THE UNIVERSITY OF THE WEST INDIES

IGDS

INSTITUTE FOR GENDER & DEVELOPMENT STUDIES
MONA CAMPUS UNIT

UNDERSTANDING GENDER AND SEXUAL SAFETY AMONG CARIBBEAN YOUTH: REPORT ON A SEXUAL SAFETY RESEARCH STUDY ON STUDENTS AT THREE UNIVERSITY OF THE WEST INDIES CAMPUSES AND IN-SCHOOL YOUTH IN JAMAICA

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for

THE FORD FOUNDATION-UWI SEXUAL SAFETY INITIATIVE PROJECT

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The hope is that these studies will help to increase our understanding of the behaviours that pose sexual safety risks and provide a framework to expand the UWI's Sexual Safety Programme within and outside the UWI community and will motivate others to continue research in this field.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IGDS	Institute for Gender and Development Studies
LGBT	Lesbian, Gay, Bisexual and Transsexual
MARPS	Marginalized and At Risk Populations
MSM	Men who have Sex with Men
SSIP	Sexual Safety Initiative Project
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UWI	The University of the West Indies

1.0 EXECUTIVE SUMMARY

This research study conducted for the Sexual Safety Initiative Project (SSIP) was funded by the Ford Foundation and was coordinated by the Institute for Gender and Development Studies (IGDS), Mona Campus Unit. Field research was conducted in the 2011/2012 aacademic year and draft and final reports were prepared in 2012/2013. It is part of a larger SSIP project of the University of the West Indies (UWI) Health Centre's Sexual Safety and Wellness Programme.

The research builds on previous studies which point to high rates of HIV infection among Caribbean youth aged 15-24 years; the 'feminisation of the HIV epidemic', the role that gender and economic factors play in influencing HIV risk among females and the impact of gender based violence on increasing risk of HIV infection among females.

The research aimed to collect data to guide the expansion of the UWI's Sexual Safety Programme: The specific objectives were to: Identify how adolescent males and females (aged 18-24 years) define and experience sexual relationships; Identify the impact of gender-based issues such as sex and power relations on HIV/STI risk. This may include: gender based violence and violence against LGBT/MARPS groups; Clarify young people's understanding of gender roles and relations, gender identity and the processes by which they form and maintain intimate partner relationships in both heterosexual and same sex relationships; explore how nationality as a comparative factor may influence risks of UWI students in forming and maintaining sexual relationships; develop a Risk Assessment Profile of UWI students by Group using analysis of data from questionnaires and focus group discussions.

Scope: A total of 461 adolescents and youths were consulted across four studies conducted: one with 310 adolescents (141 boys and 169 girls) aged 15-17 years in four Jamaican high schools and three studies with 151 UWI students males and female students aged 18-24 years registered at Cave Hill (39), Mona (67) and St Augustine (45) campuses. The UWI studies examined attitudes and sexual behaviours of males and females in four groups of students: commuting students, residential students (on campuses); students who self identify as LGBT and students with disabilities. The results would be used to expand the UWI's Sexual Safety Programme to reduce the risk of HIV infection.

Research Methods: Data collection methods included: questionnaire surveys; focus group discussions; interviews and a review of documentary sources. The main limitations were the inability to collect data using random samples from LGBT and students with disabilities and the need to use a combination of data collection strategies to assess their attitudes and behaviours. Despite these limitations the findings are considered valid and provide valuable insight to guide expand the UWI's Sexual Safety Programme. .

Main Findings

1. All adolescents and young people consulted were confirmed to be at varying levels of HIV risk linked to social, economic, and environmental factors and access to power, decision-making and sexual and reproductive health education and services.

2. *Social risk factors were*: gender-roles, identities, and behaviours; exposure to sexual abuse and gender based violence; Low and inconstant condom use with sexual partners; multiple partnering; low perceptions of risks in both heterosexual and homosexual/same sex relationships; unequal power

impacting choice and insistence of condom use; Age mixing between youth and adults of both sexes and early sexual initiation. Other factors included: gender imbalances in enrolment at UWI which impacted the demand for and supply of sexual partners; sstigma, discrimination, homophobia and violence against LGBT/MARPs which increased sexual safety risks as these behaviours encouraged multiple partnering and limited safe access to sexual and reproductive services. Risks for students with Disabilities related to multiple partnering, inconsistent and low condom use associated with stigma and discrimination. Others were the New Freedom of young students transitioning from protective family and school environments to UWI with increased responsibility for sexual decision making in an environment of increased opportunities to be sexually active, with exposure to alcohol drinking, smoking, use of illegal substances.

3. Economic risk factors were: multiple partners, unprotected and transactional sex.

4. Inadequate access to or use of sexual and Reproductive Services: There are significant risks for sexually active adolescents in schools who have limited access to relevant knowledge and services. There are also gaps in meeting the needs of some at risk -groups: more targeting of information and services is needed to young and adolescent males, MARPS/LGBT; persons with disabilities and youth who wanted to abstain.

Conclusions and Recommendations

Conclusions: The main conclusions were that all target groups consulted were at various levels of vulnerability and risk in relation to sexual safety. The Risk Assessment Profile highlighted risks from sexual activity with inconsistent condom use; inability or inconsistency in making personal safe sex choices; gender inequality from socio-cultural, economic power-inequalities and their impact on decision-making in forming and maintaining sexual relationships. Nationality did not emerge as a significant risk factor on the three UWI campuses.

Recommendations: The main recommendations were that the UWI's Sexual Safety Policy and programme must be expanded to:

- **Enhance gender mainstreaming** in the Sexual Safety Policy, all programmes and strategies to reduce gender-related vulnerabilities and risks. This includes implementation of a policy of Zero Tolerance of all forms of gender based violence, sexual violence and sexual harassment against heterosexual and LGBT students.

- **Expand and diversify the sexual safety education programme and services** offered to better meet the differential vulnerabilities and risks of youth registered at the three UWI campuses: heterosexuals, students who self-identify as LGBT and MARPS, students with disabilities and new UWI students to enhance awareness and coping strategies.

- **Increase research** on sexual safety and on factors that influence gender identity and sexual risks.

- **Expand Outreach:** Share research findings with the four participating schools and support a sexual safety programme to address the needs of at risk adolescents in these schools.

2.0 Introduction and Literature Review

This report presents the results of the research study conducted for the Sexual Safety Initiative Project (SSIP) which was funded by the Ford Foundation. The SSIP research component was coordinated by the Institute for Gender and Development Studies (IGDS), Mona Campus Unit between Academic Years 2011/2012 and 2012/2013 as part of the larger SSIP project of the University of the West Indies (UWI) Health Centre's Sexual Safety and Wellness Programme. Programme Director is Dr Blossom-Anglin-Brown, Medical Director of the UWI Mona's Health Centre. SSIP Project Coordinator is Mrs Jasneth Mullings.

Justification: From global and regional perspectives, the study was justified as data from UNAIDS, PAHO and CAREC show that the Caribbean region has the second highest rate of HIV infection after countries in Sub-Saharan Africa with an HIV prevalence rate of 1% in the general Caribbean population. UNAIDS (2012) also notes that in the Caribbean, there were 230,000 persons infected and that 13,000 newly infected persons were diagnosed in 2011.

Sexual and Reproductive Health and HIV/AIDS: Against the background of the Programme of Action of the International Conference on Population and Development (1994) which promotes sexual and reproductive rights and services for all, the SSIP study investigated some major related problems in the Caribbean which impact development. Included are factors that impact sexual behaviour and sexual decision making, the impact on unplanned pregnancy which contributes to poverty; gender based violence, HIV infection as well as sexuality and other factors contributing to this epidemic. These factors challenge the future development of countries in the region as well as unplanned fertility.

The current research builds on previous studies on UWI students conducted by Anglin-Brown et al, (2007), who noted several factors in the UWI environment that facilitated high risk sexual behaviour. Among these were: the low ratio of males to females (1:4); the party environment; excessive alcohol consumption; multiple sexual partners, peer pressure and cultural norms relating to campus lifestyle. All have contributed to unsafe sexual practices.

Given the lapse of time and perceived rapid changes in sexual risk behaviour among youth reported in the media, there was need to conduct research to guide interventions to enhance the UWI's Sexual Safety programme. It was also important to understand the sexual behaviours of adolescents who would become UWI students in a few years to guide forward planning.

Reproductive Health: The Jamaica Reproductive Health Survey of 2002-2003 noted that among youth aged 15-24 years the age at first intercourse was 13.5 years for young males and 15.8 years for young females. The report also noted that a 2001 survey of more than 1000 adolescents 73.7 % of youth aged 15-19 years and 9.5 % of children aged 10-14 years reported being sexually active[1]

[1] Source: http://www.advocatesforyouth.org/publications/434?task=view

Caribbean countries have ratified the UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Sexual and reproductive health and rights of women and children therefore need to be addressed.

While it is known that there are high rates of HIV infection among Caribbean youth aged 15-24 years the literature highlights the important role of gender and requires further research to understand trends which point to the 'feminisation of the HIV epidemic'. This trend reflects an increased rate of HIV infection among young females compared to males and females accounting for approximately 50% of infected persons. Dworkin and Ehrhardt (2007) [2] for example cited gender inequality, economic factors and migration as issues influencing HIV risk among females. Several studies and media reports also link the epidemic of gender based violence as a factor driving the HIV infection among females.

According to the 2010 UNAIDS Global Report on the HIV Epidemic, "HIV prevalence among adults in the Caribbean is about 1.0% [0.9%–1.1%], which is higher than in other all regions outside sub-Saharan Africa"(UNAIDS, 2010). The Caribbean, therefore, has the second highest rate of HIV prevalence per capita in the world in the 15 to 49 age group (UNAIDS, 2010). However, the number of people living with HIV in the Caribbean is relatively small—240,000 [220,000–270,000] in 2009—and has varied little since the late 1990s. UNAIDS (2012) Global report notes that 230,000 HIV infected persons in 2011 and 13,000 new cases in the Caribbean.

Males and females in the age group 15 to 49 years are most at risk. Students in secondary schools are between 15-17 years and students in universities are aged 18-49 years. This study however included young people 18-24 years.

Jack (2001) noted that the fastest growing group of HIV infections in the Caribbean is among teenaged females. Of interest is the fact that behaviours evident in the wider population are also seen on university campuses. In Trinidad and Tobago, it was noted that post-counselling, risky sexual behaviour changed with non-steady partners, but not with steady partners. Outside of the fluctuation of the number of partners each sexually active adolescent may have, there are other factors accounted for when analysing the risk factors for STI's/HIV and (Acquired Immune Deficiency Syndrome) AIDS, such as gender.

The study is also justified as the survival and development of future generations is threatened by gender inequalities, sexual and reproductive health challenges including HIV which is a leading cause of morbidity and mortality among young males and females aged 15-25 years in the Caribbean. The overall rate of infection is 1.7 % in the population aged 15-29 years (UNAIDS 2009), but is much higher among vulnerable populations. For example the rate of infection is 31.8% for Men who have Sex with Men (MSM) and 4.9% among Sex Workers (UNAIDS 2009). The research will help to improve understanding some of the underlying factors associated with the formation of sexual relationships that continue to drive the HIV infection as well as sexual and reproductive health challenges.

[2] Source: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1716252/

2.1 Research Aims and Objectives

The aim of the research was to collect data to inform and an expanded UWI Sexual Safety programme. The findings will support the development of peer education, counselling and communications programmes to promote safer sexual behaviours among adolescents and young males and females.

Objectives for research on In-School Youth

The specific objectives of the study with In-School Youth were to :

- Better understand how adolescent males and females aged 15-17 years define and experience sexual relationships;
- Identify the impact of gender-based issues such as sex and power relations on HIV/STI risk. This included: gender based violence and violence against MARPS groups;
- Clarify how adolescents understand gender roles and relations and gender identity as well as the processes through which they form and maintain intimate partner relationships in both heterosexual and same sex relationships.

Objectives for research on UWI students

The specific objectives of the study with UWI students were to:

a. Identify how young males and females aged 18-24 years, define and experience sexual relationships;

b. Identify the impact of gender-based issues such as sex and power relations on HIV/STI risk. This may include: gender based violence and violence against LGBT/MARPS groups;

c. Clarify young people's understanding of gender roles and relations, gender identity and the processes by which they form and maintain intimate partner relationships in both heterosexual and same sex relationships;

d. Explore how nationality as a comparative factor may influence risks of UWI students in forming and maintaining sexual relationships;

e. Develop a Risk Assessment Profile of UWI students by Group using analysis of data from questionnaires and focus group discussions;

2.2 Research Variables

Definitions

Dependent variable: The dependent variable was sexual safety which denotes behaviour that promotes sexual health as defined by the following WHO definition:

Definition of Sexual Health (WHO 2002)

"Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[3]

The operational definition of sexual safety was behaviour associated with the globally accepted ABC's of HIV prevention despite the limitation of this strategy: Abstinence, Being Faithful to one sexual partner and Consistent condom use. Gender and economic factors have also been added to this operational definition given the global acceptance that gender is a critical factor impacting social, economic, political and environmental vulnerabilities and risks for HIV.

Independent variables were:

- Gender (socially ascribed roles associated with masculinity and femininity which influence the formation and maintenance of relationships, access to and use of power and other resources etc);
- Socio-economic status: ability to meet basic needs and education expenses;
- Sexual orientation: students who self-identify as heterosexual or LGBT;
- Status of new students at UWI: commuting, resident on a hall, self-identified as LGBT or students with disabilities

The relationships between these variables was based on the findings of previous research and support global and regional plans to reduce HIV infection rates among high-risk groups. The focus was on understanding behaviours in forming and maintaining relationships that will need to be changed in general as well as high risk groups as part of an expanded UWI's Sexual Safety programme.

2.3 Research Questions

Building on the findings of previous studies, the following research questions guided the study:

a. How do adolescents males and females (aged 18-24 years) define and experience sexual relationships?

b. What is the impact of gender-based issues such as sex and power relations on HIV/STI risk?. This may include: gender based violence and violence against LGBT/MARPS groups;

[3] Source: WHO definition retrieved on December 29 2012 from http://www2.hu-berlin.de/sexology/ECE5/definition_4.html

c. How do young people's understanding of gender roles and relations, and gender identity influence the processes by which they form and maintain intimate partner relationships in both heterosexual and same sex relationships?

d. Does nationality as a comparative factor influence risks of UWI students in forming and maintaining sexual relationships.

e. What is the Sexual Risk Assessment Profile of UWI students by Group based on an analysis of data from questionnaires and focus group discussions?.

f. How do young students coming from a protective family environment transition to student life at UWI? How do they cope with the increased responsibility associated with the increased opportunities to be sexually active? Are they at increased HIV risk from exposure to alcohol drinking, smoking, use of illegal substances?

g. How does the current sex imbalance in enrolment ratios at UWI (70:30 females to male ratio at Mona for example) influence sexual safety, given the imbalance in the potential demand for and supply of sexual partners?

2.4 **Research Design and Methodology**

The research design: This involved the collection of qualitative and quantitative sex disaggregated data on gender norms, interpersonal relationships, and sexual behaviours of a random sample of adolescents and young males and females in the various institutions.

Research on in-school youth: The research study was conducted in four Jamaican high schools by an IGDS Mona Unit research team. It included the collection and analysis of quantitative and qualitative data from male and female students in four (4) high schools which are part of the broader community environment of the UWI Mona Campus.

Research on UWI students: The three (3) research studies on UWI students were conducted by research teams at the IGDS Nita Barrow Unit at UWI Cave Hill, Barbados; the IGDS Mona Unit, Jamaica; and the UWI St Augustine Unit in Trinidad and Tobago. These studies were coordinated by the Heads of the three IGDS campus Units. Researcher teams were recruited and trained to conduct the studies, analyse the data and prepare draft reports. These were reviewed, edited and finalised by the IGDS Mona Unit team. Draft reports were shared with the SSIP team and the findings were used in 2012 to prepare advocacy materials developed by CARIMAC. This document presents the synthesis report of all four studies, as well as final report of each study.

Data collection methods: These included questionnaires, focus groups discussions, in-depth interviews and a review of documentary sources

UWI students: The general methodology used across the three (3) campuses primarily consisted of focus groups conducted by the respective research teams. Focus groups were conducted with participants of the same sex, that is male only and female only groups. Focus groups provided opportunities for students share their own experiences with peers as well as respond to information shared by other group members. While this approach worked at Cave Hill and Mona for the most part, challenges were encountered in collecting data from students who self-identified as LGBT and students with disabilities.

In response, interviews were conducted at Mona and at St Augustine, interviews and questionnaires were used to collect the data.

2.5 Sampling:

UWI students: The original research design for UWI students was based on the use of random representative samples of 10% of UWI students registered on the three campus territories. Inclusion criteria were: UWI registration in 2011/2012; age (18-24years); students who were commuting, residential, who self-identified as LGBT or had a disability. A 10% random sample was drawn for residential and commuting students. However, difficulties in gaining participation from LGBT and students with disabilities resulted in non random samples of both groups and as a result they are not representative of the wider population of these groups on each campus.

Method of selection of the UWI sample

Residential Students: – the sample was based on databases of students registered on UWI halls of residence, and selection was done with assistance from Student Service Managers/ Resident Advisors/ Residence Administrators in the halls of residence

Commuting Students: – the sample and recruitment was done by the Office of Student Services

LGBT students: – participants were recruited through focal points /gatekeepers and self-selection;

Students with Disabilities: – the sample was based on lists provided by the Office of Student Services, the Office for Students with Special Needs at Mona and in the case of St. Augustine, the assistance of the Academic Advising Disability Liaison Unit.

In the case of St. Augustine, the processes above were prefaced by canvassing for volunteers in areas frequented by students and explaining the project. Many signed up/ registered, but few ultimately followed through by participating in the focus group sessions.

Inclusion Criteria UWI Students: All registered students in undergraduate and postgraduate programmes at UWI Cave Hill, Mona and St Augustine Campuses in Semester 1 2011/2012 academic year aged 18-24 years. These will include nationals and non-nationals.

*Exclusion Criteria for UWI Students***:** These included any student not registered with the Cave Hill, Mona and St. Augustine Campuses in Semester 1 2011/2012 academic year, students younger than 18 years and older than 24 years.

Method of Selecting In-School Youth:

The study was based on a random sample of 10% of adolescents registered in each of the four Jamaican high schools using class registers.

Inclusion Criteria for In-School Youth (Jamaica): Students who were aged 15-17 years, registered at one of four (4) urban -based high schools which are part of the broader community environment of the

University of the West Indies Mona campus. The sample of schools selected included two single sex schools: Jamaica College (JC) (males) and St Hugh's High School for Girls (females); and two co-educational schools: Papine High and Mona High.

Exclusion Criteria: These included students who were not registered in one of the above-mentioned high schools in Semester 1 2011/2012 academic year, and students who were either younger than 15 years or older than 17 years.

2.6 Research process:

Ethical review: The research proposal was developed and submitted to the UWI Ethics Committee, and was approved following recommended revisions. Informed consent and assent forms were prepared and signed for adolescents and informed consent forms were signed by students in the respective groups.

Pilot studies: These were conducted to test and later refine the data collection instruments used. Research teams: Persons were recruited based on knowledge and experience of gender, sexual and reproductive health issues and research skills. They were trained to meet the objectives of the study and monitored by IGDS Heads of Department.

Access: Letters of introduction were prepared for the Heads of the schools, and meetings were held in advance with relevant staff. A briefing was provided at a PTA meeting at one school. Letters were also sent to the Office of Student Services teams and contacts made with other groups to secure support for the research . Schools and the OSS assisted in selecting the sample of students, transmitting approval forms, arranging focus group meetings and access to students for the quantitative studies. Light refreshments were provided for students for the focus groups.

2.7 Limitations and Challenges:

The main limitations were the need to use a non-random sample to collect data from students who self identify as LGBT on the three campuses because they were reluctant to participate in focus groups. which means that the findings for these two groups cannot be generalised. The need also to vary the methods used for data collection among these two groups may also have had an impact. At St Augustine a questionnaire was designed and interviews were conducted based on poor response to using focus groups. At Mona, interviews were conducted instead of focus groups for the same reason. At Cave Hill as with commuting and residential students as planned. No rural schools were included in the sample of high schools. Another factor was the inability to verify the information provided by students in focus groups, interviews and questionnaires.

The major challenge related to the imbalances in the scope of the project and the resources available for its implementation. Graduate and some undergraduate students were recruited as field research coordinators and field researchers which provided them with experience but meant additional support from the Head of the Mona Unit and administrative staff for coordination, quality control and editing reports.

2.8 Data analysis:

Data analysis involved comparing the findings from various sources to assess risks for sexual safety including the risk of HIV infection. Quantitative data collected were coded and analysed using SPSS. The results from the questionnaires were compared with data collected from focus group discussions, interviews and secondary sources where appropriate. Qualitative data collected from focus groups and interviews were coded and analysed to identify themes and issues relevant to the study. For the in-school youth data from quantitative and qualitative studies were compared to inform the findings conclusions and recommendations. A similar approach was used at UWI St Augustine for the LGBT students. The findings were triangulated from the various sources and reviewed against the background of the literature reviewed to understand how students form and negotiate sexual relationships and assess their sexual safety risks.

RESEARCH FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

3. RESEARCH FINDINGS

Table 1. Research findings from focus groups across UWI campuses and Jamaican in-school youth

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
Profile of Respondents (Total 464)				
Age of Respondents	18 – 24 years old	18 – 24 years old	18 – 24 years old	15-17 years
Number of Respondents	Female - 23 (59.0%) Male - 16 (41.0%) **Total - 39**	Female - 34 Male - 33 **Total - 67**	Female - 31 Male - 14 **Total - 45**	Female - 160 (51.6%) Male - 135 (43.5%) 295 Incomplete 15 **Total - 310**
Living Status	Residential - 16 (41.0%) Commuting - 23 (59.0%) Total - 39	Residential - 20 Commuting - 47 Total - 67	Residential - 19 (11F +8M) Commuting -21 (13F + 8 M) Total 40	Parents - 84.1% Guardians 15.9%. 80% -Mother only
Sexual Orientation	Heterosexual - 29 Lesbian - 6 Bisexual - 3 Gay - 1 Total - 39	Heterosexual -60 Lesbian - 4 Gay - 3 Total - 67	Heterosexual - 42 LGBT - 3 Total - 45	Heterosexual - 65 Lesbian - 3 Bisexual - 4 Transgender - 2 Gay - 6 Total - 80
Students with Disabilities	2	20 (10 M and 10 F)	5 (1 M + 4 F)	3 students
Sexual Activity	Active - 34 Inactive - 5 Total - 39			Active - 20 Inactive - 64 Total - 84 (High NR)
Research Findings				
Definition of sexual relationships	Both genders: - interactions between two or more people which involved some	Both genders: - interactions between two or more people which involved some	Both genders: - interactions between two or more people which involved some	Both sexes: - interactions between two or more people which

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
	form of sexual activity - length varies	form of sexual activity - length varies	form of sexual activity - length varies - females also felt that the use of the word "sexual" implied no emotions were involved and it was short term	involved some form of sexual activity
Issues impacting gender-based violence	Sexist language, dominance and devaluation of women by heterosexual males	The greatest gender-based violence towards females is verbal and is linked to power in relationships. Females indicated they had negotiated power in their relationships but knew of others who had not and were abused.	Only a few females experienced gender-based violence as a result of former partners needing to highlight their power and show dominance	- Refusal to engage in sex or ridicule by a female - as unequal power relations between males and females and high levels of gender based violence that mainly affects women and girls - perceived infidelity or attempting to end a relationship
Issues impacting violence on LGBTs	Anecdotal experiences and indirect accounts of unwanted physical violence were reported in both male and female LGBT intimate partner relationships. Reasons given: - male dominant role expected - perception of smaller	Gender violence among LGBTs was attributed to the passion that they felt, power dynamics and fears of infidelity.	LGBT males indicated the need to defend themselves from emotional abuse and "difficult" (physical) situations as a result of having less power in the relationship	lesbians face less discrimination and were more accepted than gay males within the Jamaican society

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
	dating pool - heterosexism by straight men towards LGBT females and disregard of a refusal.			
Issues impacting violence on MARPs	No issues mentioned	Females and males with disabilities feel vulnerable to abuse as physical disability is generally seen as causing an imbalance in power in relationships.	No issues mentioned	Age difference between boys and girls and their partners
Issues impacting understanding of gender identity	- Gender role confusion in female LGBT relationships - Inadequacy of labels as organizing tools of sexual identity (sexual identity can be fluid) - Critical role of family in gender identity/role development - Sexist language, dominance and devaluation of women by heterosexual males	- Blind males believe that sighted females seek to exert power over them and make them subordinate - Blind males also believe that their disability puts them at a disadvantage with sighted males, with whom they compete for sighted females - Blind females believe that males with disabilities find them unattractive	- Parents' expectation of females as child-bearers - Perception among some residential females and persons with disabilities that a sexual relationship is only present and normal when it is between two married people (male and female) - For disabilities group: male gender identity constructed around active sexuality, female gender identity constructed around passive sexuality - cultural/social/legal	- traditional beliefs about male dominance a male i.e. male the provider and the female dependent for economic support/protection - strong rejection and fear of homosexuality although bisexuals tolerated (boys) - sexual insecurities - perceptions that girls in relationships less informed than male partners and did not have much power when it

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
			parameters act as barriers or risks to freedom of expressing sexual identity (LBGT)	came to using condoms
Issues impacting process by which intimate relationships are formed	- Party environments - Use of alcohol - Online Social Networking Sites - Money/gifts - Susceptibility to Peer Influence (heterosexual males only - both on and off campus) - Passage of time for committed relationships (females only - on campus, off campus, LGBT and with disabilities) - School environment (heterosexual male and female students only, on and off campus) - negative psychological states - Avoidance of Friends (LGBT only) - Social Exclusion of LGBT (LGBT males only)	- Physical appearance - Financial/ economic need - Peer pressure/ building status among peers - Physical proximity and convenience - Emotional factors such as boredom, depression and loneliness - Stress relief - Socialising on new social media - Need for a companion - Family influence - Social factors: background, goals, educational level, socio-economic status - Social environments, such as Campus and parties - Presence of STI	- Social environments, such as Campus, not necessarily parties - Physical attraction, mutual interest, convenience, and personality, among males and commuting females, lust was also a motivating factor - Morality and spirituality - Not motivated by: money, but judgement influenced by loneliness/ depression, alcohol, and stress (both genders). - Only LGBT males and some commuting males indicated pressure from peers. - LGBT males indicated that boredom might influence them - Finding persons with the same morals and values	- Monetary gain - Attainment of a level of maturity - Desire to get sex - Flattery - Some girls in violent communities enter sexual relationships for protection - Peer pressure - Coercion using threats or promises of commitment and trust - Fear of rejection - Satisfying physical urges (boys), - Satisfying the need for emotional support (girls) - Rebellious behaviours against parents

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
Issues impacting process by which intimate relationships are maintained	- Resistance of peer influence - Proximity (LGBT only) - Resistance of pressure by family not to have sex (all but heterosexual males) - Sexual activity (penetrative and non-penetrative) - Healthy sexual communication skills and respect for partner (LGBT only) - Level of fulfillment - Mutual monogamy - Outward social contact (LGBT males)	- Proximity - Opportunity - Physical attraction - Emotional needs	- Respect - Not having sex outside of a marital relationship - Consistent sex	- Proximity - Physical attraction - Emotional needs - Economic needs
Factors/ Issues impacting Risk Assessment Profile	- Sexual relationships for money - Online social networking sites - Perception that sexual preference reduces risk of HIV/AIDS infection - Discussions about safe sex practices are considered inconsequential	- General knowledge and understanding of the risks associated with STIs, although myths exist and behaviour not consistent with risks - Discussions on sex and safe sex practices not generally planned and may be vague, the	- Some level of disconnect from the reality that STD's and STI's continue to be transmitted at an alarming rate - Inconsistency in responses such as whether the participants would have unprotected sex	- Double standards and norms in relation to age differences between males and females in relationships - High-risk sexual activity including multiple sexual partners;

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
	- Multiple partners among homosexual and heterosexual males - Level of trust determines whether safe sex discussions occur and condoms are used - Greater concern about pregnancy prevention rather than STD prevention - Risky sexual behaviour at least once in past sexual history for LGBT males	other partner is assumed to be aware - - During sexual encounters, condoms may or may not be used; - Among males and females across all cohorts *safe sexual practices diminish as trust develops* - Females more likely to be friends with HIV positive persons than have relations - Females unlikely to develop long term relationships with males with disabilities - Women with a disability face exposure to physical and emotional abuse and exploitation; financial exploitation; and engage in transactional sex because of low self-esteem and mental disability - Casual sex and gay	and whether HIV testing was mandatory - Although all or most students are aware of HIV/ STIs many myths continue - Psychological issues (Depression and loneliness) influence the formation of sexual relationships for some students - *Students operate in a stressful environment which may lead to promiscuity when sex is used for stress relief* - Influence of the Caribbean being seen as a hub of hyper sexuality which is promoted through popular culture	unprotected sex; and use of plastic bags ("bread bag" or "june plum bag") if condoms not available - Perceptions that masturbation would not be a viable option for relief of sexual urges as they get older (boys) - Sexual insecurities (boys taking pills for penis growth) - Promotion of sex in music, films, and TV advertisements - Lack of knowledge of sex and sexual safety - Relationships between younger girls and older males with the attendant high risks of STI/HIV infection - *Transactional sex* for improved social and economic

	Cave Hill	Mona	St. Augustine	Jamaican In-School Youth
		men paying homeless men for sex (LGBTs) - Lesbians' perception that they were at low risk of infection - Lack of ready access to special condoms to protect LGBT from STIs/HIV infection		status - Having sex in public areas such as parks, in the yard at home, in fast food restaurants and in bathrooms; Transport Centre; ATM - Parents not open enough with their children about sex, and relationships; - Young people not having a mature adult to speak to - Perceptions among young males that *"real' sex involves not using a condom*

Table 2. Summary of Research findings from the Study on in-school Youth

Issues	Summary of Research Findings
Issues impacting understanding of gender identity	1. Fathers are absent from the majority of households of adolescents: boys (58%) and girls (63%). 2. Mothers are generally present in the majority of households: 82% of girls and 79% of boys live with their mother in the same household. 3. Relatively few adolescents of either sex speak to their father about sex-related issues. Boys are more likely to speak to their father about sex (41% occasionally and 9% often) than girls (22% occasionally and 3% often). 4. Less than half of the adolescents of either sex speak to their mother about sex-related issues. Girls are more likely to speak to their mother about sex (41% occasionally and 12% often) than boys (39% occasionally and 17% often). 5. The most important *sources of information on puberty* for girls in rank order is: their school teacher (33.9%); their mother (29.6%) and their friends (7.8%). For boys the rank order is: their mother and school teacher equally (20.5%) and their friends (19.3%). *6.* The preferred *sources of information on puberty* for girls in rank order is: their mother (31.0%) (by a ratio of more than 2: 1); their doctor (14.2%) and their friends (8.8%). For boys, the rank order was: their friends (17.5%); their mothers (13.8%) and the *Internet (12.5%).* 7. The most important *sources of information on biological factors* for girls in rank order were: school teachers (54.0%); and their mother (24.2%). For boys the rank order was: school teachers (50.6%) and their friends (12.7%). 8. The *preferred sources of information on biological factors* in rank order for girls were: their mother (28.8%); their doctor (19.2%) and magazines (17.3%). For boys the rank order was: their school teacher (24.0%); doctors (18.7%) and magazines (14.7%).

	9. The most important *sources of information on relationships* for females in rank order were: their mothers (37.9%); and their friends & school teachers, equally (11.2%). For boys the rank order was: their mother (44.2%); their friends (18.2%); and fathers and brothers, equally. 10. The preferred sources of information on relationships for females in rank order were: their mother (24.8%); and their friends (12.8%). For boys the rank order was: their friends (18%) and their father (17%).
Issues impacting process by which intimate relationships are formed	<u>Gender Analysis of factors impacting the formation of intimate relationships</u> *11. Gender, parties and risk for one night stands*: The data show that the more parties a male attends, the more likely that he will have a one night stand (71.4% for those going 11 or more times per month vs 18.2% for those who never go). The data also show that the fewer parties a female attends, the less likely that she will have a one night stand (18.8% for those going 11 or more times per month vs 0% for those who never go). *Conclusion: boys and girls have different motivations for going to parties.* *12. Gender, movies and one-night stands*: The data show that the more movies a male attends, the more likely that he will have a one night stand (61.5% for those going 11 or more times per month vs 39.0% for those who never go). The data also show that the fewer movies a female attends, the less likely that she will have a one night stand (25.0% for those going 11 or more times per month vs 4.9% for those who never go). Conclusion: *boys and girls have different motivations for going to movies.* *13. Gender, alcohol consumption and one-night stands*: The data show that the more alcohol a male consumes, the more likely that he will have a one night stand (63.0% for those going 11 or more times per month vs 31.8% for those who never go). The data also show that the less alcohol a female consumes, the less likely that she will have a one night stand (13.3% for those going 11 or more times per month vs 0% for those who never go). Conclusion: *alcohol increases the risk of one night stands for both sexes but boys are more at- risk.*

Issues impacting process by which intimate relationships are maintained	<u>Gender Analysis of factors impacting the maintenance of intimate relationships</u> 14. **Use of condoms in last sexual encounter**: The results show little difference between boys and girls: boys reported: 78% and girls reported 75%. **Conclusion: 22% of boys and 25% of girls had unprotected sex.** 15. **Sexual intercourse**: When asked "Have you ever had sex?" More boys than girls said yes: 85% of boys and 38.8 % of girls. This trend was confirmed as 61.2% of girls and 15% of boys said they have never had sex. **Conclusion: These statistics confirm earlier studies that males are more likely than females to be sexually active and males start at a younger age than girls.** 16. **Multiple partners**: The data show that males are more likely than females to have multiple partners. Some 46% of boys and 28% of girls reported having had 11 or more partners. Conversely more females than males reported having no sexual partners: 36% of females and 10% of males. **Conclusion: the data confirm previous studies by Brown and Chevannes (1995) that associate Caribbean masculinity with having multiple partners. This behaviour increases HIV risks for males but also for females.** 17. **Reasons for delaying sex:** The data show that females and males cite different reasons for not having sex. For males, 65% said the delay was because of a lack of opportunity. For females over half (xx) said they were waiting for marriage and 39% said they were waiting for a partner who loves them. **Conclusion: the results confirm studies by Kempadoo and Dunn (2001) which reported that adolescent females want love security and marriage before having sex.** 18. **Pressure for sex**: Results show that **60% of males and 53% of females** reported that they were **not** pressured to have sex. The data however show that females are more likely than males to feel pressured. The other interesting results were data that showed **24% of males** and **13% of females** confirming that they faced a *high level of pressure to have sex*. Conclusions: while both adolescent males and females face pressure to have sex, females face more pressure- *males have more choice.* However high pressure on males to have sex confirms other studies which show that boys are

	under pressure to have sex from a young age to establish their gender identity of heterosexual masculinity. But, it may also be linked to early sexual exploitation of boys by both males and females. Results for girls confirmed their higher risk of sexual exploitation and abuse.
Factors/ Issues impacting Risk Assessment Profile	19. **Gender and Age of Sexual Debut/ first sexual experience**: Analysis of the data that 128 of the 310 children in the sample (41.3%), reported that they had had sex. Of this group 103 of the 128 children (80.5%) reported that they had had sex before the age of consent and only 25 (19.5%) had had sex after the age of consent (16 years). *Some 17 of the 128 children (13.3%) had had sex before 10 years of age; 28 children (22%) had had sex between 10-12 years and 40 children (31.3%) had had sex between 13-14 years. 18 (14%) had sex at age 15 years.* The data indicates evidence of child sexual abuse in contravention of the CRC and the Child Care and Protection Act in Jamaica. Consistent with earlier studies, (Reproductive Health Survey Jamaica, 2001; Friedman et al. 1997; McFarlane et al , 2005), the data also show that females have their sexual debut at an older age than males. The results show that: Both sexes had their sexual debut between 11-15 years: 77% of females and 53% of males. For those who had their sexual debut between 16-20 years: 21% of females and 19% of males. **Conclusion: the data confirmed earlier studies that children are having sex before the age of consent and are sexually active or are abused at an early age.** 20. **Identify of First Partner**: Among the females who reported that they had had sex, the majority (93%) indicated that their first partner was their boyfriend. The **other 7% reported that the person was a stranger or relative.** Among males who reported that they had had sex, the majority (80%) reported that their first sexual partner was their girlfriend; 16% was a one night stand; 3% a stranger or relative and 1% was a commercial sex partner (paid sex). **Conclusions: the data provide valuable insight into the sexual behaviours, risks and forms of sexual abuse that both girls and boys face.** 21. **Gender and Commitment Requirements**: The data show differences in the level of commitment required by boys and girls before having sex. Boys required less commitment from a first time partner. Girls required a higher level of commitment with a first time partner. For example: more than half of the males in the sample (54.3%) reported that their first sexual relationship was causal compared to just over a third of females (35%) . Only one third (33%) of boys and 36% of girls

were engaged in a serious relationships when they had sex and for both sexes they thought /hoped that these relationships would lead to marriage. **Conclusion: the majority of adolescent males and females have casual sex which represents high risk for HIV infection. One third of both sexes will engage in sex if they feel they are in a committed relationship.**

22. **Pregnancy prevention**: Females (81%) are more likely than males (66%) to take measures to prevent pregnancy.

23. **Gender and Concern about HIV Infection**: In the sample 40.3% of males are very concerned, 29.9% are somewhat concerned and 29.9% unconcerned. Contrastingly, among females 39% were very concerned, 29% were somewhat concerned and 32% were unconcerned. **Conclusion: Females are more concerned than males about HIV infection.**

24. **Taking Measures to reduce HIV Risk**: The data show that 75% of males and 85% of females consulted reported that they took measures to reduce the risk of HIV infection. This compared to 25% of males and 15% of females who reported that they did not. Conclusion: The majority of both sexes report taking measures to prevent HIV infection but females are more likely than males to take action to reduce the risk of HIV infection. This is consistent with research that females are more likely than males to adopt health seeking behaviours.

25. **Pregnancy:** The data confirmed that several females consulted had been pregnant. Among those who reported that they were or had been pregnant: 13% had given birth; 29% reported having a miscarriage; 21% were currently pregnant and 38% had had an abortion**. Conclusions: More than a third (38%) of pregnant adolescent girls appear likely to have an abortion or a miscarriage (29%) than to give birth. These findings are not surprising given other findings which point to high levels of unprotected sex and limited use of condoms. The findings require further research and interventions to prevent pregnancy among adolescent girls, to provide support during their pregnancy and to enable them to continue their education while pregnant and after giving birth. These research findings also have implications for the national policy on continued education for teenage mothers in Jamaica and the programme of the Women's Centre of Jamaica Foundation.**

26. **Age of Sexual Partners**: The data show that 79% of adolescent girls consulted were in a

relationship with a partner aged 16-20 years; 11% were with a partner 21-25 years; 8% were with a partner 10-15 years; 2% were with a partner 26-30 years and 1% females as opposed to males who are attracted to older partners.

27. **Gender and Sexual Values:** The data show opposite values for both sexes.

    Among the students consulted 57% of females and 11% of males reported that they have high sexual values. This was supported by data which showed that the majority of males (84%) said they have low sexual values s compared to 35% of females. Conclusion: females are more likely than males to have high sexual values.

28. **Attitudes to Violence against Women**: The results show that males are more likely than females to believe that using violence against females is acceptable. The data show that 87% of females and 67% of males opposed the use of violence against females. Among those who agreed that it is acceptable, 16% were females 8% of males.

29. **Attitudes to sex before Marriage: Analysis of the data show wide gender disparities.** About half of males (50.5%) and 19% of females agreed that a man and a woman should have sex while engaged to be married. Conversely, more than half the females consulted (50%) disagreed that a male and a female should have sex before they get married. **Conclusion: The results show that females are more likely than males to support the view that sex should be in the context of marriage.**

30. **Condom Use**: Data show that among those adolescents who reported that they are sexually active, 45.8% said they always used a condom, 23% said they used one sometimes and 30% said never. More males than females reported that they had used a condom .

4.0 CONCLUSIONS AND RECOMMENTATIONS

Table 3. Summary of conclusions and recommendations from focus groups across UWI campuses and Jamaican in-school youth

SUMMARY OF CONCLUSIONS	RECOMMENDATIONS			
	Cave Hill	**Mona**	**St. Augustine**	**Jamaica In-School Youth**
1. Further research is needed into factors which influence gender identity.		- More in-depth research is needed: e.g. on the sexual safety risks of blind males to determine whether or not their disability influences their masculine identity; issues of power and decision-making in their sexual relationships		More research is needed on whether adolescent pregnancy is related to gender identity or other factors.
2. Targeted messages need to be prepared and directed towards at risk students	- Safe-sex messages should be developed to change sexual behaviour to close the gap between knowledge and practice	- Safe-sex messages should be developed to change sexual behaviour to close the gap between knowledge and practice	- Targeted messages need to reach high-risk groups. All students studying in the Caribbean need to be made aware of HIV risks and consequences of risky behaviour.	- Public education programmes on abstinence and the risks of having sexual intercourse need to expanded. - Sexual education messages need to address issues of sexual identity, gender based violence and reducing high risk behaviours. - Public education programmes need to debunk myths,

SUMMARY OF CONCLUSIONS	RECOMMENDATIONS			
	Cave Hill	**Mona**	**St. Augustine**	**Jamaica In-School Youth**
				provide facts, dispel fears and insecurities of adolescent boys about penis size; interventions are also needed to reduce violence against females.
3. Sexual safety programmes need to be strengthened.	Need to expand the UWI's Sexual Safety Initiative Programme : updating the HIV policy, revising peer education and communications programmes ; expanding counseling and promoting safer sexual behaviours among youth.	- Expand the UWI's SSIP to enhance gender-sensitive & sexually diverse Sexual and Reproductive Health Education programmes. - Provide behaviour change interventions for young LGBT	- Expand curricula to include comprehensive, interdisciplinary courses on sexuality, sexual practices and consequences; - Revise sexual health programs and strategies to suit the needs of students that think dialogue on the issues is not an immediate necessity and to ensure that the entire student population understands the risks of risky sexual behaviours - Programmes should increase knowledge and practice of condom use;	Implement gender-sensitive sexual safety programmes targeted at: a) parents - to enable them to speak more honestly and openly with their children about sex and sexual relationships; b) adolescent girls & boys about: sexuality, sexual diversity; strategies to abstain & negotiate safer sex ; to build self-esteem; c) teachers and guidance counselors to improve SRH programmes and services.

SUMMARY OF CONCLUSIONS	RECOMMENDATIONS			
	Cave Hill	Mona	St. Augustine	Jamaica In-School Youth
			communication in relationships to promote safer sex, HIV VCT with all partners including high risk groups: HIV+; LGBT.	
4. Sexual and reproductive health services need to be expanded.		- Expand variety, and access to condoms & sexual safety devices. - Expand counselling and sexual and reproductive health services for LGBT	- Increase students' access to condoms especially for high-risk students. - Expand training for Counsellors at the UWI Health Services Unit to improve ability to address psychological problems related to sexuality.	Expand adolescent sexual and reproductive health education and services to include counselling and access to contraceptives minors and adolescents who are sexually active.

5. RISK ASSESSMENT PROFILE

This section presents the Risk Assessment Profile based on research findings followed by factors influencing vulnerability and risk:

- **Adolescents at risk:** Adolescents boys and girls both face sexual safety risks. Some of their needs are similar but many are different and in response programmes and strategies must address these on the basis of gender differences. **There is an urgent need to address some of the challenges identified in the study.**

- **Youth at Risk:** Young UWI students consulted faced varying levels of sexual safety risks. Among UWI students, there were no discernible differences between heterosexual male and female students who were residential and commuting.

- **High Risk Groups:** Consistent with the literature available, higher risks were indicated for male and female students who are part of the Marginalized and At Risk Populations (MARPS): Lesbian, Gay, Bisexual and Transsexual (LGBT)

- **Students with Disabilities**: These are also at risk as they face challenges associated with stigma and discrimination because of their disability, and their needs are underserved by sexual and reproductive health services.

- **Definitions of being in a relationship**: there was consistency in the definitions used by all groups but the length of the relationships varied between adolescents and youth.

- **Formation and maintenance of relationships**: there were no discernible differences related to factors influencing the formation and maintenance of relationships. School/UWI environment provided access and outside of educational institutions, social events were used.

- **Sexual Safety Risk Factors:** social, gender, economic, and environmental factors and access to power, decision-making and sexual and reproductive health education and services influenced vulnerability and risk. Sexually active males and females were not using condoms consistently either because of personal choice, and socio-cultural and economic factors that result in inequality in access to power and decision-making about choices in relation to sexual behaviour. Inadequate access to and use of sexual and reproductive health services also increased risks.

  Socio-cultural factors

- **Gender** : Gender as expected, emerged as a critical factor that influences social and economic vulnerability of adolescents and youth in each context. Gender continues to be an important cross-cutting risk-related factor that influences sexual and reproductive health vulnerabilities and risks among adolescents and young people of both sexes. Their attitudes and behaviour reflect ggender roles learnt through socialisation in the family, and church environment. However, the education environment, their peers and the mass media increasingly appear to influence their attitudes and behaviour as they get older. Interaction with peers at school and

the exposure to mass media and increased use of social media for communications influenced gender identify, and how students define, form, experience and maintain sexual relationships and associated risks.

- **Gender based violence** - Females but also some LGBT appear to be more at risk than other groups. Interventions are needed to re-socialise young adolescent males about values, gender-equality and non violence. In one high school some boys felt it was OK to 'discipline' their girlfriends if they showed 'disrespect' indicating a need for major interventions to promote values and respect for females and power dynamics.

- **Gender imbalances in enrolment at UWI:** Risks were associated with an imbalance in the potential demand for and supply of sexual partners. This imbalance contributed to high risk sexual behaviours. For example: sexual aggression among some females who pressure males to have sex and if they refuse the males are labeled as 'gay'. Cultural norms however mediate the behaviour of individuals on each campus.

- **New Freedom: Y**oung UWI students coming from protective family environments and transitioning to independent student life at UWI faced risks. They have to learn to cope with the responsibility of sexual decision-making with increased opportunities to be sexually active, and increased exposure to alcohol drinking, smoking, use of illegal substances. Cultural norms also mediate the behaviour of individuals on each campus.

- **Alcohol, tobacco , drugs and parties**: These social factors also increased sexual safety risks hence the need to support reduced use and abuse of alcohol tobacco and illegal substances and promote sexual safety at campus parties etc

- **Age mixing** - Risks from adolescents and youths having unprotected sex with older males and females increased the risk of unplanned pregnancies, HIV/STI risks. There is high sexual safety risks from unprotected sex with older more sexually experienced partners and unequal power relations which limit choice in condom use.

- **Nationality** did not emerge as a significant risk factor related to vulnerability at UWI campuses

- **Low and inconstant condom use** with sexual partners of all groups also emerged as a risk factor. Knowledge did not consistently relate to safer sex practices. There was low condom use with steady partners and higher condom use with casual sexual partners despite evidence of multiple partnering. Perceptions of low risk also increase vulnerabilities to HIV infection in both heterosexual and homosexual/same sex relationships. Unequal power to insist on condom use was also related to gender and economic factors. Many females were unable to insist on use of condoms because of cultural norms; some did not have access to male condoms. Others lacked knowledge of, were unfavorable to and could not afford female condoms which are more expensive. Among LGBT there was also evidence of inconsistent condom use (among MSM and lesbians based on a perception of low HIV risk in the latter group) .

- **Sexual Orientation**: Both heterosexuals and LGBT/MARPS are at risk but the latter face additional risks in forming and maintaining sexual relationships because of stigma, discrimination, homophobia and violence against LGBT/MARPs. These factors increased HIV risks from multiple instead of single steady partners, and other high risk sexual behaviour**.** Discriminatory public attitudes to sexuality and sexual diversity, public hostility to members of the LGBT community, impact on access of LGBTs to basic sexual and reproductive rights and services. This hostile context also contributed to high risk sexual behaviour (sex in public places); among some students who self-identify as LGBT indicating a need to target intervention programmes specifically at this group.

- **Students with Disabilities**: Risks for these students who are in sexual relationships were associated with multiple partnering, inconsistent and low condom use; stigma and discrimination related to reluctance of some non-disabled persons being in a public relationship with a male or female who has a disability;

Economic factors:

- There are risks relating to transactional sex to meet the eeconomic needs and also 'wants' based on the responses of some male and female adolescents and youth consulted. Some risk behaviours were influenced by them trying to meet their socio economic needs through transactional sex.

Access to Sexual and Reproductive Services:

- Risks from inadequate access to or use of sexual and reproductive health services (condoms and counselling) for sexually active adolescents in schools. This led to some students reporting that they used plastic bags. Reports that some adolescent boys were taking pills to increase the size of their penis to fulfill heterosexual ideals of masculinity were disturbing. Reports also indicate inadequate services for MARPS as a group, persons with disabilities and youth who want to abstain.

RECOMMENDATIONS FOR THE UWI'S SEXUAL SAFETY POLICY AND PROGRAMME

Against the background of the SSIP research findings, building on the achievements and lessons learnt in the current programme and the emerging Sexual Safety Risk Profile the following recommendations are made to further promote sexual safety:

- **SSIP Policy**: Revise the UWI's Sexual Safety Policy, the programmes and strategies to make these more gender-responsive to meet the specific needs of at-risk groups of students on the three UWI campuses.

- **Gender**: Mainstream gender more consistently in all sexual safety intervention policies and programmes. This would include: establishing a system to collect, analyse and use of sex

disaggregated data to guide policies and programmes; developing gender-sensitive indicators; establishing and monitoring goals and targets; using these to report on progress in meeting the specific needs of both sexes in each at-risk group over an agreed timeframe. This will help to better target the sexual safety needs and address the unique forms of vulnerability of each sex. The expanded SSIP programme must increase understanding of power dynamics as well as use and abuse of power. Implement/strengthen a Zero Tolerance policy to eliminate all forms of gender based violence, sexual violence and sexual harassment against all sexes on the three UWI campuses.

- **Outreach to High Schools:** Share findings with the four high schools that participated in the study to address risks identified for each school and develop a gender-responsive sexual safety programme to meet the needs of students;

- **Research**: Develop an on-going institutional research programme to continue collecting and analysing data on sexual safety as well as research on factors that influence gender identity and sexual risks.

- **Sexual Safety Education and Services**:

- Expand Sexual and reproductive health education and sexual safety programmes and services to address the gender-related needs of sexually active adolescents in schools and youth at UWI campuses. The programme should enhance sexual safety and reduce the risk of HIV infections among UWI commuting and residential students, students who self-identify as LGBT and MARPS and students with disabilities.

- Expand the UWI Orientation Programme for new students to increase awareness of sexual safety and specifically HIV-related risks and provide awareness training to enhance their coping strategies.

- Revise the public education and awareness programme to target messages to specific at- risk groups in high schools and on UWI campuses.

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