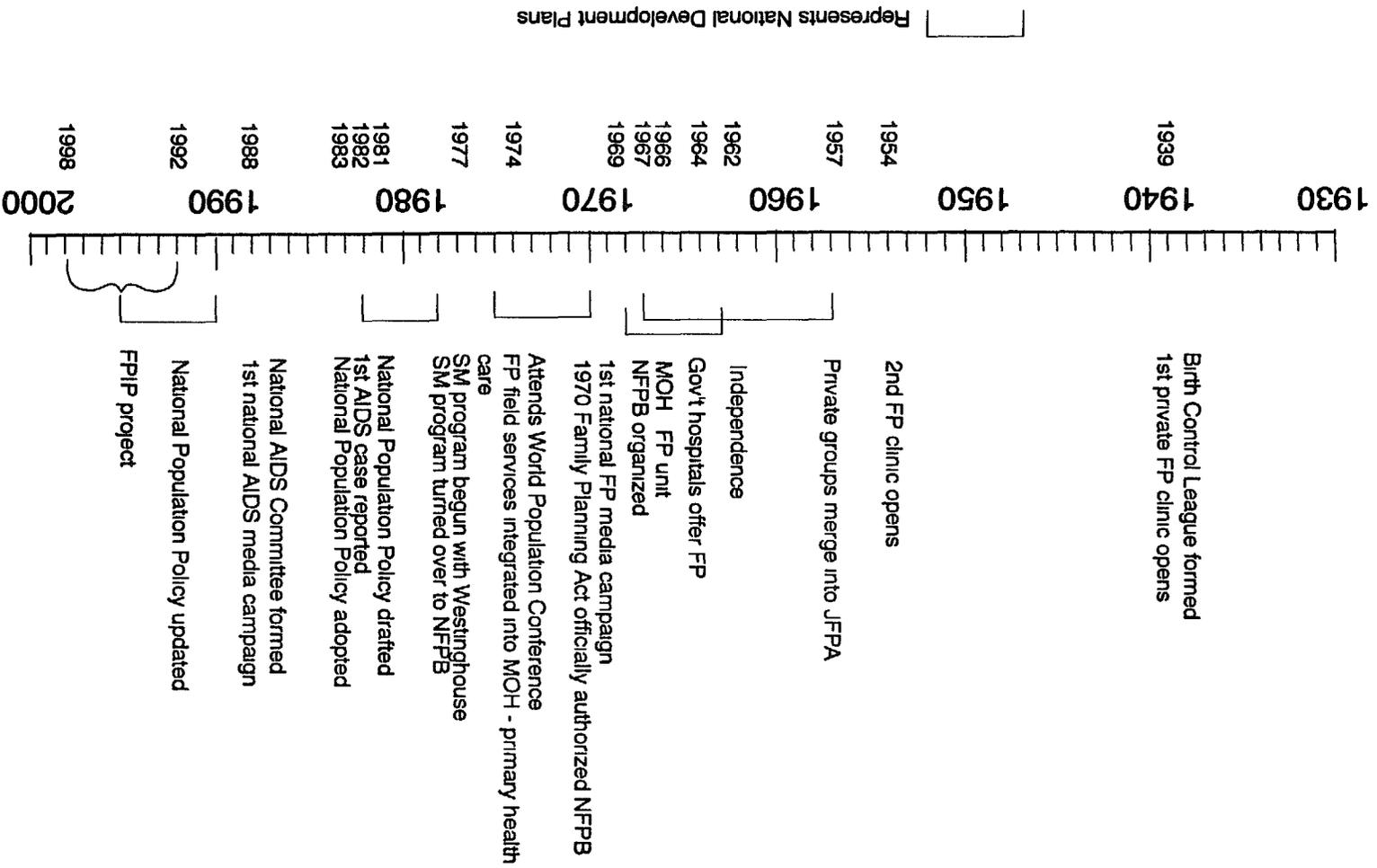
## ECONOMIC ENVIRONMENT

- The World Bank classifies Jamaica as a "lower-middle income" country. It has an estimated GNP per capita of US\$1,260, which is in the middle of the range for other Caribbean island nations.
- Economic growth outpaced population growth throughout the 1960s and early 1970s. The economy then went into a period of decline, beginning with the oil price increases in 1974 and ending in 1986. Since 1986, the economy has steadily grown at a rate slightly faster than the population.
- The current economic situation is dominated by the fall of the Jamaican dollar and the subsequent rise in inflation. When the currency was allowed to freely float in September 1991, it stood at J\$8 = US\$1. In May 1992, it stands at J\$23 = US\$1. Inflation soared to 80% in 1991 and is expected to be 35% in 1992. Wages have not kept pace and consequently living standards have been sharply reduced. Demand for many consumer products has also been sharply reduced, by as much as 50-70% for some drugs, infant formula, and other consumer products. Economic pressures will likely increase demand for family planning as couples hope to delay or forgo having more children.
- Income distribution is heavily skewed. The wealthiest 20% of the population accounts for 49% of national consumption. It is estimated that one-third of the population lives below the poverty line.
- Minimum monthly wage is J\$560 for domestic helpers and J\$640 for other workers. Minimum annual wage is J\$12,000 for government employees. The bottom third of the population that is estimated to live below the poverty line has household incomes of less than J\$12,000 per year.

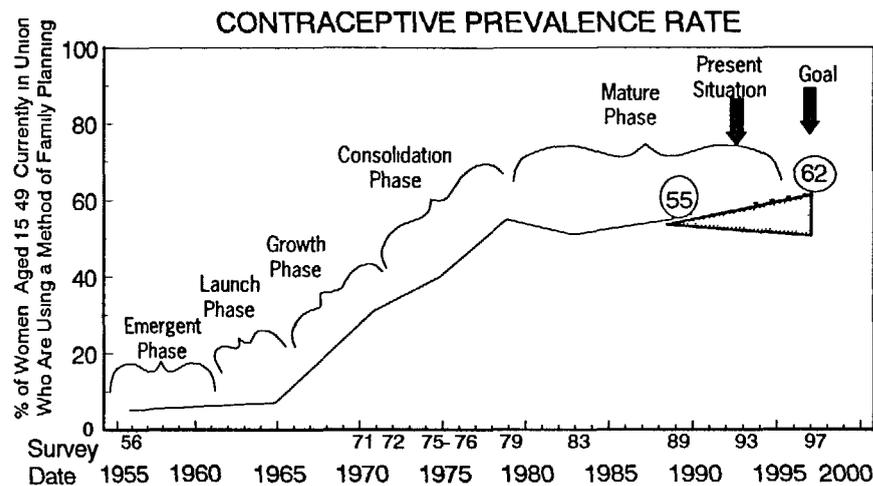
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## **II PROGRAM ENVIRONMENT**

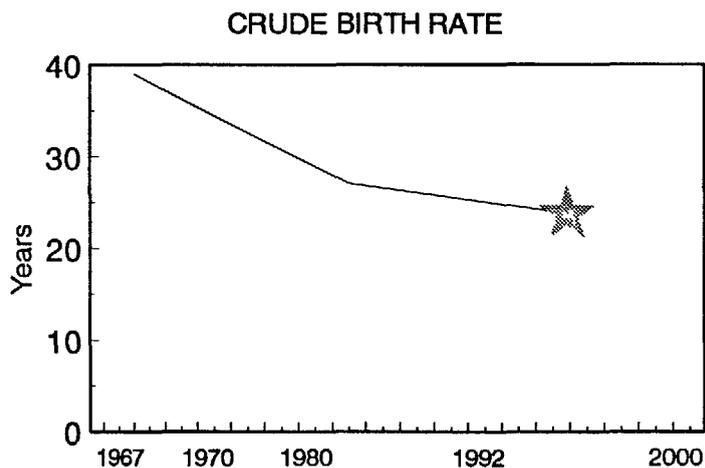
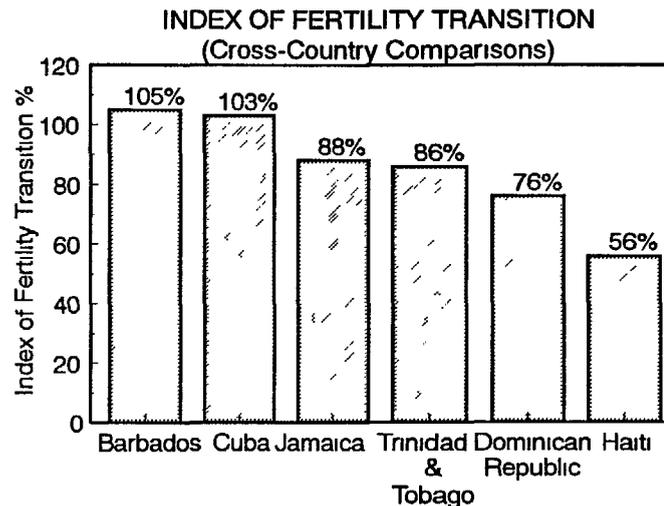
# EVOLUTION OF FAMILY PLANNING POLICIES AND ACTIVITIES



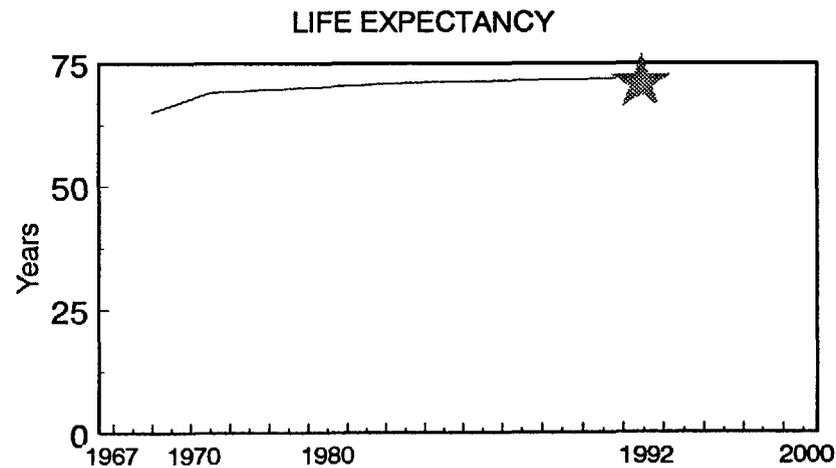
## FAMILY PLANNING PROGRAM HAS BEEN HIGHLY SUCCESSFUL



Source 6



Source 12



Source 12

## **GOJ's POPULATION POLICY AND GOALS**

- Jamaica was one of the first Latin American and Caribbean countries to become actively concerned about population issues. Initial goals focused on reducing the crude birth rate from 39 per 1,000 in 1967 to 25 per 1,000 by 1976 and then to 20 per 1,000 by 1990. First National Population Policy was drafted in 1981 and adopted by Parliament in 1983. The population policy has recently been updated and is currently under review.

### **Overall Goal**

- To improve satisfaction of basic human needs and quality of life of Jamaican people

### **Quantitative Goals**

- Population growth and size      To keep population growth rate under 1% per annum so that the population does not exceed 2.7 million by the year 2000 or 3.0 million by 2020
- Fertility      To achieve replacement level fertility by 2000. This will require the total fertility rate (TFR) to be reduced from 2.9 in 1989 to 2.1 by 2000. It is estimated that the contraceptive prevalence rate (CPR) will have to increase from 55% in 1989 to 63% in 2000 to achieve this goal. [Required CPR is probably closer to 65%.]
- Mortality      To further reduce infant mortality and thereby increase average life expectancy from 71 to 74 years by the year 2020
- External migration      To reduce external migration
- Internal migration      To reduce rate of urbanization and achieve a balanced spatial distribution of the population

## **GOJ's POPULATION POLICY AND GOALS**

### **Qualitative Goals**

- **Gender**            To promote greater equity between the sexes with regard to social, cultural and economic factors
- **Children**        To improve the survival, protection, education and social well-being of children    Specific measures will include the strengthening of family life education in schools
- **The aged**         To enable the aged to lead comfortable, functional and productive lives
- **The environment**    To promote a responsible, productive and sustainable use of natural resources — balancing economic development with environmental protection

Source 31

## **PURPOSE AND GOALS OF FPIP**

### **Purpose of FPIP**

- To increase effectiveness and sustainability of the national family planning system

### **Goals of FPIP**

- 1 Increase CPR from 55% in 1989 to 62% by 1998
- 2 Reduce unmet need (baseline is 16% or 103,000 women)
- 3 Increase use of long-term methods from 42% in 1989 to 60% by 1998
- 4 Increase in proportion of supplies/services distributed by private sector from 28% in 1989 to 40% in 1998
- 5 Establish financial self-sustainability of CDC program

Sources 27, 37

## GOALS OF HIV/STD CONTROL PROGRAM

- I Surveillance
- II Laboratory Facilities
- III Control of STDs
- IV Counselling
- V Training and Staff Development

### VI Health Promotion

Objective To reduce high risk sexual behavior including

- i) Reduction in the number of sexual partners
- ii) Reduction in the number of casual partners
- iii) Increase the use of condoms
- iv) Increase the correct use of condoms

Target groups STD clinic attenders, prostitutes, homosexuals, youth, migrant farmworkers, ICIs, travellers, seamen, tourism workers, and general public

Methods Mass media (conventional and nonconventional, i e , soap opera, dramas, etc ), interpersonal forums, community outreach, Ministry of Education and schools

Research Use research to design and evaluate intervention activities

Resource Center Establish resource center to facilitate program development

- VII Case Management
- VIII Infrastructure
- IX Management of the National AIDS Control Program

## LEGAL AND REGULATORY ENVIRONMENT

- **Import Licenses/ Permits**      **Pharmaceutical Act requires drugs to be registered and importers to receive a drug permit for every shipment. Frequently in the past, the Trade Board has also required an import license with every shipment. Presently no import license is required. Norplant has not yet been registered.**
- **Import Duties**      **Following duty schedule applies to commercially imported contraceptives — 10% import tax on condoms, 15% import tax on oral contraceptives, no GCT tax on contraceptives. All USAID-donated commodities (including social market products) come in duty free.**
- **Products**      **Sterilization is legal and must be performed by a physician. Norplant is undergoing a clinical trial. IUDs and injectables can be provided by certified (i.e., trained) medical personnel.**
- **Marriage**      **Minimum legal age for marriage is 16 for both women and men. Common law marriages are legally recognized.**
- **Consent**      **No official approval from spouse or parent is required to obtain family planning products or services. Physicians factor in medical as well as lifestyle considerations before administering long-term (or permanent) methods.**
- **Distribution**      **Oral contraceptives must be distributed by licensed pharmacists. Prescriptions are required for all oral contraceptives except for Perle, which can be sold on an over-the-counter basis. (In practice, many oral contraceptives are sold without a prescription.) All clinical methods can only be distributed by certified medical personnel.**
- **Pricing**      **No government price controls exist for commercial contraceptive products or physicians' fees. NFPB controls price of social marketing products.**
- **Advertising**      **Branded consumer advertising for family planning products (including oral contraceptives) is allowed. MOH, however, must approve each ad.**
- **Abortion**      **Illegal.**

## COMMUNICATION RESOURCES

- **Television**      One station — Jamaica Broadcasting Corporation (JBC) — government owned, commercial station  
Broadcasts islandwide 100 hours per week    Second station scheduled to come on-line in summer of 1992  
Set count 527,000    Potential audience 950,000 [low] — peak hours evenings
- **Satellite dishes**    Upscale audience    Dish count 13,600
- **Radio**              Five national stations, two regional stations    Set count 1.6 million    Potential audience 1.4 million [low]  
Most broadcast 24 hours a day — peak hours daytime

### 1991 audience share

- |  |     |
|--|-----|
| - Radio Jamaica -- RJR Supreme Sound                     | 41% |
| - Grove Broadcasting -- IRIE FM                          | 21% |
| - JBC -- JBC Radio 1                                     | 17% |
| - JBC -- JBC Radio 2                                     | 9%  |
| - Island Broadcasting Service -- KLAS FM (regional)      | 5%  |
| - Radio Jamaica -- FAME FM                               | 5%  |
| - Western Broadcasting Service -- Radio Waves (regional) | 2%  |

More detailed, dramatized radio serials have been used as an entertaining way of communicating family planning messages (e.g., JFPA's Naseberry Street)

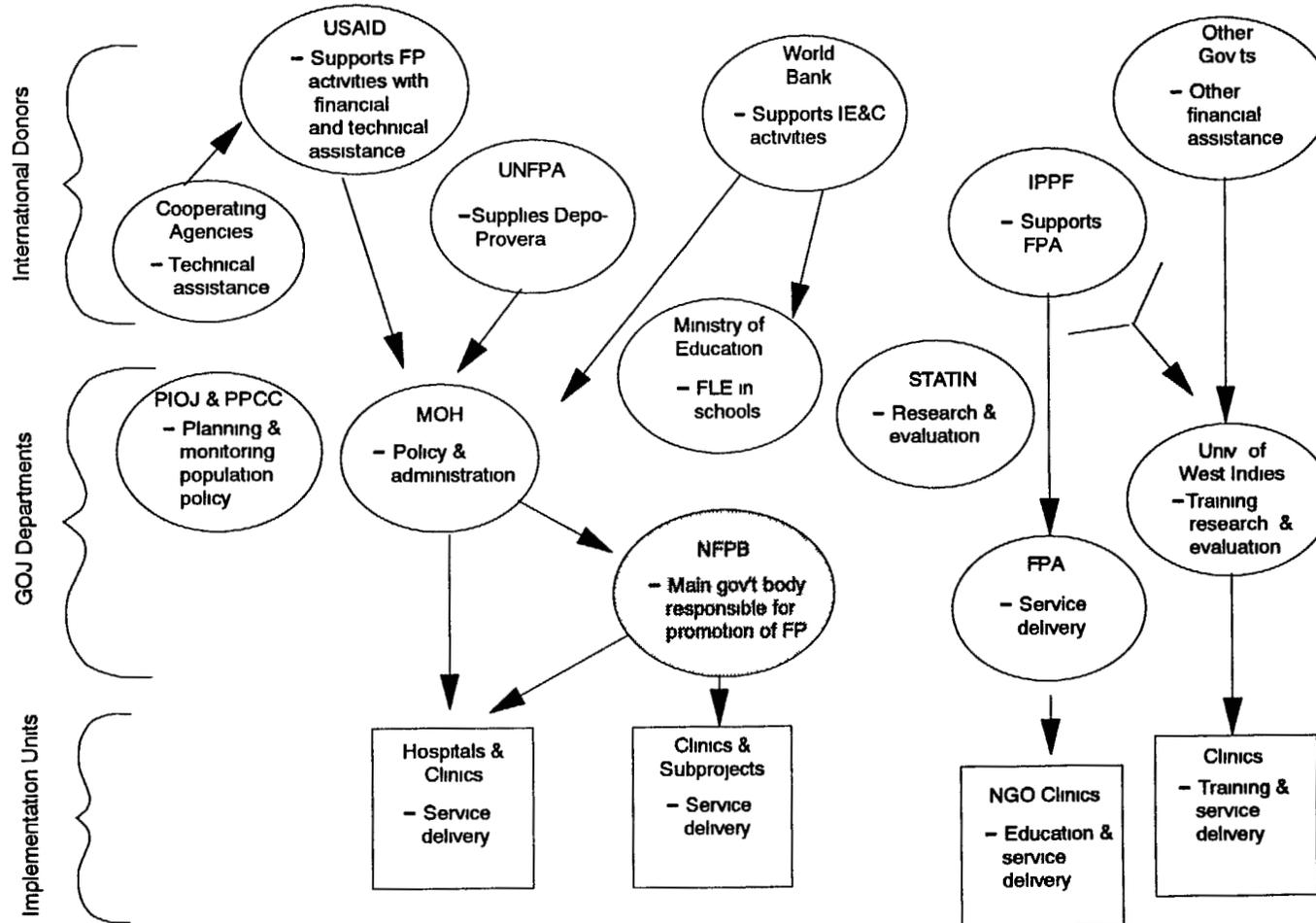
- **Press — Dailies/weeklies**
  - Daily Gleaner, middle market, circulation 42,000, readership 382,000
  - Sunday Gleaner, middle market, readership 443,000
  - Daily Star, lower end market, circulation 49,000, readership 359,000
  - W/E Star, lower end market, readership 377,000
  - Twin City Sun, regional weekly, middle market, readership 83,000
  - Western Mirror, regional

## COMMUNICATION RESOURCES

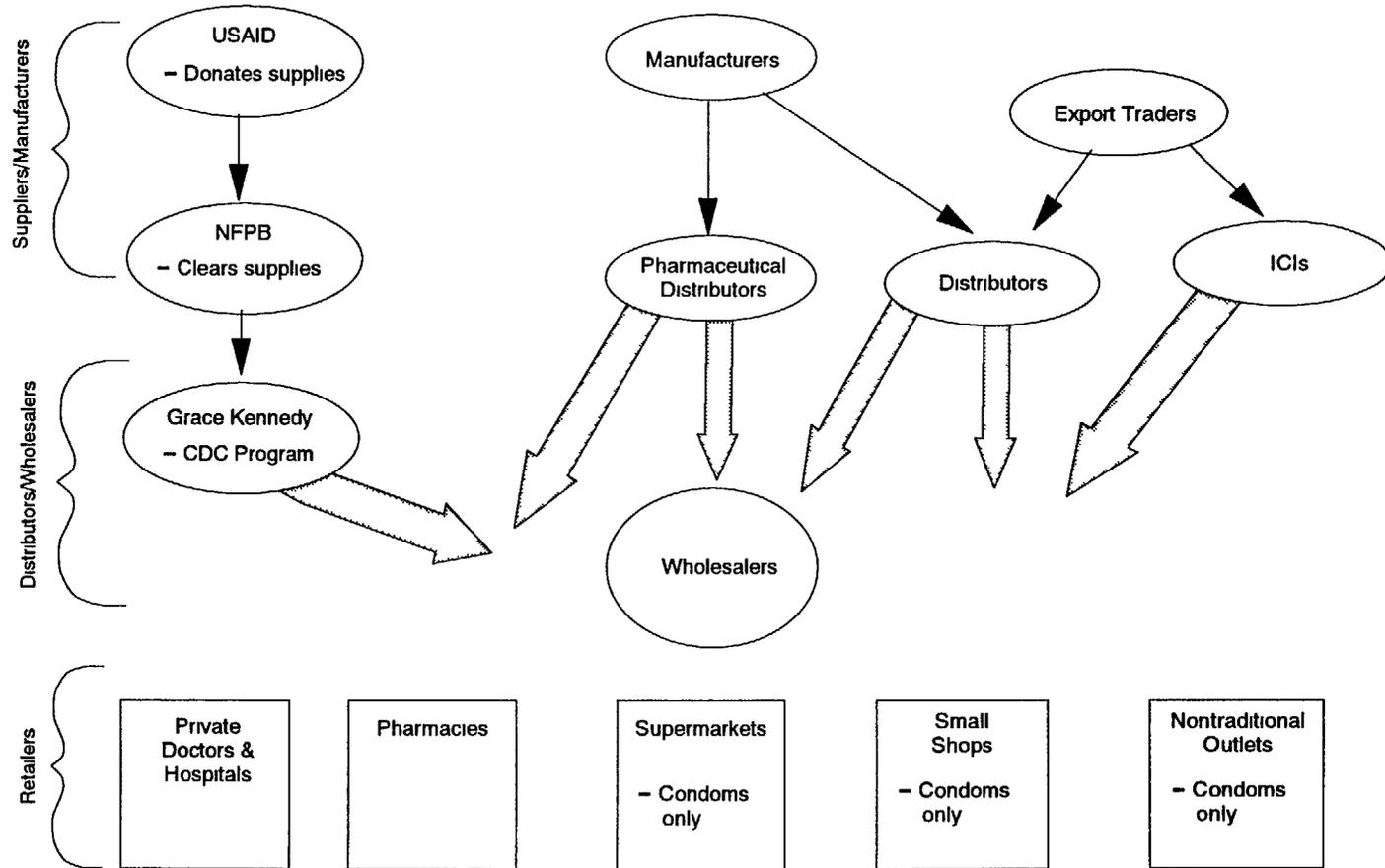
- Periodicals — upscale market, Money Index, Lifestyle, Skywritings (Air Jamaica), Jamaica Quarterly, tourist magazines  
Average circulation 5,000
- Cinemas One-week viewership 180,000 Prime audience is young males, 15-24 years old from lower socioeconomic classes
- Posters Available and allowed Can target locations based on target market
- Videos Good medium for lengthier educational film Could be shown at health clinics or community centers
- Interpersonal forums MOH has used a speakers program for AIDS education
- Traditional media Two theatre groups Groundwork Theatre Company and Sestern Theatre Collective have performed dramatized productions aimed at educating community groups about social issues/problems  
Reggae singers have been used for family planning messages
- Advertising agencies Nineteen advertising agencies Two agencies -- McCann-Erikson and Dunlop Corbin Compton -- have prior experience in family planning and AIDS

Source 96

## OVERVIEW OF PUBLIC AND NGO SECTOR PLAYERS



# OVERVIEW OF COMMERCIAL SECTOR PLAYERS



### III ATTITUDES AND PRACTICES OF USERS/POTENTIAL USERS

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## CHARACTERISTICS OF DEMAND

Future Pregnancy Desires					
		% of All Women (14-49)		% of Exposed Women (14-49)	% of Potential Users (14-49)
Not sexually active	(2093)	33			
Infecund	(668)	11			
Pregnant	(309)	5			
Wants to become pregnant now	(153)	2	(153)	5	
Postponer <sup>1</sup>	(534)	9	(534)	17	(534) 19%
Spacer <sup>2</sup>	(725)	11	(725)	22	(725) 26%
Limiter <sup>3</sup>	(1559)	25	(1559)	48	(1559) 55%
Uncertain	(273)	4	(273)	8	
<b>Total</b>	<b>(6314)</b>	<b>100</b>	<b>(3244)</b>	<b>100</b>	<b>(2818) 100</b>

Notes

<sup>1</sup>Postponer — Wants to delay first pregnancy

<sup>2</sup>Spacer — Wants to have more children, but not in near future

<sup>3</sup>Limiter — Does not want to have any more children

Source 48

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**PROFILE OF EXPOSED WOMEN**

**AGE**

Type	% by Age				
	Mean	<20	20-29	30-39	40-49
Postponers	21	51	45	4	<1
Spacers	25	13	70	16	1
Limiters	33	3	31	40	26

**PARITY**

Type	% by Parity						
	Mean	0	1	2	3	4	<5
Postponers	0	100	-				
Spacers	2	0	62	26	9	2	1
Limiters	4	0	7	21	22	16	34

**UNION STATUS**

Type	% by Union Status			
	Married	Common Law	Visiting Partner	Boyfriend
Postponers	2	9	64	25
Spacers	12	35	48	5
Limiters	36	34	28	2

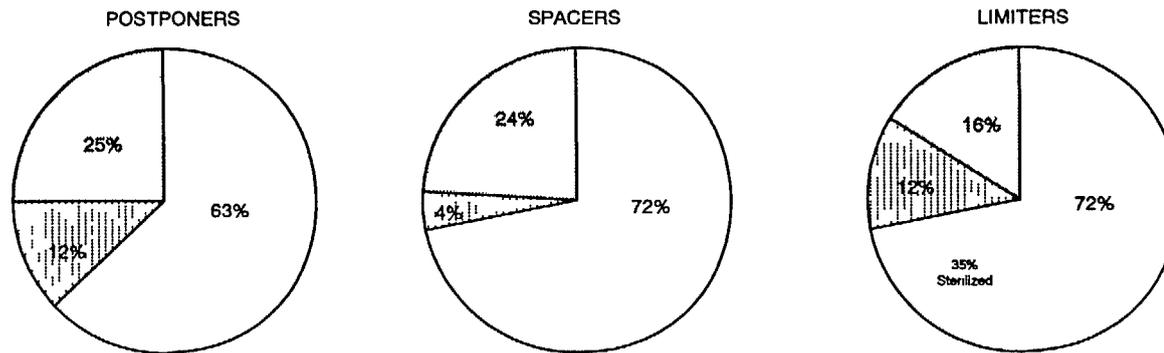
**REASONS**

Type	Major Reason for Wanting to Control Fertility
Postponers	= Not ready to have children
Spacers	= Improves economic and social well being of family
Limiters	= Reduces economic burden and improves quality of life
Uncertains	= Unsure whether present partnership will work out might want to have more children with possible future partner

\*Qualitative research

### CONTRACEPTIVE PRACTICES OF EXPOSED WOMEN

	Method	Postponers (N=534) % Using	Spacers (N=725) % Using	Limiters (N=1559) % Using
Appropriate Methods <sup>1</sup>	Female Sterilization	0	0	35
	Pill	27	41	21
	Injection	<1	14	13
	IUD	<1	3	2
	Condom	35	13	8
	Vagnals	<1	<1	<1
Inappropriate Methods <sup>2</sup>	Withdrawal	9	3	2
	Rhythm	3	1	1
Non Use	Non Use	25	24	16



Note

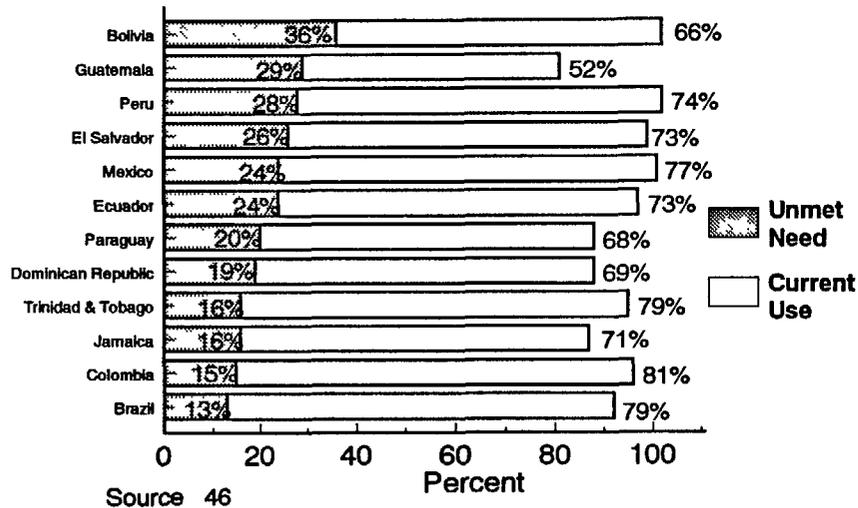
Using appropriate method<sup>1</sup>
 Using inappropriate method<sup>2</sup>
 Nonusing

<sup>1</sup>Appropriate methods for postponers and spacers are considered to be pill injection IUD condom and vagnals  
<sup>2</sup>Inappropriate methods are all other methods

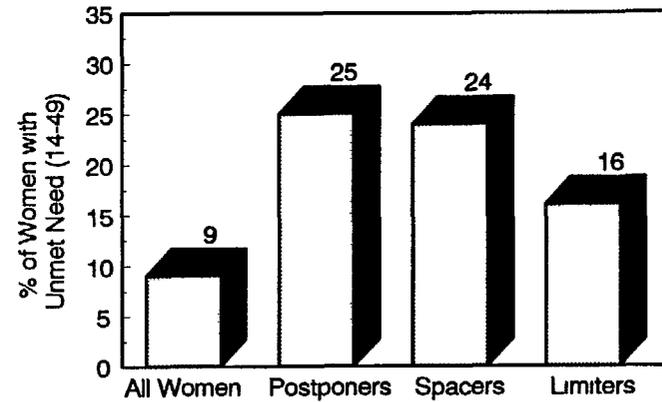
Source 48

**UNMET NEED**

**TOTAL DEMAND FOR FAMILY PLANNING --  
UNMET NEED AND CURRENT USE  
(CROSS-COUNTRY COMPARISONS)**

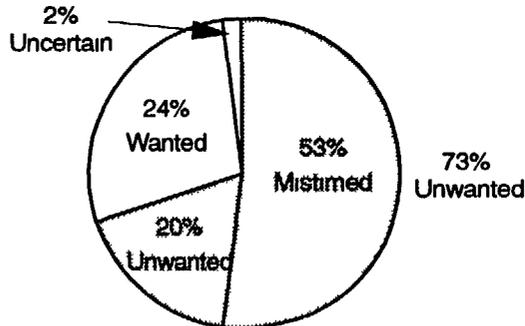


**UNMET NEED -- JAMAICA**



Source 48

**DESIRE FOR CURRENT PREGNANCY  
(% of Currently Pregnant Women)**



Source 48

**OTHER MEASURES OF UNMET NEED**

	% of 19 Year Olds Who Have Become Pregnant	% of Teenage Pregnancies that Are Unwanted	% of Teen Pregnancies (1987)	Estimated # of Unwanted Teen Pregnancies Per Year
<b>Postponers</b>	47%	81%	52,476	42 000
<b>Limiters</b>	Average Actual # of Children 40	Average Desired # of Children 37	Fertility Gap 07	% of Limiters with Excess Fertility 60%

Source 48

## **DISCUSSION OF UNMET NEED**

- **Procedures to calculate unmet need and consequently the results vary greatly. If FPIP's goal to reduce unmet need is to be measured and evaluated, care must be taken to use an agreed-upon consistent definition**
  - **The set of bar charts on the upper-left-hand side of the previous page compares unmet need and total demand for family planning for Latin America and Caribbean countries, according to the standard DHS calculation for unmet need. Jamaica, with an unmet need of 16%, ranks toward the bottom.**
  - **The 1989 Jamaica CPS report shows an unmet need of 16% of Jamaican women (or approximately 103,000 women). This figure was derived by taking all women (15-49 years old) in union who were sexually active, fecund, not contracepting (not using any method), and who did not want to become pregnant (Fourteen year olds were excluded, sexual activity was determined by ever having had sex, and women who were unsure of their pregnancy desires were included).**
  - **The 1989 CPS report further identifies that those most in need are between 20 and 24 years old, with 1-3 children, in a common law or visiting partnership, have only a primary school education, and live in Kingston, St Ann, or St Mary's parishes. Interestingly, women in urban areas appear to have a slightly greater unmet need.**
- **The chart showing Jamaica alone on the upper-right-hand portion of the previous page shows unmet need for total female population as well as for postponers, spacers, and limiters. These figures are lower and were derived by including 14 year olds, defining sexually active as those women who had a current "partner" (included were married, common law, visiting relationship, and boyfriend with whom they have sex), and by leaving out women who were unsure of their desire to become pregnant.**
  - **Of those with unmet need, 37% of postponers, 67% of spacers, and 73% of limiters have tried a method. Of the overall group only 37% have never tried a method.**

**WHAT IS THE SITUATION WITH POSTPONERS?**

**AWARENESS OF METHODS**

Method	Percent Aware*	
	Non-Users (N=134)	Inappropriate Method Users (N=64)
<b>Ever heard of an appropriate method</b>	100	98
Pill	100	97
Condom	99	98
Injection	92	92
Female sterilization	83	90
Vaginals	70	76
IUD	67	65
<b>Inappropriate methods</b>		
Withdrawal	60	95
Rhythm	31	57

Prompted awareness

Source 48

**POSTPONERS — EVER USE OF METHODS**

Method	Percent Ever Used	
	Non-Users (N=134)	Inappropriate Method Users (N=64)
<b>Ever used an appropriate method</b>	37	39
Condom	24	32
Pill	22	16
Vaginals	1	3
Injection	1	0
IUD	1	0
<b>Inappropriate methods</b>		
Withdrawal	8	90
Rhythm	3	23

Source 48

**POSTPONERS--PRIMARY REASON FOR DISCONTINUING METHODS  
(% GIVING REASONS)**

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 198)

Reason Method	Health/Medical Reasons	Experienced Bad Side Effects	Reduces Pleasure/ Dislikes Method	Not Sexually Active (Now)	Partner Opposes	Desires Pregnancy	Missed Period	Lack of Knowledge	Embarrassed	Ineffective	Difficult to Use	Too Costly	Not Readily Available	Religious	Other and Don't Know
Pill	23	42	12	8	4	.	-	4	-	-	.	-	-	-	7
Injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Condom	-	6	22	39	6	-	-	-	-	-	-	-	-	-	27
IUD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source 48

## POSTPONERS--PRIMARY REASON FOR NEVER USING A MODERN METHOD

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 120)

Reason	% Giving Reason
% Never Using a Modern Method	22
Doesn't Like/Doesn't Want to Use	15
Fear of Side Effects	11
Not Sexually Active (Now)	11
Partner Opposes	5
Lack of Information	4
Health/Medical Reasons	4
Religious Reasons	2
Embarrassed	2
Desires Pregnancy (In Future)	1
Other	27
Don't Know	18

**WHAT IS THE SITUATION WITH SPACERS?**

**AWARENESS OF METHODS**

Method	Percent Aware*	
	Non-Users (N=174)	Inappropriate Method Users (N=29)
<b>Ever heard of an appropriate method</b>	99	100
Pill	99	100
Condom	99	100
Injection	98	94
Female sterilization	95	90
IUD	90	90
Vaginals	77	84
<b>Inappropriate methods</b>		
Withdrawal	65	97
Rhythm	33	68

Prompted awareness

Source 48

**SPACERS — EVER USE OF METHODS**

Method	Percent Ever Used	
	Non-Users (N=174)	Inappropriate Method Users (N=29)
<b>Ever used an appropriate method</b>	67	61
Pill	51	48
Condom	33	32
Injection	26	19
Vaginals	4	7
IUD	4	3
<b>Inappropriate methods</b>		
Withdrawal	13	77
Rhythm	5	36

Source 48

**SPACERS--PRIMARY REASON FOR DISCONTINUING METHODS  
(% GIVING REASONS)**

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 203)

Reason Method	Health/Medical Reasons	Experienced Bad Side Effects	Reduces Pleasure/ Dislikes Method	Not Sexually Active (Now)	Partner Opposes	Desires Pregnancy	Missed Period	Lack of Knowledge	Embarrassed	Ineffective	Difficult to Use	Too Costly	Not Readily Available	Religious	Other and Don't Know
Pill	36	29	2	7	5	5			2	-	-			-	14
Injection	36	32	11	3		3	4								11
Condom		6	24	24	12						6		-		28
IUD	50	25					-						-	-	25

Source 48

## SPACERS--PRIMARY REASON FOR NEVER USING A MODERN METHOD

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 72)

Reason	% Giving Reason
% Never Using a Modern Method	10
Doesn't Like/Doesn't Want to Use	22
Fear of Side Effects	13
Not Sexually Active (Now)	9
Health/Medical Reasons	5
Religious Reasons	4
Desires Pregnancy (In Future)	3
Lack of Information	2
Other	21
Don't Know	21

Source 48

**WHAT IS THE SITUATION WITH LIMITERS?**

**AWARENESS OF METHODS**

Method	Percent Aware*	
	Non-Users (N=249)	Inappropriate Method Users (N=187)
<b>Ever heard of an appropriate method</b>	100	100
Pill	100	100
Injection	98	98
Female sterilization	94	98
IUD	90	93
<b>Inappropriate methods</b>		
Condom	99	99
Vaginals	76	87
Withdrawal	49	74
Rhythm	26	47

Prompted awareness

Source 48

## LIMITERS — EVER USE OF METHODS

Method	Percent Ever Used	
	Non-Users (N=249)	Inappropriate Method Users (N=187)
<b>Ever used an appropriate method</b>	68	64
Pill	56	55
Injection	38	27
IUD	5	7
<b>Inappropriate methods</b>		
Condom	25	80
Vaginals	5	14
Withdrawal	9	36
Rhythm	3	15

Source 48

**LIMITERS--PRIMARY REASON FOR DISCONTINUING METHODS  
(% GIVING REASONS)**

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 436)

Reason Method	Health/Medical Reasons	Experienced Bad Side Effects	Reduces Pleasure/ Dislikes Method	Not Sexually Active (Now)	Partner Opposes	Desires Pregnancy	Missed Period	Lack of Knowledge	Embarrassed	Ineffective	Difficult to Use	Too Costly	Not Readily Available	Religious	Other and Don't Know
Pill	36	27	2	2	2	1	1	1	1	-	-	1	--	--	25
Injection	41	30	5	2	-	2	5	-	-	-	-	-	2	-	13
Condom	--	20	20	10	10	--	-	-	-	-	-	-	--	--	40
IUD	50	25	-	--	-	--	-	--	-	-	--	--	-	--	25

Source 48

## LIMITERS--PRIMARY REASON FOR NEVER USING A MODERN METHOD

(NON-USERS AND INAPPROPRIATE METHOD USERS, N = 91)

Reason	% Giving Reason
% Never Using a Modern Method	8
Doesn't Like/Doesn't Want to Use	24
Health/Medical Reasons	10
Religious Reasons	10
Fear of Side Effects	6
Not Sexually Active (Now)	4
Partner Opposes	2
Too Expensive	2
Other	36
Don't Know	6

Source 48

**LIMITERS--PRIMARY REASON WHY SOME LIMITERS DO NOT WANT TO BE STERILIZED  
(LIMITERS WHO HAVE NOT ALREADY BEEN STERILIZED)**

**% Giving as Primary  
Reason for  
Female Sterilization (N = 989)**

Fear of Operation	28
Not Ready/May Want More Children	16
Prefers Other Methods	7
Have Interest -- Don't Know Source	7
Fear of Side Effects	6
Too Young	5
Other	29
Don't Know	2

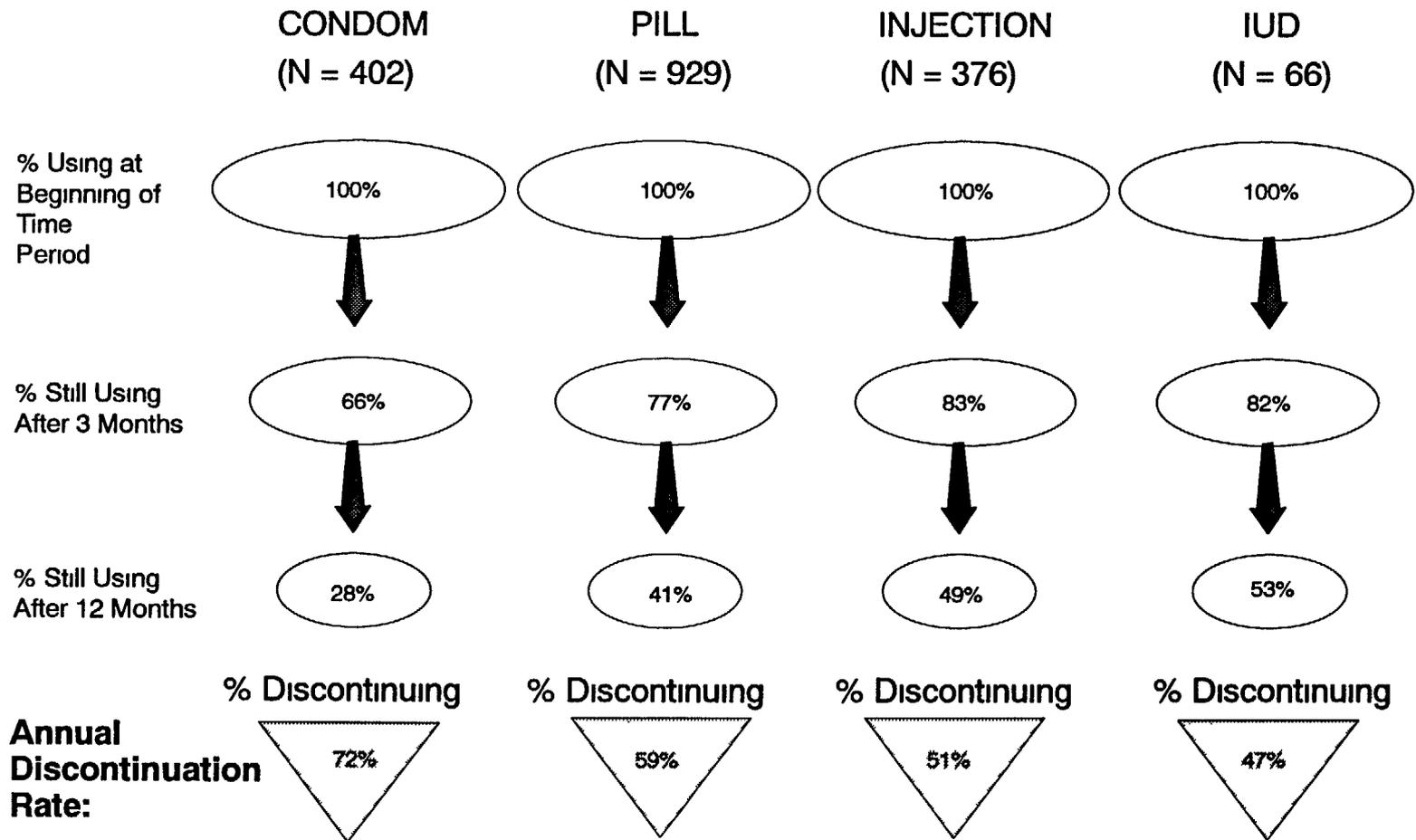
**Males**

- 11% of males say they would consider having a vasectomy

Sources 48 84

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### DISCONTINUATION IS A MAJOR PROBLEM



Source 48

## PRIMARY REASONS FOR DISCONTINUATION

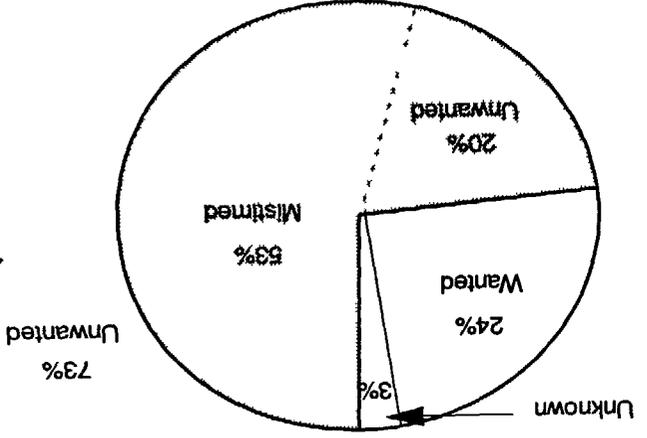
### Postponers, Spacers & Limiters % Giving as Primary Reason

	Pill (N = 184)	Injection (N = 92)	IUD (N = 10)	Condom (N = 45)
Health Reasons	34	41	45	2
Had Bad Side Effects	31	36	33	7
Not Sexually Active (Now)	5	1	--	28
Reduces Pleasure/Doesn't Like Method	3	7	--	21
Partner Opposes	3	--	--	7
Desires Pregnancy	2	1	--	2
Other	13	9	22	12
Don't Know	5	4	--	19

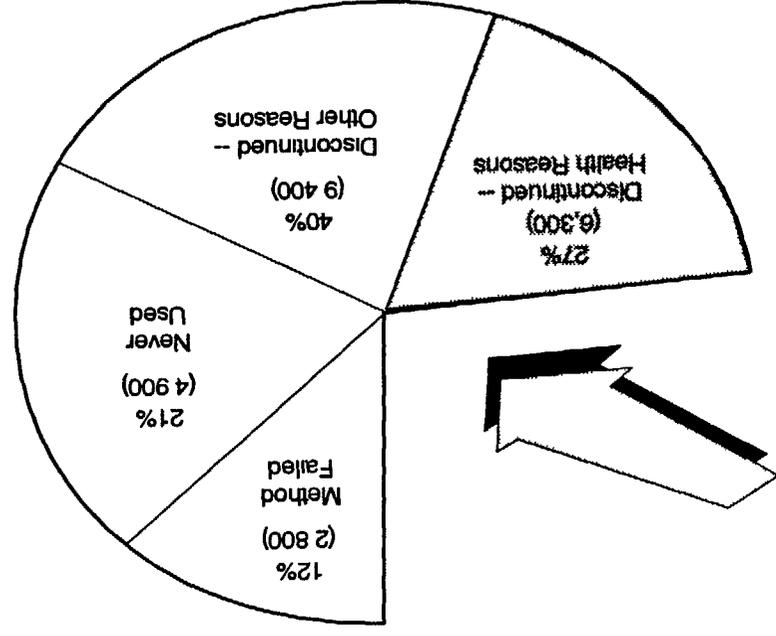
Source 48

**DESIRE FOR PREGNANCIES AND REASONS FOR UNWANTED PREGNANCIES**

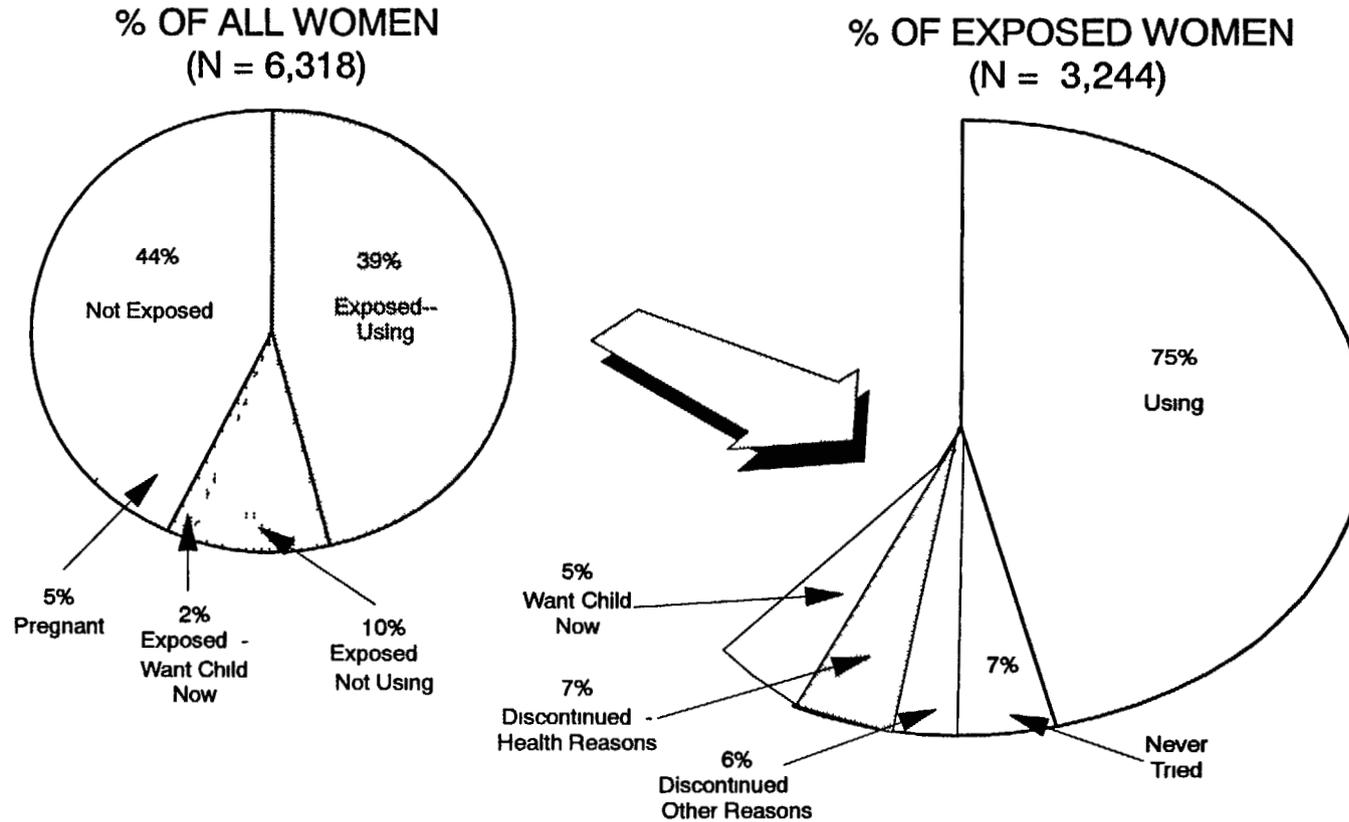
**DESIRE FOR CURRENT PREGNANCY**  
 (% of Pregnant Women 14-49, N = 309)



**REASON FOR UNWANTED PREGNANCY**  
 (N = 226)



## HOW BIG A PROBLEM IS THE HEALTH ISSUE?



- If the current 7% of exposed women who have discontinued for health reasons could be kept as continuous users, the goal of increasing prevalence by 8% would be almost reached by resolving with this one problem alone

Source 48

## MYTHS, MISCONCEPTIONS AND SIDE EFFECTS

- Condom**
- Image of being used with unclean women for promiscuous sex
  - Not used by ordinary people
  - "Not natural " "Could break" — Unreliable " "Could come off and become lost inside body "
- Oral Contraceptives**
- Believe pill works mechanically, not chemically Believe pill blocks sperm from entering the uterus and thus results in "blocked up tubes "
  - Is harmful, therefore, must brace oneself to take pills and then take frequent breaks to let body rest and recover
  - Any menstrual irregularity produces fear
  - Fear of infertility and cancer
  - Nausea, dizziness, headaches, weight gain
  - Vast majority don't know different types (dosages) of pills exist.
- Injectables**
- Believe menstrual regularity is a sign of good health Consequently, when period is missed or lessened, women fear that too much bad blood is accumulating inside their bodies
  - Fear of infertility and cancer
  - Is harmful, must take breaks to let body rest and recover
- IUD**
- Fear that IUD might drift upwards and become lost in the body
  - Fear of infection, birth defects, infertility
  - Device becomes unclean and smelly because it stays in place for years
- Implant**
- Unknown
- Female Sterilization**
- "Fear of the knife " "Fear of belly being cut open" and of having to stay in the hospital
  - Concern that if all doesn't go well with current partner, might take a new partner and want to have more children with him
- Male Sterilization**
- Fear will affect sexual desire and ability
  - "Cease to be a man," against social image of male virility
  - Fear will lose strength, can't work hard or lift heavy objects

**ATTITUDES TOWARD ORAL CONTRACEPTIVES**

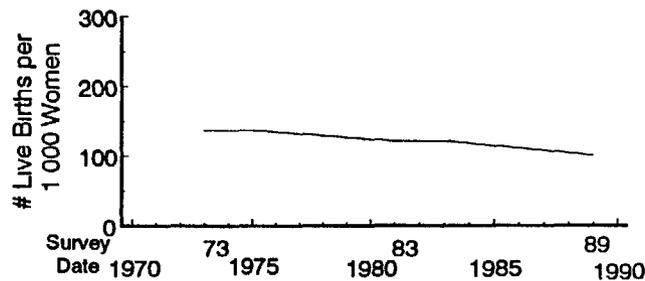
	Attitudes of Women (N = 1092)		
	<u>Agree</u>	<u>Disagree</u>	<u>Don't Know</u>
Effective in Preventing Pregnancy	87	5	8
Is Harmless to Users	29	33	38
Reduces Period Pains	45	22	33
Causes too Much Weight Gain	38	29	33
Causes Infertility	16	37	47
Causes Heart Problems	9	28	63
Causes Cancer of Female Organs	18	24	58
Mainly Used by Poor	20	72	8
Perle Is as Good as Any Other Brand	57	10	33
Low-Dose Pills Are Better than Others	15	13	72

Source 48

## TEENAGE PREGNANCY PROBLEM

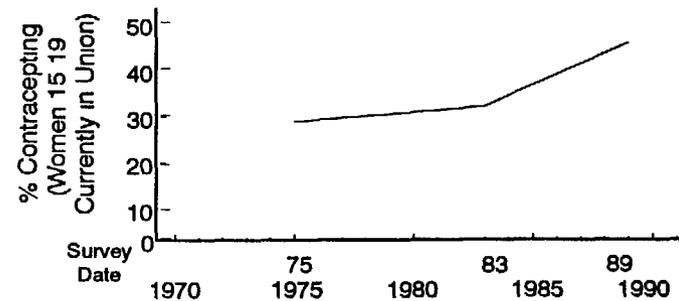
### Recent Improvements

FERTILITY RATE IS DECLINING  
(Females 15-19)



- Finding is corroborated by vital statistics
- Sources 45 47, 48

CONTRACEPTIVE USE IS INCREASING



- Finding is corroborated with service statistics
- Sources 45 47 48

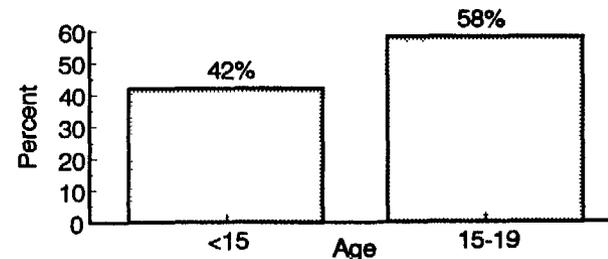
### Areas of Concern

MANY TEENAGERS ARE SEXUALLY ACTIVE  
(Females 14-19)



Source 48

AGE AT FIRST INTERCOURSE IS YOUNG  
(Females 14-19)

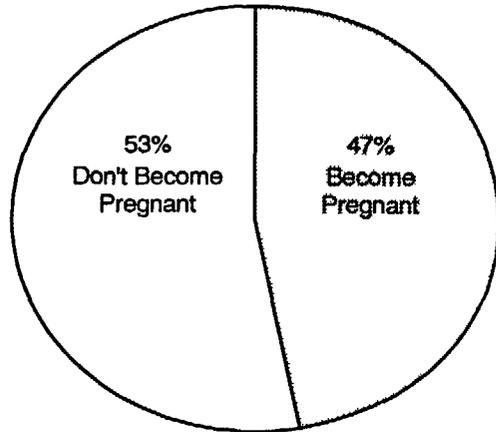


- Average age of first intercourse for females 14-19 is 14.8 years old
- Finding is corroborated with data from 1987 YARHS

Source 48

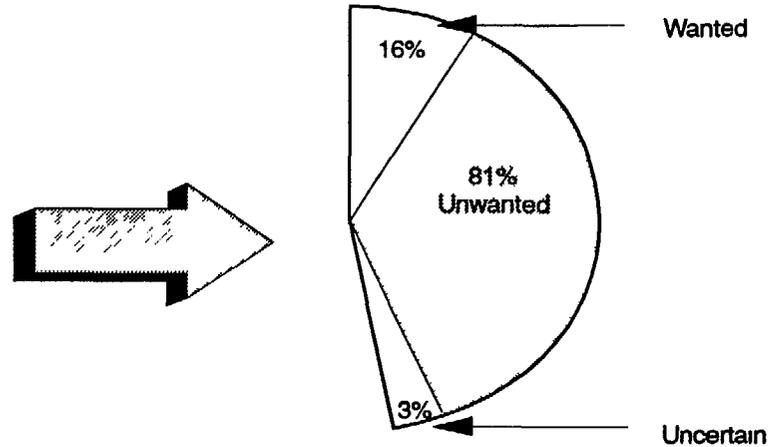
## MAJORITY OF TEEN PREGNANCIES ARE UNWANTED

**% OF TEENAGERS WHO BECOME PREGNANT\***



\*% of 19 year olds who have become pregnant

**% OF TEEN PREGNANCIES THAT ARE WANTED  
(Females 14-19)**



**Reasons for Unwanted Teen Pregnancies**

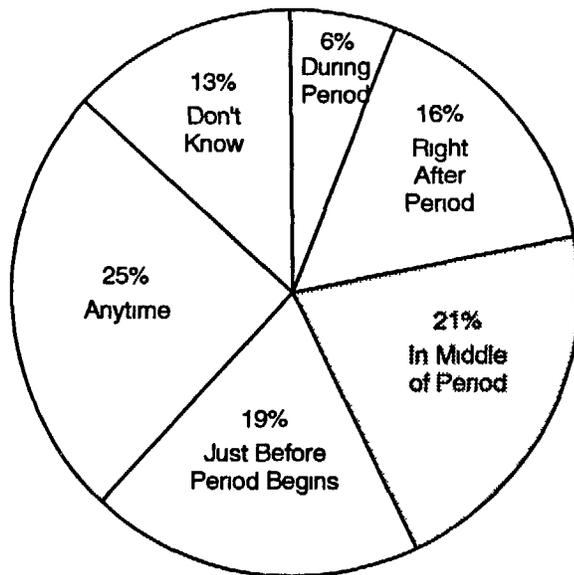
Never tried	48%
Discontinued--other reasons	23%
Discontinued--health reasons	20%
Method failed	9%

- Approximately two-thirds of women aged 14-19 are enrolled in school YARHS points out that 81% of students who become pregnant drop out of school This suggests that a significant proportion of young women are failing to complete their schooling due to an unwanted pregnancy

Sources 48, 77, 9

## KNOWLEDGE OF FERTILITY AND METHODS

**Knowledge of Time during Menstrual Cycle When Women Are Most at Risk of Getting Pregnant**  
 (All Nonpregnant Women 14-49 N = 2005)



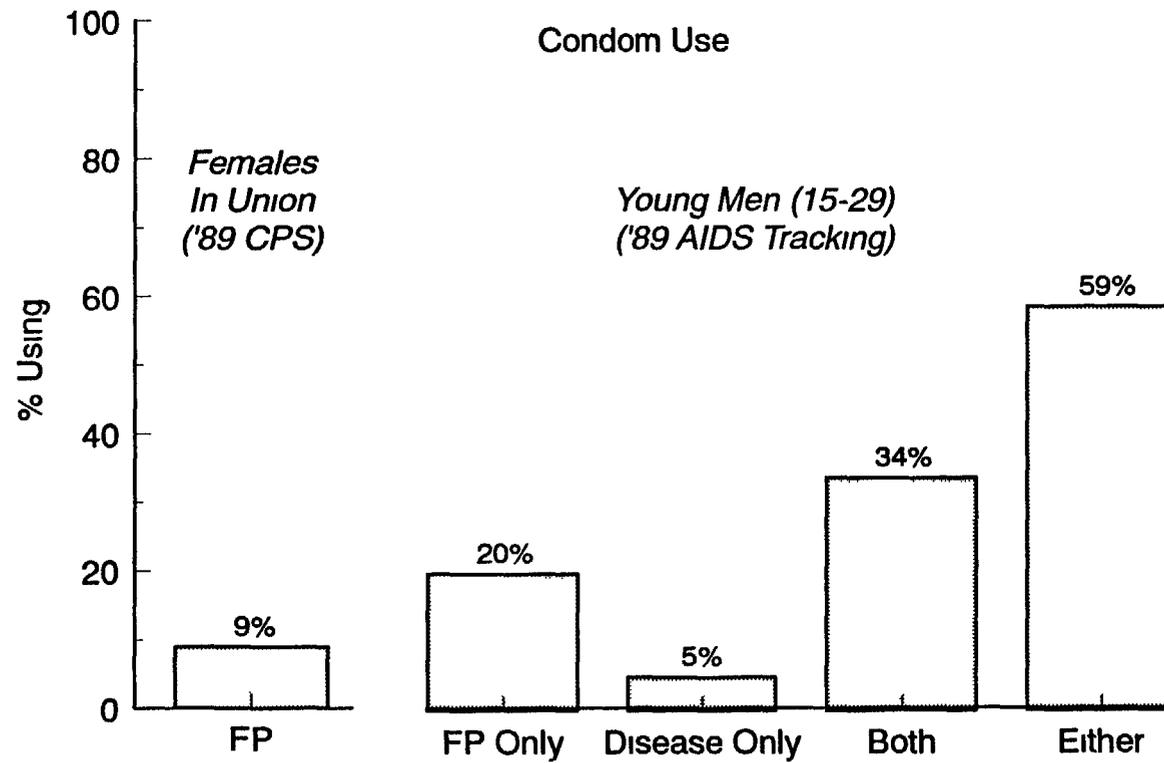
Source 48

- Only 20% of women have correct knowledge of their fertile period
- No quantitative data could be found on women's knowledge (not awareness) of methods and of correct use
- Qualitative evidence reveals poor understanding of how methods work
- Vast majority (75+%) of women don't know that there are different types (dosages) of pills

### METHOD FAILURE RATES

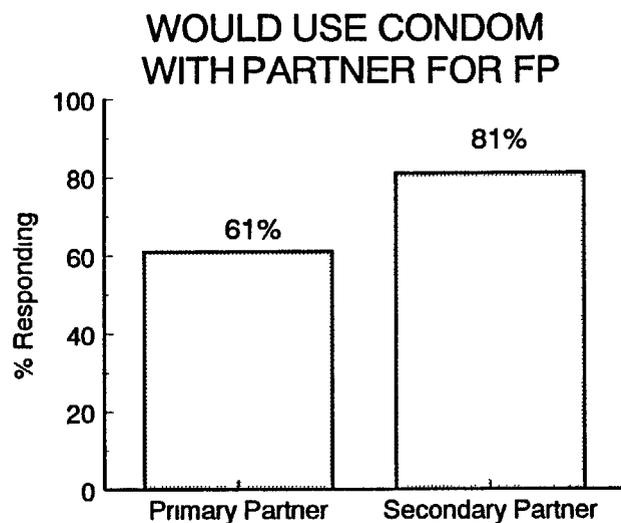
	Average Annual Failure Rates (Life Table Method)
IUD	5.2%
Pill	4.6%
Condom	2.4%
Injection	0.5%

**CONDOMS ARE INCREASINGLY BEING PROMOTED AND USED FOR AIDS**

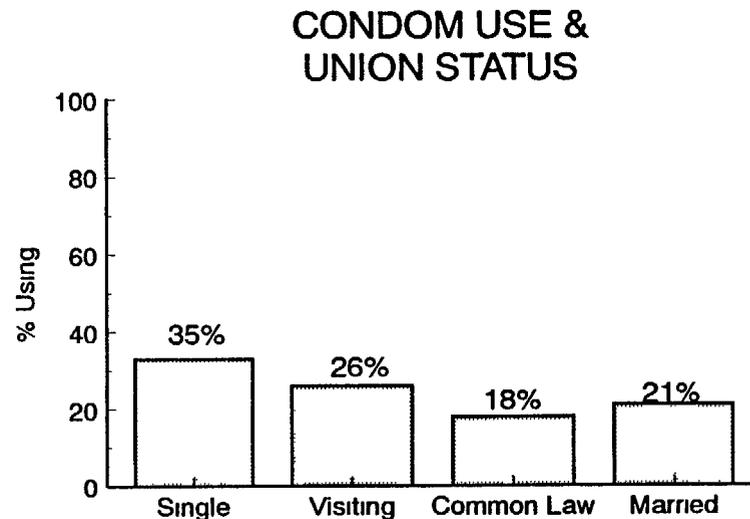


- Raises issue of multiple method use

## CONDOMS ARE GENERALLY USED IN LESS STABLE RELATIONSHIPS

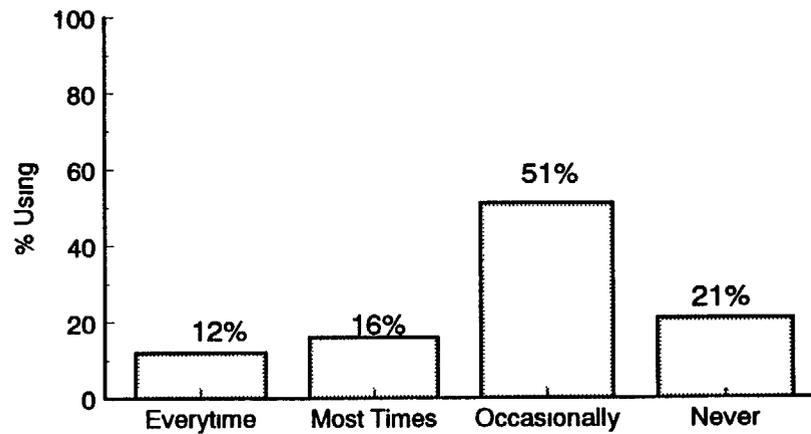


Source 110



Source 110

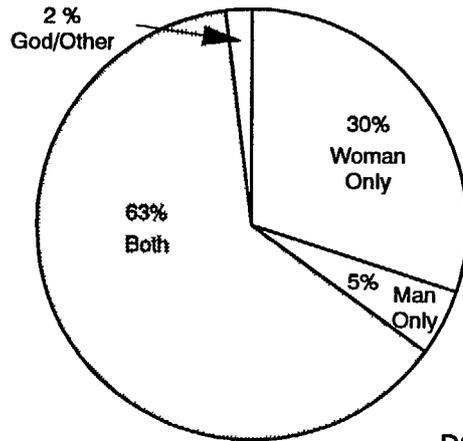
## AND ON AN OCCASIONAL BASIS



Source 110

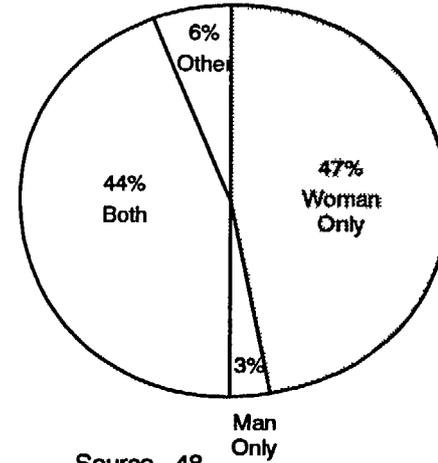
## FAMILY PLANNING DECISIONMAKING

**WHO SHOULD DECIDE NUMBER OF CHILDREN A COUPLE HAS?**  
(N = 6112)



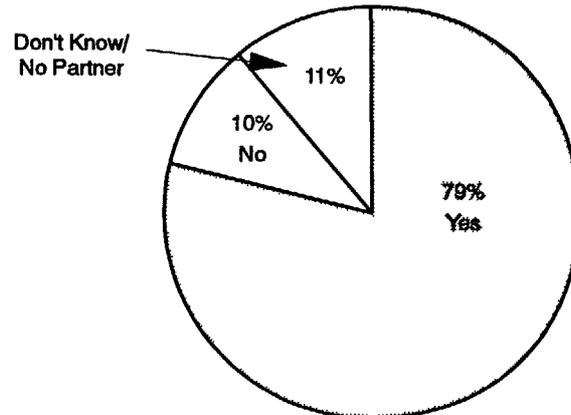
Source 48

**WHO SHOULD DECIDE WHETHER A WOMEN USES FAMILY PLANNING?**  
(N = 6112)



Source 48

**DO YOU AND YOUR PARTNER AGREE ABOUT FAMILY PLANNING?**  
(N = 667)

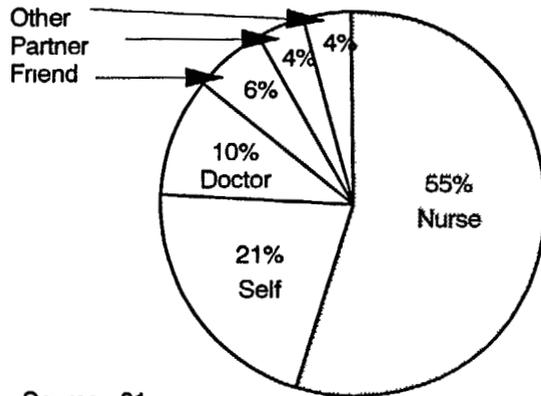


Source 61

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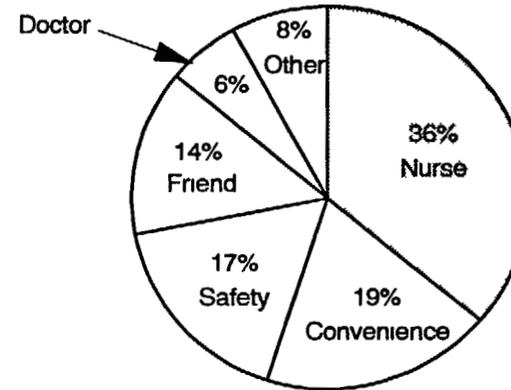
## INFORMATION SOURCES AND NEEDS

**WHO ADVISED YOU ON METHOD TO USE?**  
(Current and Past Users, N = 575)



Source 61

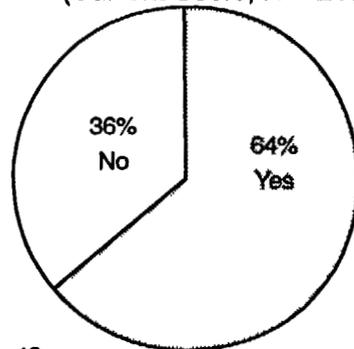
**DECIDING FACTOR ON CHOICE OF METHOD**  
(N = 359)



Source 61

- Partner plays little role in choosing a method of family planning

**DID YOU RECEIVE COUNSELING ABOUT FP METHODS?**  
(Current Users, N = 2156)



Source 48

- Average length of time for counseling was 10 minutes (Estimated average length of time required to explain family planning methods is 45 minutes) Source 88
- Many users lack adequate understanding of how methods work and possible side effects. This fosters misconceptions and high rates of discontinuation

**IV SERVICE DELIVERY**

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## WHAT PRODUCTS AND SERVICES ARE BEING OFFERED?

### ORAL CONTRACEPTIVES

- Types Low standard and high dose, triphasic, & progestin-only
- Importers Approximately 5 commercial importers
- Brands Over 20 brands
- Market leaders Lo-Femeral, Perle, & Ovral
- Prices MOH - Free (donation)  
JFPA - \$5  
SM - \$5  
Commercial - \$40-\$100
- Margins Wholesaler 35%, retailer 55%
- Outlets 375 clinics, 270 pharmacies
- Est market size 1.2 million cycles per year

### INJECTABLES

- Types Depo-Provera and Nonsterat
- Prices MOH - Free (donation)  
JFPA - \$30  
Commercial - \$200
- Margin Retailer 20%
- Outlets Clinics, pharmacies private doctors

Note See Appendix C for more complete listing  
No reliable market share data is available

### CONDOMS

- Importers Approximately 5 commercial importers and ICIs
- Brands Over 2 dozen brands
- Market leaders Panther Sultan, Rough Rider
- Prices MOH - Free (donation)  
JFPA - \$2 (12)  
SM - \$3 (3)  
Commercial - \$10-\$35 (3)
- Margins Wholesaler 20% retailer 35%
- Outlets 375 clinics 270 pharmacies, 100 supermarkets, 2 000+ small shops
- Est market size 8 million per year

### IUDs

- Types Five types
- Prices MOH - Free (donation)  
JFPA - \$100  
Private doctor - \$450
- Margins Wholesaler 30%  
retailer 60%
- Outlets Clinics, hospitals, private doctors

### VAGINALS

- Types Diaphragms sponge, spermicidal foams, jellies, creams and tablets
- Brands Approximately 10 brands
- Prices MOH - Free (donation)  
JFPA - \$25-\$50  
Commercial - \$40-\$250
- Outlets Clinics and pharmacies

### NORPLANT

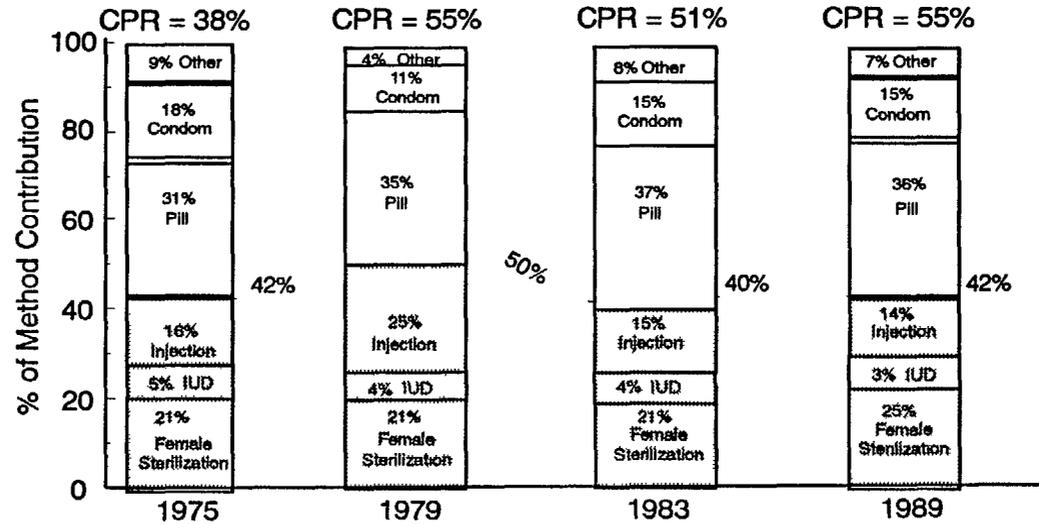
- Status Clinical trial with 6 doctors
- Prices Import price US\$23  
Est total insertion cost US\$60-\$75

### STERILIZATION

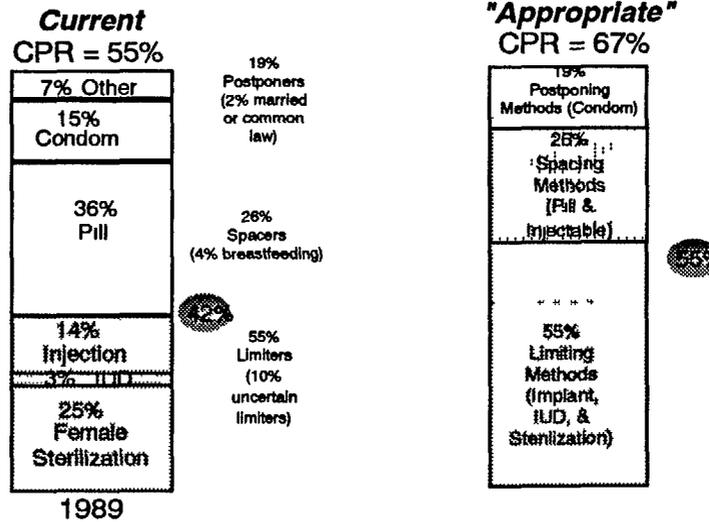
- Types Tubal ligations and vasectomies
- Prices (TL) MOH - Free (donation)  
JFPA - \$200  
Private doctor - \$4 000-\$6,000  
(Vasectomy) JFPA - \$400
- Outlets TL approximately 27 clinics and hospitals vasectomy approximately 17 sites
- Est market size TL 3,000-4 000 per year, vasectomies 2-3 per year

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### TRENDS IN METHOD MIX



"APPROPRIATE" METHOD MIX SUGGESTS SHIFT TO LONG-TERM METHODS IS NEEDED



## COMPARISON OF CURRENT METHOD MIX WITH "APPROPRIATE" MIX

- A comparison of current method mix with what an "appropriate" mix might be (as determined by fertility intentions and life stage) is a useful exercise for program planning purposes
- First step is to identify fertility intentions of population From the 1989 CPS, we learn that 55% of potential users want no more children, 26% want to space out future births and 19% want to postpone their first birth Further analysis shows that only 11% of postponers (or 2% overall) are married or in common law unions, 15% of spacers (or 4% overall) are breastfeeding, and 13% of limiters (or 7% overall) are not certain that they do not want to have any more children
- Next step is to loosely assign "appropriate" methods to the various life stage groups Most analysts consider condoms to be the most appropriate method for young unmarried women, who might be having infrequent sex with different partners A special concern with any group likely to have multiple partners is protection from STDs The most appropriate methods for spacers are usually considered to be oral contraceptives and injectables Barrier methods and progestin-only pills or injections are appropriate for breastfeeding spacers If long birth intervals are desired, the IUD might also be appropriate Finally, long-acting methods such as IUDs, the implant, and sterilization are considered the optimal method for limiters Sterilization is only recommended for individuals who are certain they do not want to have any more children
- A comparison of the current with "appropriate" mix indicates that the program should continue to emphasize condoms to youth so that the 19% of postponers are well protected from both unwanted pregnancies and diseases At the same time, a need exists to shift some limiters away from the pill and injectable to more appropriate long-acting methods such as the implant, IUD, or sterilization
- This analysis simply maps stated fertility intentions of a population with "appropriate" methods When making program plans obviously other considerations such as costs and cultural situations will also have to be factored in

**SHIFT TO LONG-TERM METHODS WILL BE CHALLENGING DUE TO EXISTING CONCERNS**

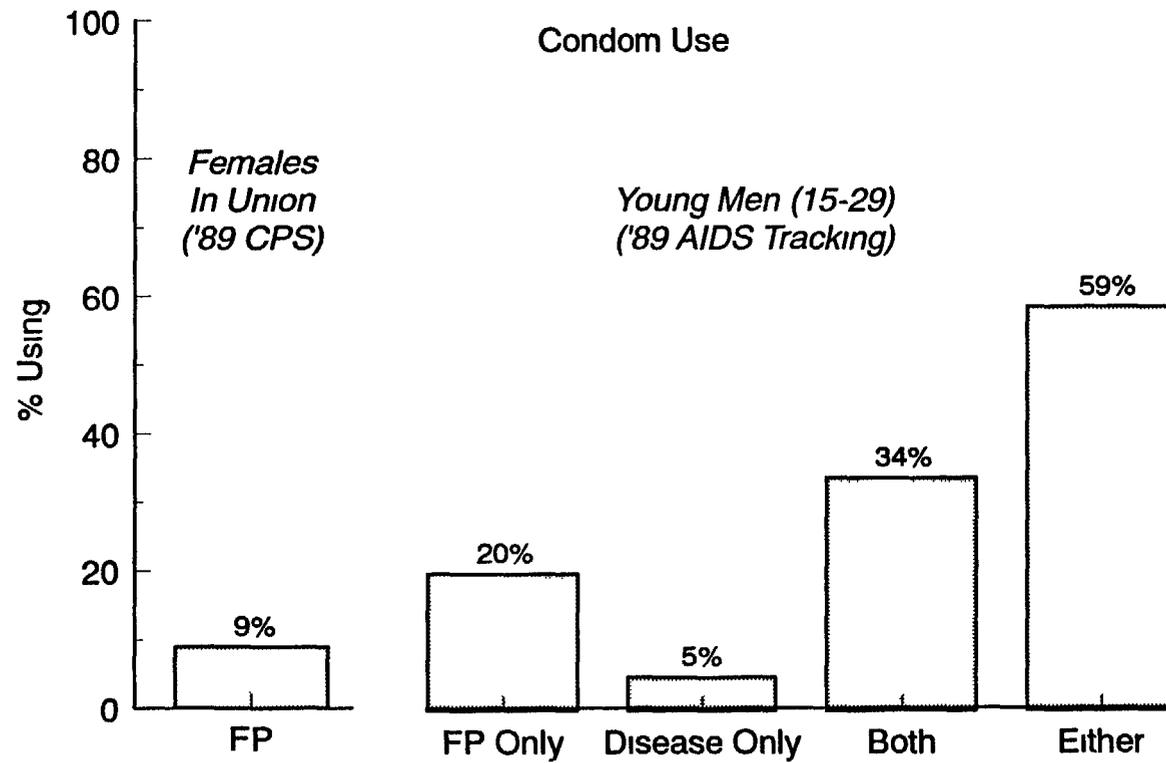
	<b>% of Doctors Having Concerns (N = 49)</b>	<b>% of Patients Having Concerns (N = 44)</b>		<b>Major Concerns (Doctors/Patients)</b>
IUD	59	100		STDs and pelvic infections/infections
Injectable	78	73		Safety (not approved by USFDA)/side effects
Female Sterilization	2	41		--/Fear and finality of operation
Male Sterilization	--	Widespread		Counter to social image of male virility
Implant	Not Well Known			Method not well known

Source 88

## CONSTRAINTS AND OPPORTUNITIES TO SHIFTING LONG-TERM METHODS

	<b><u>Constraints</u></b>	<b><u>Opportunities</u></b>
IUD	STDs & PID Training/Access	Retraining
Implant	Training required Expensive	No negative history
Male Sterilization	Cultural barriers Training	Simple procedure, 11% would consider
Female Sterilization	Counselling intensive	Positive image, 45% are certain limiters

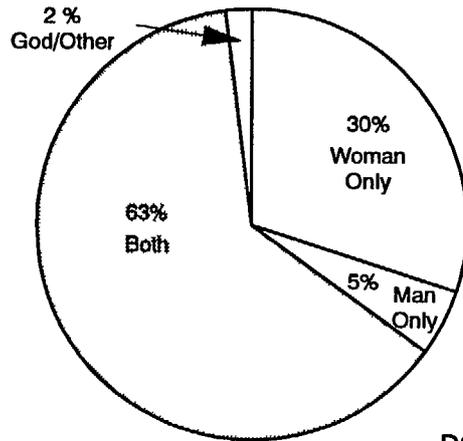
**CONDOMS ARE INCREASINGLY BEING PROMOTED AND USED FOR AIDS**



- Raises issue of multiple method use

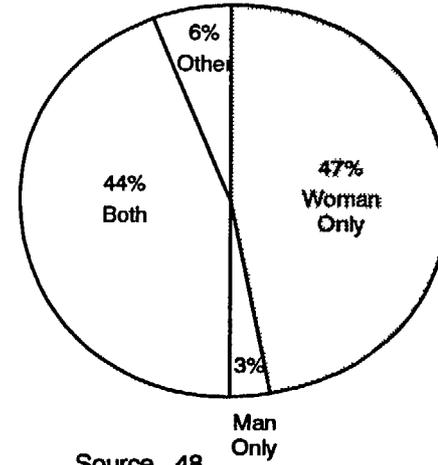
## FAMILY PLANNING DECISIONMAKING

**WHO SHOULD DECIDE NUMBER  
OF CHILDREN A COUPLE HAS?  
(N = 6112)**



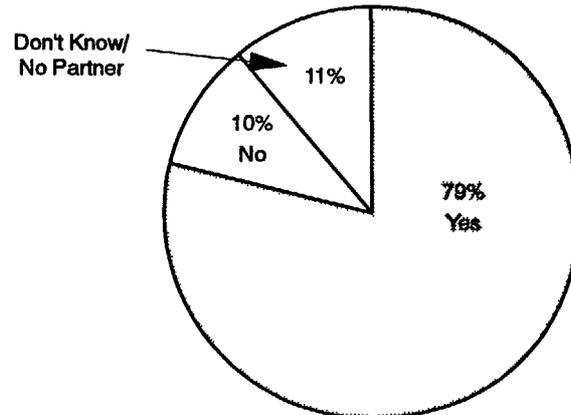
Source 48

**WHO SHOULD DECIDE WHETHER  
A WOMEN USES FAMILY PLANNING?  
(N = 6112)**



Source 48

**DO YOU AND YOUR PARTNER  
AGREE ABOUT FAMILY PLANNING?  
(N = 667)**



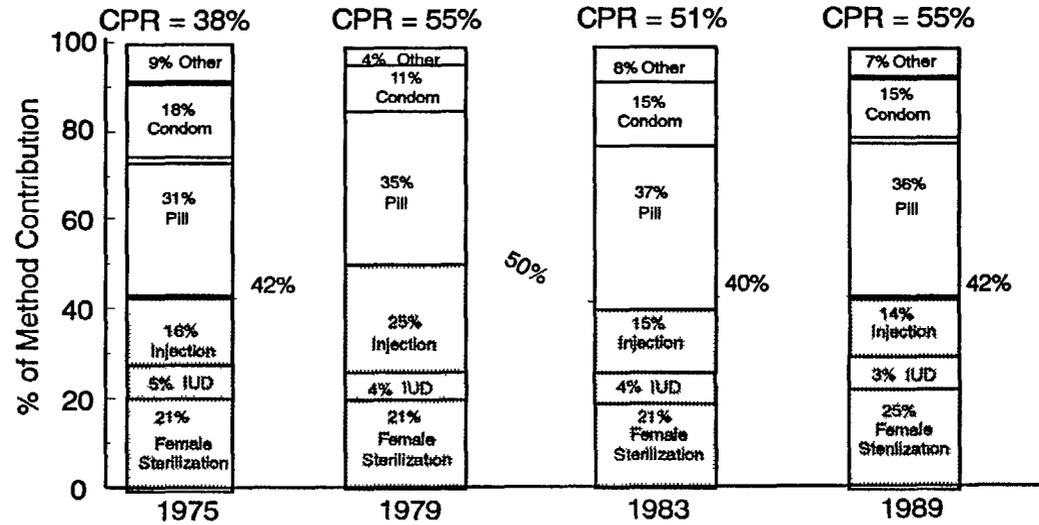
Source 61

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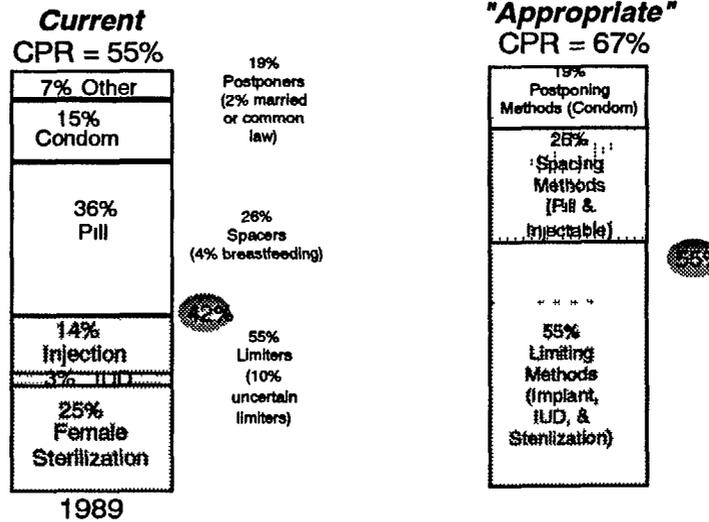
**IV SERVICE DELIVERY**

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### TRENDS IN METHOD MIX



"APPROPRIATE" METHOD MIX SUGGESTS SHIFT TO LONG-TERM METHODS IS NEEDED



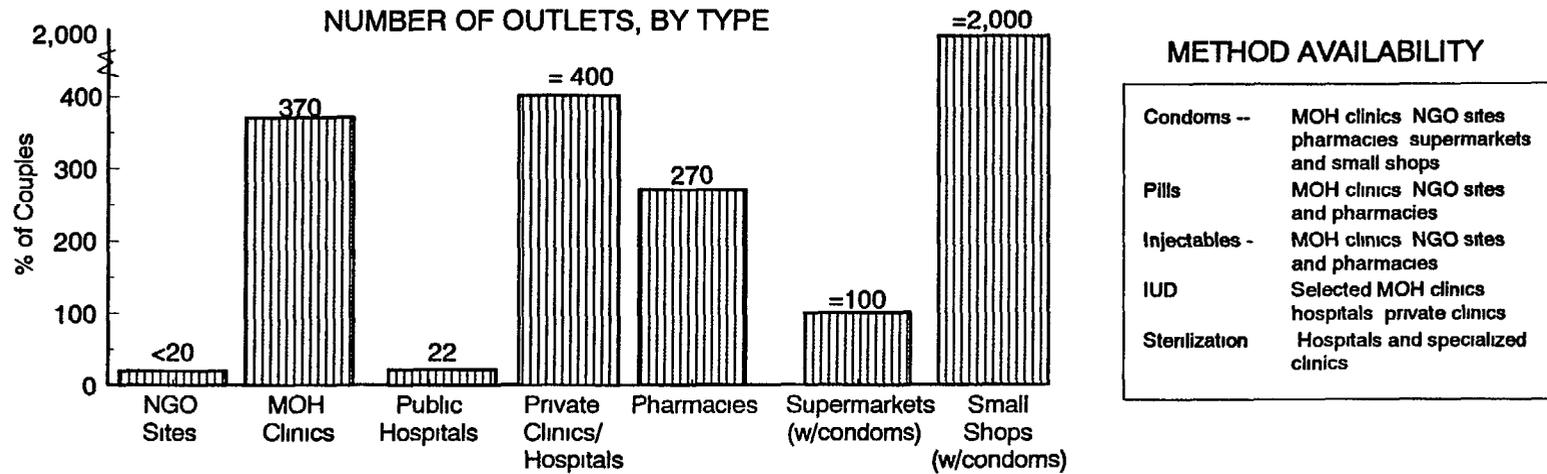
Sources 27 48

1989

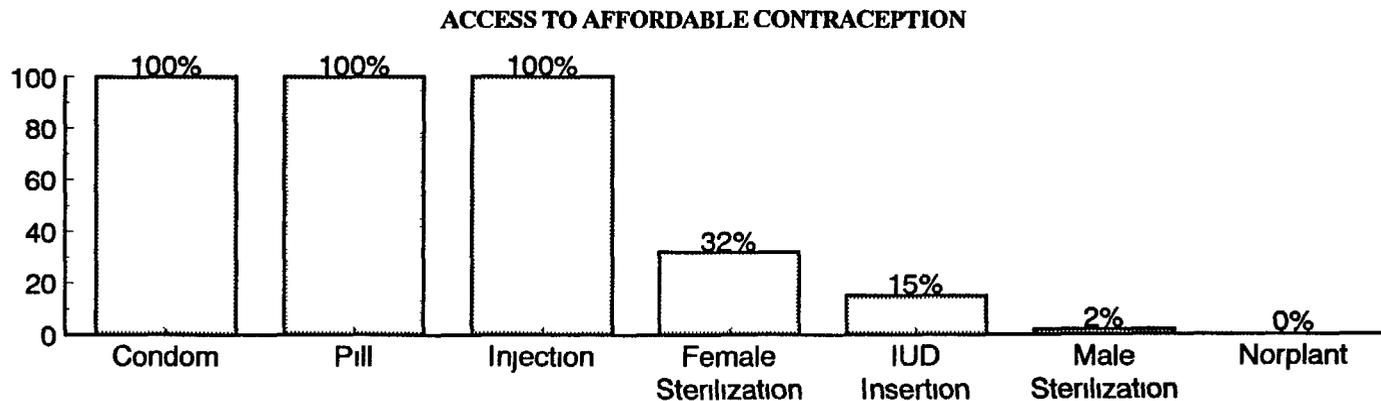
## CONSTRAINTS AND OPPORTUNITIES TO SHIFTING LONG-TERM METHODS

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Implant	Training required Expensive	No negative history
Male Sterilization	Cultural barriers Training	Simple procedure, 11% would consider
Female Sterilization	Counselling intensive	Positive image, 45% are certain limiters

### HOW AVAILABLE ARE FAMILY PLANNING PRODUCTS AND SERVICES?



■ 90% of population lies within 10 miles of an MOH clinic. Average distance traveled to clinic is 2.4 miles



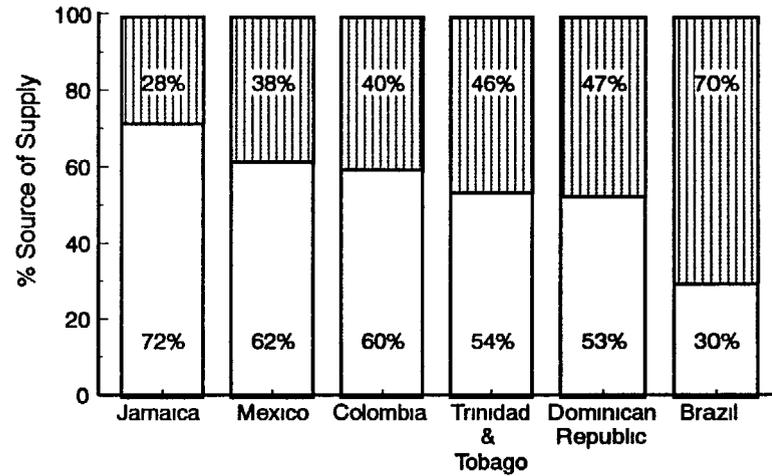
- "Ready and easy access" was defined as "the recipient spends no more than an average of two hours per month to obtain contraceptive supplies and services"
- Affordable was defined as "a one-month supply of contraceptives should cost less than 1 percent of a month's wages"

## SOURCE MIX FOR SUPPLIES/SERVICES

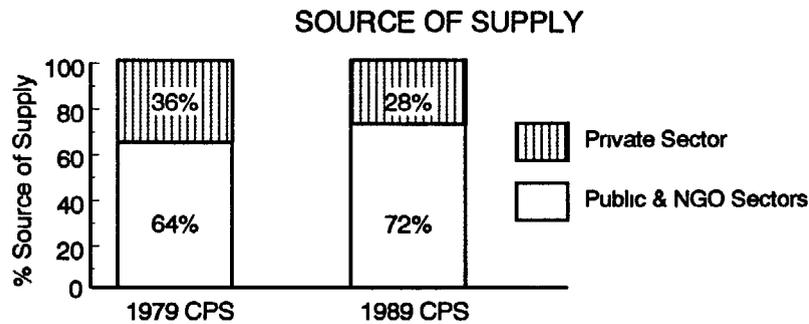
	Survey Date	CPR
Dominican Republic	1986	50
Trinidad & Tobago	1987	53
Mexico	1987	53
Jamaica	1989	55
Colombia	1986	66
Brazil	1986	66

Source 46

SOURCE OF SUPPLY -- CROSS-COUNTRY COMPARISONS



**RELATIVE CONTRIBUTION OF PRIVATE SECTOR HAS BEEN DECREASING IN JAMAICA**

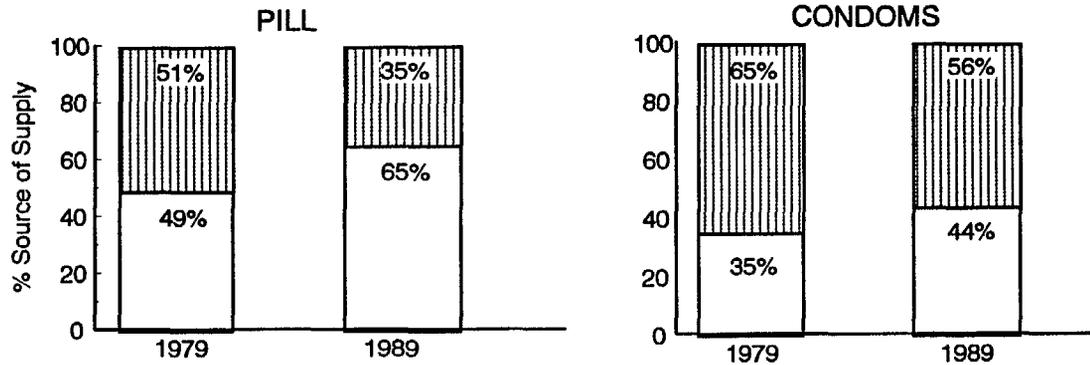


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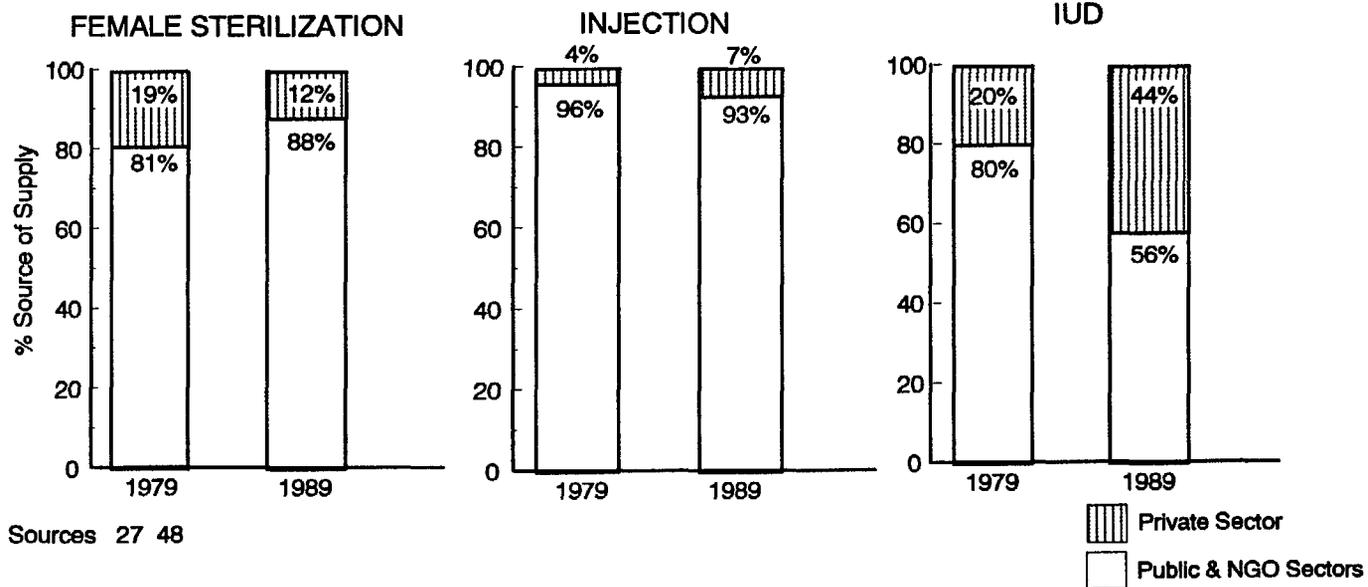
- Goal is to increase private-sector participation

### SOURCE MIX FOR SUPPLIES/SERVICES

RELATIVE CONTRIBUTION HAS BEEN DECREASING FOR NONCLINICAL METHODS



PUBLIC SECTOR DOMINATES AS A SUPPLIER OF CLINICAL METHODS



## REASONS FOR PATTERN OF METHOD SOURCING

Reason for Using Source	% Giving Reason	
	MOH Clinic (N= 243)	Private Doctor/ Pharmacy (N = 38)
Less Expensive	70	--
Convenient	26	58
More Privacy	3	24
Other	8	18

Percentages may add to more than 100% due to multiple responses

### ATTITUDES AMONG PUBLIC CLINIC USERS

DID YOU DISCUSS YOUR FP PROBLEM WITH A NURSE/DOCTOR?		WHY DIDN'T YOU DISCUSS FP PROBLEM WITH A NURSE/DOCTOR?		PURPOSE OF FP VISIT TO CLINIC	
	% Responding (N = 292)	Reason	% Responding (N = 163)	Purpose	% Responding (N = 482)
Yes	44	Not ready/No Need to	45	Obtain Supplies	66
No	<u>56</u>	Not Interested	21	Seek Advice	17
	100	Not Sexually Active	19	General Check-Up	9
		Shy/Uncomfortable	11	Had a Problem	<u>8</u>
		Other	<u>4</u>		100
			100		

- To a large extent medical advice and professional counselling is not recognized as an important service when choosing a method of family planning 85% of users use clinics merely as a source of supply

Source 61

## PERCEIVED ADVANTAGES AND DISADVANTAGES OF SOURCE OF FP SERVICES

### SATISFACTION WITH MOH CLINICS

Level of Satisfaction	% Responding (N = 628)
Very Satisfied	30
Satisfied	60
Somewhat Satisfied	8
Not at All Satisfied	2

### CONCERNS WITH MOH CLINICS

Concern	% Responding (N = 617)
Long Wait	35
Afraid to Talk to Nurses/Nurses Unfriendly	18
Shortage of Doctors	16
Lack of Privacy	10
Not Thorough Check-Up	8
Other	8
No Problems	35

Percentages add to more than 100% due to multiple responses

### ADVANTAGES OF USING A PRIVATE DOCTOR

Advantage	% Responding (N = 1049)
Better Check-Up	31
Shorter Wait	26
Treats Serious Illness Better	17
Doctors Are More Polite than Nurses	8
Other	17

### REASON FOR NOT USING PRIVATE DOCTOR FOR FP

Reason	% Responding (N = 286)
Too Costly	51
Clinic Is Nearer	19
No Need to/Not Ready	16
Other	14

Source 61

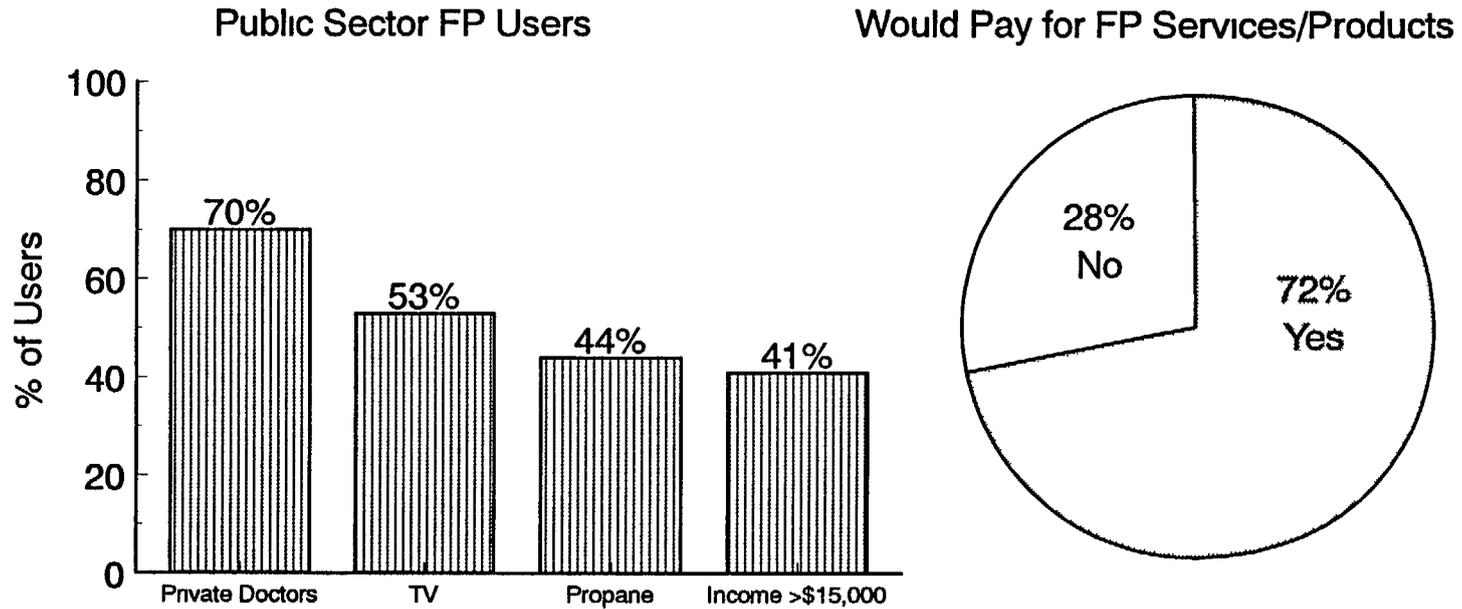
## **RESEARCH ADDRESSES THREE POSSIBLE OPTIONS FOR COST RECOVERY/PRIVATIZATION**

- 1 Ability of public sector users to pay (user fees or shifting them to private sector)
- 2 Increasing participation of private-practice physicians
- 3 Improving image and commercial viability of social marketing products

### **OTHER POSSIBLE FINANCING STRATEGIES NOT ADDRESSED BY THE RESEARCH INCLUDE**

- 1 Seeking out other donors for support (revenue enhancement)
- 2 Obtaining larger proportion of funding from GOJ (revenue enhancement)
- 3 Improving efficiency and cutting costs (expenditure reduction) (This option is addressed somewhat as a part of the goal to move to more effective long-term methods )
- 4 Finding other revenue sources, e g , employer programs, health insurance, etc

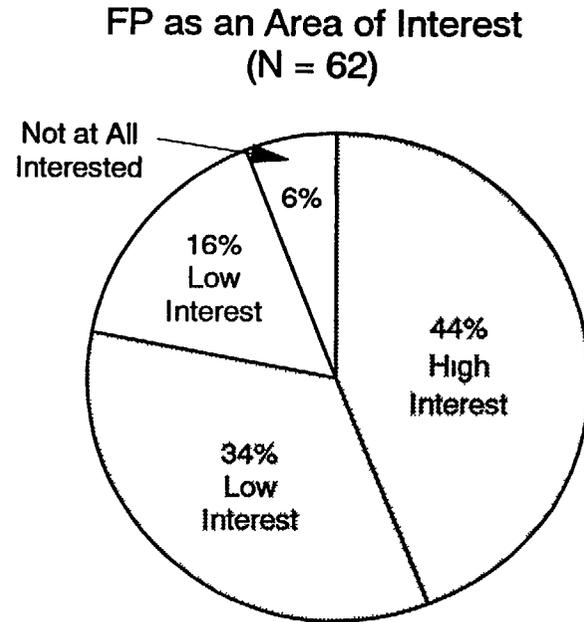
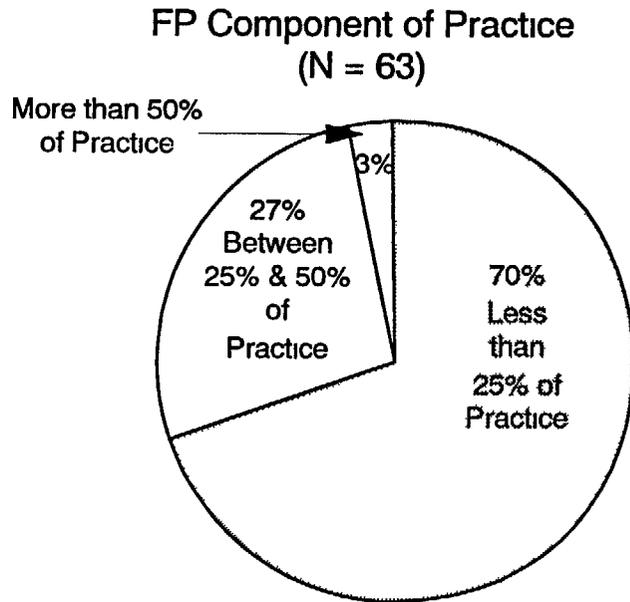
**RESEARCH SHOWS MANY PUBLIC-SECTOR USERS HAVE AN ABILITY-TO-PAY**



- Most clinic users said they would be able to pay \$16-\$30 for general family planning services and \$6-\$14 for a cycle of pills. This did not vary significantly by income category.
- With the recent shortage of Depo-Provera in the public clinics, a sizable group of women have taken to buying the supply at a hospital pharmacy for J\$200 and then taking it to the clinic to get it injected.

Source 61

## PROFILE OF PRIVATE-PRACTICE PHYSICIANS



### ATTITUDES TOWARD METHODS

	<u>Discussed by Doctor (%)</u>	<u>Prescribed by Doctor (%)</u>	<u>Accepted by Patients (%)</u>	<u>Major Concerns Exist (Doctors)</u>
Pill	100	97	97	
IUD	79	48	6	⇒ STDs & PID
Injection	71	62	18	⇒ Safety
Condom	68	41	46	
Female Sterilization	64	41	13	

Source 88

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**WHAT WOULD BE REQUIRED TO GAIN INCREASED INVOLVEMENT OF PRIVATE PHYSICIANS**

**WHAT IS REQUIRED TO MOTIVATE DOCTORS TO GREATER INVOLVEMENT IN FP?**

<u>Incentive</u>	% Responding (N = 63)	
Financial Compensation	68	 <ul style="list-style-type: none"> <li>Physicians can earn more money treating more serious illnesses</li> <li>Family planning is time intensive and the financial returns are relatively low</li> </ul>
Involvement in FP Counselling	21	
Resensitizing to FP Concerns	19	
Potential to Expand Practice	6	
Provision of Equipment	3	
Trained Paramedics	3	

**AREAS REQUIRING ATTENTION IF DOCTORS BECOME MORE INVOLVED IN FP**

<u>Areas of Support</u>	% Responding (N = 63)	<u>What Information Is Needed?</u>
Contraceptive Supplies	71	 <p>81% Method-specific information and side effects</p>
Equipment	54	
Additional Staff	46	
Educational Materials	64	
Seminars/Workshops	49	

**WHAT ACTIVITIES WOULD YOU LET NURSE HANDLE?**

<u>Areas of Support</u>	% Responding (N = 63)
Give Injections	79
Counsel Patients	78
Teach Group Sessions	19
Insert IUD	3

## SUMMARY OF OPTIONS INVESTIGATED FOR PRIVATE-PRACTICE PHYSICIANS

### LEVEL OF INTEREST IN VARIOUS OPTIONS

% RESPONDING (N = 62)

Option	Wouldn't Increase Use	Would Increase Use Somewhat	Would Increase Use A Lot	Don't Know
Low-Cost Injectable	48	34	16	2
Low-Cost IUD	37	40	21	2
	Not Interested	Interested	Very Interested	
IUD Insertion Training	41	48	11	
VSC Training	41	37	22	
OR Facilities	41	29	30	
	Not Interested	Interested	Don't Know	
Start-Up Financing	57	32	11	

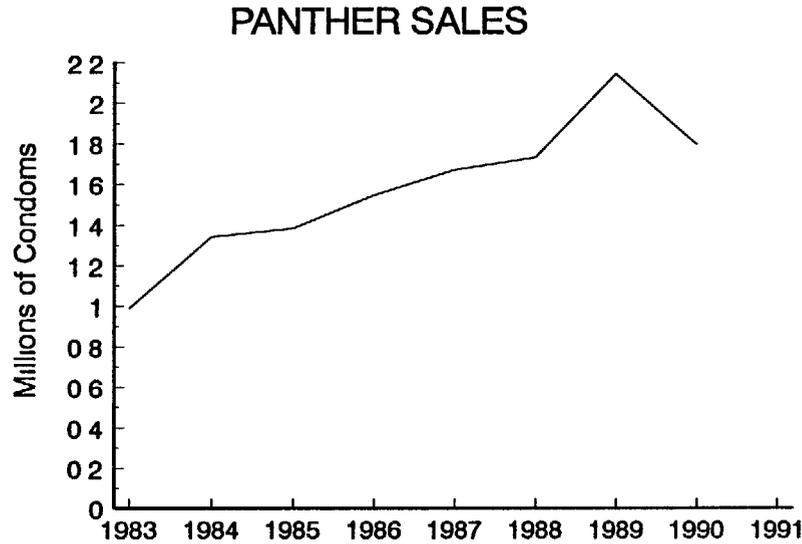
- Subgroup of young, rural doctors expressed most interest

### SUMMARY OF ISSUES

- Overall, limited interest
- Potential target group identified -- young, rural doctors
- Prerequisite -- must work to reduce concerns about methods
- Incentives of most interest -- access to OR facilities and skills upgrading
- Concerns -- family planning is time intensive and doesn't bring high financial returns
  - Possible solution -- utilize nurses for FP counseling

Source 88

## SOCIAL MARKETING PROGRAM HAS BEEN SUCCESSFUL



Source NFPB



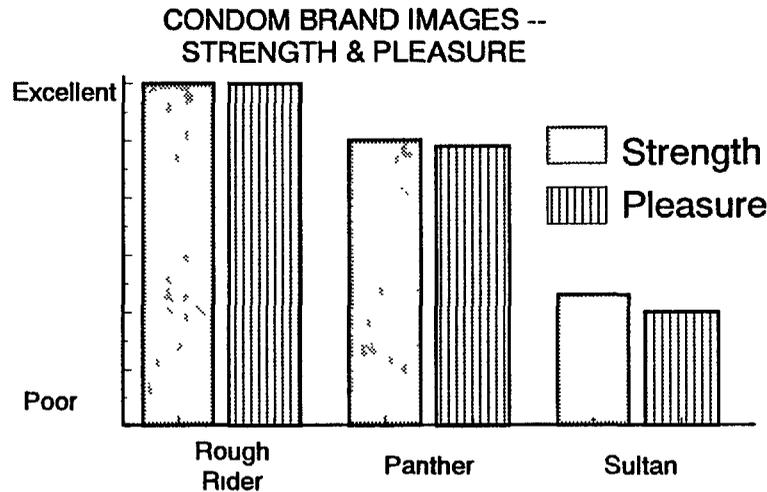
### Market Penetration

- Panther is in all 270 pharmacies, approximately 100 supermarkets and several thousand small shops (including some hotels and guest houses)
- Perle is available in all pharmacies and is authorized to be sold on an OTC basis

### Market Position

- Brand awareness is very high
- Both Panther and Perle are market leaders in the commercial sector

**POSSIBLE TO REVITALIZE IMAGE AND VALUE OF CDC PRODUCTS**



**VALUE OF PERLE COULD BE INCREASED BY**

- Training pharmacists
- Informing consumers that Perle is low dose
- Offering POP materials that address concerns with oral contraceptives
- Advertising Perle to communicate benefits

Source 56

**RELATIVE COSTS ARE LOW**

<b>COSTS FOR PANTHER &amp; PERLE</b>	<b>J\$</b>	<b>COSTS FOR OTHER CONSUMER PRODUCTS</b>	<b>J\$</b>
Month's supply of Panther (9)	\$9 00	Two Red Stripe Beers	\$20 00-\$22 00
		Two Sodas	\$16 00
Month's Supply of Perle	\$5 00	One Pack of Cigarettes	\$20 00-\$24 00
		2% of Minimum Monthly Wage (Domestic Helper)	\$11 20
		2% of Minimum Monthly Wage (Other)	\$12 80

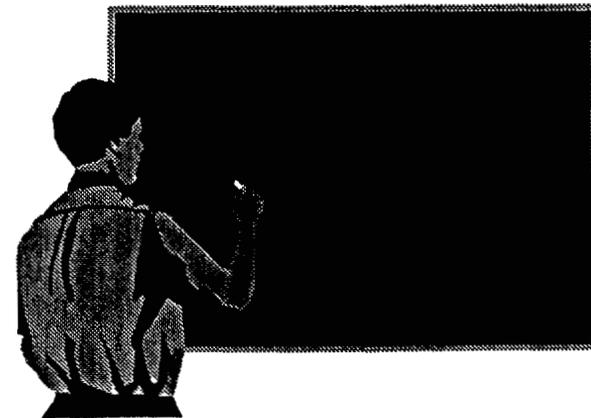
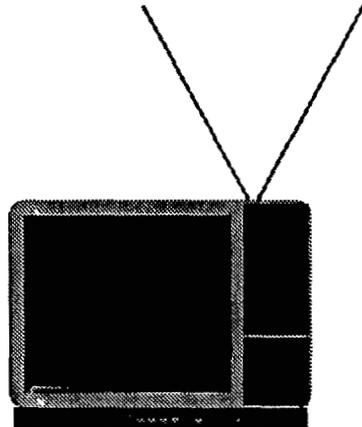
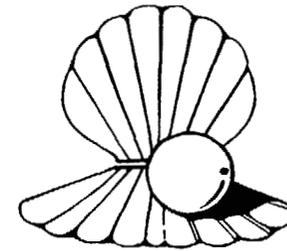
## LACK OF ADEQUATE COUNSELLING IS A CONCERN

- Average actual time spent counselling patients on family planning methods is 5-10 minutes
- Estimated actual time required to cover material is 45 minutes
- Problems are shortage of staff at clinics and low financial return for counselling at private clinics
- Assessment reports also point out that the full range of options is frequently not discussed because of lack of expert knowledge of some methods. In addition, users' questions and concerns are frequently not aired due to lack of sensitivity and/or time
- Factors perceived to most influence successful contraceptive use

	Public-Sector Providers (N = 20)	Private-Sector Providers (N = 63)
Better counselling	55%	67%
Improved education (including FLE)	45%	79%

Source 88

**SUMMARY OF TRAINING, IE&C, FLE, ADVERTISING ACTIVITIES**



## **VARIOUS COMMUNICATIONS OUTREACH UNITS OF NFPB**

### **COMMUNICATIONS UNIT**

- Mass media campaigns
- Marge Roper family planning telephone counselling service
- Development and dissemination of FP/FLE materials

### **TRAINING UNIT**

- Teacher training for FLE program sponsored by MOE
- Out-of-school program sponsored by MOY
- Training of agricultural and home extension officers
- Seminars and workshops for private sector
- Male responsibility program
- Parent education program

### **FIELD SERVICES UNIT**

- 19 liaison officers to coordinate FP activities at parish level
- Assist in parish-level training
- Disseminate FP/FLE materials
- Educate specific target groups within communities

## **MASS MEDIA**

**High impact, well sustained and multifaceted media campaigns have been used to**

- **Impact and change public attitudes**
- **Create awareness and demand for family planning "Plan your family, better your life"**
- **Create a downward shift in the desired family size "Two is better than too many" campaign**
- **Make the products of the Social Marketing Program household names in Jamaica through brand specific advertising for Panther condoms and Perle oral contraceptives**
- **Address the issue of teenage pregnancy "Before you be a mother, be a woman"**
- **Address the need for a more responsible male attitude toward family planning**

**Nontraditional use of media to support the family planning effort**

- **Radio soap opera with grassroots appeal**
- **Reggae song recorded by popular artist**

## **CHRONOLOGY OF FP MEDIA ACTIVITIES**

**1967-1973**

**First mass media campaign "Plan your family, better your life"**

**Highly successful in increasing awareness of family life issues**

**This period saw the decline in the birth rate from 38/1,000 to 30/1,000**

**Campaign continued to be aired periodically through to the early 1980s**

**1973-1980**

**Brand advertising for Panther condoms and Perle oral contraceptives**

**These supported the social marketing program and ran alongside the more general campaign to create awareness and demand for family planning services**

**Successful in increasing awareness of family life issues, doubling use of oral contraceptives and significantly increasing condom usage**

**1982**

**Second mass media campaign aimed at encouraging the two-child family "Two is better than too many"**

**TV, radio, press posters and billboards**

**Bumper stickers were also used to launch the campaign in 1982**

**Effective in reducing desirable family size and contraceptive use**

**This campaign continued to be used periodically for program maintenance until February 1990**

## **CHRONOLOGY OF FP MEDIA ACTIVITIES**

- 1983-1984 Campaign promoting male responsibility "Don't be a Georgie "
- Radio, press
- February 1985 Radio soap opera — Naseberry Street — used to expose family planning myths and traditional male attitudes
- September 1985-  
January 1986 New campaign aimed at teens "Before you be a mother be a woman"
- TV, radio, press, cinema, billboards
- A popular song utilizing the same theme was also recorded by a well-known reggae artist
- January 1986 New campaign highlighting deepening economic hardships and the consequent relevance of the two child "mama me hungry"
- TV, radio
- Campaign withdrawn at request of government within the first month of airing
- February 1986 Small press campaign encouraging male responsibility developed for a teens magazine "Be a man "
- March 1986-  
March 1987 Media maintained during this period with the teen "Before you be a mother be a woman "
- November 1990-  
November 1991 New brand specific campaign for Panther condoms "Protect yourself "
- Radio, press, billboards

## **TRAINING**

**The NFPB's Training Unit continuously undertakes training activities designed to upgrade professional skills and in changing attitudes and practice**

**Training is conducted among**

### **Health Workers**

**Providers of contraceptive services  
Ministry of Health personnel  
General practitioners  
Pharmacists**

### **Educators**

**Teachers and guidance counsellors**

### **Community Leaders**

**Male motivators  
Parent educators**

### **Adolescents**

**Youth leaders  
Peer counsellors**

### **NFPB Staff**

**NFPB liaison officers  
Other NFPB staff**

**Other training of health professionals is also undertaken in collaboration with the Ministry of Health**

## **FAMILY LIFE EDUCATION**

**Family life education is weak and fragmented although included by various agencies in their programs**

### **Reasons:**

- **Wide differences exist in the training of educators, hence, programs have mixed success rates**
- **FLE offered in schools infused in subjects such as social sciences and home economics**
- **Family life education not institutionalized in schools as an examinable subject but rather is optional**

## V CONCLUSIONS AND RECOMMENDATIONS

10/10/10

## SUMMARY OF MAJOR FINDINGS AND POLICY ISSUES

### Program Environment

- The Jamaican family planning program has a long and successful history. The program has entered a mature stage and for the last several years there has been appreciable gains in contraceptive prevalence rates. Future improvement will be more difficult to achieve and will come only with specially targeted program efforts.
- The new family planning goals are ambitious and the economic environment, both in terms of phased out USAID support and inflationary pressures, is extremely challenging. Economic pressures are likely to increase demand for family planning. Much of this demand will likely be focused on the free public-sector clinics--contrary to program goals--unless special efforts are undertaken to channel it elsewhere.
- The research, and consequently this document, only addresses some of the options for replacing USAID funds. Options addressed include increasing program effectiveness by shifting more users to long-term methods, having public-sector users pay part of the costs of service or shifting them to the private sector, and increasing the involvement of private-practice physicians and the appeal of the social marketing program. Other possible options for consideration include further increases to program efficiency and cost cutting, seeking other international donors, seeking out other sources of support (e.g., employers or health insurance) and increasing GOJ's share of the contribution.
- The social situation is such that youth are becoming sexually active at earlier ages and that unstable unions and "outside" partners must be factored into both pregnancy and disease protection decisionmaking.

### User Issues

#### Demand, Trial, and Sustained Use

- Demand for family planning is high among all segments of the population. The primary reason for wanting to control fertility has to do with economic burdens and the desire to improve one's quality of life.
- Awareness of modern methods is virtually universal. It should be pointed out, however, that awareness does not equate to a functional knowledge.

- Trial of modern methods is moderately high Trial needs to be bolstered among youth Primary barriers to trial among youth are lack of education about the specifics of family planning, lack of a social support system that encourages responsible behavior, and to some extent lack of access to supplies
  - Although the teenage pregnancy rate is showing signs of decline, the largest unmet need for family planning still exists among youth
- Some attitudinal barriers exist to trial of long-term methods These include fear of infections, sterility, and birth defects with the IUD, fear of "the knife" with female sterilization, and concerns about "ceasing to be a man" with male sterilization Norplant is relatively unknown
- The largest barrier to increasing (and sustaining) contraceptive prevalence is the very high discontinuation rates The biggest reason for discontinuation is health concerns, including bad side effects
- Myths and misconceptions about the methods and their safety abound It should be noted, however, that most discontinuation is based on some type of personally experienced side effect--not merely rumors Many of these (unfounded) concerns arise from menstrual irregularity and from a misunderstanding of how the methods actually work Many women steel themselves to use these "harmful" methods and then stop frequently to give their bodies a chance to rest and recover Lack of adequate, method-specific knowledge is the major barrier to sustained use
- Men are involved in general family size considerations They, however, are relatively uninvolved in actual method choice and do not act as gatekeepers or barriers to use

### Service Delivery Issues

#### "Appropriate" Method Mix and Shift to Long-Term Methods

- According to stated fertility desires, 55% of potential users are limiters, 26% are spacers, and 19% are postponers This suggests an "appropriate" method mix as follows 45% of certain limiters using sterilization, Norplant, or IUDs, 10% of uncertain limiters using Norplant or IUDs, 26% of spacers using oral contraceptives or injectables (with 4% of breastfeeding women using barrier methods or the IUD), and 19% postponers using condoms (with the 2% of married or common law postponers possibly using oral contraceptives or injectables) In any case, both from an appropriateness of method mix

perspective as well as from the goal of increasing program effectiveness, a need exists to shift users onto more effective long-term methods

- Supply-side barriers to increasing use of long-term methods include concerns about the safety of the methods, lack of training and access to methods, and weak patient counselling about methods
- The cultural factors of unstable unions and the image of male virility also act as significant deterrents to use

### Cost Recovery and Privatization

- Most users perceive family planning to be a relatively low value-added service, i.e., without much medical counseling required. As a result many simply use the public clinics as a source of family planning supplies and use private doctors for more "serious matters"
- Many public-sector users have an ability to pay something for their supplies. Evidence for this conclusion rests on the fact that seventy two percent of public-sector users say they would be willing to pay something for supplies, as opposed to stopping the method. In addition, approximately one-half of public sector clinic users have household incomes greater than J\$15,000 [1991] and own televisions, refrigerators, and cook with propane gas
- Most private-practice physicians have limited interest in becoming more involved in increasing their involvement with family planning. The primary reason for this is financial--family planning is a time intensive practice and the physician can make more money by treating more serious illnesses
- A pocket of opportunity exists among young, rural doctors who are motivated to expand their practice. A prerequisite is to work to reduce their concerns about the safety of the methods. Incentives of most interest were offering skills upgrading sessions and free access to operation room facilities at clinics
- The social marketing program has been very successful in making good quality, low-cost, contraceptives more widely available. An opportunity exists, however, to entice more users away from the generic brands and long waits at the clinics by revitalizing the images of the brands and by offering greater value. The new Rough Rider condoms, which have captured the attention of the market, seem to convey a image of strength, protection, masculinity, and pleasure. The vast majority of women do not know that Perle is a low dose pill and that an initial period of side effects is normal. Value could be increased by addressing issues such as these

- In spite of the recent price increases for Panther and Perle (to J\$9 00 and J\$5 00, respectively, for a month's supply), they still remain at a price point below other non-luxury consumer items such as two Red Stripe beers, two soda, and a pack of cigarettes. Another indicator of "affordable" price that is frequently used is a price that is less than 2% of minimum monthly wage. Two percent of a domestic helper's minimum wage would be J\$11 20. (There is anecdotal evidence that the image of the brands has suffered due to the very low price.)

#### Quality of Counselling and Increased and Sustainable Use

- There is much concern among medical providers that the quality of counselling is lacking. The problem appears to be three-fold. The primary problem is one of lack of time. Both public- or private-sector providers comment that family planning counselling is time intensive and they lack the time to offer proper individual counselling. Related to this is a concern that many women do not perceive the need to seek medical advice when choosing a contraceptive and many do not feel free to openly discuss their concerns and fears. An additional problem is that many providers are not, themselves, sufficiently informed and comfortable with the methods to offer guidance and answer questions of others.

## **RECOMMENDATIONS**

### **Education and Counselling**

- **Demand for family planning and awareness of the methods has already been well established. Usage problems stem from incomplete and incorrect information. Future IE&C work should, therefore, be directed to providing detailed, method-specific information and to correcting popular misconceptions. Research should be used to fully probe and identify specific fears and misunderstandings. Since much of these concerns have been built up based on bad personal experiences, and not merely based on the rumors of others, it is unlikely that vague general statements will be sufficient to correct them. The specific health concerns will have to be confronted head on. Furthermore, with the possible exception of youth, there is little need for general motivational statements about family planning.**
- **Since most young people are still at the stage of trial, it would be appropriate for FLE and other communication materials directed to them to address general family planning motivational issues. Still, however, the greatest need is to go beyond this level and impart a direct and detailed understanding of family planning and the methods. Also, beyond a mere understanding of the methods, young people need to be given tools and a support system for making tough decisions and for taking responsibility for their lives. Much of this could be addressed through FLE in the schools.**
- **Since skilled medical personnel are in short supply, creative, less-labor intensive efforts should be sought out. Examples of ideas that have been proposed include making a video on the various methods and disseminating it to clinics, having a mobile resource person visit clinics and hold informal discussions, disseminate easily understood method-specific information in the form of point-of-purchase brochures, utilize dramas and soap operas to highlight the myths and convey a more detailed understanding of correct use, and have nurses conduct group sessions.**

### **Training and Service Delivery**

- **The first priority is to address the safety issue and health concerns of the long-term methods among the service provider community. These concerns could be addressed in a series of workshop and seminars, as a part of clinical training and skills upgrading programs, or as a part of pharmacist training under the auspices of the social marketing program.**
- **The limited access issue to some of the longer-term methods could largely be resolved through the training and equipping of more staff. Difficulties such as insufficient patient flow in centralized training centers has posed problems in the past. Alternative arrangements such as mobile field trainers or internships abroad need to be fully explored.**

- Improved counselling should be included as a part of the training activities. Again, creative, less-labor intensive ways need to be sought out. For example, if videos were available in many of the clinics, users would come into the nurses with a much higher skills base and thus shorten the time required for personal, one-on-one counseling. It is believed that a correct understanding of the methods obtained through improved counselling will go a long way toward improving the sustainability of contraceptive use. Improved counseling could also increase the value of family planning services and make people more willing to seek out expert advice and to be more willing to pay for it.
- A special issue needing attention under counselling is the ability of youth to easily access supplies. Anecdotal evidence indicates that some service providers appear unapproachable or simply refuse to give supplies to young, single people. This problem should be specifically and fully addressed as a part of retraining efforts.

#### Cost Recovery and Privatization

- Consider instituting mechanisms to recover some costs from public-sector users. Mechanism such as a sliding fee scale or a means test could be more fully explored--perhaps on a pilot basis. It is recognized that for social or other reasons this suggestion might not be found to be acceptable. The research conducted to date, however, suggests that a sizable portion of public-sector users both could and would pay something for services.
- Explore further the possibilities for increasing the involvement of young, private practice physicians in family planning. The specifics of such arrangements need to be more fully developed and discussed. It might be possible to pursue this option by working through the Medical Association of Jamaica.
  - An additional point to consider under this option is the possible introduction of Norplant through a select set of private physicians. Owing to the high price of Norplant, it seems more reasonable to emphasize private-sector involvement in this new, long-term method as opposed to relying heavily on the public sector.
- The image and value of the social marketing products--Panther and Perle--could be enhanced through an integrated set of training, advertising, and promotional activities. In light of the new competition from Rough Rider condoms, the image of Panther needs to be repositioned or reenergized. Focus group research among young males should be used to craft and test specific advertising messages. If the research reveals that the image of Panther is so deeply entrenched that it cannot easily be change, a new brand of condoms could be introduced. Care should be taken on all condom-related research and communications to address both the pregnancy and disease issues.

- The value of Perle could be enhanced by training of pharmacists, offering point-of purchase materials that address specific health concerns, side effects, and correct use, and by introducing some new, fresh advertising or promotions
- In order to attract users away from the public sector, men need to be made to feel more excitement about using Panther condoms and women need to be given more information and be reassured that Perle is a safe pill that is right for them
- There is room to move the price upwards somewhat for either of the social marketing brands. A good time to do that might be with the launch of a new advertising campaign. This decision, however, will have to be taken based on the entire marketing plan, an analysis of break-even points, and in light of the larger financial self-sustainability issue/strategy. The messages of the social marketing campaign could be used to reinforce other, more detailed, method-specific information being disseminated through IE&C efforts

#### Special Issues--MIS System and Condom Use

- This research review did not deal with very much logistics and MIS data simply because much of the data is incomplete and inconsistent. This, however, points up the need to improve the MIS system so that this important source of data can be more easily used in the future. (The means for addressing this situation is in place through a provision of technical assistance and training from the Centers for Disease Control.)
- Condoms are increasingly being promoted and used for AIDS prevention. Condoms tend to be used with "outside" partners and on an occasional basis. The promotion of one method to the same target group (i.e., young people) for dual purposes has the potential of being confusing. In addition, it raises the question of which groups can safely be discouraged from using condoms in favor of more effective family planning methods. It also raises the question of the possibility of promoting multiple methods, e.g., using condoms with casual partners and using a more effective family planning method with one's primary partner. All future condom research and communication activities should keep the dual use of condoms in mind and work to build upon each other's agendas.

#### Future Research

- It is suggested that the materials collected for this review be given to the NFPB and added to their collection for the beginning of a family planning resource center. In the future, all research would be documented and included as a part of this center.

- **Qualitative research studies should be designed to assist in the development and evaluation of all training and communications materials. Some of this work has already been done--it should also be documented, if at all possible. Much of the new work could be conducted in a coordinated and combined manner, once program plans are in place.**
- **Although men do not play a major role in family planning decisionmaking, their attitudes toward some methods are particularly relevant. Not much research on male attitudes toward family planning and toward male methods has been done. It is suggested that some small scale, attitudinal research be conducted on the issues of increasing male involvement in family planning.**
- **Follow-up investigations are required into specific mechanisms and incentives for enticing private-practice physicians into family planning. (Investigation into mechanisms for involving other private sector participants is also needed and is being pursued through interviews and meetings.)**
- **A baseline audit of the commercial distribution system for contraceptives should be conducted for the purpose of establishing a baseline measure of the market situation. The baseline, coupled with a series of periodic updates, would provide rich information from which one could better manage and evaluate the social marketing program. This information is also needed to get a complete picture of the contraceptive market and to track the increasing involvement of the private sector.**

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**FAMILY PLANNING-RELATED RESEARCH STUDIES**

Report Date	Title	Author(s)	Prepared For	Availability	Methodology	Comments
<b>National Contraceptive Surveys</b>						
1964 (Fieldwork 1956)	<u>The Control of Human Fertility in Jamaica</u>	J M Stycos & Kurt W Black	'	Report  Data — Roper Public Opinion Research Center (data tape degraded unreadable)	Nationally representative 1,359 household interviews with lower class women aged 14-40	First contraceptive use survey Reported ever use 10% reported current use 5% (lower class women 15-39 currently in union) Most popular methods — withdrawal vaginal methods, condom
1978 (Fieldwork 1971-72)	Contraceptive Use in Jamaica Institute of Social and Economic Research Work Paper No 19 UWI	Doran Powell Linda Hewitt and Prudence Woo-Ming Dept of Sociology UWI	Dept of Sociology UWI NFPB and JFPA	Report — Powell UWI  Data ?	Nationally representative household interviews — 2,021 with all women aged 15-44 and approximately 2,300 with women aged 45-64	Reported ever use 52% reported current use 29% (women 15-44 ever in union) Most popular methods — pill condom female sterilization and IUD
1979 (Fieldwork 1975-76)	<u>Jamaica Fertility Survey 1975-76, Vol I and II</u>	Carmen McFarlane Dept of Statistics and World Fertility Survey Office International Statistical Office	NFPB	Report — NFPB  Data ?	Nationally representative 3,096 household interviews with all women (nonstudents) between 15 and 49	First contraceptive use study for NFPB Reported ever use 69% (ever in union) Reported current use 40% (reported on several bases — women 15-49 currently in union) Most popular methods — pill female sterilization condom and injection
1979	<u>Survey of Contraceptive Use in Jamaica, 1979</u>	Doran L. Powell Dept of Sociology UWI	NFPB	Report — NFPB  Data ?	Nationally representative 2,198 household interviews with all women between 14 and 44	Reported estimated ever use 69% (ever in union) Reported current use 57% (women 15-44 currently in union) Most popular methods — pill injection female sterilization and condom
1979	<u>Survey of Contraceptive Behavior, 1979 — The Male Study</u>	Doran L. Powell Dept of Sociology UWI	NFPB	Report — NFPB  Data ?	Separate male sample 166 interviews with males in Kingston (urban) 66 interviews with males in St Thomas (rural) age range 15-55	Reported ever use 66% reported current use 22% (males 15-55)
August 1984 (Field work 1983)	<u>Contraceptive Prevalence Survey Jamaica 1983</u>	NFPB Doran L. Powell Dept of Sociology UWI and Westinghouse Health Systems	NFPB	Report — NFPB  Data — Westinghouse	Nationally representative 2,199 household interviews with all women between 15 and 49	Reported ever use 73% (ever in union) Reported current use 51% (women 15-49 currently in union) Most popular methods — pill female sterilization condom and injection
December 1989	<u>Contraceptive Prevalence Survey Jamaica 1989 — Final Report</u>	NFPB Carmen McFarlane McFarlane Associates and Charles W Warren Division of Reproductive Health CDC	NFPB	Report — NFPB  Data — CDC, NFPB	Nationally representative 6,330 household interviews with all women between 15 and 49	Reported ever use 71% (all women) Reported current use 55% (women 15-49 currently in union) Most popular methods — pill female sterilization condom and injection

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## FAMILY PLANNING-RELATED RESEARCH STUDIES

Report Date	Title	Author(s)	Prepared For	Availability	Methodology	Comments
Planned 1993 and 1997	Contraceptive Prevalence Survey	NFPB Division of Reproductive Health CDC	NFPB		Nationally representative household interviews (all women between 15 and 49 separate male sample)	Planned
<b>Consumer Studies</b>						
Early 1980s	<u>Low Contraceptives Affecting Utilization of Family Planning Services in Jamaica</u>	C. P. MacCormack London School of Hygiene & Tropical Medicine	MOH/Planning & Evaluation	Report — See bibliography	In-depth interviews with 268 women in anti natal clinics	Excellent description of common myths and misconceptions regarding methods
January 1984	<u>A Qualitative Assessment of Attitudes Towards and Usage of Contraceptives Among Jamaican Females</u>	Don Anderson Market Research Services	NFPB	Report — NFPB	Four focus group discussions, participants included C&D SES class women between 15 and 44 from both urban and rural settings	Part of series of market assessment studies for NFPB's CDC program
April 1984	<u>A Qualitative Assessment of Attitudes Towards and Usage of Contraceptives Among Jamaican Males</u>	Don Anderson Market Research Services	NFPB	Report — NFPB	Four focus group discussions, participants included C&D SES class men between 15 and 44 from both urban and rural settings	
November 1984	<u>A Consumer Baseline Survey on Behavior, Attitudes and Practices of the Jamaican Contraceptive User and Potential User</u>	Don Anderson Market Research Services	NFPB	Report — NFPB Data — MRS?	Nationally representative 998 household interviews with all adults (male and female) over age 13	41% report current use of family planning (men and women over 13) Most popular methods — condom and pill Panther and Perle dominate market No apparent support for introduction of new products Teenagers and discontinued users are prime target markets
November 1989	<u>1989 Jamaican Survey of Living Conditions — Fertility Module</u>	Planning Institute of Jamaica	PIOJ	Report — PIOJ Data — STATIN	Nationally representative 2,210 household interviews with women between 15 and 49	Excellent description of common myths and misconceptions regarding methods
August 1991	<u>A Qualitative Assessment of Mistimed and Unwanted Pregnancies Among Jamaican Lower Income Women</u>	Maxine Wedderburn Hope Enterprises	NFPB	Report — NFPB	Twelve focus group discussions, participants included female MOH clinic users aged 16-49 who were sexually active and not using family planning or who became pregnant while using family planning	

**FAMILY PLANNING-RELATED RESEARCH STUDIES**

Report Date	Title	Author(s)	Prepared For	Availability	Methodology	Comments
November 1991	<u>Public Sector User Survey for Women 15-49 Years — Final Report</u>	Maxine Wedderburn Hope Enterprises	USAID/ Kingston	Report — USAID/Kingston Data — Hope Enterprises	Nationally representative of female MOH clinic users, 708 non family planning users and 708 current family planning users (interviews in clinics)	
1991	<u>A Survey of the Contraceptive Market in Jamaica</u>	Roy Russell Agro-Socio Economic Research	NFPB	Report — NFPB Data — NFPB	Nationally representative household interviews — 1 111 with all women aged 15 50 and 873 with all men aged 15 65	Data should be reanalyzed and represented for better understanding of results 47% of females 15 50 report current use of family planning 35% of males 15-65 report current use of family planning Most popular methods — pill sterilization condom and injection Panther has 49% market share followed by Rough Rider with 29% and Sultan with 16% Perle has largest market share followed by Ovral and Lo Femenal
<b>Young Adult Studies</b>						
1974	"Teenage Pregnancy A Jamaican Case Study	Dorian L. Powell Dept of Sociology UWI	?	Report [Get]		
?	Adolescent Pregnancy Some Preliminary Observations on a Group of Urban Young Women	Dorian L. Powell Dept of Sociology UWI	?	Report — Powell UWI	100 unstructured and semi structured interviews with first time pregnant teenagers additional interviews with mothers of pregnant teenagers	
1982	"Teenage Pregnancy in Jamaica	Pansy Hamilton	NFPB	Report [Get]		
March 1988 (Fieldwork 1987)	<u>Young Adult Reproductive Health Survey Jamaica 1987</u>	NFPB Dorian Powell and Jean Jackson Dept of Sociology UWI Vernon James STATIN Charles W Warren Leo Morris and Anne Whatley Division of Reproductive Health CDC	NFPB	Report — NFPB Data — CDC, NFPB	Nationally representative household interviews 2 141 with females aged 14 24 and 2 084 with males aged 14-24	Very high percentage of young adults are sexually active Average age of first intercourse is 17 for females and 14 for males 41% of females and 11% of males used contraception at first intercourse
<b>Sexual Practices</b>						
1984	In Depth Study of Jamaican Male Sexual Beliefs and Behaviors	Barry Chevannes Dept of Sociology UWI	NFPB	Report — NFPB		

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FAMILY PLANNING-RELATED RESEARCH STUDIES

Report Date	Title	Author(s)	Prepared For	Availability	Methodology	Comments
March 1984	Twelve In-Depth Interviews with Physicians Regarding Attitudes Towards and Involvement with Contraceptive Issues in Jamaica	Don Anderson Market Research Services	NFPB	Report — NFPB	Eight in-depth interviews with OB/GYNs	
April 1984	Twelve In-Depth Interviews with Jamaican Retailers Islandwide	Don Anderson Market Research Services	NFPB	Report — NFPB	Twelve in-depth interviews with retailers (two pharmacists two supermarket managers six grocery store shopkeepers and two bar managers) six outlets sold contraceptives four interviews were in Kingston and eight were in other major towns	
September 1991	Study Conducted Among Private General Practitioners — Final Report	Marine Wedderburn Hope Enterprises	USAID/Kingston	Report — USAID/Kingston	Nationally representative interviews with 63 GPs open discussion format used with structured questionnaire	
<b>Communication Design Tests and Campaign Evaluations</b> Communication design tests which are documented are very old						
1974 [very old]	Results of a Comprehensive Depth Research Study of Penetration, Communication and Understanding of the Recent Advertising Campaign for Family Planning Phase I — The Qualitative Study		NFPB	Report — NFPB	12 focus group discussions and 13 in-depth interviews	
1987	An Evaluation of the NFPB's Teenage Fertility Campaign	Roy Russell Agro-Socio Economic Research	NFPB	Report — NFPB	Nationally representative 1,500 household interviews with all young adults between 13 and 19	
1988	Report on a Study on Peer Counseling in Jamaica	Barry Cherannes, Dept of Sociology UWI	NFPB	Report		

**FAMILY PLANNING-RELATED RESEARCH STUDIES**

Report Date	Title	Author(s)	Prepared For	Availability	Methodology	Comments
<b>AIDS Studies with Implications for Family Planning</b>						
January 1989 (Fieldwork 1988)	<u>A Baseline Survey on AIDS and Sexually Transmitted Diseases in Jamaica</u>	John Stover and Susan Smith The Futures Group and Don Anderson Market Research Studies	MOH Epi Unit	Report — MOH Epi Data — TFG	Nationally representative AIDS baseline survey 1,200 household interviews with both men and women between 15 and 59	
June 1990	<u>Impact of the 1988 89 National AIDS Communications Campaign on AIDS Related Attitudes and Behaviors in Jamaica</u>	John Stover and Susan Smith The Futures Group	MOH Epi Unit	Report — MOH Epi Data — TFG	Nationally representative AIDS tracking survey 1 124 household interviews with both men and women between 15 and 59	
1989	A Condom Use Assessment and Intervention Study	AIDSCOM	MOH Epi Unit (AIDSCOM)	Report — MOH Epi? Data — ?	Male sample within JDF	
September 1991	<u>Knowledge, Attitude, Practice Study for AIDS in Schools</u>	Maxine Wedderburn Hope Enterprises	MOH Epi Unit (WHO)	Report — MOH Epi Data — Hope Enterprises	540 students from grades 6 9 (aged 11 15) interviewed in 9 parishes 162 opinion leaders interviewed	
January 1992 (Fieldwork 1991)	AIDS Indicators Community Survey Briefing Packet	John Novak Academy for Educational Development	MOH Epi Unit and USAID	Report [Get] Data — Hope Enterprises		
Planned 1992	1992 AIDS KAP Survey	Maxine Wedderburn Hope Enterprises	MOHs Epi Unit (AIDSCAP)		Nationally representative	Planned

**C. CONDOM AND ORAL CONTRACEPTIVE BRANDS**

## CONDOMS

Manufacturer	Importer/ Distributor(s)	Brand/ Presentation	Pill Type	Packaging	Instructions	Retail Price (J\$)	
Ansell (U S)	Central Trading Co, Lasco (ordered) Cari Med (ordered)	Contempo Family Rough Rider (3) Bareback (3) Kiss of Mint (3) Wet N' Wild (3) Erotica (3) Power Play (3) Rough Rider (3)	Studded Sensitive (thin) Scented Lubricated Ribbed Extra Strong Studded	Hanging box (blue) Flat pack Hanging box Hanging box Flat pack Hanging box Flat pack (brown)	Insert Pack instructions Insert Insert Pack instructions Insert Pack instructions	15 00-19 00 15 00-19 00 15 00-19 00 15 00-19 00 15 00-19 00 15 00-19 00 12 50-15 00	
	Lasco & others	Lifestyles Assorted Colors (3) Nuda (3) Stimula (3)	Colored Thin Ribbed			25 00 10 00-15 00 10 00-15 00	
	Lasco (ordered)	Body & Shine (3) Prime (N 9) (3) Prime (Extra strong) (3) Prime (Lubricated) (3)	N 9 Extra strong Lubricated			10 00-15 00 10 00-15 00 10 00-15 00 10 00-15 00	
	MOH/NFPB	Sultan (1) (No longer importing)	Plain, noncolored	Branded foil wrap	None	Free	
	MOH/NFPB	No logo (1)	Plain, noncolored	Unbranded foil wrap	None	Free	
	MOH/NFPB	Panther (3)	Plain, noncolored	Box	None	3 00	
	MOH/NFPB	Panther (1) Also sold singly	Plain, noncolored	Branded foil wrap	None	1 00	
	Geddes Grant (no longer importing) Lasco (ordered)	Sultan (3)	Textured	Box	None	15 00	
	Durex (London Rubber)	Facey Commodity	Arouser (3) (old)	Ribbed, N 9	Box	Pack instructions	21 00-35 00
			Arouser (3) (new)	N 9	Box (different design)	Pack instructions	21 00-35 00
			Gossamer (3) (old)	Plain (thin?)	Box	Pack instructions	21 00-35 00
			Gossamer (3) (new)	N 9	Box (different design)	Pack instructions	21 00-35 00
			Fiesta (3)	Colored	Box	Pack instructions	21 00-35 00
Gold (3)			N 9, plain ended	Box	Pack instructions	21 00-35 00	
Nu Form (3)			N 9, shaped	Box	Pack instructions	21 00-35 00	
Fetherlite (3)			Sensitive (thin)	Box	Pack instructions	21 00-35 00	

Note All prices are quoted in Jamaican dollars as of May 1992

## CONDOMS (Cont.)

Manufacturer	Importer/ Distributor(s)	Brand/ Presentation	Pill Type	Packaging	Instructions	Retail Price (J\$)
National Sanitary Labs (U S)	Geddes Grant (no longer importing)	Protex	Ribbed Thin ribbed Shaped	Flat pack	Pack instructions	8 00
		Arouse (3)		Flat pack	Pack instructions	9 65
		Scentuals (3) Man Form Plus (3) (old)		Flat pack	Pack instructions	N.A.
Lifeforce Interna- tional (U S)	Hercules (no longer importing)	Lifeforce (3)	Plain	Hanging box	Detailed use instructions and information on AIDS	4 50-6 00
N.A	Grace Kennedy (no longer importing)	Maximum (12)	Form fitted	Box	None	14 75
	Grace Kennedy (no longer importing)	Maximum (12)	Ordinary	Box	None	14 75
Alfa	Montrose Labs	Jellia Skins (3)	Spermicide	Box	None	6 00
Jiffi (England)	ICIs?	Jiffi Flavours (3)	Flavoured	Box	Insert with graphics and note to young people (Also mail order insert)	15.50
	ICIs?	Jiffi Long Player (3)	Specially lubricated "for prolonged lovemaking"	Box	"	15.50
	ICIs?	Jiffi Gold (3)	Spermicide	Box	"	15.50
Carter-Wallace (U S)	Informal	Trojan Enz (1)	Non lubricated	Foil wrap	None	7.50
		Trojan Enz (1)	Lubricated	Foil wrap	None	7.50
		Trojan Ribbed (1)	Ribbed, spermicide	Foil wrap	None	7.50
(Malaysia) Distributed by U C Imports (U S)	ICIs ICIs ICIs	Pamitex (3)	Thin	Hanging box	Pack instructions	10 00
		Black Jack (3)	Extra strong	Hanging box	Pack instructions	10 00
		Ginza (3)	Colored	Hanging box	Pack instructions	10 00
(Korea) Distributed by American Impex (U S)	ICIs	Fantasy (3)	Plain	Hanging box	Pack instructions	10 00

**CONDOMS (Cont.)**

Manufacturer	Importer/ Distributor(s)	Brand/ Presentation	Pill Type	Packaging	Instructions	Retail Price (J\$)
<b>(Korea) Distributed by Licks Interna- tional (U S )</b>	N A	Licks (3)	Flavoured	Hanging box	None	75 00
<b>N.A</b>	N A N A N A N A N A	Spartan (3) (old) Mates (3) (old) Mates (studded) (3) (old) Crown (3) (old) Magic (1) (old)	N 9 Extra strong Studded N A N A	Hanging box Flat pack Flat pack N A N A	N A N A N A N A N A	8 00-9 80 8 00 N A 6 00 25 00(?)

Note Brands imported informally tend to vary over time

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## ORAL CONTRACEPTIVES

Manufacturer	Importer/ Distributor(s)	Brand/ Presentation	Pill Type	Packaging	Instructions	Retail Price (J\$)	
Wyeth (U S )	MOH NFPB, JFPA	Lo-Femenal (28)	Low dose	Card	Card diagram	Free - 3 00	
		Noriday (28)	Low dose	Card	Card diagram	3 00	
	Wyeth (Germany)	Facey	Ovral (21)	High dose	Card	Card diagram	41 20
			Nordette (21)	Low dose	Card	Card diagram	51 10
			Trinordiol (21)	Low dose (triphase)	Card (folds into case)	Card diagram and technical insert	60 00
			Minulet (21)	Low dose	Box	Card diagram and technical insert	213 30
		Microval (35)	Mini pill (Progestin only pill)	Box	Card diagram and user friendly insert	49 30	
Schering (Germany)	Lasco	Microgynon (21)	Low dose	Box	Card diagram and technical insert	72 40	
		Microgynon 30ED (28)		"	"	86 30	
		Eugynon (21)	High dose	Box	Card diagram and technical insert	96 55	
		Eugynon ED (28)	" "	"	"	82 65	
		Logynon (21)	Low dose (triphase)	Box	Card diagram and technical insert	105 30	
		Logynon ED (28)	" "	"	"	83 75	
		Neogynon (21)	Std dose	Box	Card diagram and technical insert	97 55	
		Gynera (21)	Low dose	Box	Card diagram and technical insert	168 30	
		Diane 35 (21)	Low dose (good for acne also)	Box	Card diagram and technical insert	207 309	

**ORAL CONTRACEPTIVES (Cont.)**

Manufacturer	Importer/ Distributor(s)	Brand/ Presentation	Pill Type	Packaging	Instructions	Retail Price (J\$)
Syntex (U S )	NFPB/ Grace Kennedy	Perle (Noriday 28)	Std dose	Box 1 cycle	Card diagram and user friendly pack instructions	5 00
		Synphasic (28)	Std dose (biphasic)	Box 3 cycles	Card diagram	13 50
				Carrying Case	Card diagram and technical insert	N A
Searle (England)	Commercial	Ovulen 50 (21)	High dose	Box	Card diagram, pack instructions, and technical insert	20 65
Ortho (Canada)	Cilag Caribbean	Ortho 1/35 (21)	Low dose	Package	Diagram	91 40
		Ortho-Novum 1/50 (21)	Std dose	Package	Diagram	105 80
Ortho (England)		Ortho 7/7/7 (21)	Low dose (triphasic)	Package	Diagram	84 45
		TriNovum (21) "	Low dose (triphasic) "	Box Box 3 cycles	Card diagram and technical insert	61 20 188 40
Chemical Works of Gedeon Richter (Hungary)	Medimpex	Anteovin (21)	Std dose (biphasic)	Box	Card diagram and user-friendly insert	30 65
		Tri Regol (21)	Low dose (triphasic)	Box	Card diagram	46 80