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ORIGINAL ARTICLE

Females Of The Reproductive Ages Who Have Never Used A Condom With A Non-Steady Sexual Partner

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ABSTRACT

Background: Previous studies have demonstrated that those with multiple sexual partners are more likely to be unmarried, younger (in adolescence years), and have a greater risk of contracting a sexually transmitted infection than those with single sexual partners. Yet, no studies have examined the females who are involved in multiple sexual relationships, who have never used a condom with their non-steady partners. **Aims:** The aim of the current study is: to elucidate (1) the socio-demographical characteristics of the females who have never used a condom with a non-steady partner, (2) the factors which account for their method of contraception, and (3) the factors that explain the age at the first sexual intercourse of this cohort. **Methods:** The data for this analysis was taken from the 2002 Reproductive Health Survey. The current study extracted a sample of 109 female respondents who were aged 15-44 years, who indicated having never used a condom with their non-steady sexual partners, from a sample of 7,168 individuals. **Results:** One and one half percentage of the females aged 15-49 years indicated having never used a condom with a non-steady sexual partner. Almost 81% of the sample had sex in the last 30 days, and the mean age was 30.4 years (SD = 8.1 years). Two variables emerged as the statistically significant factors of the ages at the first sexual intercourse of the samples, and they explained 38.8% of the variance. Three variables emerged as the statistically significant factors which explained the ages at which the females never used a condom with their non-steady sexual partner and this explained 40.1% of the variability. **Conclusion:** A multi-level approach to intervention has to be used to address polygamy and the inconsistent condom use among females who have non-steady partners in Jamaica; otherwise this risky behaviour will not be changed.

Keywords: Condom use, reproductive health matters, sexual relationship, non-steady sexual partner, transactional sexual relationship, age at first sexual intercourse, age at which the females began using a method of contraception

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Introduction

According to Edwards, “Unmarried American women who had their first intercourse when they were younger than 17 and those who were born in the western United States, are more likely than other women to have recently had more than one sexual partners, ...”[1]. While Edwards’ research provides pertinent information on the statistical association between the age at first sexual intercourse and multiple sexual partners, the exclusion of married and widowed females from the sample may create a perspective that they are not involved in extra-marital relationships or polygamy. Another reality of multiple sexual relationships is the high risk of contracting sexually transmitted infections (STIs), particularly HIV/AIDS and human papillomavirus [2-4], thus suggesting that the exclusion of any cohort will be detrimental to the public health policy intervention outreach. The recognition that risky sexual behaviour is open to humans, and so the exclusion of heterosexuals [3] is similar to that of married females as sexual intercourse is a practices of all and not a specified human population. If public health practitioners need to institute programmes that will effectively address and change behaviour, then, the fact as to why people with multiple sexual partners do not use a condom with non-steady sexual partners, cannot be left unresearched.

Previous studies have demonstrated that those with multiple sexual partners are more likely to be unmarried, younger (in adolescence years), and have a greater risk of contracting a sexually transmitted infection [1-4] than those with single sexual partners. One group of researchers found that only a small percentage of female undergraduate students in China, with multiple sex partners, were having unprotected sexual relations [5]. Such a reality is a public health concern within the general context of the association between unprotected sexual intercourse and the risk of contracting an STI. Furthermore, according to Yan et al. [5], 5.31% of the female undergraduate students in China had multiple sexual partners, and although the percentage of the people who were at a high risk of contracting an STI was low, the reality is that

STIs, in particular HIV/AIDS, have been increasing in the young aged cohort in the developing world, and this is moreso among young women [6-9]. HIV is the 2nd leading cause of death in the World [8], the 1st in the Caribbean (among 15-49 year olds) [8] and the 2nd in Jamaica [9], thus indicating that inconsistent condom usage and promiscuity have accounted for the HIV statistics in the developing nations.

By using a stratified probability sample of 2,848 Jamaicans who were aged 15-74 years, Wilks et al. [10] found that 24.4% indicated having at least 2 sexual partners (females, 8.4%; males, 41.0%). Furthermore, 11% of the female population reported having had an STI (3.4% in the last 12 months) as compared to 18.2% of the males (1.3% in the last 12 months). While Wilks et al. [10] did not state the prevalence of STIs among those with multiple sexual partners as compared to those with a single sexual partner, it can be extrapolated from their study, that inconsistent condom usage, premarital sex and multiple sexual relationships are a reality among Jamaicans. Despite the positive association between multiple sexual partners and STIs, as well as between inconsistent condom usage and STIs [11] and earlier sexual relationships and the risk factors for contracting STIs, no empirical studies exist, that have examined the females in the reproductive ages, who never used a condom with a non-steady sexual partner in Jamaica and their reproductive health matters.

There is high importance in wanting to understand the females in the reproductive ages who never used a condom with a non-steady partner, the factors which account for their method of contraception, and the factors that explain the age at first sexual intercourse of this cohort. The aim of the current study is; to elucidate (1) the sociodemographical characteristics of the females who never used a condom with a non-steady partner, (2) the factors which account for their method of contraception, and (3) the factors that explain the age at first sexual intercourse of this cohort.

Methods and material

Sample

The data for this analysis was taken from the 2002 Reproductive Health Survey (RHS) [12]. The RHS is an annual household interview survey of the civilian, noninstitutionalized population aged 15-44 years for females and 15-24 years for males. Since 1997, the National Family Planning Board (NFPB) has been collecting information on women (ages 15-49 years) in Jamaica regarding contraception usage and/or reproductive health. Stratified random sampling was used to design the sampling frame from which the sample was drawn. By using the 2001 Census sector (or sampling frame), a three-stage sampling design was used. Stage 1 was the use of a selection frame of 659 enumeration areas (or enumeration districts, EDs). This was calculated, based on a probability proportion to size. Jamaica is classified into four health regions. Region 1 consists of Kingston, St. Andrew, St. Thomas and St. Catherine; Region 2 comprises Portland, St. Mary and St. Ann; Region 3 is made up of Trelawny, St. James, Hanover and Westmoreland, with Region 4 being St. Elizabeth, Manchester and Clarendon. The 2001 Census showed that region 1 comprised 46.5% of Jamaica, as compared to Region 2 (14.1%); Region 3 (17.6%) and Region 4 (21.8%). [12].

Stage 2 saw the clustering of households into primary sampling units (PSUs), with each PSU constituting an ED, which in turn consisted of 80 households. The previous sampling frame was in need of updating, and so this was carried out between January 2002 and May 2002. The new sampling frame formed the basis upon which the sampling size was computed for the interviewers to use. Stage 3 was the final selection of one eligible female and this was done by the interviewer on visiting the household.

The Statistical Institute of Jamaica (STATIN) provided the interviewers and the supervisors who were trained by the McFarlane Consultancy to carry out the survey. The interviewers administered a 35-page

questionnaire. The data collection began on Saturday, October 26, 2002 and was completed on May 9, 2003. The data was weighted in order to represent the population of women who were aged 15 to 49 years in the nation [12].

The current study extracted a sample of 109 female respondents who were aged 15-44 years, who indicated having never used a condom with their non-steady sexual partners, from a sample of 7,168 individuals (1.5%). A questionnaire was used to collect the data from the respondents. It was a 154-item instrument. The questions were demographical characteristics, sexual history (including number and type of partners and having/not having sexual relationships with commercial sex workers), and condom usage. The interviewers were trained for a 5-day period, of which 2 days were devoted to field practices. The interviewers were assigned to a team which comprised of two females, two males and a supervisor. Oral consent was sought and given before the actual interview would commence. The interviewees were informed of confidentiality and their right to stop the interview at any time if they so desired. No names, addresses or other personal information was collected from the respondents in order to ensure anonymity and confidentiality.

Statistical analyses

The data were entered, stored and retrieved by using SPSS for Windows, Version 16.0 SPSS Inc; Chicago, IL, USA). Descriptive statistics were performed on particular sociodemographical characteristics of the sample. Multivariate logistic regressions were fitted by using one outcome measure: self-reported confirmed positive HIV test results. We examined the correlation matrices to examine multicollinearity. Where collinearity existed ($r > 0.7$), the variables were entered independently into the model to determine those that should be retained during the final model construction [13]. To derive the accurate tests of statistical significance, we used the SUDDAN statistical software (Research Triangle Institute, Research Triangle Park, NC), and this adjusted to the survey's complex sampling design. A p-value <

0.05 (two-tailed) was used to establish statistical significance.

Measurement

Crowding was the total number of persons in a dwelling (excluding kitchen, bathroom and verandah). Age was the number of years a person was alive, up to his/her last birthday (in years). The contraceptive method was derived from the question, “Are you and your partner currently using a method of contraception? ...”, and if the answer was yes, the question, “Which method of contraception do you use?” was asked. The age at which contraception use was begun, was derived from the question, “How old were you when you first used contraception?” Area of residence was assessed by asking, “In which area do you reside?” The options were rural, semi-urban and urban. The current sexual status was assessed by asking, “Have you had sexual intercourse in the last 30 days?” Education was measured from the question, “How many years did you attend school?” Marital status was measured from the following question, “Are you legally married now?”, “Are you living with a common-law partner now? (that is, are you living as man and wife now with a partner to whom you are not legally married?)”, “Do you have a visiting partner, that is, a more or less steady partner with whom you have sexual relations?”, and “Are you currently single?” Age at first sexual intercourse was measured from, “At what age did you have your first intercourse?” Gynaecological examination was assessed by asking, “Have you ever had a gynaecological examination?” Pregnancy was assessed by, “Are you pregnant now?” Religiosity was evaluated from the question, “With what frequency do you attend religious services?” The options ranged from at least once per week to only on special occasions (such as weddings, funerals, christenings, et cetera). The subjective social class was measured from, “In which class do you belong?” The options were lower, middle or upper social hierarchy.

Results

[Table/Fig 1] presents information on the sociodemographical characteristics of the study population. Almost 81% of the sample had have sex in the last 30 days, and the mean age was 30.4 years (SD = 8.1 years). Further examination of the age composition of the population revealed the percentages of the sample (their mean ages) who had sex in the last 30 days ie; 8.3% (mean age 15-19 years) s; 19.3% (mean age 20-24 years) ; 17.4% (mean age 25-29 years) ; 20.2% (mean age 30-34 years); 19.3% (mean age 35-39 years); 10.1% (mean age 40-44 years), and the remaining was 45-49 years (mean age).

[Table/Fig 1]: Socio-demographic characteristics of study population, n = 109

Characteristic	n	Percent
Employment status		
Employed	45	41.3
Unemployed	7	6.5
Housewife	81	28.4
Student	8	7.3
At home, not keeping house	18	16.5
Area of residence		
Urban	44	40.4
Semi-urban	14	12.8
Rural	51	46.8
Socioeconomic class		
Lower	25	22.9
Middle	51	46.8
Upper	33	30.3
Marital status		
Legally married	16	14.7
Common-law	36	33.0
Visiting	53	48.6
Divorced, separated, widowed	4	3.7
Frequency of condom usage (with steady partner)		
Always	56	51.4
Most times	42	38.5
Sometimes	11	10.1
Never		
Number of sexual partners (in last 3 months)		
None	0	0.9
1	1	93.4
2+	2+	5.7
Religiosity		
At least once a week	29	26.6
At least once a month	21	19.3
Less than once a month	13	11.9
Only on special occasions (weddings, funerals, christening)	34	31.2
Does not attend at all	11	10.1
No response	1	0.9
Shared sanitary convenience		
No	86	80.4
Yes	21	19.6
Age of respondents mean (SD)	30.4 years (8.1 years)	
Age of first sexual intercourse mean (SD)	16.5 years (2.3 yrs)	
Age of person had sexual debut with mean (SD)	29.7 years (23.5 yrs)	
Education (in years of school) mean (SD)	13.4 (2.9)	

All the respondents indicated that they have had sexual relationships in the past. One and one half percentage of the females aged 15-49 years (based on the sample size for the 2002 Reproductive Health Survey) indicated having never used a condom with a non-steady sexual partner.

[Table/Fig 2]: Fertility and other reproductive health characteristic of study population, n = 109

Characteristic	n	Percent
Current had sexual relations (in last 30 days)		
Yes	88	80.7
No	21	19.3
Current pregnant (at time of survey)		
Yes	2	1.8
No	107	98.2
Ever been pregnant		
Yes	86	78.9
No	23	21.1
Want to be pregnant		
Yes	0	0.0
No	0	0.0
Refused to answer	109	100.0
Want more children		
Yes	45	42.8
No	51	48.6
Unsure	9	8.6
Forced sexual relations on sexual debut		
Yes	19	17.6
No	89	82.4
Forced sexual relations (over lifetime)		
Yes	24	22.0
No	85	78.0
Tested for HIV/AIDS (when pregnant)		
Yes	38	44.7
No	30	35.3
Not sure	16	18.8
Refused to answer	1	1.2
Pelvic inflammatory disease		
Yes	1	0.9
No	107	98.2
Don't know	1	0.9
Refused to answer	0	0.0
Urinary tract infection		
Yes	15	13.8
No	91	83.5
Don't know	1	0.9
Refused to answer	2	1.8
Number of pregnancy that resulted in		
Live births median (range)		2(1-9)
Still births median (range)		0(0-0)
Miscarriages median (range)		0(0-4)
Abortions median (range)		0(0-0)
Age at menarche mean (SD)		13.2 years (1.5 yrs)

[Table/Fig 2] shows information on the fertility and other reproductive characteristics of the study population. Six percentage of the respondents indicated that they have had at least 2 sexual partners in the last 3 months. Of those

who were sexually assaulted over their lifecourse (22%), 41.7% indicated that it occurred once; 37.5% mentioned that it was 2-5 times; 4.2% stated that it was 6-10 times and 12.5% reported that it was at least 11 times. When they were asked, 'By whom?', most of them stated that it was by their boyfriends (45.5%), followed by close friends (22.7%), husbands or common-law partners (13.6%), visiting partners (9.1%) and lastly, by casual acquaintances (4.5%) and other individuals (4.5%).

Forty-nine percentage of the respondents stated that they began using a method of contraception before having their first child; 43.1% indicated that it was after their first child; 4.6% reported that it was after their second child, 1.8% stated that it was after their third child and 0.9% said that it was after their fourth child. Although the study did not used a condom with their non-steady sexual partner during sexual intercourse, 51.4% stated that they always used one with their steady partner; 38.5% mentioned that they used one most of the times and 10.1% revealed that they had seldom used one. Forty-three percentage of the respondents indicated that they wanted to have more children in the future and 9% stated that they were uncertain about this.

When they were asked as to which method of contraception they were using, most said that they were on the pill (56.8%), followed by injection (32.4%), tubal ligation (8.1%) and IUD/coil (2.7%). Only 2% of the sample was commercial sex workers. Fifty percent of the respondents have had a gynaecological examination in the last 12 months, and 27% had done a Pap smear in the same period.

Multivariate analyses

[Table/Fig 3] examines those variables which explain (or not) the age at the first sexual encounter of the study population. Two variables emerged as statistically significant factors of the age at the first sexual intercourse of the sample (F-statistic = 4.324, P < 0.0001), and they explained 38.8% of the variance (R-squared) in the dependent variable (age at first sexual intercourse).

[Table/Fig 3]: Table 3: Multiple linear regression: Variables of age at first sexual intercourse

Dependent variable: Age at first sexual intercourse	Coefficient	Std. error	CI (95%)
Constant	9.805	1.871	6.079 - 13.532
Shared sanitary convenience (1=yes)	0.465	0.565	-0.661 - 1.591
Married or in common-law union (1=yes)	-0.204	0.444	-1.088 - 0.679
Employment status (1=employed)	0.513	0.458	-0.399 - 1.426
Lower class	-1.283	0.666	-2.609 - 0.043
Middle class	-0.627	0.581	-1.784 - 0.531
Upper class (reference group)			
Semi-urban	-1.438*	0.701	-2.834 - -0.042
Rural	0.321	0.570	-0.815 - 1.456
Urban (reference group)			
Forced into having sex (1=yes, over lifetime)	-0.496	0.478	-1.448 - 0.457
Age	0.014	0.029	-0.044 - 0.071
Education (in years of schooling)	0.092	0.078	-0.063 - 0.248
Age began using contraceptive method	0.289*	0.078	0.133 - 0.446

*P < 0.05

[Table/Fig 4]: Multiple linear regression: Variables of age began using method of contraception

Dependent: Age began using method of contraception	β Coefficient	Std. Error	CI (95%)
Constant	6.479	2.866	0.770 - 12.188
Shared sanitary convenience (1=yes)	-0.831	0.763	-2.352 - 0.689
Married or in common-law union (1=yes)	1.283*	0.583	0.121 - 2.445
Employment status (1=employed)	-0.106	0.626	-1.352 - 1.141
Lower class	-0.270	0.923	-2.110 - 1.569
Middle class	-0.101	0.793	-1.680 - 1.479
Upper class (reference group)			
Semi-urban	0.225	0.975	-1.717 - 2.168
Rural	-1.170	0.762	-2.688 - 0.348
Urban (reference group)			
Forced into having sex (1=yes, over lifetime)	0.813	0.646	-0.473 - 2.099
Age	0.090*	0.038	0.015 - 0.165
Education (in years of schooling)	0.098	0.106	-0.113 - 0.309
Age at first intercourse	0.531*	0.144	0.245 - 0.818

*P < 0.05

[Table/Fig 4] presents information on the variables which explain (or not) the age at which contraceptive use was begun in the study population. Three variables emerged as statistically significant factors which explained the age at which the females (15-49 years), who had never used a condom with their non-steady sexual partner, began using a method of contraception (F-statistic = 4.564, P < 0.0001), and these explained 40.1% of the variability in age at which the females began using a contraceptive method.

Discussion

This study found that although the sample never used a condom with a non-steady partner, they used one with their steady partner (always- 51.4%; most times- 38.5%; seldom- 10.1%); 2% of the sample was commercial sex workers; 43% wanted more children; 47% of the sample was in the middle class; 47% of the sample was in the rural areas; 49% was in visiting unions; 13.8% had urinary tract infections; 22% was forced into sexual encounters; 17.6% was forced into sexual intercourse for their sexual debut; and that the mean age at the first sexual intercourse of the sample was 16.5 years, while the mean age of the person that the sample had the sexual debut with, was 29.7 years. The factors which accounted for the age at first sexual intercourse were the area of residence and the age at which contraceptive use was begun ; and the variables which accounted for the age at which contraceptive use was begun, were marital status, age of the respondents and the age at the first sexual intercourse.

As in the case of the undergraduate students in China [5], only a small percentage of the female Jamaicans who were aged 15-49 years, indicated having never worn a condom with a non-steady sexual partner. The current study provides a thorough examination of the reproductive health practices of those individuals, unlike the study in China [5].

Females with multiple sexual partners, who did not wear a condom with their non-steady partners, 1 in every 2 of them consistently, used a condom with their steady partners. It can be extrapolated from the current

study that (1) these females did not see their current partners as the possible parents of their future child/ren, (2) the sexual promiscuity was such that the rush of the encounter over-rode the logistics of the high risk of sexually transmitted infections, and that the (3) desire to have child/ren was a rationale which explained this activity. Clearly, the multiple sexual partnerships and polygamy among females is due to their desire to become parents, which is so dominant that their sexual urge overshadows the high risk of sexually transmitted infections as well as the cultural role of polygamy, while they are trapped within economic and material deprivation. It can be deduced from this study, that childbearing is used by females as economic leverage over males, and that some children would be illegitimate for the females' steady partners.

Another issue which is embedded in this study, is the sexual dissatisfaction of the females about their steady partner and otherwise, which is supported by literature [14]. When the respondents were asked as to who was responsible for the sexual assault, 46 out of every 100 indicated a boyfriend; 23 of every 100 indicated a close friend; 14 out of every 100 stated that it was a husband or common-law partner and 9 out of every 100 mentioned a visiting partner. The sexual dissatisfaction of the females is therefore embodied in their reduced sexual autonomy with their steady sexual partner, and the facts that their choice of having sexual relations with a non-steady partner was a choice, and that this could also be autonomous and financial. Clearly, sex is important to humans, but the role of economical reasons is critical [14] and this has overridden the risk of pregnancy. Sexual promiscuity appears to be more economical on the part of the females, as most of them were using a second method of contraception to prevent pregnancy and as the non-usage of a condom could be a part of the economic plan that would be used to exhort money from the non-steady sexual partner.

This study revealed that as the females become older, they are more likely to wear a method of contraception as well as get married,

in common-law unions and age at first sexual debut. The fact that as females become older, they are more likely to use a method of contraception supports the literature findings which demonstrate that young people are less likely to use a method of contraception. The present work highlights that females begin having sexual relationships with males who are at least 13 years their senior, thus suggesting the importance of economical reasons in sexual relationships. It should be understood that this transactional sex is not commercial, as only 2% of the respondents indicated being commercial sex workers. According to Shelton [14], "Rather than a specific fee-for-service sex, transactional sex describes a social norm of expectation of gifts and economic support from men as part of a sexual relationship, in part expressing value, commitment, love, and respect." Thus, multiple sexual relationships and the non-usage of a condom by some of females is a transactional encounter that is used by women to assist themselves economically from their financial and material deprivation; and this is the rationale for the choice of older men. Older men in these types of sexual relationships provide luxury goods, gifts and money to younger females that they are sexually engaged with, and the younger females offer sexual favours [15], [16].

Polygamy, within the context of the transactional sexual relationship, clearly is a low risk activity for many females, as only 14 out of every 100 of them indicated having urinary tract infections. Although this research did not have information on the prevalence of STIs among the study population, Wilks et al.'s study [10] demonstrated that 11 out of every 100 females aged 15-74 years had STIs, even though 8.4% had multiple sexual relationships. Furthermore, they found that 4.2% of the females who were aged 15-24 years, had STIs, 5.5% of those who were aged 25-34 years had STIs, 3.9% of the females who were aged 35-44 years had STIs, 1.1% of females who were aged 45-54 years had STIs and 0% of those who were aged 55-74 years had STIs, thus suggesting that younger females, in particular adolescents, may be more vulnerable to STIs than the older females, which is demonstrated by the literature [11], [17]. The results revealed that 41 in every 100

females in the study sample were employed, which indicates a high dependency on a partner, family or relative for survivability. While there were clear economic benefits for females who were being involved with older men, the opportunity cost of being sexually engaged with them was STIs, particularly HIV/AIDS and human papillomavirus [6], [17].

Inconsistent condom usage, promiscuity and multiple sexual relationships account for the high incidence of HIV infections in South Africa [6], and women in rural South Africa, on an average, begin having sexual relationships at 18.5 years. While the prevalence of HIV in South Africa is greater than that in Jamaica, inconsistent condom use among females with non-steady partners in Jamaica is exposing many of them to the virus, and this means that the public health department must immediately address this reality. A study by Nnedu et al. [18], which demonstrated that 1.5% of the females who were aged 15-49 years had HIV/AIDS is not any solace for the reproductive health matters of females aged 15-49 years who were having risk sexual relations with their non-steady partners. Empirically, it has been established that HIV is greater among heterosexuals [19] and young risk taking individuals [20], which means that the females who do not use a condom with their older non-steady sexual partners could be at high risk of contracting any STIs in the future. It is evident from this work, that futuristic challenges of public health can rest without using a multi-level approach to alleviate and change the sexual behaviour of these females.

Human behaviour is a complex phenomenon and so is human behavioural change. People will not change a particular behaviour just because outsiders are indicating that it is best to do so. Thus, people's participation in healthy behaviour and changing risky behaviour is embedded in risk perception. People have to live, and the desire is such that the culture and economic deprivation may not be enough for them to practice behaviour modification despite the threat to survivability. Risk perception is different between age and gender, which can account for the motivation (or

lack of) in lifestyle changes [21]. By using the results from Wilks et al.'s study [10], it was suggested that the risk of females contracting an STI in Jamaica was low and the findings from the current work equally demonstrate this fact, as only 14 out of every 100 females who did not use a condom with a non-steady partner indicated that they had urinary tract infections and only 1 in every 100 indicated that they had pelvic inflammatory disease. According to Gibbison [22], the cumulative AIDS prevalence in Jamaica was 100 per 100,000 in rural areas to about 1000 per 100,000 in urban zones, which validates the self-reported statistics. Clearly, the results from these findings and from that of the literature support the fact as to why people would have a low risk perception to change their risky behavioural practices.

It was not because of lack of knowledge that the females in this study did not want to use a condom with a non-steady partner, as they were cognizant of the risk factors such as HIV/AIDS and human papillomavirus among other STIs. According to Goldberg et al. the awareness about the condom is high in Latin America and the Caribbean [23], thus demonstrating the role of risk perception in the behavioural choices of women in the study. The reality is that the probability of sexual violence among females is greater than the risk of contracting an STI, particularly HIV, AIDS or a pelvic inflammatory disease. The aforementioned findings can be supported by a study which was conducted on sex workers in Jamaica. The study found that 9% had HIV, 90% had an easy access to a condom and that 30% used a condom with a non-paying partner [24].

Outside of the previous mentioned rationale for the behaviour of the study population, another issue which must be examined is sexual unions. According to Ebanks "Firstly, women believe that children in themselves add more stability to a union, than is achieved merely by a companionate relationship; and secondly, women want these additional children because the men want them and if they (the women) do not comply, the men will go elsewhere" [25]. This is a potent explanation for the risky behaviour which was

exhibited by the study population, as 49 out of every 100 females were in a visiting union and although the average number of the children that they had was 2, the premarital sexual relationship could be a sexual union transition seeking mechanism for these women. It is for this reason that many of the females in the study still desired to have another child, because of the current instability of unions. With visiting unions being the shortest in duration in Jamaica [26], historically, fertility has been a part of the approach which was used to change sexual unions and this clearly had some merit in contemporary Jamaica. Drayton [27] provides an apt explanation for the need to have children in Caribbean societies, when he opined that “In the Caribbean, however, many pregnancies may be unplanned, but few babies are unwanted”, because the babies are the opportunity of stable unions, financial assistance and a leverage over the males. Hence, there is a need to have a multifaceted approach to the public health intervention strategies which are geared towards countering the issues which have been raised here.

Conclusion

Multiple sexual relationships, polygamy and inconsistent condom usage are practiced by females who have non-steady partners in Jamaica. These individuals include married, rural, employed, wealthy, educated, religious and sexually assaulted females, and some whom are currently pregnant. Therefore, delaying the public health intervention for this cohort will only add to the number of individuals who will comprise future HIV/AIDS cases. Thus, these results provide pertinent information which public health and policy specialists can use to remedy some of the issues which are raised herein. In Jamaica, transactional sex is not construed by females in the same way as commercial sex is and so, the practices that emerged in this study highlight how this should be addressed in order to reduce STI infections and risky sexual behaviours.

Adolescents and adults learn and fashion an elaborate set of norms, practices and ideas about their culture, including sexuality and their sexual roles, well in advance of their

engagement in sexual relationships. Although people are somewhat knowledgeable about risky sexual behaviours, particularly the link between STIs and infertility, ectopic pregnancy, preterm birth, foetal abnormality, HIV/AIDS, and premature mortality, there is a degree of understanding in ignorance about the probability of contracting a STI, particularly HIV/AIDS, from the risk perception which they would have also learnt. Even though this is not scientific with regards to their risk perception, this guides their sexual involvements. The challenge of public health therefore, is not to increase the access to contraceptive methods and to provide more knowledge about the risk factors, but it forms the linkage between personal risk, further economical reasons and social deprivations that are likely to result from contracting an STI that is life treating, which causes infertility and which removes the vetoing power of sexuality from the male partner.

In summary, evidence exists, which showed that socioeconomic deprivation accounts for the aspects of the transactional sexual relationship between females and males in Jamaica. Clearly, in order to address polygamy, inconsistent condom use and risk perception among the females who have non-steady partners in Jamaica, a multi-level approach to intervention must be used; otherwise, the risky behaviour that emerged in this study will not be modified.

Conflict of interest

The authors have no conflict of interest to report.

Disclaimer

The researchers would like to note that while this study used secondary data from the Reproductive Health Survey, none of the errors in this paper should be ascribed to the National Family Planning Board, but to the researchers.

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