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Quality of Life Among Jamaican Women: Trends Over the Past Two Decades

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Quality of Life Among Jamaican Women

Trends over the past two decades

By
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An Honors Thesis Submitted in Partial Fulfillment of the
Requirements for Graduation from the
Western Oregon University Honors Program

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Abstract

While advancements have been made in Jamaica that allow for growth in multiple social and economic sectors, this does not necessarily extend to society's treatment of women. Moreover, some aspects of the country's evolution lag behind, especially in the field of women's health. This thesis examines several facets of what make up women's quality of life. These include the history of women in Jamaica, traditional gender specific attitudes pertaining to sex, healthcare practices, and the significant presence of violence in the country. Jamaica is a leader in many respects when compared to countries in similar stages of development. Indeed, some aspects of women's health and quality of life mirror this. Data show that Jamaica is doing well in providing access to family planning, for example. However, the rates of violence against women are at a contrasting high. Statistics showing improvement with the promise of a continued development fail to look at the entire picture. This research has implications for multiple types of social policies and health programs that are becoming plausible given Jamaica's economic growth.

Introduction

The quality of life among Jamaican women is similar to that among societies of many developing countries. While advancements are being made in Jamaica that are allowing it to grow and evolve, this does not necessarily extend to society's treatment of, and the healthcare provided for Jamaican women. This is in part, due to the persisting attitudes regarding women's place in society in tandem with the highly structured gender roles widely accepted within the culture. Moreover, some aspects of Jamaica's evolution are lagging behind, especially in the field of women's health.

This thesis examines several facets of what make up women's quality of life. These include the history of women in Jamaica, traditional gender specific attitudes pertaining to sex, healthcare practices, and the significant presence of violence in the country. While important work has been done to evaluate each of these topics individually, this thesis analyzes the greater implications each aspect has on the whole. Further, it examines why Jamaican women are currently living in these societal and physical conditions by looking into possible implications based on this analysis.

Historically speaking, Jamaican women's purpose was to reproduce. Prior to the abolition of slavery, which happened in full by 1838, a female slave was judged by her capacity to bear children. Young women were preferred as slaves because they would have more childbearing years and therefore could produce more slaves (Turner, 2011). The rape of slaves was widely accepted, as it meant a more profitable use of the women on the part of those who purchased them. Once slavery was abolished, and the slaves freed, there was a dramatic increase in sexual assault prosecutions. These continued to rise until the late 1850's, when the criminal justice system determined these prosecutions

as unrealistic and freed those already imprisoned to work off the remainder of their sentence. The theme of little importance being put on women's rights over their own bodies remained consistent throughout reports by adolescents on what they had been taught of sex in 1999 (Eggleston et. al., 1999). While some changes have occurred since then, and women's role in society appears to be gradually changing, reports mirroring a lack of respect for women—especially regarding sex—continue to surface.

Jamaican women's healthcare has improved significantly over the past two decades. Their overall life expectancy is increasing, and cardiovascular health among women has seen major advancement. This however is somewhat dependent on the socio-economic level of the woman (Tulloch-Reid et. al., 2013). Moreover, while the overall life expectancy has improved, major factors still exist that are not seeing any measurable change. Many women go their adult lives without ever receiving a pelvic examination for example. Beyond this, more often than not, women who do seek out reproductive healthcare fail to follow up once they receive test results (Bourne et. al., 2010). In addition, the average birth rate has gone down significantly which shows improvement in availability and utilization of family planning methods, but contraceptives are widely thought to be for the sole use of protecting against pregnancy as opposed to pregnancy and sexually transmitted diseases or infections (Department of Economic and Social Affairs, 2015; Wood et. al., 2011).

The final factor examined for its effect on women's health and quality of life is the prevalence of violence in Jamaica. The country was recently reported to have one of six highest homicide rates in the world (Harriot et al., 2016). While this does not apply solely to violence against women, the implications for women were most closely

analyzed. Violence has been recognized as a significant threat by the Jamaican government, and legislation has been passed with the intention of addressing sexual assault in the country. Many violent crimes have seen a decrease—rape, however has not seen this same trend (Harriot et al., 2016).

To create as accurate and specific of an analysis as possible, results will be drawn from several studies examining Jamaican history, healthcare opportunities and practices, and violence. Once this data has been clearly explained and analyzed, a discussion of results and limitations will be presented, as well as suggestions for further research.

Methods

The core research of this study seeks to analyze the factors that contribute to Jamaican women's health and to measure how these women's quality of life has changed and evolved over the past two decades. To supplement analysis and better understand the background of this topic, research into the history of societal roles and treatment of women in Jamaica is augmented. In order to accurately evaluate and cohesively analyze this topic, an extensive literature search was performed using EBSCOhost and Google Scholar to ensure all facets of the topic that have been measured were included in analysis.

Results

Women in Jamaica have faced a plethora of obstacles on their way toward finding success in life. Sexual violence in particular is still at the forefront of issues Jamaican women are facing. This review will examine what work has already been done, looking at the history of women's struggle in Jamaica, the stem of this problem in adolescents' ideas revolving around sex and the education they are given regarding it, and the status and situation Jamaican women are currently in. The Guttmacher Institute is a leader in research pertaining to sexual health and violence, and in 2009, they released a study of women between the ages of 15 and 17 living in Jamaica's capital regarding teen pregnancy. One-third of the girls reported that they had been either coerced or forced into their first sexual experience, making the fact that they became sexually active at such a young age not in their control (Baumgartner et al., 2009). It is because of things like this that it is important to see what research has already been done that relates to Jamaican women's lives so as to continue the work being done instead of restating what has been found thus far.

Early History: Late 1400s - Early 1800s

From the birth of slavery came the idea that a woman's purpose was a sexual one—so much so that female slaves were most highly valued for their ability to increase profit by birthing new slaves, providing more free laborers that need not be purchased since they came from the slave owner's "property". Slaveholders would purposely calculate how to get the most out of their female slave's fertility. Any female above the age of twelve was considered prime birthing-of-future-laborers material. One of the ways this was justified was the women's incredible capability to give birth and then only a few

days later go back to performing hard labor. The slaveholders considered this evidence of their “brutishness” and found them fit for “productive and reproductive exploitation” (Turner, 2011). Just like that, “black women’s reproductive abilities became the lifeblood of perpetuating Jamaica’s sugar economy” (Turner, 2011). One of the problems slaveholders came across was disciplining the pregnant slaves. The women were seen as “containers” for future laborers to replace slaves before them, which meant they needed to stay safe until they gave birth. There were several instances where women were beaten so brutally they had miscarriages, gave birth to stillborn babies, were permanently sterilized, or killed. This was not productive for the slaveholders as they lost their free laborer and potentially their already existing slave, so something had to be done. Slaveholders were concerned about getting the most out of labor productivity and therefore decided that whipping was a fitting punishment for the pregnant slaves (Turner, 2011).

1830s-1900

Post-emancipation in 1838, Jamaica had a drastic rise in reported cases of sexual assault. Before this, approximately 1% of cases were sex-offense related, which then rose to 14% after emancipation and in the years following continued to grow at a remarkably fast rate. The reasons for this are up for debate, especially since before emancipation, it is likely there could have been just as many sex offenses that were simply not reported—as slaves were raped regularly. But, because they were “property” this would not have been reported in the way rapes were reported post-emancipation (Dalby, 2015). Figure 1 shows the percentage of sex offence prosecutions out of total prosecutions from 1832-1899, where we can see this rise following the 1838 emancipation. After 1850, rehabilitation

was, “more or less abandoned as a realistic goal” (Dalby, 2015) and those who were already incarcerated had their sentences significantly shortened and changed to field work. This may account for the drastic fall in the number of prosecutions from the early to late 1850’s (Dalby, 2015).

Sexual Activity in Adolescents

While history plays an important role in establishing a culture of oppression against women, a significant portion of the challenges stem from very recent history, as in the way children are raised and the education they receive. The following data reflects common ideas prior to modern Jamaica and is important to consider when looking at the way in which things have both changed in some contexts and stayed the same in others. Two studies, one by Eggleston and colleagues and another by Wood and colleagues show the importance of sex education in the 1990s.

In 1996, 40% of Jamaican women had been pregnant before the age of 20. Eggleston and colleagues found that the younger children are when they become sexually active, the more likely they are to practice unsafe sex. Becoming pregnant at such a young age is also correlated with non-completion of school which then results in fewer job opportunities. While statistics have improved, in recent history, less than one-third of women who had a child before their fourth year of secondary school returned to school after their child’s birth (Eggleston et al., 1999).

A large part of the contribution to early sexual activity and unwanted pregnancies can be attributed to Jamaica’s education system. Upon completion of elementary school, all of the children take a placement test that determines where they go next. Children who score well go on to technical schools or high schools that are equipped to prepare the

students for college, while children who do not do well attend a catch-all school that fails to prepare them for post-secondary school. These students are also more likely to suffer from low self-esteem (Eggleston et al., 1999).

In the 1990s there was also a lack of sexual education in schools. The knowledge children had was widely varied and also somewhat contradictory. When asked about contraceptive methods, one girl said, “some of them say when they have sex, they can drink a Pepsi or take an aspirin [to prevent pregnancy]” (Eggleston et al., 1999). When asked what age boys and girls should first have sex, the children responded saying they should be around 20 years old, and yet, these same boys admitted minutes later that if they had the opportunity, they would have sex. These children were also asked to share what they thought sex is like, or what it should be like. One boy explained a scenario, describing that, “a boy and a girl a play dolly house—the boy the father and the girl the mother. Them a sleep and things get outta hand. Him start feel her up, you know, them take off clothes, kissing go on...him push it in, she start cry” (Eggleston et al., 1999). There were also contradictions in the children’s reasoning behind sex. Over half of the boys and 30% of the girls felt that if a boy, “spends a lot of money on a girl,” (Eggleston et al., 1999) that the result should be sex, as shown in Table 1. This went to the extent in one girl’s mind that if this hypothetical girl did not have sex with the boy, he might dump her.

A lack of sexual education creates misconceptions in all areas of sexual activity. Moreover, almost half of the boys felt that girls should become pregnant while they are teenagers so that they can prove their fertility. When it comes to the increased risk of pregnancy that stems from a lack of education on the topic, one of the largest problems

has to do with what the children feel and know about contraceptive methods. Both girls and boys agreed that contraceptive methods were an indicator that the boy or girl was having sex with multiple people. One girl reported difficulty in buying oral contraceptives saying that if she wanted them she couldn't get them because she was too young and wouldn't be sold them, and that they were unaffordable anyway. A boy had similar thoughts on condoms being too expensive to buy. Numbers on surrounding topics, along with statistics mentioned can be seen in Table 1 (Eggleston et al., 1999). While these attitudes reflect the thoughts of adolescents from some time ago, it is important to recognize that while the knowledge possessed by adolescents today has improved from this, it was not long ago that these were common sentiments among youth—some of which still exist and are prevalent today.

In a study conducted with the intent of analyzing relationships adolescent Jamaican girls have with older male partners, the relationship dynamic tended to revolve around a sense of power on the part of the man and reliance on the part of the young women. Three types of partners were commonly described, called “big men”, “sugar daddies”, and “Dons” (Wood et al., 2011). As described by one participant, “big man is based on your maturity. The definition of big man comes with how mature you are and your chronological age. If... after you past forty, you automatically become a big man [laughing]” (Wood et al., 2011). Beyond their age, “big men” were characterized as having a disposable income to spend on their younger women. In some cases, the relationship was also emotional and like that of a boyfriend and girlfriend, while in others the man may be married or have other sexual partners. The term “sugar daddy” was reserved for men whose sole purpose was financial support. No expectation of emotional

support or commitment was indicated by the participants. They were reported to be, “the one with money and you just go to him for money purposes... ‘[later in interview, discussing an older partner]’ that’s my boyfriend...but the others, the sugar daddies, you just go to them for money or whatever it don’t matter and you can have more than one sugar daddy” (Wood et al., 2011). It was a recurring theme in discussion about a relationship with a “sugar daddy” that the man’s central motivation was sex from the girls. The last category, the “Don”, was primarily described as a source of extreme power and authority; these men were often drug lords and leaders of gangs, but many saw them as community leaders. Dons rule over their women, predominantly using their influence or violence to coerce the girls to appease them. When speaking of a relationship with a Don, a participant described the sexual dynamic: “If you over there washing, he don’t care. He say ‘come over here I want some sex,’ and you come over here! Yeah, that’s it” (Wood et al., 2011). The girls went on to explain that Dons tend to have about five girls, around the age of eleven or twelve. The young age of the girl had no importance but rather the size of their body. While the girls had extensive knowledge of what a relationship with a Don looked like, none of them admitted to engaging in one themselves. Many of the girls reported experiencing pressure from their peers around the age of twelve or thirteen to pursue relationships with older men, often with the aim of obtaining a higher status socially or for financial gain. In some cases, pressure came from family members due to a need for money. In other instances, girls reported seeking out an older man for emotional support, some linking this to the absence of their own fathers.

Traditional Male vs. Female Attitudes on Sex

There is a wide gap in attitudes concerning sexual activity for boys compared to girls. For instance, in a study done focusing on sexual activity in adolescents, “girls in all of the focus-group discussions made derogatory comments about girls their age who were sexually active, but no girls indicated disapproval of boys their age who have sex” (Eggleston et al., 1999). The researchers asked the girls and boys in the focus group what response they would expect if a peer their age were to have sex and the girls responded saying, “them would call her a sketel [slut],” while the boys responded saying, “him would feel good ‘cause him friends biggin’ him up...him tell him relative and cousin and friend and everybody” (Eggleston et al., 1999). This incongruence also exists in the age and circumstances at which boys and girls became sexually active in the group. The average age for girls was just over eleven years, and the average age for boys was about nine and a half (see Table 2). These numbers differ more in the age of the individual with whom they had their first sexual encounter. The girls’ first partner was typically around three years older than her, while the boys’ partner was on average a year older. The lack of contraceptive use however, was low in both the boys’ and girls’ cases as seen in Table 2. When talking about contraceptives, many of the boys associated condoms with being made fun of for being “a little boy” and reported they were afraid of seeming unmanly if they used a condom. Similarly, girls had negative connotations associated with pregnancy prevention methods, but for them it was associated with promiscuity (Eggleston et al., 1999).

The attitudes and beliefs held by grown Jamaican men and women vary drastically as well. A study published in 2008 examined these discrepancies. The first of

which dealt with general agreement of attitudes toward gender issues, which can be viewed in Figure 2. Questions given to the participants involved whether a wife was obligated to have sex with her husband, the idea that a good wife obeys her husband regardless of agreement, that a man should show his partner who is the boss, and if the participant agreed that it is acceptable for a wife to refuse sex if her husband is seeing other women. A high percentage of both men and women agreed that a good wife obeys her husband even if she disagrees. The number of women in agreement was just 6.8% below that of men, at 48.6%. 65.4% of women believed that it would be acceptable to refuse sex to a husband if he was seeing other women, while 44.2% of men agreed with the sentiment (Serbanescu, Ruiz, & Suchdev, 2010). In general, while more men agreed with the statements than women, a relatively large percentage of women were in agreement as well.

Modern Attitudes About Sexual Activity

The relationship between young girls and their mothers is often a source of sexual education, but this is dependent on the closeness of a mother and daughter. Expressed by one girl, “having a close relationship to your parents makes it easier to talk to your mother about sex” and another, “some children is afraid of their parents abusing them” (Hutchinson et al., 2012). Whether or not a child feels comfortable enough to talk to their mother may determine their level of sexual education in instances such as this. Mothers who felt it important to discuss sex with their daughters,

“referred to sexual communication with daughters as a positive thing to do that had protective effects. For example, ‘We can protect her from making the wrong decision. Encourage her not to have sex’; ‘I wouldn't want my daughter to hear

about it from somebody else, I would rather be the first person to tell her about it.’

Mothers identified numerous positive outcomes, including ‘Less teenage pregnancy, less STIs. They will understand more what caution to take’”

(Hutchinson et al., 2012).

Even in this case however, there was little to no mention of discussing how to have safe sex, but rather the discussion of an abstinence only method. Mothers who felt it inappropriate to discuss sex with their daughters at all voiced their concerns saying, “[their daughter could] get carried away with the wrong ideas and get involved too soon” (Hutchinson et al., 2012). The idea that this topic was improper was also common. For example, “some mothers don't think it right if talk to them children about sex” (Hutchinson et al., 2012). Another parent offered that, “most Christian parents bury them head under the sand when it comes to sex ... not my child because she go to church. But they don't know in between school them skip class. Some of those parents take it real hard when they find out them pregnant” (Hutchinson et al., 2012). The behaviors of the women themselves did not mirror what they expected of their daughters however. One woman’s sentiment was, “I live a lifestyle where my daughter doesn't see me bringing men home and I expect you [her daughter] to do the same” (Hutchinson et al., 2012). This was not uncommon as many women reported bringing multiple men home but expected abstinence from their daughters (Hutchinson et al., 2012).

Women’s Health

Some areas of women’s healthcare have increased in quality, such as cardiovascular health, as shown in Figure 3, and can be accredited to the increase in women’s life expectancy. Other improvements shown here include digestive diseases,

chronic respiratory problems, nutritional deficiencies, neonatal disorders, and diarrhea/lower respiratory infections/other. This being said, women who have a lower income and level of education attainment were found to have a much worse cardiovascular risk profile than women with higher income and education. This is likely in-part due to the greater stress and strain to obtain medical care (Tulloch-Reid et al., 2013). While health statistics are improving overall, this does not necessarily apply equally to all Jamaican women. In whole, these improvements to women's health have added 2.3 years onto the overall life expectancy since 1990 (IHME, 2015).

In the same study referenced above which had the goal of evaluating cardiovascular diseases among Jamaican men and women, it was found that women have a higher rate of obesity than men, and that sex changed how socio-economic status affected the person's cardiovascular health. While women with lower income and education were found to be at higher risk, the same does not apply to men (Tulloch-Reid et al., 2013). There are also a few major factors decreasing Jamaican women's overall life expectancy—the most prevalent of these being diabetes, self-harm and violence which will be discussed in more detail, as well as HIV/AIDS and tuberculosis.

Reproductive Health

One principal aspect of women's physical wellbeing falls under the category of reproductive health. There has been extensive research done on both the access and use of this type of medical resource among the female population in Jamaica. A study conducted by Bourne and colleagues reviewed reproductive health in women ages 15-49 and found that 56.9% of the women had never had a pelvic examination. When questioned as to why, 35.9% of the women reported never having thought to have an

examination done, 15.9% said they had no signs of gynecological problems and therefore did not need an exam, 11.8% reported that it was not recommended by their physician, and 10.6% indicated that they simply “did not need to go” (Bourne et al., 2010). Another study was conducted with the purpose of analyzing the rate of follow-ups completed by women who received abnormal Pap smear results. Of these women, just over half (51.2%) returned for adequate follow-up care. Of those who did not, over half reported that the costs would be expensive; over 75% of all women in the study felt similarly. The women who did receive adequate follow-up care had—on average a lower number of children and a higher monthly income. In addition, many women were not given instruction by their physician as to how to follow up or what the next steps were when they received an abnormal Pap smear result. Those who did and received information regarding timing of when to execute these next steps were almost six times more likely to receive adequate treatment. It is necessary to note that during the time of this study, the closest medical facility providing the necessary resources was three hours away from the largest city (Port Antonio) in the parish of study: Portland (Jeong et al., 2011).

Improvements have been made in the field of reproductive health of Jamaican women. In 1990 the average birth rate per woman was 2.9 children, which as of 2015 decreased to 2 children, and 98% of pregnant women were receiving prenatal care as of 2011. However, the number of women dying from pregnancy related causes increased from 79 to 89 women per 100,000 from 1990-2015 (World Bank, 2016). Congruent with the decrease in birth rates, Jamaica has been doing increasingly well with their availability and use of family planning. Use of contraceptive methods by married women ages 15 to 49 saw an 11.2% increase from 60.6% in 1994 to 71.8% in 2015 (Department

of Economic and Social Affairs, 2015). As can be seen in Figure 4, Jamaica ranked among the highest of its surrounding countries including Barbados, the Bahamas, Trinidad and Tobago, and Saint Vincent and the Grenadines at an 83.1% demand met using modern contraceptive methods. This was 8.4% higher than the Caribbean as a whole¹ (Department of Economic and Social Affairs, 2015). However, use of contraceptive methods does not always indicate safe sex practices. In many cases, contraception is viewed to protect from pregnancy alone, rather than to prevent the spread of STDs. In a study examining sexual relationships between women in late adolescence (18-21 years of age) and older men, it was commonly expressed by the women that, “[while] acquiring HIV infection would be the worst consequence to having an older male sexual partner, becoming pregnant was a more immediate concern for young girls because it was an obvious sign of sexual activity and meant additional life responsibilities” (Wood et. al., 2011). While this shows a positive step in the movement for family planning, it also highlights the lack of importance put on contraception for the purpose of sexually transmitted diseases and infections. In addition, the projected change in the percentage of Jamaican women with an unmet need for family planning does not expect improvement. Trinidad and Tobago for example are projected to see a significant decrease in the number of women with an unmet need, while Jamaica is projected to remain at the level it currently is, as seen in Figure 5 (Department of Economic and Social Affairs, 2015). As a whole, improvements to women’s reproductive health indicators are being made, but some indicators have seen very little improvement.

¹ Caribbean defined as including Anguilla, Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, United States Virgin Islands

Violence in Jamaica

Jamaica's violence level is one of the highest in all of the Caribbean. As of 2015, Jamaica was ranked 3rd highest in number of homicides of all countries surveyed by World Bank (World Bank, 2016). In 2016, Jamaica had a population of 2.9 million, with a homicide rate of 36.1:100,000, giving the country one of the top-five highest homicide rates in the world (OSAC, 2017). While there is no single factor to contribute this to, there are a few major factors that have been examined.

Significant work is being done to address violence of all types in Jamaica. In a 2016 study, Harriot and colleagues concluded:

“since 2009, the government of Jamaica has pursued an active legislative agenda that has collectively updated and strengthened the framework for addressing sexual violence against women and girls, strengthened criminal penalties, improved accountability of the police, established new law enforcement units, and clarified or updated definitions. Gender-based legislation has increased punishment for perpetrators, and several laws have been amended to conform to treaty obligations, increase penal sanctions, and strengthen the response to international and transnational crimes” (Harriot et al., 2016).

Since 2009, when homicide rates peaked at 63 incidents per 100,000 inhabitants, there has been a decline as seen in Figure 6 (Harriot et al., 2016). Violence rates including interpersonal violence and the prevalence of interpersonal partner violence have been declining as well—shown in Figures 7 and 8 (IHME, 2016). Despite these improvements and the apparent effort on a legislative level to decrease violence rates, in 2013 Jamaica's homicide rate remained ranked sixth highest in the world and has persisted as having the

highest homicide rate of other Caribbean countries: Bahamas, Barbados, Trinidad and Tobago, and Suriname as shown in Figure 9 (Harriot et al., 2016). Beyond what is recorded of Jamaica's homicides, arrests only occur in 54% of homicides every year, and perpetrators are convicted in just 7% of homicides (OSAC, 2017).

In addition, while many violent crimes saw decrease, rape was an exception to this trend, which increased 20.5% between 2009-2013 (Harriot et al., 2016). While sexual assault certainly affects both men and women, it is a much more widespread concern for women. Sexual violence is especially common within sexual relationships where the man is older and perceived to be more powerful—as previously discussed. One woman interviewed in a study examining relationship dynamics described an instance where an older man was willing to go to extreme lengths, “they will not allow the young ones to leave. You know there was an incident, ago some time ... a girl I knew from [unclear] and she was talking to a taxi driver and she decided that she would finish the relationship ... so, I mean he could not bear it, so he kidnapped her, and killed her” (Wood, 2011). In this instance, the presence of sexual assault is especially clear; however, this is not always the case. While not specific to Jamaica, many instances of rape and/or sexual assault go unreported. A US study on the unreported incidences of rape in 2010 found that less than one in six rapes are disclosed to the police. This percentage (15.8%) is congruent with studies dating back to the 1990s (Wolitzky-Taylor et al., 2011). This is often in large-part due to women feeling as though their assault was not serious or relevant because the assault didn't end in something as severe as death as it did in the previous woman's story, or because the act of violence was committed by an acquaintance. In a survey which sought to find both male and female opinions of when

intimate partner violence might become acceptable, 21.5% of men agreed with one or more of the circumstances given which can be seen in Figure 10. (Serbanescu, Ruiz, & Suchdev, 2010). The factors responsible for decline in women's life expectancy reflect this as well. Data gathered from IHME demonstrates this in Figure 11 as self-harm and violence contributed among the highest loss in years of life. The only factors with a higher contribution than violence were health related issues such as diabetes. HIV/AIDS ranked equally alongside self-harm and violence, mirroring a need for sexual education.

Some of the questions in the study pertaining to intimate partner violence (IPV) conducted by Serbanescu and colleagues included: when physical violence would become an appropriate response towards a woman, more specifically—a wife. Reasons included a woman being unfaithful, disobeying her husband, not completing housework sufficiently, asking if her husband had other partners, and refusing to engage in sex. As seen in Figure 10, very few, but nonetheless some women agreed that some of these were acceptable reasons for intimate partner violence. 2.9% of women found one or more of these circumstances to justify violence. In comparison, 16% of men felt that a wife being unfaithful was reason enough in itself to react in physical violence, 10.8% felt similarly if a wife were to disobey their husband, and 21.5% agreed that one or more of the circumstances justified IPV. (Serbanescu, Ruiz, & Suchdev, 2010)

Research was done on the topic of IPV at the Women's Crisis Center in Kingston, Jamaica between the months of September and November, 1999. Over 98% of the women participating at the center had experienced both emotional and psychological abuse, and over half of them were the victim of assault by their partner or ex-partner. 94% of the women in the study were victims of assault in their own home, and only 24%

reported it to the police. There were various reasons as to why no report was given—shown in Table 3, the most common being that they reported the assault to someone else. The detailed statistics on the reasons the women chose not to report their assault to the police can be seen in Table 3. The study went further into this topic to find which type of injuries the women sustained and the correlation to reporting the incidents, finding that although almost three quarters of the women sought medical help for their injuries, only 26% of the women needing medical attention reported the trauma to the police. The different injuries, rate of reports of these injuries, and the number of each of the traumas is listed in Table 4. It is also important to keep in mind that the women represented in the table sustained mental abuse in addition to their physical injuries (Arscott-Mills, 2001).

At its deepest roots, violence against women is embedded in the idea that women are unequal to men. This culture of violence in Jamaica and its ideals of inequality result in high rates of violence against women. There are many facets that go into this including a long history of the maltreatment of women, minimal education and misinformation given to youth, and cycles of abuse that cannot be stopped by any one action. The topic of Jamaican women's place in society is not one that has gone unexplored. A common theme in the studies on Jamaican women's lives is the agreement that more research and work need to be done to combat the issue. While the inability to pinpoint exact roots or problems exists, it is possible to analyze the lives Jamaican women currently have and to find what seems to have been working to improve their situation.

Discussion/Evidence Based Analysis

Jamaica is a leader in many respects when compared to countries in similar stages of development. Some aspects of women's health and quality of life mirror this. Data shows that Jamaica is doing well in providing access to family planning for example. This being said, the rates of violence are at a contrasting high. In addition to this, many of the statistics showing improvement with the promise of a continued development fail to look at the entire picture. Some degree of analysis must therefore be done to understand the quality of life Jamaican women currently experience and how it has evolved over time.

History

Slavery is at the root of Jamaica's founding and cultivation as a society and culture. Sexual assault and violence are not unique to Jamaica's beginning, but with the magnitude at which these events played into the country's foundation, it is not surprising that they endure as accepted facets of the society. A woman's purpose was to provide offspring—to produce more slaves and to serve men until they no longer could. Young girls were preferable as slaves because they would have more childbearing years. A parallel can be drawn in the study by Wood and colleagues that focused on older, wealthy men seeking out young girls in current day Jamaica (2011). Post-emancipation, sexual assault cases flooded the court system. Yet, just over ten years later, efforts to prosecute were all but dropped and convicted rapists were released early to work in fields and reintegrated into society—refer to Figure 1. A current concern is that Jamaica's renewed focus on curbing violence—sexual and otherwise—could possibly see the same drop in attention.

While most of the research conducted about the history of Jamaican women is evidence of the poor conditions they lived in, there are a few glimmers of hope. In 1942, women gained rights from the Employment of Women Act which included provisions such as prohibiting working more than 10 hours in a day, required equal pay for women, and mandated that women be given eight weeks of paid maternity leave. Women have made strides in the political field as well. While they do not hold as much ground as their male counterparts, women in the Jamaican House of Representatives held eleven positions of sixty-three as of 2016. Women also hold positions in Jamaica's Senate (Jamaica Information Service, 2016).

Women's Health

As Jamaica is still developing, it is important that all individuals—women specifically in this instance—are well informed in their healthcare. Access is a start, but if women are not utilizing these services they are rendered useless. Without the proper instruction by assigned medical professionals, it is less likely that women will seek out medical help. As described by the women who took part in the gynecological health study reported previously, only half who received abnormal test results returned for follow-up care. This is due in-part to lack of money to pay for treatment, in addition to the fact that the closest facility that could provide treatment was three hours away from most of these women (Jeong et al., 2011). Despite the fact that there are resources available, the accessibility of those resources makes it difficult for women to utilize them.

Whether or not Jamaican women are technically equal under law has little connection with how society treats them and does not transcend every law. For instance, abortion is illegal in Jamaica; if a woman has an abortion she and anyone who aided in

ending the pregnancy can be sentenced to life in prison. The only exception to this is if it is deemed medically necessary by a doctor (World Trade Press, 2010). Beyond this, lack of education in the past has led to less than adequate reproductive health practices among women. Rather than going through the difficult and painful process of seeking out an abortion, or using adequate birth control methods to begin with, women are often left with very little choice but to go through with a pregnancy and try to come up with the means to provide for yet another child.

As a whole, it is possible that beauty norms are a contributing factor to women's less than stellar health. The lack of focus on internal physical health is likely due to an emphasis on outward appearance. While the practice is becoming less culturally accepted, some Jamaican women bleach their skin in order to fit the unrealistic and unnecessary beauty standards set by society. Lighter skin is associated with privilege and access to power in Jamaica, despite being a historically black community (Charles, 2011). Because of this, some women are willing to go through immense pain and risk permanent damage to their skin and internal organs, all in attempt to fit into a societal mold.

Reproductive Health

While the availability of contraceptive methods has improved in recent years, the importance of using contraception designed to prevent sexually transmitted diseases like HIV remains a prevalent issue. Despite the increase in access to birth control being a step forward for women, there is a myriad of work that has yet to be done. As shown in Figure 11, HIV/AIDS is responsible for a 0.2 decrease in life expectancy in years. Beyond this, the women seeking reproductive healthcare are not receiving the quality of care necessary

for such a prominent issue, as described previously in discussion of Jeong and colleagues' work. Any argument about the reproductive health needs being met for Jamaican women therefore needs to be called to question. As a country they are doing well at increasing access to family planning methods but are failing to focus on the health aspect of a women's reproductive system. This is likely because of the positive image an increase in family planning accessibility gives them, without having to address the expensive and complex issue of providing affordable and accessible reproductive healthcare.

Modern day Jamaica looks much different than it did even 10 years ago. Strides have been made in the field of women's healthcare, yet the areas of focus are neglecting vital things like sexual health. Women now have access to family planning but fail to receive adequate information from physicians providing birth control methods in regards to things like sexually transmitted diseases that they remain susceptible to while using certain methods of birth control. This can be seen in the incongruence between an increase in access and use of family planning methods, but the ever present threat of HIV/AIDS. They have access to things like pelvic exams, but rarely follow up regardless of the outcome of their test results because of things like lack of transportation to treatment centers or the money treatment would require.

Male Vs. Female Attitudes/Sexual Activity in Adolescents

An additional factor that is not helping women's societal position is that, "the traditional perspective in Jamaica and the Caribbean has been that police should not interfere in the private relationship between a man and 'his woman'" (Danns & Persad, 1989). While this sentiment comes from nearly thirty years ago, societal norms do not

quickly dissipate, especially in a country that values their heritage and cultural practices so heavily. These ever present skewed views of male/female relationships can be reviewed in Figure 2. These include agreement with several statements—including the belief that a wife is obligated to have sex with her husband and that a good wife obeys her husband even if she disagrees. While more men agreed with these statements than women, an alarming number of women felt similarly (Serbanescu, Ruiz, & Suchdev, 2010). This is ingrained into many people's view of relationships early on which can be seen in Eggleston's work interviewing adolescents on their thoughts on sex. Boys as young as eleven felt that if they spent money on a girl, she was then obligated to have sex with them (Eggleston et al., 1999). This carries over into adulthood which becomes discernible in the widely varying opinions on the way women should be treated and the level of dignity they deserve. As discussed, Serbanescu and colleagues found it was not uncommon of male participants in a reproductive health survey to report agreement with circumstances including a wife disobeying, not completing housework, or refusing to engage in sex—as justifying the use of physical violence. More details can be viewed in Figure 10. Women are not exempt from these flagrant misconceptions. While the percentage of women in agreement with the circumstances was drastically lower, 2.9% of women agreed that at least one of the scenarios justified physical violence (Serbanescu, Ruiz, & Suchdev, 2010). Even women who may not agree that violence is an acceptable response rarely report violent attacks against themselves because of the stigma and overwhelming opinion that what happens in the walls of the home is the business of a husband and his wife.

Violence

The trends of violence in Jamaica are among the most concerning challenges for the country's health, especially for women—as sexual assault is on the forefront of this issue. While violence is decreasing in some areas, sexual assault rates are increasing despite efforts by the government to address sexual violence. The lack of significant improvement is likely correlated to the difference in attitudes between men and women as well as the prevalence of sexual activity in adolescents. An added factor is the pervasiveness of young girls engaging in relationships with older, powerful men. Three categories or types of older men: “big men”, “sugar daddies”, and “Dons”, were identified by young women interviewed about their experiences (Wood et al., 2011). Each of these enforce the societal view of men having power over their women, even if in many cases the women are voluntarily involving themselves in the power dynamic. It is difficult to decipher how common relationships like these are, as the women in the study told stories of experiences of their peers and did not divulge whether or not they engaged in relationships with older men themselves. This is likely due to the stigma surrounding sex.

Limitations

On the forefront of limitations in this study is the lack of direct, first-hand data, as all information analyzed came from previous studies or accounts. This created some level of difficulty when critically analyzing correlations between data as the research came from different sample sizes, populations, and used different scales of measurement. There was also a great deal of information lacking updated data. Much of the research available was completed prior to 2008 which limited its current relevance and made it only useful

for historical data. For example, more recent data on Jamaican children's knowledge of reproductive health would have been valuable.

Another major limitation is the disparity between the number of sexual assaults and the amount of those reported. It is difficult to discern the prevalence of sexual assault when it is likely that many, if not most, of the cases are never reported. Beyond this, many peoples' definitions of sexual assault differ. While one person may acknowledge a man forcing a wife to have sex with him as being rape, another may believe that sex within a marriage is expected and therefore would not consider it assault. This applies to sexual assault within premarital relationships as well. Women in Wood and colleagues' study (2011) reported things they had heard of happening to other women in relationships with older men for example but did not share of their own experiences. Without transparency on the part of all women being interviewed, the data is incomplete.

Future research on Jamaica's crime and violence rates in relation to women's treatment and health would be of great use to the further analysis of the evolution of Jamaican women's quality of life. A study of women from across the country stating willingness to be transparent in their responses with the promise of anonymity would be ideal. Interviews with the women about their upbringing, sexual education, and experience with violence would be examined.

Conclusion

Economic development does not equal societal advancement. Despite the development of the country due to tourism and a substantial GDP increase, women's quality of life does not mirror this level of growth. As found by Amartya Sen who devoted much of his life to studying welfare economics, without utilizing economic growth towards community and health services, education, and the wellbeing of the people of the country, true freedom cannot be achieved. Freedom “involves both the *processes* that allow freedom of actions and decisions, and the actual *opportunities* that people have, given their personal and social circumstances” (Sen, 1999). At the center of the majority of the disparities is the unequal position women hold in society and the idea stemming from women's purpose from the foundation of the country—that being a sexual one. While improvements have been made, prevalence of sexual assault and health—especially reproductive health—have seen little to no positive changes. The history of a country can reveal a great deal about why things are the way they are in modern day society. While things continue to evolve and change, similar patterns emerge. The prevalence of violence remains high overall, but has especially seen an increase in sexual assault. The same applies to societal views of sex and a woman's rights, as well as women's healthcare and accessibility.

This research has implications for multiple types of social policies and health programs that are becoming plausible given Jamaica's economic growth. These could include programs with the mission of destigmatizing talking about sexual assault, teaching young people what safe sex looks at from a mental and physical health perspective, providing accessible and affordable healthcare—especially reproductive—to

name a few. If done correctly, the dream of social equity in Jamaica would not only be feasible, but comfortably within reach.

Reflection

In the Summer of 2016 I went to volunteer at a children's orphanage in Montego Bay, Jamaica. I planned for weeks, looking up everything I could possibly need in this foreign country I knew nothing about. The agency I was volunteering through sent me my host mom's information and told me I would travel with another volunteer who lived nearby to and from our placement. They informed me of the customs, how to dress appropriately at the orphanage I was placed with, what the currency exchange rate was, how to protect myself from having my money or information stolen, and any other thing I thought I could possibly need. I was prepared for anything.

I stepped off the plane to the overwhelming August heat and found my way to a man holding a sign with my name on it. He drove me to my host mom's house and on the way, warned me of a few of the things I actually needed to be cautious of. He told me where the best place to have taxi drivers drop me off was: far enough away so that they didn't know where I lived, but close enough that men on the streets wouldn't follow me. He dropped me off and my host mom welcomed me then proceeded to tell me which taxis I should and shouldn't accept rides from, and gave me the key to the gate out front. I met my peer volunteer the following morning, a girl a few years older than me who was from Italy. She kept me sane, and because she understood very little English, she was oblivious to the cat calls on the streets which made it easier for me to ignore. Our placement itself was incredible, I was grateful for the hours in the day taken up by our

work as the workers were all women, and the children at the orphanage filled my heart to the brim with their yearning to be loved.

Stepping outside the orphanage was a completely different experience. Men would grab us on the street telling us to come home with them and have their children, and for the first few days I would jerk my arm away looking around in bewilderment waiting for someone else to acknowledge the interaction, but I soon discovered the best way to protect myself was to not show any response. The one time I snapped and told a man to get off me, a group of men behind him turned to me in warning. I was a young, white, female and had absolutely no power.

There were quite a few gaps in the information I'd been given. The most memorable, was what went on while I was traveling across the country by bus with my peer-volunteer from Montego Bay to Mandeville, Mandeville to Kingston, then Kingston to Port Antonio on the opposite side of the country to stay with some friends she'd made for the weekend. I was told it would be an experience. The first leg of the trip was the experience my friend had been talking about: they pack the buses past capacity so that they can sell tickets for cheap and get as many people on as possible. If there were three seats per row, they'd put a bench down in the aisle and fit two more people per row. It was claustrophobic and a fire hazard to say the least, but by the second and third legs of the trip I was wishing I was back on that first bus.

We arrived in Mandeville at the bus station where rows of buses were stationed waiting to depart. We asked our first driver where the line for Kingston was and were directed to a line of buses. I was headed for one of the buses farther back because I knew the driver wouldn't leave until the man taking money at the door reported they were at

full capacity, and I wanted to make sure I got a seat next to—or at least near to my friend. She was walking to the left of me, nearest to the buses, and one of the men taking money grabbed her asking if we were going to Kingston, and pulled her onto the bus. I climbed on, pushing away the hands around my waist trying to “help” me and discovered the bus was already at capacity. I was greeted by a man in one of the front seats offering his lap as a seat, and my friend had already been pulled up to sit on the floor next to the driver. I had two options: sit on this man’s lap for the next four hours, or stand up against the man taking the money. I wedged myself in the corner by the door (and money collector), put my headphones in, and did my best to ignore my surroundings because it was out of my control at this point. As the trip went on, I watched the money collector grope and speak inappropriately to women getting on and off the bus. I would have to move past him to let others off, and he looked at me in confusion when I shoved his hands off me time after time.

I could go on for pages about what I saw happen to others, and what I personally experienced in Jamaica, but the reality is that what I experienced is irrelevant. Yes—it prompted this research, but my own experience in Jamaica isn’t the reason I am so passionate about this project. I was a volunteer and tourist...I could leave. There are over a million women in Jamaica who have accepted sexual harassment and assault as their reality. These women should be heard, even if they haven’t been told by society they deserve to have a voice yet. The scariest part of this trip wasn’t the disgusting looks, the touchy men, or the constant underlying fear that someone would grab me when my friend went to get a drink or use the restroom. The scariest part was watching women get harassed and say nothing because it was their norm. The scariest part was the fierce sense

of protection I developed for women I didn't even know, because I knew if I didn't volunteer to stand in front of the money collector, the woman who did would let him get away with far more than I would. The quality of life among Jamaican women goes far beyond what health statistics and surveys can show. In a perfect world, Jamaican women—all women for that matter—would realize they have the right to stand up against their abusers. Until I have the chance to go back to Jamaica someday and do real, on-the-ground work, I'll settle for calling out the injustices, and hope that by joining the army of people doing the same, real change will happen.

Appendix

Table 1

Table 1. Percentage of adolescents aged 11–14 answering selected questions about reproduction correctly or agreeing with selected statements on sexual behavior, family planning and pregnancy, Jamaica, 1995 (n=945)

Question or statement	Girls (n=490)	Boys (n=455)
Knowledge of reproduction		
Time during menstrual cycle when pregnancy most likely to occur.	4.3	9.3**
Pregnancy is not possible at first intercourse.	27.4	32.7
Condoms protect against STDs.	52.5	77.7**
Birth control pills protect against STDs.	14.7	16.1
Having sex while standing prevents pregnancy.	14.9	30.3**
Drinking Coke or Pepsi after sex prevents pregnancy.	16.4	23.9**
Attitudes about sexual behavior		
It is okay for a girl to have sexual intercourse with a boy who is not her steady boyfriend.	3.5	17.8**
It is okay for a boy to have sexual intercourse with a girl who is not his steady girlfriend.	5.1	28.4**
If you really love your boyfriend or girlfriend, you should have sex with him/her.	32.0	69.2**
If a boy spends a lot of money on a girl, she should have sexual intercourse with him.	29.8	57.6**
Attitudes about family planning		
A girl who uses birth control pills is being responsible.	64.7	67.3
A boy who uses a condom is showing respect to his girlfriend.	85.7	85.7
Condoms are only for boys who have sex with more than one girl.	53.9	71.4**
Birth control pills are only for girls who have sexual intercourse with more than one boy.	42.5	58.9**
Attitudes about pregnancy		
A girl my age is responsible enough to be a mother.	9.2	22.2**
A boy my age is responsible enough to be a father.	9.4	25.9**
At my age, being a mother/father would be a good thing.	5.9	28.7**
A girl should have a baby when she is a teenager to prove she is not a mule.†	28.9	40.0**
**Difference is statistically significant at $p < .001$. †Meaning that she would want to prove her fertility.		

Eggleston, E., Jackson, J., and Hardee, K. (1999). Sexual attitudes and behavior among young adolescents in Jamaica. *International Family Planning Perspectives*, 25(2):78-84 & 91. Retrieved from https://www.guttmacher.org/sites/default/files/article_files/2507899.pdf

*Table 2***Table 2. Selected measures of sexual activity and contraceptive use at first sexual intercourse among adolescents aged 11–14**

Measure	Girls		Boys	
	% or mean	n	% or mean	n
Percentage reporting intercourse**	5.8	490	64.4	455
Mean age at first intercourse	11.3	28	9.4	284
Mean difference (in years) between first partner's age and respondent's age*	3.2	28	1.2	284
Percentage who used contraceptive at first intercourse	42.9	28	37.7	284

*Difference is statistically significant at $p < .05$. **Difference is statistically significant at $p < .001$.

Eggleston, E., Jackson, J., and Hardee, K. (1999). Sexual attitudes and behavior among young adolescents in Jamaica. *International Family Planning Perspectives*, 25(2):78-84 & 91. Retrieved from https://www.guttmacher.org/sites/default/files/article_files/2507899.pdf

Table 3

**Primary Reason Women Gave for Not Reporting to
the Police Violent Incidents Perpetrated by Their Partners**

<i>Primary Reason</i>	<i>Frequency</i>	<i>%</i>
I reported it to someone else	80	61.0
I took care of it myself	17	13.0
I was afraid for my safety if I reported it	13	10.0
I did not want to get the offender in trouble	10	8.0
The police would not help	6	5.0
Other reasons	2	1.0
The police could not do anything	1	< 1.0
It was not important enough to report	1	< 1.0
Total	130	100.0

Arcscott-Mills, S. (2001). Intimate partner violence in Jamaica: A descriptive study of women who access the services of the women's crisis centre in Kingston. *Violence Against Women*, 7(11), 1284-1302. Retrieved from <http://ezproxy.wou.edu:2797/doi/abs/10.1177/10778010122183865>

Table 4**Number of Women Reporting to the Police by Type of Injury Sustained**

<i>Injury</i>	<i>Reporters</i>		<i>Nonreporters</i>		<i>Unknown Frequency</i>	<i>Total Number of Injuries by Type</i>
	<i>Frequency</i>	<i>%</i>	<i>Frequency</i>	<i>%</i>		
Bruising	36	24.0	110	72.0	6	152
Cuts ^a	28	37.0	42	55.0	6	76
Bites	11	22.0	39	78.0	0	50
Burn	4	50.0	3	37.0	1	8
Broken bone(s)	11	37.0	19	63.0	0	30

NOTE: More than one injury could be reported per incident.

a. $p < .001$, risk ratio = 2.5

Arcsott-Mills, S. (2001). Intimate partner violence in Jamaica: A descriptive study of

women who access the services of the women's crisis centre in Kingston.

Violence Against Women, 7(11), 1284-1302. Retrieved from

<http://ezproxy.wou.edu:2797/doi/abs/10.1177/10778010122183865>

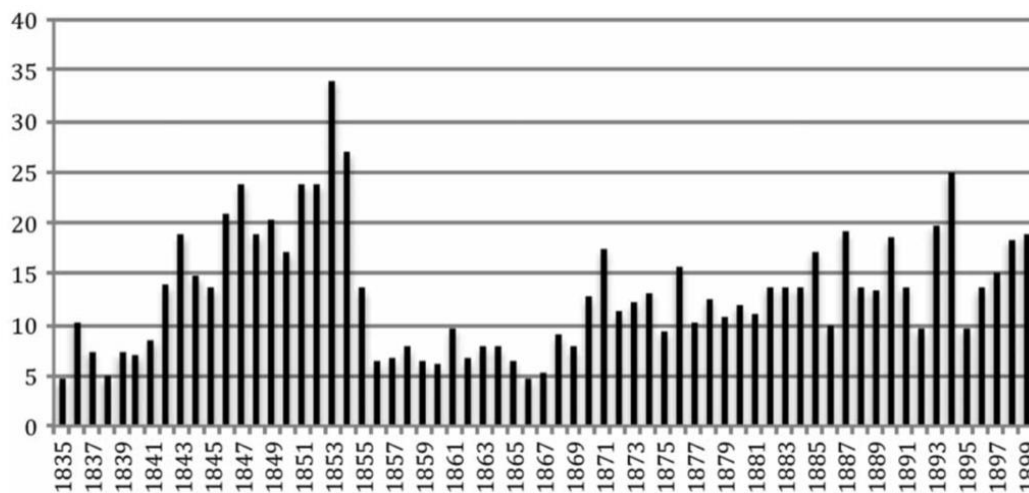
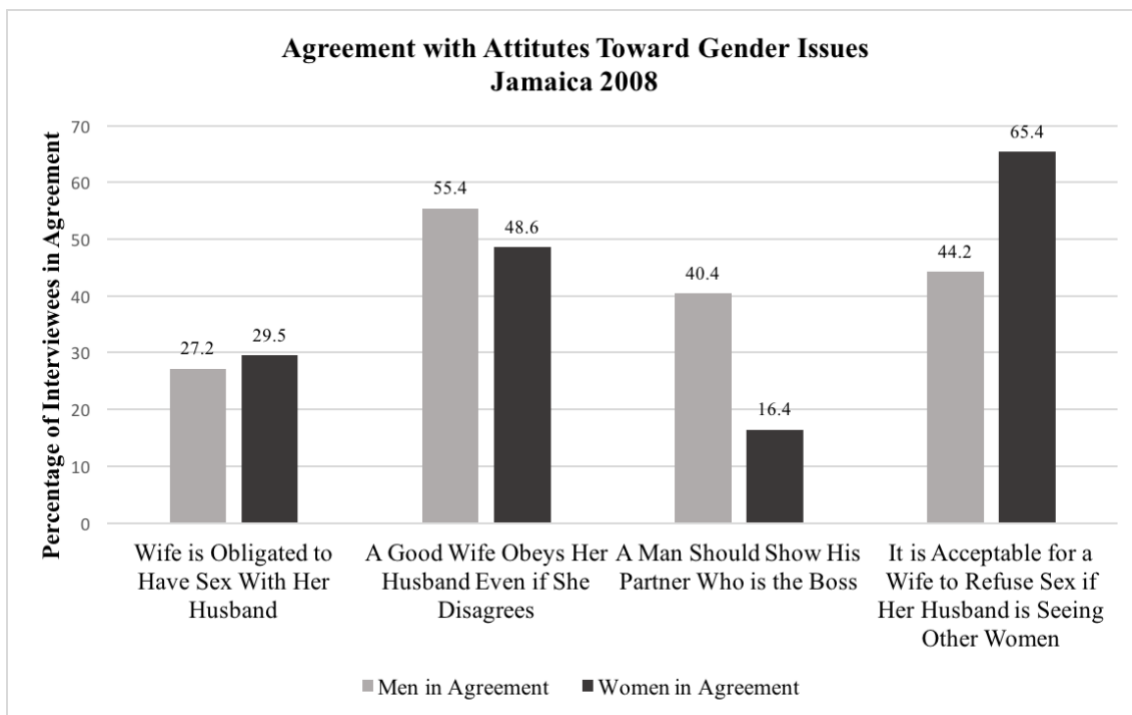
Figure 1

Figure 1 Sex offence prosecutions as per cent of total prosecutions, 1835–1899 (Assize/Circuit courts).

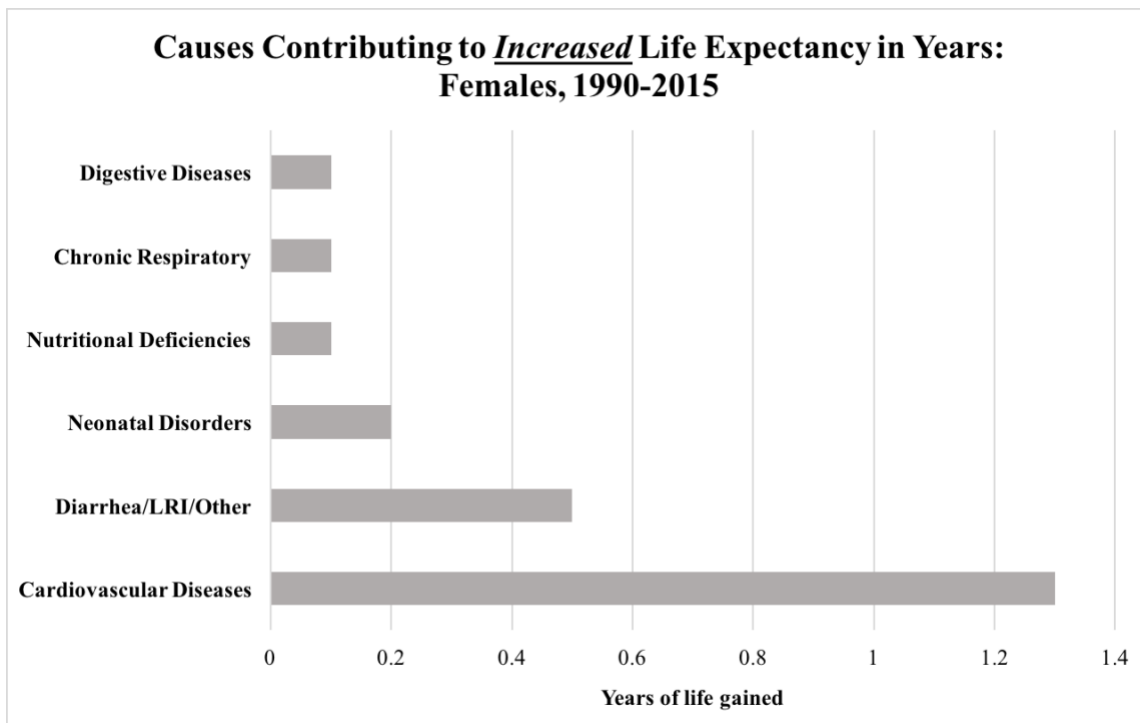
Dalby, J. R. (2015). 'Such a mass of disgusting and revolting cases': Moral panic and the 'discovery' of sexual deviance in post-emancipation Jamaica (1835–1855). *Slavery & Abolition*, 36(1), 136-159.
 doi:10.1080/0144039X.2014.929815. Retrieved from
<http://ezproxy.wou.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=101141476&site=ehost-live>

Figure 2

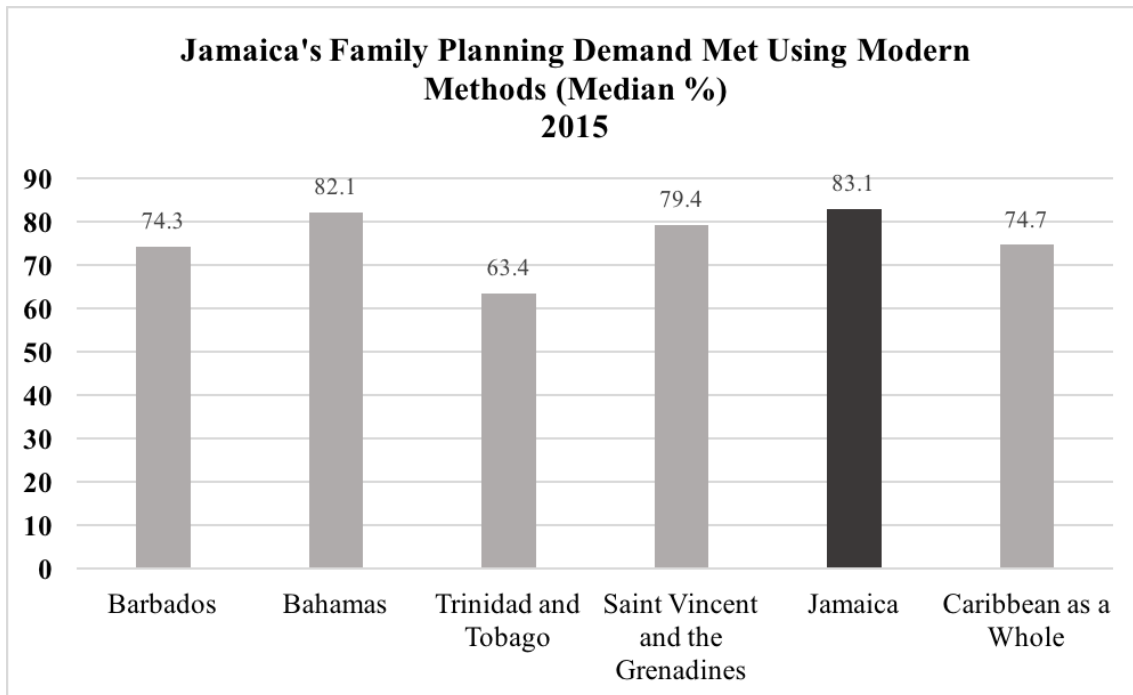


Serbanescu, F., Ruiz, A., Suchdev D. B. (2010). Reproductive Health Survey: Jamaica, 2008. *National Family Planning Board Statistical Institute of Jamaica*. Retrieved from <http://jnfpb.org/assets/2008%20Final%20Report%20Jamaica.pdf>

Figure 3

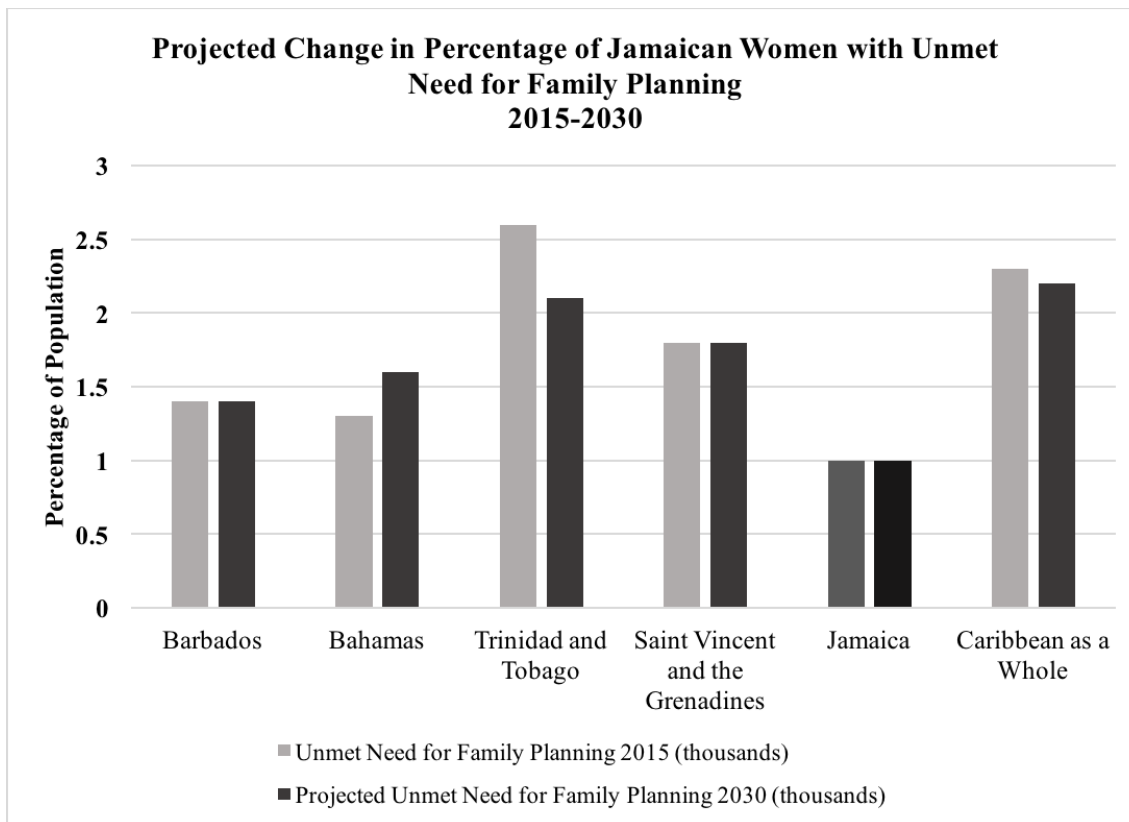


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Figure 4

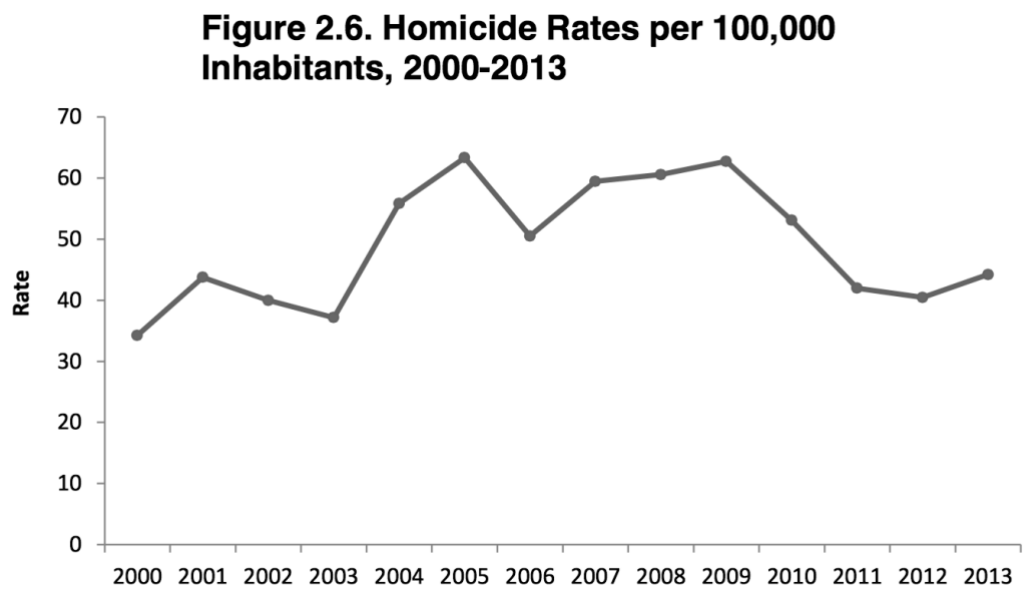
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Figure 5



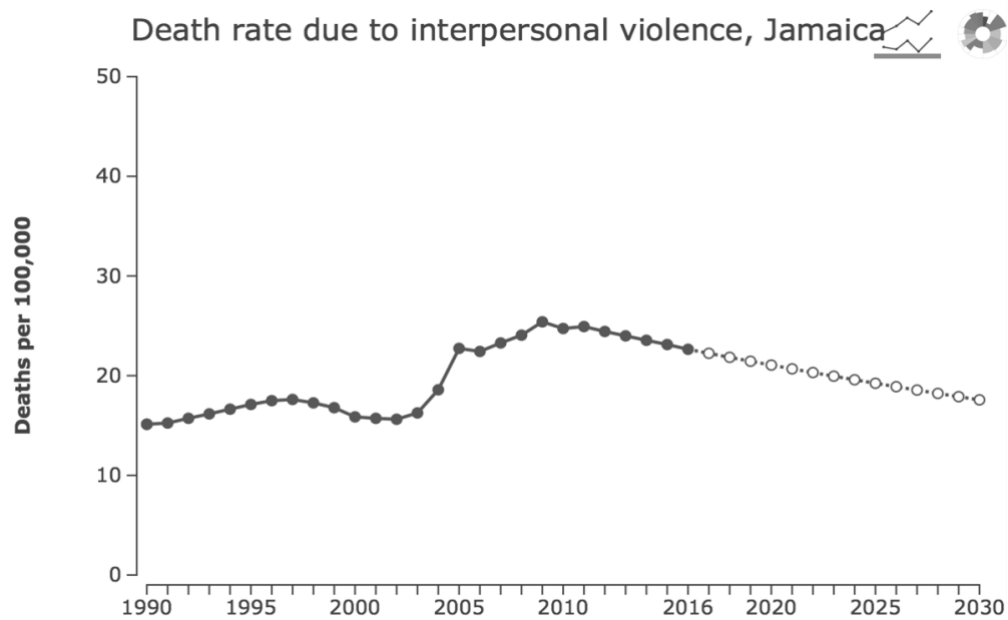
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Figure 6

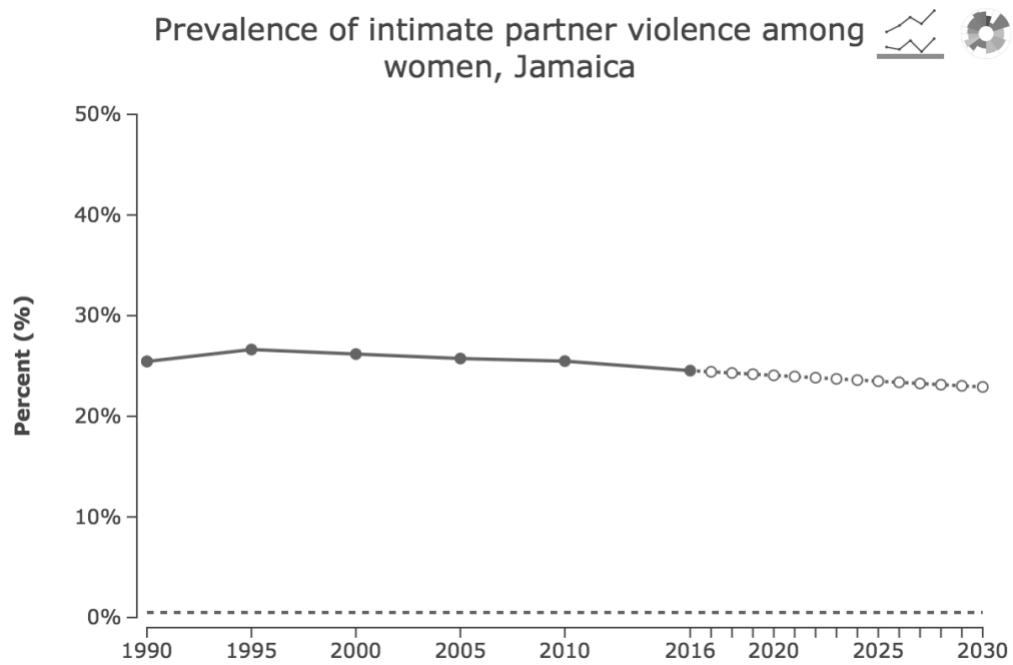


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Figure 7



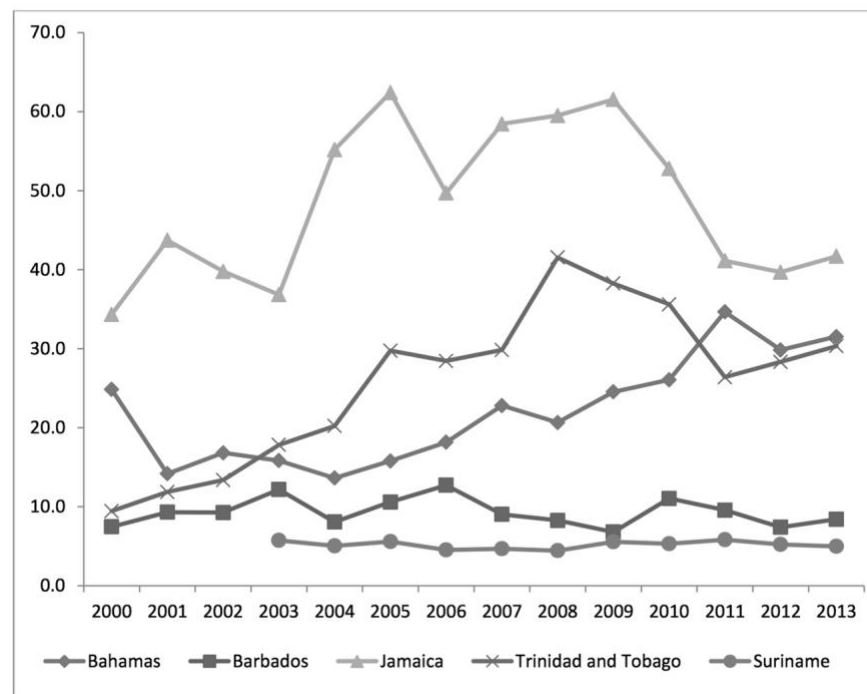
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Figure 8

Institute for Health Metrics and Evaluation. (2016). Health-related SDGs: Jamaica. *University of Washington*. Retrieved from <https://vizhub.healthdata.org/sdg/>

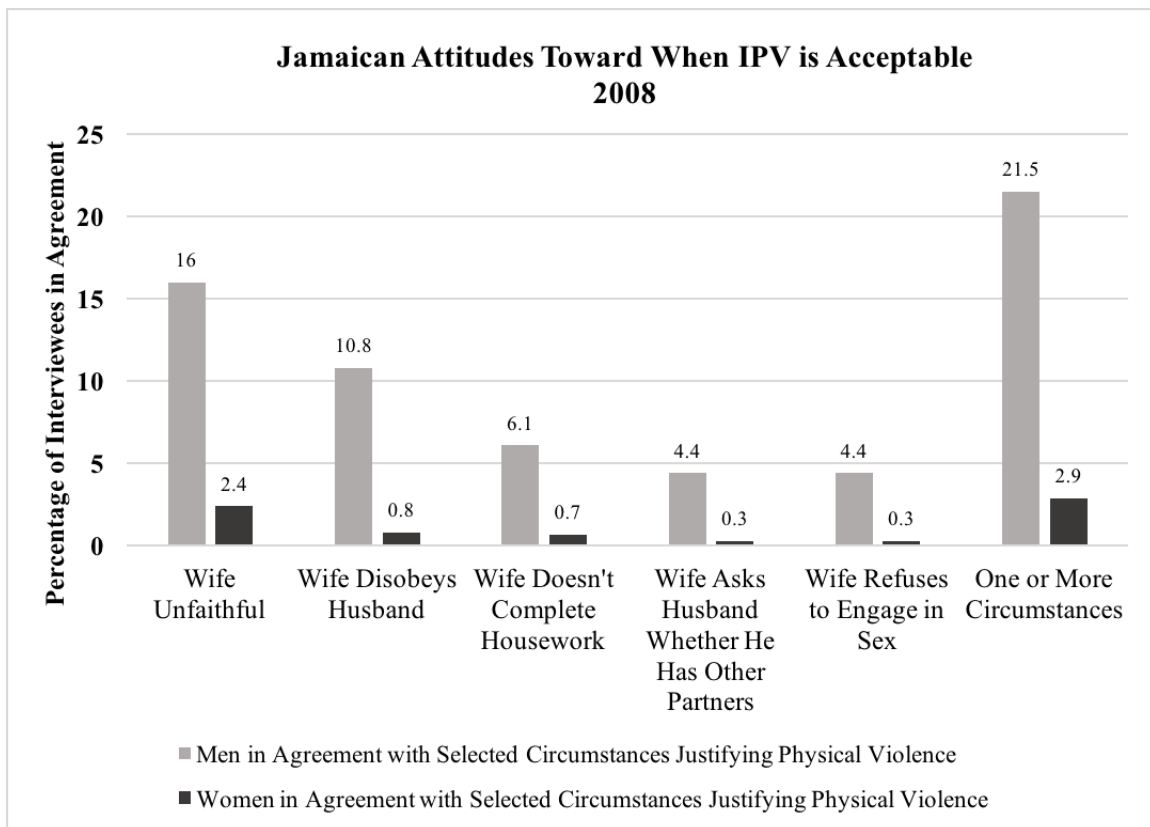
Figure 9

Figure 2.7. Comparison of Homicide Rates per 100,000 population in Jamaica and Other Caribbean Countries, 2000-2013



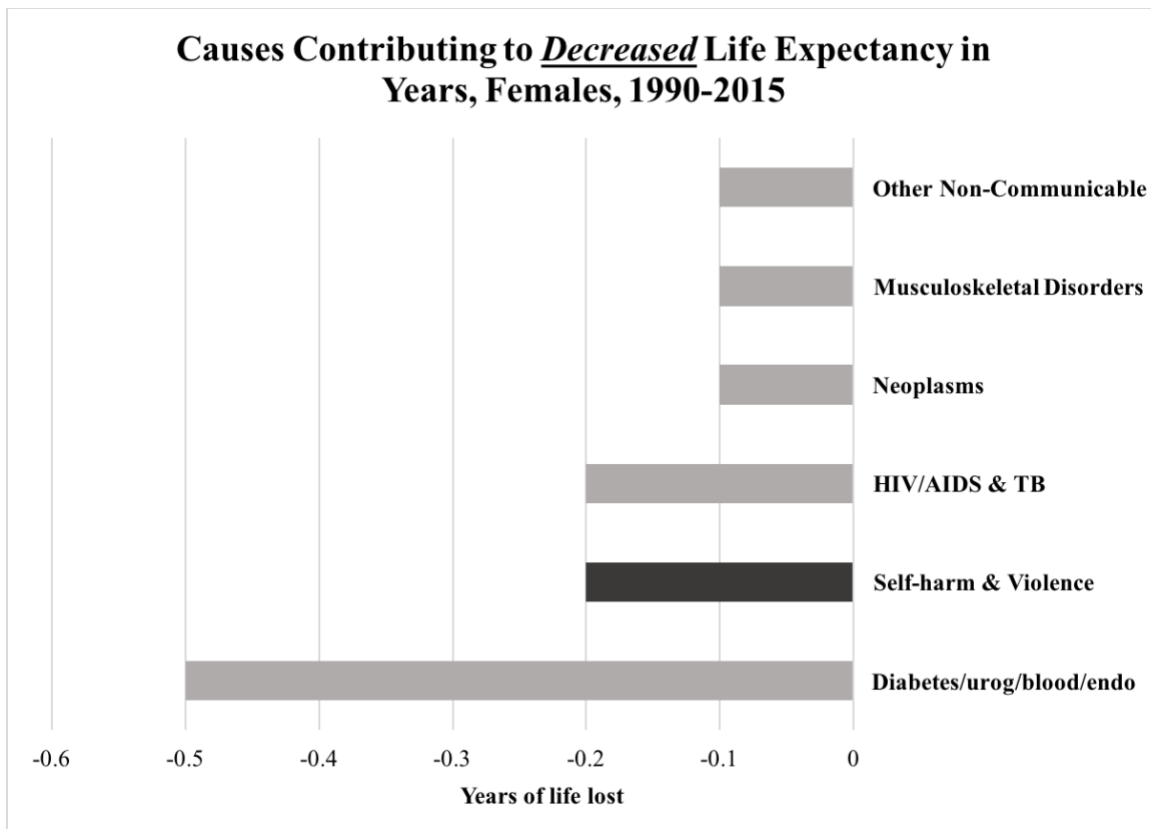
Harriot, Anthony D., & Jones, Marlyn. (2016). Crime and violence in Jamaica. *Inter-American Development Bank*. Retrieved from <https://publications.iadb.org/bitstream/handle/11319/7773/Crime-and-Violence-in-Jamaica-IDB-Series-on-Crime-and-Violence-in-the-Caribbean.pdf?sequence=4>

Figure 10



Serbanescu, F., Ruiz, A., Suchdev D. B. (2010). Reproductive Health Survey: Jamaica, 2008. *National Family Planning Board Statistical Institute of Jamaica*. Retrieved from <http://jnfpb.org/assets/2008%20Final%20Report%20Jamaica.pdf>

Figure 11



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