

# **STRENGTHENING THE EVIDENCE BASE ON YOUTH SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE EASTERN CARIBBEAN**



**CAROLINE ALLEN AND KAMILAH B. THOMAS-PURCELL**  
for the United Nations Population Fund (UNFPA)

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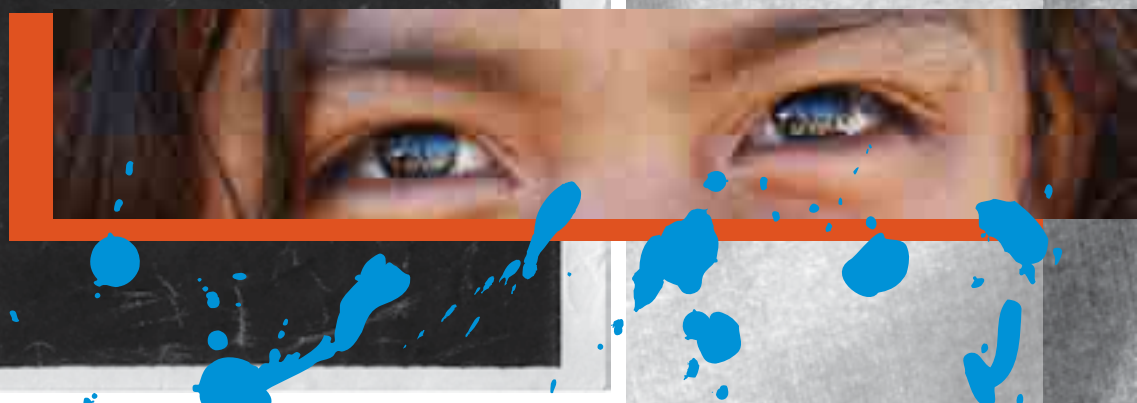
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# LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioural Surveillance Survey
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CDC	Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
CHAP	Caribbean HIV/AIDS Partnership
CSO	Central Statistical Office
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
IRB	Institutional Review Board
MoH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-governmental organization
OECS	Organisation of Eastern Caribbean States
PAHO	Pan American Health Organization
STI	Sexually Transmitted Infection
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization



# EXECUTIVE SUMMARY



**The United Nations Population Fund (UNFPA) Sub-Regional Office for the Caribbean/Barbados** is working to strengthen the evidence base on adolescent and youth sexual and reproductive health and rights in four countries: Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. The research presented in this document aims to generate new knowledge and provide the baseline data to inform the development of programmes to support adolescent and youth sexual and reproductive health and rights. It also aims to inform UNFPA's 2012 – 2016 programme of assistance to these English-speaking Windward Islands. The research comprises three components:

1. Desk review
2. Consultations through interviews with key stakeholders
3. Focus group discussions with young people

## EXECUTIVE SUMMARY

0.

### RESEARCH METHODS

The desk review focused on analysing the status of sexual and reproductive health and factors affecting it based on the existing research and epidemiological evidence in project countries. It sought to answer the following questions.

1. What is the status of sexual and reproductive health among adolescents and young people aged 10 to 24?
2. What are the social and economic vulnerabilities of youth that have been identified in research to date?
3. What is the existing evidence on the risk and protective factors for sexual and reproductive health among adolescents and young people?

Documents have been accessed via online searches, through email communications with authors of particular studies and via visits to project countries.

To assess the response to the issues identified in the desk review, an interview guide was administered to stakeholders in each country involved in or with an interest in the design and delivery of sexual and reproductive health services to youth. These included representatives of youth organizations, government ministries and non-governmental organizations.

Via focus group discussions, the project collected primary data among young people in an especially vulnerable age group, 15 to 17 years. The rationale for focusing on this demographic is that they are often engaged in or contemplating sexual activity, yet do not have full access to sexual and reproductive health services, mainly because they have not yet reached the age of 18 when they attain legal majority. The FGDs helped identify issues of importance to young people and how and why some of them are vulnerable with regard to HIV, sexually transmitted infections and teenage pregnancy. In each country, single sex focus groups were conducted with in-school and out-of-school youth. Additionally,



another geographic area was selected in which a male and a female FGD were conducted. These areas were the Kalinago Territory in Dominica, Carriacou in Grenada and Bequia in St. Vincent and the Grenadines. The inclusion of a hurricane-affected town or village was planned for St. Lucia, but time constraints for selection of potential participants prevented this from taking place.

Informed consent was obtained from parents of the children selected for the study. The children also independently provided their assent to participate before being accepted as research participants. Research methods were approved by the Ethics Review Committees in the four countries, and by the Institutional Review Board of St. George's University.

## RESULTS FROM THE DESK REVIEW

### HIV

Overall prevalence of HIV in project countries is estimated to be lower than the Caribbean regional rate of 1 per cent in adults age 15-49. Estimated HIV prevalence is 0.75 per cent in Dominica, 0.56 per cent in Grenada, 0.9 per cent in St. Lucia and in 0.4 per cent in St. Vincent and the Grenadines. For the Caribbean as a whole, 47 per cent of diagnosed HIV cases are among males, but in all four project countries the majority of HIV cases are among males. Among young people aged 10-19, there are more female than male cases, suggesting the vulnerability of girls and young women in this age group. Many HIV cases among young people may be undiagnosed because of low rates of testing among them.

### Sexually transmitted infections

Gonorrhoea and syphilis are notifiable diseases and the Caribbean Epidemiology Centre (CAREC) publishes figures on numbers of cases of these in project countries. Numbers of gonorrhoea cases reported in project countries were highest in the 1980s, reflecting the general pattern across CAREC member countries. St. Vincent and the Grenadines had the largest number of cases for the four countries over the period 1980-2005. Numbers of annual syphilis cases fluctuated widely over the same period and were highest in St. Lucia which also has the largest national population of the four countries.

In 2006, the STI surveillance system was revised to include reporting on syndromes [genital ulcers or genital discharge] as well as the numbers with specific aetiologies including gonorrhoea, syphilis and chlamydia. Not all countries have reported in every category each year. In none of the project countries in any year between 2006 and 2009 was the number of reported diagnosed chlamydia cases more than 24, the number of diagnosed gonococcal infections more than 95 and the number of diagnosed syphilis cases more than 564. As expected the number of reported syndromes was higher, up to 908 for genital discharge and 129 for genital ulcer. Largest numbers of cases of syphilis, genital discharge and genital ulcer syndrome were reported in Grenada. CAREC is now planning to

move to a web-based STI data capture system in which the data on individual cases will be entered.

This review did not reveal age disaggregated data on STIs, except for Dominica where, among 10-24-year olds from 2000 to 2010, the numbers are small, not exceeding 5 in any one year for gonorrhea, 6 for syphilis and 3 for trichomonas. Surveys in project countries that included self-reported STI symptoms have shown higher rates of genital discharge in females than males but little difference between 15-24-year olds and older people.

### Pregnancy and maternal health in women and girls under 25

The countries in the sub-region seem on track to meet Millennium Development Goal targets with respect to maternal mortality, antenatal coverage and the presence of skilled attendants at birth.

For the populations of project countries as a whole, the number of births per woman has declined over time. For instance in St. Lucia, the rate fell by 55 per cent between 1992 and 2009, from 3.1 to 1.4. However, the percentage of births to girls under the age of 19 in project countries has not fallen and, since the year 2000, has ranged from 14 to 22 per cent in the four countries. In St. Vincent and the Grenadines, on average 20.1 per cent of girls under 19 became pregnant between 1996 and 2008, as compared with 17.5 per cent in St. Lucia for 2000 to 2009 and 15.1 per cent in Dominica for 2000 to 2010 (no similar data were found for Grenada). Data from Grenada suggests that teenage pregnancies are concentrated among girls of low socioeconomic status.

The data show that numbers of teenage pregnancies are high in comparison with numbers of diagnosed HIV and STI cases among youth in project countries.

### Social and economic status of youth

The populations of these countries are young, with around 45 to 50 percent under the age of 25 and around 30 percent of the population attending school. Project countries are characterized by declines in key economic sectors, including agriculture and to a lesser extent tourism, and high rates of emigration of skilled labour. The economic opportunities for youth are limited, and some are involved in drug production and dealing. There is substantial poverty in each of the countries, with young people particularly likely to be poor.

Higher proportions of females than males attend secondary school and further education while males aged 15-24 participate in the labour force at higher rates than females.

A UNFPA survey of youth on the block in St. Vincent and the Grenadines showed low levels of education and high unemployment, but also gave the sense that



“block culture” in most cases provides important social support and relaxation for young people in difficult circumstances.

### Sexual behaviour

In the World Health Organization’s Global School-Based Health Surveys (2007-9), the percentage of students age 13-15 who said they had had sexual intercourse ranged from 26 percent (1 in 4 students) in Grenada and St. Lucia to 47 percent (almost half) in Dominica. In all project countries, greater proportions of boys than girls of this age group said they had had sex. Males were also more likely to report that they had had two or more partners. Reported condom use at last sex ranged from 54 percent in St. Lucia to 65 percent in Dominica. Thus the Dominican students were apparently more sexually active but also more likely to use condoms. Gender differences in condom use at last sex were not substantial in any of the countries.

Behavioural Surveillance Surveys in 2005-6 showed median ages at first sex of 15 or 16 in all project countries, with a median of 15 for males and 16 for females in three of the countries. The lowest age at sexual debut was reported as five for boys and eight for girls. The patterns of earlier sex for boys repeat those from a number of sexual behaviour surveys in the Caribbean, and contrast with many regions of the world where females tend to report sex at an earlier age than boys. The figures highlight the need to address child abuse and early sex among boys as well as girls.

In the Behavioural Surveillance Surveys, the percentages reporting that their partners were 5 to 9 years older than them when they first had sex ranged from 9 percent in Dominica to 20 percent in Grenada. The percentages reporting that their first partners were 10 or more years older ranged from 3 percent in Dominica and Grenada to 5 percent in St. Lucia. In every country, a substantially larger percentage of girls than boys reported first partners 5 or more years older. The figures suggest that females are particularly likely to have older partners, confirming qualitative studies including those that have noted the “sugar daddy syndrome” [girls having older partners for access to material resources].

In 2010-11, HIV Knowledge, Attitudes, Beliefs and Practices studies were conducted with 15-49-year olds in Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis. Among 15 to 24-year olds, 15.4 per cent of Dominicans and 21.5 per cent of Grenadians reported that they had had sex below the age of 15. Reflecting results from other surveys, more of the males than females in both countries reported earlier sexual intercourse. Turning to percentages of respondents with more than one partner in the past 12 months, in Dominica the percentages were 22.7 and 15.8 among 15-19 and 20-24-year olds respectively, while the corresponding percentages for Grenada were 17.3 and 26.9. Again, more of the males reported more than one partner. Condom use at last sex among men and women who had more than one partner in the past year was

highest among 15-19-year olds and dropped in older age groups. In the age group 15-19 years, more females than males used a condom. With between one fifth and half of young people not using a condom at last sex, even though they have more than one partner, there is still substantial room for improvement.

### Biological risk factors

Biological risk and protective factors have been largely overlooked by sexual and reproductive health decision-makers concerned with prevention in the Caribbean. Biological factors influencing HIV/STI transmission include:

- Biological sex: per vaginal sex act, females are more susceptible to HIV transmission than males
- HIV virus sub-types
- Presence of other STIs
- Stage of infection
- Prevalence of HIV/STIs
- Antiretroviral treatment: this has recently been shown to decrease the risk of transmission
- Male circumcision, shown to reduce the likelihood of HIV transmission from females to males by around 60 per cent
- Vaginal practices such as douching have been shown in some studies to increase risk of HIV/STI
- Male genital hygiene. Limited evidence shows that cleaning inside the foreskin has a minor impact on reducing HIV risk

The current study is one of very few in the Caribbean looking at genital practices, including douching and male circumcision.

### Gender-related norms and transactional sex

Several mostly qualitative studies have shown the importance of sex in exchange for goods in the Caribbean, especially among youth. These are related to the social norm that males should provide economically to their partner, in a social context of materialism. Young women are at risk of teenage pregnancy and both young men and women of HIV and STI because of their willingness to shift partners and have unprotected sex for access to material possessions.

### Clustering of risk factors among a minority of youth

The Caribbean Youth Health Survey was carried out among 15,695 in-school youth aged 10-18 in nine countries, including Dominica, Grenada and St. Lucia. It showed that participating young people who had ever had sex were more likely to have been sexually or physically abused. Those who had had early sexual intercourse, defined as initiating sexual intercourse at or before thirteen years of age (representing over 22 per cent of respondents), were significantly more likely to be involved in other practices that are potentially damaging to health, including carrying or fighting with a weapon, smoking, alcohol use, marijuana



use, gang membership, running away from home and skipping school. These results point to the need to target interventions towards the minority of youth who are at higher risk as a result of abuse or involvement in behaviours such as gang membership, dropping out-of-school and drug use.

#### Gender based violence and child sexual abuse

Limited evidence suggests that intimate partner violence is more prevalent among teenage girls. Forced sex and domestic violence have been shown to be associated with HIV risk factors such as non-use or inconsistent condom use and STI. A contributing factor is the widespread acceptance of violence against women as a taken-for-granted aspect of life in the Caribbean. This means that many cases are unreported and there is a lack of law enforcement. Disabled youth are anecdotally reported throughout the Caribbean to be at high risk of sexual and other forms of abuse and thus of HIV, STI and teen pregnancy, but data on this are lacking. Research with female survivors of domestic violence in St. Lucia showed that their partners often used violence to stop them from using contraceptives and to control pregnancy and the outcome of pregnancy.

Research indicates that Caribbean children are exposed to a variety of kinds of violence [physical, sexual, emotional, verbal] and that there is a high level of tolerance of violence, especially within the context of discipline and punishment in the home and in school. The extent of incest is not known but is often found to be a factor in the sexual abuse of children in the Eastern Caribbean. A study of child sexual abuse in the Eastern Caribbean found that it was associated with an attitude that teenage girls were legitimate sexual targets. Most of the perpetrators of child sexual abuse were male but some females contributed by failing to protect their children. Transactional sex played a major part in the abuse of children. Cell phones, clothes and fast food meals were typical goods exchanged for sex. Pornography via cell phones and the internet was an important recent trend. Data from the Welfare Department in Dominica show that child sex abuse happens on a large scale there. Recent data from Dominica and Grenada show that a quarter of 15-19 year old girls have been sexually molested.

#### Drug and alcohol use

The Global School-Based Health Survey among 13-15-year olds shows high usage of alcohol. The prevalence of alcohol use in the last 30 days ranged from 46 percent in Grenada to 56 percent in St. Lucia. Slightly more of the boys than girls drank alcohol. The incidence of drunkenness in the young people's lifetime was also lowest in Grenada [27 percent] and highest in Dominica [33 percent]. In all countries, higher percentages of boys than girls had been "really drunk" in their lifetimes.

In Grenada, 14 percent had used drugs, in St. Lucia 22 percent and in St. Vincent and the Grenadines 20 percent. In each of the three countries, the prevalence of drug use was higher among boys than girls. Use of drugs was not reported in

the Dominica Fact Sheet.

#### HIV stigma and discrimination

In the context of concentrated epidemics, as appear to exist in the four countries in this study, discrimination against vulnerable groups, including MSM and sex workers severely restricts their access to prevention and treatment services and thus increases the risk of proliferation of the epidemic. Studies among faith based organizations in Eastern Caribbean countries showed that the extent of compassion towards people living with HIV was conditional on perceptions of whether they had engaged in homosexual activity or sex work. This and other studies also showed that stigma was high with regard to unwillingness to share food or drink with an HIV positive person. Several studies in the Eastern Caribbean have shown that young people display the highest levels of stigma and discrimination.

#### HIV knowledge among youth

The 2010-2011 OECS KABP surveys report on the percentage of young people who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV. In Dominica, 45 per cent of 15-19-year olds and 64 per cent of 20-24-year olds had correct knowledge. The corresponding percentages were 63 per cent and 64 per cent in Grenada. Higher levels of knowledge were found among females than males except among 15-19-year olds in Grenada.

#### FOCUS GROUP DISCUSSIONS AMONG YOUNG PEOPLE

Four FGDs were conducted in Dominica, five in Grenada, two in St. Lucia and six in St. Vincent and the Grenadines. A total of 100 young people participated in the FGDs across the four countries, of which 51 were male and 49 female. Challenges faced by institutional partners in identifying out of school youth from among whom to select potential FGD participants in the available time for fieldwork between receipt of ethical approval from countries and the end of project funding in 2011 were the main reason that fewer than the six planned FGDs were conducted in Dominica and St. Lucia. There were also challenges in securing the approval of schools to conduct the research with students, in receiving lists of students, in contacting parents or guardians to complete the informed consent process and in assembling potential participants on the day scheduled for the discussion.

#### What are the factors that drive youth vulnerability, or protect youth from HIV/STI/ teen pregnancy?

The discussions began by asking young people their perceptions of the opportunities and challenges of living as young people in their countries, and about the amount of power they believed that they had in relation to school, parents, government, work, relationships and religious leaders. Answers to these



questions provide important contextual information about how young people are living and some key constraints on their abilities to control their sexual and reproductive health and rights.

### *Adolescence as a time of freedom and opportunity*

When asked about the opportunities for young people in their countries, several respondents immediately pointed to the freedom they felt they enjoyed, since there was a “lot of pleasure time” and they did not face the responsibility of meeting all their subsistence needs. It was also noted that the freedom often involved an element of rebellion against the restrictions that parents and others tried to impose. Several pointed to this being a time of potential and possibility when their bodies and minds were strong, while adulthood was seen as a time when options were progressively closed. Young people valued the internet and free education and health care which were not available to previous generations. However, participants noted that things were expensive and that there were few structured activities available to young people as well as few job options. The absence of privacy and limitations in one’s freedom to express one’s individuality were expressed as concerns. Adults were viewed as “talking down” or “talking at” young people rather than listening to what they had to say.

### *Safety and violence*

It was perceived that, relative to other countries in the Caribbean, levels of crime were not high. However, peer pressure could lead young people to become involved in illegal activity or risky sexual practices. Boys taking drugs were seen as a bad influence.

Attention was drawn to the risk of violence through beatings and physical restrictions from parents, sexual abuse and bullying. Even at their young age, some girls had become cynical about men and boys, viewing them as exploitative and abusive, based on experiences of lies and beating. Girls also referred to groups of young men leering at them on the streets and disturbing them from their studies at school.

### *Perceptions of youth power and self-determination*

Few young people felt that they have power in relation to their government, partly because they were not yet old enough to vote. There was a perception that when they reached the age of majority things would change for the better. However, there was also the sense that governments did not listen to young people or take their views seriously.

It was generally felt that “parents make the decision for you”. This was usually seen as appropriate, “because parents know better”. For example, parents’ efforts to stop their children from staying out very late were seen as appropriate. However, some young people felt that that they were never really involved in decisions that affected their lives and were old enough to make more of the

decisions for themselves.

Some said that parents “don’t want us to speak out” or to listen to young people. They felt that they could not discuss their relationships with their parents, because of lack of understanding and discomfort in discussing sex or that the parents were too busy. It was noted that therefore young people sometimes needed to rely on their peers for advice.

### *School*

Several participants felt that the decisions they were allowed to make at school were the appropriate ones; for example, choosing their exam subjects. Some girls felt that if they concentrated on their studies they would be respected and listened to at school and in their communities. Boys in several groups said they did not have enough power at school because of “rules and regulations.” There was a gender difference in willingness to conform at school.

### *Relationships*

Among males in several groups, the view was expressed that they had the power to decide whether or not to have a girlfriend. Females did not mention anything about power to have relationships; they seemed more concerned about abuse within relationships and power to say no to sex. Seduction, threats of abandonment and violence were used by males to persuade or coerce girls to have sex. Jealous, controlling behaviour and stalking were also used by some male partners, to the extent that one girl said that girls with such partners were unable to explore the world and it was as if they were “locked up”.

### *Who has more power, youth in-school or out-of-school?*

Many participants thought that young people in-school had more power because of the opportunities available to them, social as well as educational. Those who spoke about the power of youth who were out-of-school emphasized the fact that fewer restrictions were placed on their actions. Interestingly, participants in the FGDs that were conducted with out-of-school youth overwhelmingly thought that in-school youth had more power than out-of-school youth, principally because of the greater job opportunities available to youth with qualifications. Girls noted that females without qualifications sometimes had to submit to sexual advances of employers to get and stay in work.

### *Sex and relationship education*

Education on sex and relationships in school seemed, from the responses of participants, to concentrate on the biology of sex, on telling young people to abstain until married or use a condom, and on the negative consequences of sex such as teen pregnancy and HIV/STIs. There was a general feeling that the number of hours allocated to these subjects was insufficient and that relationship education was lacking. Some had been told about condoms at school but were

warned that they might not be effective and might burst. Some teachers were not comfortable teaching about sex, and did not even want to use the words “penis” and “vagina”.

Levels of communication from parents about sex and relationships varied. They focussed more on the risks of pregnancy than HIV/STI. Parents advised their children not to have sex, and seemed to be more likely to advise boys than girls to use a condom. Some were just told not to get pregnant or get anyone pregnant. Some parents drew on their own experiences to advise their children about relationships. Some would advise children only after they found out they were having sex.

Sometimes peers, along with internet searches and reading, filled in gaps in information left by school and family. Young people were concerned about the trustworthiness of the information they received from these sources.

#### WHY AND HOW DOES YOUTH VULNERABILITY OCCUR? WHY AND HOW ARE SOME YOUTH PROTECTED?

##### *Influences on abstinence among young people*

It was generally felt that a minority of 15-17-year olds were virgins and that abstinence was not socially acceptable for boys in particular. It was also seen as difficult to maintain among girls given multiple social influences.

The types of young people mainly believed not to be having sex included youth involved in the church, those with controlling parents, those who had decided to wait, those focussing on their studies, those who were afraid, those who were “nerds” or not attractive, and children who were not sufficiently mature.

The immediate response to the question of abstinence was often to mention “church girls” or “church boys” who are heavily involved in faith based organizations. The influence of religious teachings about waiting for sex until marriage was seen to be strong. Youth who went to church were often also under heavy parental supervision so had few opportunities for relationships.

People who concentrated on their school work were also seen as likely to stay away from sex. Some groups lauded this behaviour in terms of what could be achieved through studying, but studious girls and boys were described by others as unattractive. The “nerd” label was particularly likely to be applied to boys. Male nerds were mocked for being uninterested in females and being shy and awkward in their movements. Boys who did not have sex were sometimes labelled as homosexual.

Girls were said to be afraid of the consequences of sex, such as pain and bleeding from first intercourse, parents finding out and pregnancy. Males were also said

to be afraid of losing control, getting a girl pregnant and not being able to take up the responsibility.

##### *Influences on sexual activity*

##### *Male obligation to have sex*

It was felt that males had choice about when to have sex, since they were goal-oriented and ideally could control sexual situations. But male participants found it difficult to accept that a male would refuse or not want sex, and said this would only happen if the girl was ugly or had a serious disease such as AIDS. Some girls said that they thought all boys had sex by their age, or at least they boasted about it and spread stories about girls with whom they said they had had sex.

Girls were generally portrayed in a relatively passive role in sexual encounters, being persuaded, coerced or forced to have sex, with a few still managing to abstain as noted above. Male participants acknowledged that women could be raped and in these circumstances had no choice, but also emphasized that girls had to make the choice to refuse sex to maintain their good name. Thus they highlighted one of the contradictions of femininity, that chastity must be guarded but that men can force them to have sex.

##### *Persuasion, coercion and violence*

Tactics used by males to persuade girls to have sex included referring to how long they had been seeing each other, implying that sex was necessary for the relationship to be serious and sustained. Boys would also refer to friends who were having sex in order to persuade their partner to do so. Some were coercive, threatening to leave their girlfriend for another partner or becoming violent.

Some girls spoke of incidents of incest involving older male relatives. This often happened when the mother went out and left the daughter with her father or uncle. It was also an outcome of living with many relatives in the same house.

Some children were said to become sexually active at a young age because they had seen sex acts. Exposing young children to seeing sex was sometimes regarded not as intentional but as resulting from neglect on the part of the parents.

Among some participants there was a subtext of females being at least to some extent responsible for the behaviour of males. Dressing in revealing clothing was seen as a justification for rape. A phenomenon referred to in three FGDs from three countries was group sex or gang rape of girls. Some important features were apparent from what the groups said about this activity. One is that gang rape was conceptualized as an outcome of unacceptable female behaviour. Secondly, it was a humiliation, partly because several people would have observed the girl having sex. Thirdly, participation in group sex was a result of low self-esteem



among girls and a misguided desire to fit in. Gangs of boys were said to pick on lonely girls they saw as weak. Acceptance into some male gangs called for sharing the same partner, sometimes through a ritual group sex event or rape.

#### *Peer pressure, materialism and transactional sex*

Peer pressure was a major factor in males having sex and being involved in sexual violence. The culture of materialism also played a major part, with sex being a medium of exchange to advance economically and socially through the acquisition of goods. Offering certain sorts of goods was thought especially powerful in persuading girls and some boys to have sex, especially Blackberry cell phones and other flashy brand name items. Girls referred to seeing friends with these things but knowing that their parents could not afford to give them. Older partners were seen as more successful than school-age boys in persuading girls to have sex because they had the resources to provide these goods to their partners. Drug dealers were said to be offering smart phones to young people to obtain their loyalty and sometimes to have sex with them.

#### *Popular culture and pornography*

FGD participants noted the influence on sexual behaviour of popular culture, especially Jamaican dancehall music. They also noted that young people were now exposed to pornography via new technologies such as DVDs, the internet and cell phones. Music videos sometimes contained sexual language and pornographic images that could influence young people. Pornography is now highly accessible to young people, and participants noted that girls as well as boys watched it. Young people of both sexes were actively involved in the production and transmission of pornographic material via cell phones or the internet.

#### *Condom use*

It was generally agreed that only some young people used condoms and that use was inconsistent. FGD participants said that the main reason for use was to prevent pregnancy. Male condoms were known by participants in all FGDs and were generally believed to reduce sexual pleasure. The terms “raw” or “bare” were widely used to describe unprotected sex, and males tended to say that females wanted “raw” sex, while females said that it was males that wanted this. It was noted that in the heat of the moment people would not focus on condom use. Some boys were said not to care if they contracted HIV or got someone pregnant because they were focussed only on getting sex and would deny responsibility if they did get a girl pregnant. Participants in several FGDs said that some young men would resist condom use or would damage condoms by putting holes in them. The threat of withdrawal of gifts in transactional sexual encounters also prevented condom use. Condom use usually ceased within relationships once the couple had made the transition to becoming “serious” or stable.

Female condoms were known by many of the participants but there was no

evidence that any had used them. A few had seen female condom demonstrations and others had learned about them from television or books.

#### *Alcohol and drug use*

Participants appeared familiar with the effects of alcohol on the sexual behaviour of youth. Males were thought to become more sexually aggressive and to harass girls when they were drunk, with some incidents of rape associated with drunkenness. Alcohol was also said to be a factor in females having multiple partners. Marijuana was mentioned in some FGDs but was not thought to lead to the degree of lack of sexual self-control associated with alcohol. Use of aphrodisiacs such as Spanish Fly were mentioned by a few participants.

#### *Vaginal practices*

Very few participants had heard the word “douching” though some were familiar with Summer’s Eve and similar products whereby liquid is squirted into the vagina to cleanse it. Females were said rarely to use these products. However, some would use them to remove sperm after sex for contraceptive purposes or to remove blood at the end of the menstrual period. Girls with multiple partners were seen as more likely to use them to remove sperm and to remove unpleasant odours that may be associated with STI. These girls may be at especially high risk from their use. Some substituted vinegar or hand sanitizer for commercial douching products.

Several participants indicated that they knew that it was important not to disturb the vaginal flora or chemical balance through douching as the vagina could “clean itself”. Regular bathing routines would not include cleaning inside the vagina but would usually consist of cleaning the external genitalia with some combination of water, soap or body wash and a wash cloth.

Participants in several FGDs noted practices designed to make the vagina seem tighter and thus enhance the sexual experience. These included the insertion of sea water, blue soap or other household cleaning products.

#### *Penile hygiene and male circumcision*

Some participants knew of young men who had been circumcised at birth, but it appears that this practice was uncommon. Boys had been taught as part of their daily hygiene routine to pull back the foreskin of the penis and use soap and water to clean underneath.

Most participants had not heard about the research showing that male circumcision can reduce the risk of female to male HIV transmission by 60 per cent. Participants generally felt that young men would be interested in having the option of accessing safe, voluntary medical male circumcision (VMMC) services if they were offered, in order to be protected against HIV. However, they also said that some young men would be anxious about safety, the pain of the operation

and about people operating on their private parts. It was noted that male uptake of preventive health care was low and this might also affect uptake of VMMC. One participant thought that removal of the foreskin might reduce sexual pleasure.

### *Teenage pregnancy*

Participants in all groups knew of at least one girl who had become pregnant. The experiences of these girls were generally portrayed in negative terms. It was said that some teenagers became ashamed and depressed. Participants in several groups pointed out that teenage mothers often had to stop their education. Teenage pregnancy had an intergenerational impact, being associated with poverty and crime. Many teenage mothers were abandoned by the fathers and, less frequently, by parents as well.

Young fathers still in school were generally seen as unsupportive, denying fatherhood, trying to persuade the girl to abort or in any case being very anxious about the implications for their own future. Older partners had more resources to support mother and child but abandonment was also common, partly because of fear of legal censure if the girl was below the age of consent. Most parents, after the initial shock and disappointment, provided support for the mother and often child care to enable her to return to studies or get a job. Supportive services and assistance with continuing with education were available in some but not all places.

Faced with dim prospects for the future, some pregnant teens sought abortions, known as “throwing” the foetus. Participants in Dominica mentioned drinking hot Coca-Cola or taking paracetamol as a way to cause a miscarriage, while in St. Vincent and the Grenadines they would drink hot Guinness and Epsom salts for the same purpose. Abortions are illegal in project countries but it seems that some young women were able to obtain them. However it was acknowledged that they posed risks to the health of mothers.

### *Health service responses*

The gender and age of patients were said to condition the response of health care workers to the sexual and reproductive health needs of their patients. With regard to condom provision, they often asked young people why they wanted condoms and, while usually providing them, would accompany this with questioning about the girl's or boy's sex lives and who they were having sex with. They would also suggest that the parents should know and sometimes that the child should attend church. They were more likely to do this with girls than boys, and girls regarded the questioning and comments as unhelpful and intrusive. Some boys, on the other hand, said that the girls were receiving education that they would like to receive from health care workers. Some health care workers required the parent to come along when condoms were sought for a child under 18. Some participants held the view that younger health care workers were more friendly and understanding than older ones.

Participants were concerned about levels of confidentiality in public services and several said young people chose to avoid them or use private organizations instead. This included buying condoms from pharmacies, but there were concerns about confidentiality there too. Some young people would seek HIV tests from National AIDS Programmes or NGOs but many were concerned that others would see them there and spread rumours. Private HIV testing was sought but was unaffordable to many.

## **DISCUSSION AND RECOMMENDATIONS**

This study includes secondary and primary data collection and analysis in four countries on a wide range of dimensions of sexual and reproductive health and rights. The challenges facing youth have been shown in quantitative and qualitative research to be numerous. At the macro level, economic conditions are not promising in terms of young people obtaining gainful and fulfilling work opportunities, while consumer culture and technological innovation have bred new temptations and aspirations. Sexual behaviour and crime are conditioned by this context, with new challenges posed by easy access to the internet and pornography. The research has shown that many young people are not being equipped with the skills they need to navigate these challenges and enjoy a brighter future with safe and fulfilling sexual relationships and reproductive health.

We now summarise the recommendations put forward by young people and add a few more relating to policy and legal reform. Given the multiple challenges identified in this report it is difficult to be comprehensive with regard to recommendations and the following may be regarded as preliminary and may be supplemented by others through discussion with stakeholders and experts.

### *Recommendations from young people*

The recommendations from FGD participants can be grouped under several headings.

#### *1. Greater involvement, greater respect*

A major theme in participants' recommendations was the **greater involvement** of young people and **greater interactivity** in teaching methods, accompanied by **greater respect** for the voices of youth. Participants called for **discussions** of sex, sexuality and methods of protection, in contrast to the one-way, didactic teaching style adopted at school. They wanted “more talk about sex in school and at home” and also on the television and radio. It was suggested that learning had become too individualistic and there was a need to go back to the days when



groups used to sit down and debate things together.

There were also calls for people who wanted to promote the sexual and reproductive health of young people to draw on the sexual *experiences* of themselves and others, using *personal scenarios* and stories to engage young people, interest them and imagine how they would respond to a similar situation, thus sharpening their problem-solving skills. Participants called for better communication with parents, who should also be encouraged or even trained to use their own experiences to teach their children.

*Community outreach* was thought necessary, especially for vulnerable and out-of-school youth.

*Counselling* was suggested as another interactive method to include young people in addressing their own challenges. More counsellors should be available in schools and in community settings.

*Specialist youth health services* should be developed, employing people with a strong interest in helping young people, including at least some workers who are young themselves.

Young people should be assisted in *forming organizations and fund-raising* to develop campaigns to improve sexual and reproductive health.

## 2. Greater confidentiality

Given the call for experience-based learning, the need for *confidentiality* of personal information becomes all the more pressing. All people, including young people, who are involved in delivering sexual and reproductive health education and other services to youth should undergo *training stressing the human right to privacy and the duty to protect confidentiality*. Sanctions should be applied, including dismissal, for personnel who break confidentiality.

## 3. Improve access to biological prevention methods

Participants suggested that *young people should have more involvement in the provision and distribution of condoms* and this would remove the perception that older people were judging them and trying to restrict them.

Community outreach should include HIV testing and provision of male and female condoms at events and through non-traditional outlets.

Girls at high risk should be provided with *education about the risks of douching* as well as with condoms and contraceptives. Community workers should assist in identifying girls at high risk who may be involved in activities such as alcohol consumption and transactional sex as well as multiple partnerships

*Voluntary medical male circumcision* should be among the services offered in a comprehensive package of sexual and reproductive health care services for men. This would necessitate thorough training and quality control with respect to service safety, as well as awareness campaigns, following guidelines developed by the WHO and UNAIDS.

## 4. Improved support for teenage mothers

The *right to education* should be assured in all countries and this should be supplemented by special facilities such as *nursery care and business training* centres for young mothers alongside good *advice on child care and how to access existing services and get back to school*. They should be assisted in attending another school if they feel uncomfortable attending the school they were at when they became pregnant.

## ADDITIONAL RECOMMENDATIONS

The research points to the need to *prioritize the employment of youth*, not only as a poverty reduction strategy but in the interests of sexual and reproductive health. In this regard special attention should be paid to the provision of *attractive income-earning and career opportunities*. For young men, these should give them greater incentive to focus on obtaining academic or vocational qualifications and disincentives to multiple sexual partnerships and violence against women and girls. Males should be engaged in further discussions of the challenges they face and how these relate to issues of *masculinity*, while being presented with alternative opportunities and role models.

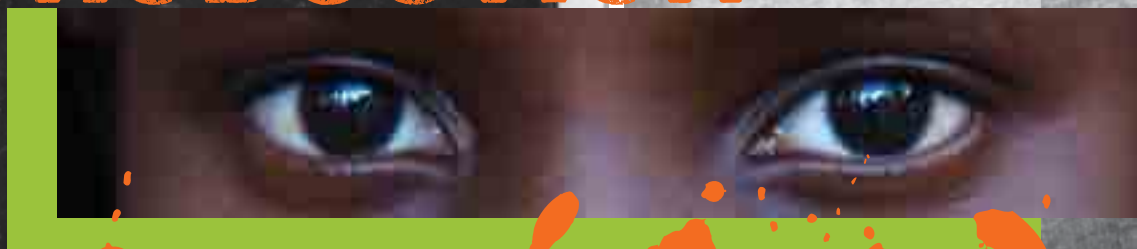
Existing *laws relating to sexual and domestic violence should be better enforced*, with attention being paid to the long-term welfare of children as survivors or perpetrators. There is also a need for laws, policies and protocols to address child pornography and transactional sex.

The research suggests the *critical roles of parents, teachers and religious leaders* in the response to sexual and reproductive health challenges of youth, since “connectedness” with parents, schools and church can protect children from risky activity. In all these three institutions, adults should seek closer, more trusting and respectful relationships with children, especially with regard to discussion of sexual matters. Experts in adolescent development and communications experts should assist and train parents, teachers and religious leaders in ways to improve communication and dialogue with young people, especially around sensitive issues such as sex among youth.

Attention should be paid in schools to *improve HIV knowledge* using the teaching and communications methods recommended above. Interactive methods should also be used to *discuss how HIV stigma relates to personal moral values and especially compassion*, with a view to developing more helpful and less discriminatory attitudes to vulnerable populations.



# INTRODUCTION



**The United Nations Population Fund (UNFPA) Sub-Regional Office for the Caribbean/Barbados** is working to strengthen the evidence base on adolescent and youth sexual and reproductive health and rights in four countries: Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. The research presented in this document aims to generate new knowledge and provide the baseline data to inform the development of programmes to support adolescent and youth sexual and reproductive health and rights. It also aims to inform UNFPA's 2012 – 2016 programme of assistance to these English-speaking Windward Islands. The research comprises three components:

1. Desk review
2. Consultations through interviews with key stakeholders
3. Focus group discussions with young people

## INTRODUCTION



**THE METHODS** DESCRIBED IN THIS SECTION WERE PRESENTED IN A RESEARCH PROTOCOL DOCUMENT THAT WAS APPROVED BY THE ETHICS REVIEW COMMITTEES IN THE FOUR COUNTRIES, AS WELL AS BY THE INSTITUTIONAL REVIEW BOARD OF ST. GEORGE'S UNIVERSITY.

### 1.1 DESK REVIEW

The desk review aims to provide existing evidence on the vulnerabilities of adolescents and youth to STIs, HIV and unintended pregnancies and on the sexual and reproductive health services available to them. It seeks to collate and present existing information on the sexual and reproductive health of young people aged 10-24 in the four project countries. It seeks to answer the following research questions:

**1. What is the status of youth sexual and reproductive health?**

Epidemiological data and statistics on HIV, STI, pregnancy and maternal health have been sought, presenting trends over time and disaggregating by age group wherever existing data allow.

**2. What is the existing evidence on the risk and protective factors for sexual and reproductive health among adolescents and young people? What are the social and economic vulnerabilities that have been identified in research to date?**

Existing qualitative and quantitative research studies and surveys have been reviewed to answer these questions. Studies from the wider Caribbean or further afield are presented if insufficient information is found for the project countries. A comparative analysis of the vulnerabilities and risks faced by in-school and out-of-school adolescents and youth has been conducted to the extent that the data allow.

**3. What are the existing health and social services and policies relating to youth sexual and reproductive health?**

This question has been answered primarily by the interviews with stakeholders described in the section on *Stakeholder interviews: Responses to youth sexual and reproductive health in the Eastern Caribbean*. Policy documents and legal analyses relating to youth sexual and reproductive health have also been reviewed.



Documents have been accessed via online searches and through email communications with authors of particular studies. Additionally, some reports were provided by stakeholders during visits to project countries.

## 1.2 STAKEHOLDER INTERVIEWS

An interview guide was administered to stakeholders involved in or with an interest in the design and delivery of sexual and reproductive health services to youth in each country. These included:

- Youth advocates and representatives of organizations of young people.
- Senior civil servants in ministries with responsibility for youth, health, gender, education and social security/ welfare. Managers of national AIDS programmes, public assistance and child welfare services have been included.
- Non-governmental organizations, e.g. with a focus on family planning, HIV prevention, empowerment of people living with HIV, empowerment of women, disability, violence against women or youth employment/ livelihoods.
- Managers of key facilities providing services to young people.
- UN counterparts implementing programmes with a focus on youth, adolescents and HIV.

The emphasis in selection was on including *key stakeholders* with a professional and personal interest in sexual and reproductive health of young people. The Project Advisory Team advised on the selection of appropriate people.

These interviews did not ask for personal information and were not considered to pose considerable risk to participants. Prior to the interview, interviewees were provided with an introductory document about the project [Appendix 1] followed by a verbal statement about their potential role in it [Appendix 2]. The statement outlined the purpose, methods, risks and benefits of the research. Verbal consent was sought.

Interviews were recorded using a digital voice recorder. Following each interview, the digital voice recording or notes were reviewed and converted into summary form. If a potential interviewee refused digital recording, notes were written during the interview and written up within two days to maximize recall. For each agency, a separate summary on findings was written, using the questionnaire headings and questions to structure the data.

Appendix 3 presents the interview guide. Basic demographic information (age group and sex) was collected to enable description of the sample. Following this, open-ended questions were used to generate descriptions of services, youth access to services, policies and protocols, views on the vulnerabilities and protective factors for young people and recommendations for action.

## 1.3 FOCUS GROUP DISCUSSIONS WITH YOUNG PEOPLE

It is important that the voices and opinions of adolescents and youth be reflected in any project designed to benefit them, and that projects are built on understanding of their experiences and challenges. This will help maximize responsiveness to the issues that are important to them. In addition to including youth advocates among stakeholder interviewees and collating existing information on adolescents and young people age 10-24, the project collected primary data among young people in the especially vulnerable 15 to 17-year age group. The rationale for focusing on this demographic is that they are often engaged in or contemplating sexual activity, yet do not have full access to sexual and reproductive health services, mainly because they have not yet reached the age of 18 when they attain legal majority.

A qualitative methodology, involving focus group discussions (FGDs), was chosen for the following reasons:

- This research is exploratory, seeking to identify issues of importance to young people.
- There is little or no information on some key issues for young people in these countries (e.g. genital hygiene).
- Open-ended rather than structured questions are appropriate to enable young people to define the issues that are important to them, and the solutions.
- It is important to know why and how vulnerabilities occur. Quantitative research using pre-defined questions is inappropriate to this.
- Face-to-face structured interviews have been shown to yield data of relatively low validity on sensitive sexual behaviour (*Plummer, Ross et al. 2004; Allen, Lees et al. 2007*).

Budgetary constraints also prevented the conduct of a quantitative survey. The qualitative data collected via FGDs are supplemented by a thorough analysis of quantitative and other surveys in the desk review.

FGD research questions

Via the FGDs, the research sought the views and experiences of young people with regard to the following questions:

- 1. What are the factors that drive youth vulnerability to HIV/STI/ teen pregnancy?
- 2. What are the factors that protect youth from HIV/STI/ teen pregnancy?
- 3. Why and how does youth vulnerability occur? [Processes, stories]
- 4. Why and how are some youth protected? [Processes, stories]
- 5. How would young people like things to change to reduce their vulnerabilities?

Analysis included looking at differences by sex, by country and between in-school and out-of-school youth.

Note that these questions were included in the semi-structured interview guide that was administered to stakeholders [Appendix 3], and the focus group data was triangulated by comparison with the stakeholder interview data as well as by the findings from the desk review. Questions 1 to 5 were translated into more specific questions to be asked by facilitators in the discussions themselves – see Appendix 8.

Sample selection

In each country, six FGDs were planned – a total of twenty-four for the study as a whole. The six were distributed as:

	IN-SCHOOL	OUT-OF-SCHOOL	OTHER AREA
MALE	1	1	1
FEMALE	1	1	1

The “other areas” were identified by Project Advisory Teams as presenting important cultural differences or particular vulnerabilities as compared with other parts of the country. These other areas are the Kalinago territory in Dominica, Carriacou in Grenada, a hurricane-affected village in St. Lucia and a Grenadine island in St. Vincent and the Grenadines.

Each FGD was designed to comprise five to ten male or female participants [up to sixty participants in each country]. For each FGD, ten participants were selected, allowing for non-participation of up to five in each group.

Project Advisory Teams advised on the schools to be included in the study. School registers of male and female students aged 15-17 were used to select the in-school sample. Students were made ineligible for in-school FGDs if they had missed school for more than eight days in the past eight weeks [>20 percent absenteeism]. Males and females were selected at random from the male and female sample frames respectively.

The Project Advisory Team also advised on the location and geographically-based sampling for the out-of-school youth. Within a selected village or other location, it was planned that key informants such as youth workers or youth advocates would be asked to list males and females age 15-17 who had left school or attended school for no more than sixteen days in the past eight weeks [>60 percent absenteeism]. Males and females were to be selected at random from the male and female sample frames respectively.

In the other areas, key informants were asked to list males and females age 15-17 who resided in the area for at least five days a week. Males and females were selected at random from the male and female sample frames respectively.

With the selection of only one school, one out-of-school location and one other area per country, it was not possible to generalize from the study to the country as a whole. However, the FGDs were a vehicle for young people to indicate their concerns and views that can form the basis for questions to be asked in national surveys using more representative sampling methods. In qualitative research, the objective is to develop rich understanding rather than description of the population as a whole. Sample size in qualitative research should be sufficient to reach “saturation” in understanding, where the addition of one unit of analysis [such as an FGD] would not yield major additional insights. Analysis builds up understanding iteratively through each successive piece of data collection [e.g. FGD] [Mason 2010]. Ideally data collection should continue until “saturation” is reached but in practice, as in this case, sample size often has to be pre-determined for budgetary reasons. The FGDs were designed to provide a picture of the vulnerabilities of youth age 15-17 from their own perspectives, with the data being supplemented by those from the stakeholder interviews and desk review.

RESEARCH ETHICS

The FGDs elicited collective views about the vulnerabilities of young people and did not delve into the personal sexual lives of individual participants. Nevertheless, there was the possibility that participants would experience distress as a result of the FGDs. In each country, at least one professional counsellor was recruited prior to the conduct of the FGDs to provide support on a referral basis to participants who experienced distress.



The age of the participants raised the question of informed consent among minors. Ethical guidelines recommend that consent from a “proxy” be sought in situations of diminished capacity (e.g. mental illness or disability) and where someone is needed to protect the interests of the person. “Diminished capacity” is arguably not the case for most 15-17-year olds, but the requirement of parental consent follows logically from the law. Parents or guardians of the selected children were contacted and provided with the project information document at Appendix 1. A covering letter from UNFPA noted that the selection of their child was done on a random basis, to assure parents that their children were not “singled out”. Parents were invited to a meeting at the school, village or other location from which the samples of young people would be selected. Three parent’s meetings were planned per country; one for parents of the in-school sample, one for parents of the out-of-school sample, and one for those from the other area. Parents of both male and female potential participants were included in each. The meetings were facilitated by the same facilitators who were to conduct the FGDs. At these meetings the purpose, methods, risks and benefits of the research were explained and the opportunity given to ask questions. In particular, it was noted that for reasons of confidentiality the information gathered about particular participants during the FGDs would not be shared with parents or guardians by the research team. Following the meeting the parents were asked to sign the informed consent form at Appendix 4.

Some parents or guardians may have been unwilling or unable to attend these meetings. The introductory letter offered them the option of signing the consent form without attending the meeting. For those who did not return the consent form or participate in the introductory meeting, members of the research team followed-up with phone calls or visits to collect forms or to find out whether non-response meant refusal for their child to participate. Up to three attempts were made to reach each parent. If all three attempts at contact were unsuccessful the child was not chosen to participate in the study.

Assent to participate was also sought from the selected young people whose parents or guardians consented. In the process of inviting each person via phone or in person to participate in an FGD at a particular place, date and time, members of the research team verbally explained the study to them, outlining the purpose, methods, risks and benefits of the research. The young people were told that there would be further opportunities to seek clarification when they assembled prior to the FGD itself. When the young people gathered for the FGD, the first part of the meeting was dedicated to seeking informed assent from the potential participants. Following an “icebreaker” activity, the purpose, methods, risks and benefits of the research were reiterated, adhering to the guidelines in Appendix 5, and each potential participant was invited to sign the assent form [Appendix 6].

The young people selected to participate in the FGDs were provided with transport or with funds to cover transport to the FGD venue. They were provided with juice on arrival at the venue and hot and cold drinks and snacks following the end of the FGD.

In social research, there are issues of power/authority and potential for breaches in confidentiality depending on the location of data collection. For instance, locating an FGD on school premises might lead student participants to be cautious in their responses because of the fear that teachers would find out what they had said. The locations for FGDs were closed areas where it was not possible for outsiders to overhear or see the proceedings. The Project Advisory Team was asked to identify suitable spaces in each country for FGDs to take place.

DATA COLLECTION INSTRUMENTS

A short questionnaire was used to collect socio-demographic characteristics immediately prior to the FGD [Appendix 7]. This was self-completed by each participant after the facilitator read out and explained how to complete it. The data was used in the final report to describe the sample.

The topic guide for the FGDs is presented in Appendix 8.

DATA MANAGEMENT

For data management purposes, codes were used to refer to each FGD and each FGD participant as follows:

- D = Dominica   G = Grenada   L = St. Lucia   V = St. Vincent and the Grenadines
- M = Male   F = Female
- I = In-school   O = Out-of-school   T= Other area
- 1 to 10 = Participant identification number

Thus LFT8 is female participant number 8 in an FGD in St. Lucia in the selected “other area” [hurricane-affected village]. These codes were matched with a list of participant names kept by the research team that will not be shared with anyone outside the team.

### SELECTION AND TRAINING OF FGD FACILITATORS

Local facilitators were selected and trained to conduct the FGDs. The aim was to match facilitators and groups by sex. However, there were challenges in recruiting male FGD facilitators and all the facilitators except one were female. The male facilitator conducted the male FGDs in his country (St. Vincent and the Grenadines). The facilitators were selected from lists of recommended candidates provided by local Project Advisory Teams and other stakeholders. They were professionals or peer educators/youth advocates with a record of working with and for young people and who were generally agreed to have achieved the trust and confidence of young people on the basis of working on their behalf and not violating their confidences. Experience in conducting qualitative research and academic qualifications such as a social science degree were regarded as an asset but not essential.

The eight successful candidates were provided with FGD training over a three-day period. They were also provided with training in contacting and tracing selected respondents, providing them with information about the study, and on the informed consent procedures to be followed with parents and young people. FGD training itself included practice sessions and commentary on the research instrument, which was then slightly revised. Facilitators were also trained in how to transcribe the discussions.

### DATA ANALYSIS

To ensure a full record of what was said by young people, the FGDs were fully transcribed. The transcription of each interview was analysed using qualitative data analysis software (QSR NVivo 9). The text was first coded into categories defined by the Lead Researcher and based on the FGD topic guide and previous research. Codes were also developed for portions of text based on themes emerging from the data. Qualitative data analysis software enabled coding under more than one theme and the exploration of connections between themes. Analysis proceeded iteratively to develop “grounded theory” of youth SRH, i.e. based on the views and experiences of young people themselves (Charmaz 2006). This final report makes extensive use of quotations, showing the sex, in-school/out-of-school/other area status and country of the person quoted.

### LIMITATIONS

The focus groups focussed on youth aged 15-17 rather than the full age range of 10-24 covered by the full research project. This limited age range was chosen in order to explore in depth the issues for a highly vulnerable population of young people. Given budget and time constraints, it was not possible to carry out separate FGDs for younger and older youth. Existing studies for youth aged 10-24 have been included in the desk review.

Qualitative research does not allow generalization to the entire population of young people in a country. However, the samples have been selected to reflect some level of diversity with respect to in-school and out-of-school youth and geographic area. The qualitative research is supplemented by the desk review that includes existing quantitative samples providing broader representation of youth. The qualitative research may reveal new concerns for young people that can be explored further in quantitative research.



# DESK REVIEW

## 2. DESK REVIEW: YOUTH SEXUAL AND REPRODUCTIVE HEALTH IN THE EASTERN CARIBBEAN

This desk review aims to generate a rounded picture of youth sexual and reproductive health in each of the four countries in the study - Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. It draws on documents provided by stakeholders in each country as well as other sources gathered from searches by the researchers. It starts by analysing epidemiological evidence for youth on HIV, STIs and pregnancy and maternal health in women and girls under 25 [sections 2.1 to 2.3]. Section 2.4 gives contextual information on the social and economic status of youth. Section 2.5 looks at risk and protective factors for sexual and reproductive health among young people. In this section we include various qualitative and quantitative studies of sexual behaviour, knowledge, attitudes and beliefs among youth. Section 2.6 looks at biological risk factors for HIV and STIs. Section 2.7 examines the social, economic and cultural environmental factors that affect the

## DESK REVIEW: YOUTH SEXUAL AND REPRODUCTIVE HEALTH IN THE EASTERN CARIBBEAN

### 2.

vulnerability of young people. This includes sections on gender-related norms and transactional sex, “clustering” of risk factors among a minority of youth, gender-based violence, drug and alcohol use, stigma and discrimination and vulnerable populations.

Published data on HIV are much more plentiful than for STIs and teenage pregnancy. In section 2.1 to 2.3 we present available data on each of these.

#### 2.1 HIV

In this section, we report on epidemiological data on HIV. In section 2.5, behavioural data from Knowledge, Attitudes, Beliefs and Practices and Behavioural Surveillance Surveys are included in the analysis of behavioural risks.

The Caribbean region has an adult HIV prevalence of about 1.0 percent that is second only to Sub-Saharan Africa [Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010]. The number of people living with HIV (PLHIV) in the Caribbean, around 240,000, has not shown much variation since the 1990s. - AIDS related deaths also declined during this same time period from an estimated 19,000 in 2001 to 12,000 in 2009 [Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010b]. This decline is attributed to increasing coverage of antiretroviral treatment in the Caribbean [Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011]. Compared to 2001, the overall reduction in new HIV infections in 2009 was 14.3 percent as new HIV infections dropped from 21,000 to 18,000 [Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011].

The first cases of HIV in the Caribbean were found among men, but increasing numbers of women are contracting the disease. Fifty-three percent of people living with HIV (PLHIV) are women and 47 percent are men [Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011]. However this situation is skewed by data from Haiti and the Dominican Republic where 68 percent of Caribbean PLHIV live, and where more women are living with HIV than men. In most other Caribbean countries there are more males than females living with HIV.

In the four countries in our study, the bulk of HIV infections are found in men [see below]. This high percentage of HIV in men provides support for the idea



that the epidemic may be concentrated among men who have sex with men (MSM) (United Nations General Assembly Special Session [UNGASS] 2010). At the same time, there is also a culture that condones men having multiple, concurrent female partnerships, which amplify HIV risk (Bombereau and Allen 2008). Epidemiologists have shown that concurrent partnerships carry greater risk of HIV transmission than monogamy. This is because HIV is most easily transmissible in the immediate post-infection phase, and any of the man's partners can bring a new infection into his sexual network (Pisani 2011). Thus those men who have concurrent partners are at especially high risk.

The economic climate, poverty, and the new information age have altered patterns of sexual behaviour (UNAIDS, 2008). Unprotected sex between men and women is thought to be the main mode of HIV transmission in the Caribbean, with transactional sex (the exchange of sex for money, goods, or security) thought to play an important role (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2010b). However, sex between men also plays a major role and prevalence surveys among men who have sex with men have revealed HIV rates in excess of 20 percent (UNAIDS 2010) although differing levels of openness about sexual orientation pose challenges to arriving at accurate estimates of prevalence in this population.

Young people should be considered a priority population in national responses to HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2010a). A variety of factors place young people at the centre of HIV vulnerability (Ogunnaike-Cooke 2007). These include lack of information on sexuality and HIV/AIDS, low perception of personal risk for HIV, inadequate access to prevention and HIV testing services and a low adoption rate of known prevention methods. Young females are of particular importance since it has been found that HIV is several times more prevalent among them than among young males in the same age group in several Caribbean countries. Young people are thought to be receptive to behavioural change. If they are given the correct information and introduced to safe practices about human sexuality, HIV and other sexually transmitted infections, they will have the ability to protect themselves against HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS] 2010a).

2.1.1 DOMINICA

The first documented case of HIV/AIDS in Dominica was in 1987 (United Nations General Assembly Special Session [UNGASS] 2008). In Dominica the HIV prevalence at 0.75 percent is somewhat lower than in the rest of the Caribbean and in 2009 the cumulative figures stood at 350 reported cases (United Nations General Assembly Special Session [UNGASS] 2010). Over the years 1997-2009, the Health Information Unit (HIU) documented 77 HIV-related deaths. Additional information from the HIU shows a decrease in HIV-related mortality since 2005 (United Nations General Assembly Special Session [UNGASS] 2010).

In Dominica, the male to female ratio of HIV cases has fluctuated widely over time, ranging from 0.8 to 15 male cases for every female cases by year from 1987 to 2006. The wide fluctuation is likely to have resulted from the small numbers of HIV diagnoses; no more than 24 in any one year (Dominica National HIV and AIDS Response Programme 2006). Between the first case of HIV diagnosed in 1987 and 2010, 350 cases of HIV were confirmed in Dominica, of which 70% are among males (Dominica Ministry of Health, Public Health Agency of Canada et al. 2011)

Those within the 25-44 age group are most affected, with close to 70 percent of reported HIV/AIDS cases occurring in this age group (United Nations General Assembly Special Session [UNGASS] 2008). However, people under 25 may be more affected than apparent from the statistics because rates of testing are low among them and HIV symptoms may not be apparent until they are older. Testing is much higher among females than males in the age categories 15-19, 20-24, and 25-34 age groups, probably because of testing in the antenatal period.

The table on the following page presents data on the number of reported HIV cases among 10-24-year olds for 2000 to 2010. A total of six male and 10 female cases were reported in this age group over the period, reflecting the predominance of females among HIV cases in this age group in the Caribbean. The figures are likely to be underestimates as many HIV cases go undiagnosed and some are detected at older ages. None of the reported cases were among 10 to 14-year olds; three were among 15 to 19-year olds and the rest were among 20-24-year olds.

Table 1: Dominica:  
Number of reported  
HIV cases among  
10-24-year olds,  
2000 to 2010

		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
HIV	Male	0	0	3	0	0	0	0	1	1	0	1	6
	Female	1	1	0	1	0	1	1	0	1	2	2	10
	Total	1	1	3	1	0	1	1	1	2	2	3	16

Source: Health Information Unit, Ministry of Health

Seroprevalence studies carried out by the Caribbean Epidemiology Centre (CAREC) in prisons in six Eastern Caribbean countries in 2004-5 showed overall HIV prevalence of 2.8 percent among male incarcerated populations. HIV prevalence among inmates of the prison in Dominica was 2.6 percent. The authors of the CAREC study concluded that HIV prevalence among male prison inmates was three times higher than the estimated Organisation of Eastern Caribbean States (OECS) population prevalence in 2003, slightly higher than the prevalence among incarcerated males in the United States of America and Canada. Preventative services, voluntary counselling and testing, and appropriate care and treatment should be available to all inmates as this would be an opportunity for many who might not otherwise access these services (Boisson and Trotman 2009). This is



an important vulnerable group that moves in and out of the general population, and many male inmates are under the age of 25.

In 2010, the Dominica Ministry of Health conducted a pilot HIV seroprevalence and behavioural study with men who have sex with men (MSM) to obtain preliminary results to guide programmes and to lead to the development of a protocol for HIV surveillance in this population. The report of the anonymous, cross-sectional study of MSM was submitted to the funding agency, the Pan-American Health Organization in 2011. Participants were sampled through chain-referral sampling and, when necessary, convenience sampling. The target survey sample size was 100 MSM and participants had to be 16 years or older and live or work in Dominica. Behavioural data were collected using an interviewer-administered questionnaire. Interviewers were members of the local and/or regional MSM community who were provided with specialized training for this project (Dominica Ministry of Health, Public Health Agency of Canada et al. 2011).

There were 72 participants who gave informed consent and 65 gave an oral specimen. Five of the 65 had inconclusive results. The prevalence of HIV in this sample was 26.7 percent. The following table shows that HIV was less prevalent among the under 25-year olds than among the older men (16.0 versus 34.3 percent HIV positive respectively).

HIV Prevalence	Age group				Total		No Report	Refused
	<25 years		<25 years					
	N	%	N	%	N	%		
Positive	4	16.0	12	34.3	16	26.7		
Negative	21	84.0	23	65.7	44	73.3		
Total	25		35		60		5	7

Source: Health Information Unit, Ministry of Health, Dominica.

These remarkable results appear to confirm high vulnerability among MSM in the Caribbean; recent studies with MSM in other Caribbean countries have shown HIV prevalence rates of up to 33 percent (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010a; Figueroa, Weir et al. 2011). They also suggest that the HIV epidemic is especially concentrated among this key population. The report points to the need for interventions and support for this vulnerable group, but caution should be exercised in interpreting the result since it was not possible to use probability sampling methods in this survey. The study report states:

One reason for the high prevalence in this sample is the strong connection that these participants have to the Caribbean HIV/AIDS Partnership (CHAP) Dominica, an organization which has a strong history of collaboration with the National HIV/AIDS Unit of the Ministry of Health. Most of the interviewers who were trained

are active members of CHAP and since the chain-referral method was used as well as convenience sampling, the participants of this survey are linked to them. Reasons for becoming a member of CHAP are not known, however participation in CHAP activities may be related to knowledge of one's HIV status, especially if HIV positive. Therefore, this seroprevalence figure may be an overestimate (Dominica Ministry of Health, Public Health Agency of Canada et al. 2001: 58)

The interpretation of the data is thus limited by the nature of the data collection methodology but represents the best information available presently. The study report notes that since 2005 the National HIV/AIDS Response Programme in Dominica has stepped up its efforts to reach this most-at-risk community so as to better understand their health needs and to plan targeted interventions for the prevention of HIV among this group (Dominica Ministry of Health, Public Health Agency of Canada et al. 2011).

2.1.2 GRENADA

Since the start of the HIV epidemic in 1984, a cumulative total of 403 HIV/AIDS cases were confirmed in Grenada up to the end of 2009 (United Nations General Assembly Special Session (UNGASS) 2010). Out of the 5,963 people tested in the years 2008 and 2009, there were 56 newly diagnosed HIV positive cases. The estimated prevalence rate was 0.57 percent and 0.56 percent in 2009 and 2008 respectively.

Table 3:  
Grenada:  
Cumulative HIV  
and AIDS cases  
and HIV Deaths  
from 1984 to  
2008

	Gender	HIV cases	%	HIV deaths	%	PLHIV [at the end of December 2009]	%
HIV	Male	184	70%	138	72%	n/a	
	Female	80	30%	54	28%	n/a	
	Total	264	100%	192	100%	381	100

Source: (HIV/AIDS Programme Surveillance Unit 2009 and Grenada UNGASS Report 2010)

As shown in the Table above, most HIV cases and deaths from AIDS are among males. The cumulative male to female ratio is currently 1.8:1 (United Nations General Assembly Special Session (UNGASS) 2010). Eighty-five reported cases (70 percent) and 76 (82.6 percent) of AIDS-related deaths were among persons aged 15-44 years old. Among 15-24-year olds, there are more reported HIV cases among females than males, as indicated in the data for 2009 in the table below. Girls and women in this age group may be at risk for HIV/AIDS because of associated factors such as child abuse, early sexual initiation and gender power issues among girls and young women.

A further point to note is that no new cases of infection were found among babies less than one year old. This finding indicates the success of the Prevention of Mother to Child Transmission (PMTCT) programme in Grenada, where the PMTCT coverage increased from 50% in 2008 to 100% in 2010 (United Nations General Assembly Special Session (UNGASS) 2010).

Table 4: Grenada:  
New HIV diagnoses  
by age group, 2009

	Female	Female %	Male	Male %
Age group	0	-	0	-
0 to 4	0	-	0	-
5 to 14	3	75%	1	25%
15-24	4	40%	6	60%
25-34	1	20%	4	80%
35-44	3	60%	2	40%
45-54	0	-	0	-
55-64	1	100%	0	-
65+	12	48%	13	52%
Total				

Source: HIV/AIDS Programme Surveillance Unit 2009

The primary mode of transmission is believed to be heterosexual intercourse. The key populations at risk of HIV contraction are said to include men who have sex with men, sex workers, prisoners, and female youth in particular (United Nations General Assembly Special Session [UNGASS] 2010). The 2004-5 CAREC study among male prison inmates showed HIV prevalence of 2.2 percent in Grenada.

2.1.3 ST. LUCIA

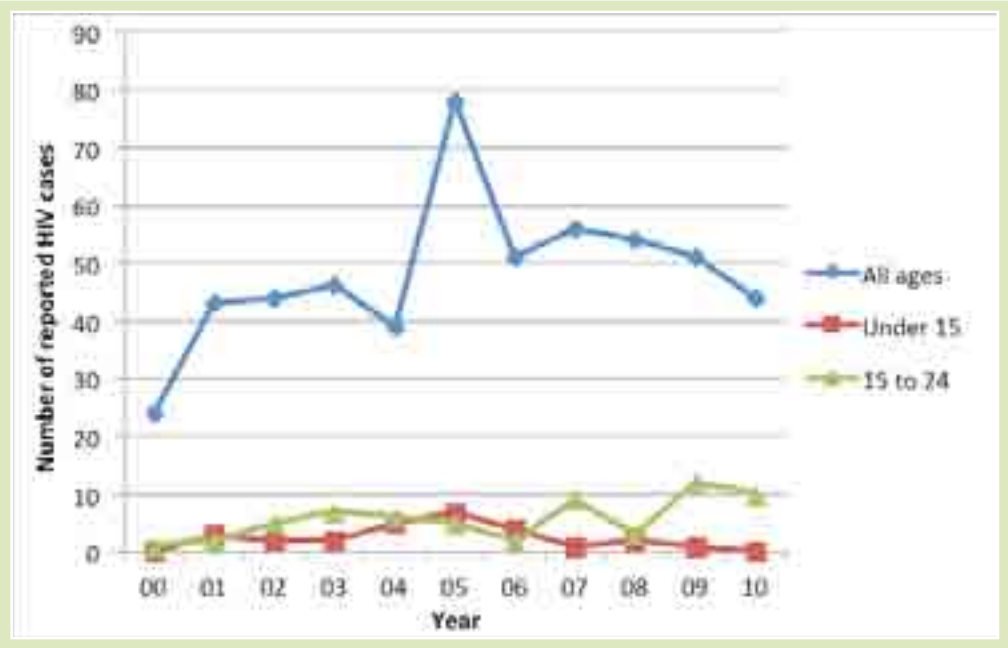
The first case of HIV was diagnosed in 1985 (United Nations General Assembly Special Session [UNGASS] 2009). By the end of 2009, a total of 760 HIV cases had been reported, of which 51.7 per cent were male, 42.5 per cent female and 5.7 per cent sex unknown. Of this total 314 (41.3 percent) cases have died. An increase in testing and improved reporting in 2006 (following commencement of a project funded by the Global Fund Against AIDS, Tuberculosis and Malaria) has led to an increase in HIV diagnosis. Deaths have seen a decline, particularly with the introduction of antiretroviral therapy in 2004. Except for prisoners and cocaine crack users, there have been no studies to determine HIV prevalence among key populations (United Nations General Assembly Special Session [UNGASS] 2009). This has resulted in a lack of adequate data to estimate the current HIV and AIDS prevalence in the country. Despite this and based on the current number of people living with HIV (PLHIV), from the National Register, St. Lucia UNGASS 2009 calculated a prevalence of approximately 0.28 percent. This is likely to be an underestimate, attributable to the lack of data on key populations, to data indicating that a significant amount of individuals are being first diagnosed at advanced stages of the disease and the lack of broad coverage and targeted services within St. Lucia's voluntary counseling and testing programme (United Nations General Assembly Special Session [UNGASS] 2009). Based on these factors, the population prevalence has been estimated to be approximately 0.9 per cent (Ministry of Health St. Lucia and National AIDS Program Secretariat 2010).

Of the 51 reported new cases of HIV in 2009, males made up 58 percent and females 42 percent (United Nations General Assembly Special Session [UNGASS] 2009). Males also made up a slightly larger percentage of those diagnosed with AIDS at 52 percent.

The age group with the highest numbers of reported HIV cases is those 25-49 years, with 22 reported cases in 2009 (United Nations General Assembly Special Session [UNGASS] 2009). The age group 15-24 made up 13.8 per cent of all people diagnosed and reported with HIV in 2009, while 0 to 14-year olds made up 9.7 per cent and 15-49-year olds 60.7 per cent (data supplied by the National AIDS Programme, St. Lucia).

The following chart shows numbers of HIV cases for 2000 to 2010, contrasting total figures with those for the under 15 and 15-24 age groups. As noted, the total jumped in 2005 and declined between 2007 and 2010. However, there has been a rising trend in numbers of HIV cases among 15-24-year olds since 2006. Reflecting gender-related patterns across the Caribbean, there was a higher percentage of female HIV cases among 15 to 24-year olds (54.8 per cent) than in the population as a whole (42.3 per cent) (data provided by the National AIDS Programme).

Figure 1: St. Lucia:  
Total number of HIV  
cases and number  
of HIV cases among  
young people  
15-24-year olds and  
under 15, 2000-2010



Source: HIV/AIDS Programme Surveillance Unit 2009

Between 2008 and 2010, there were 10 pregnancies among women diagnosed HIV positive and who were under 24 years of age. Four of the young women already had a child (data supplied by the National AIDS Programme).



The 2004-5 CAREC study among male prison inmates showed HIV prevalence of 2.0 percent in St. Lucia. A seroprevalence rate of 4.6 percent was found in a study among homeless and poor crack cocaine users in Saint Lucia [Day 2009]. While this is clearly an important key population in St. Lucia, it should be noted that of the 325 participants in the study, only 7.7 percent were in the 15-24 age group, while 83.0 percent of participants were over the age of 34. As will be shown below, young people in project countries are more frequent consumers of marijuana and alcohol than cocaine and crack.

#### 2.1.4 ST. VINCENT AND THE GRENADINES

The first case of HIV in St. Vincent and the Grenadines was diagnosed in 1984 [UNGASS 2006]. During the 1984-1993 time period, 128 cases were reported with an average of 13 cases per year. During the second decade [1994-2003] the number of cases increased to 560, an average of 56 cases per year, representing a four-fold increase from one decade to the next. In 2004, 108 cases were recorded, the highest number before a significant drop to 62 cases in 2005. Forty-six deaths were attributed to AIDS in 2008-2009 [United Nations General Assembly Special Session [UNGASS] 2010], a decrease of 32 percent from 68 total deaths in 2006-2007. St. Vincent and the Grenadines remains a low HIV-prevalence country with an estimate of 0.4% prevalence in the general population, based on cumulative reported cases at the end of 2006 [UNGASS 2008].

The male to female ratio averaged 1.3:1 with heterosexual contact as the most common form of transmission [UNGASS 2008]. AIDS-related deaths, which accounted for about 5 percent of total deaths, consisted of about 66 percent male and about 34 percent female deaths.

The age group 20-44 accounted for 70 percent of total cases, with teenagers representing 7 percent and the age group under five, 4 percent [UNGASS 2006]. Females outnumbered males in the age groups 15-19 and 65-69. All other age groups are dominated by males. This is also similar in the AIDS category with the 20-44 age group accounting for 67 percent of cases.

The 2004-5 CAREC study among male prison inmates showed HIV prevalence of 4.1 percent in St. Vincent and the Grenadines. This was considerably higher than the rate of 2.8 percent across the six countries in the study.

As in Dominica, the Ministry of Health in St. Vincent and the Grenadines has recently completed a pilot HIV seroprevalence and behavioural study with MSM in collaboration with the Public Health Association of Canada, CHAP, UNAIDS and PAHO. The results of this study were not publicly available at the time of data collection.

## 2.2 SEXUALLY TRANSMITTED INFECTIONS

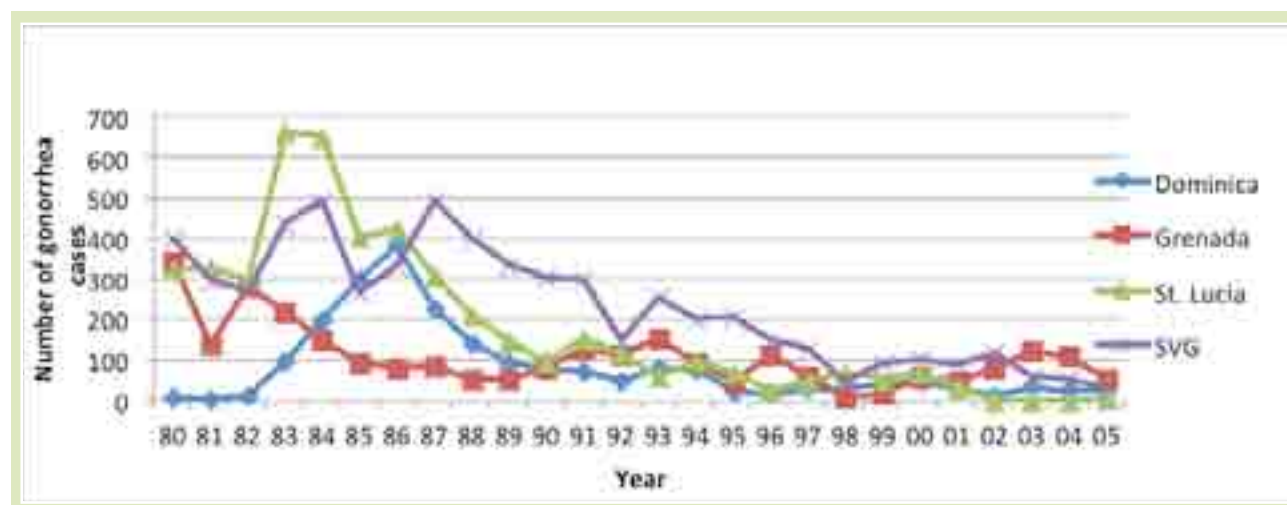
Gonorrhea, HIV, AIDS and syphilis are notifiable communicable diseases that have been reported to CAREC by its member countries since 1980. The CAREC website provides data on cases notified to them between 1980 and 2005. The following two sections provide data on cases of gonorrhoea and syphilis reported to CAREC by the four countries in our study over that period. This is followed by a discussion of STI surveillance since that period and analysis of self-reported sexually transmitted infection [STI] symptoms from surveys in the four countries.

### 2.2.1 GONORRHOEA

Gonorrhoea is a common sexually transmitted infection that is caused by the bacteria *Neisseria gonorrhoeae*. Symptoms differ between males and females in terms of course, ease of recognition and severity. Genital tract gonorrhoea can be treated successfully by single dose therapy if the causative organism is susceptible to the antibiotic used. CAREC member countries reported both confirmed and suspected gonococcal infections to CAREC, with 20 to 58 percent of cases being laboratory confirmed during 1995 to 2005 [Caribbean Epidemiology Centre Undated].

Fig. 1 shows that numbers of gonorrhoea cases reported in project countries were highest in the 1980s and this follows the general pattern across CAREC member countries. CAREC reports that numbers of cases across the region rose to a peak in the 1980s and fell from around 1987. There has been a slow gradual declining trend in numbers since the 1990s. The figures in the chart are absolute numbers, so the countries with smaller populations may be expected to have lower numbers of cases. Thus Dominica has the lowest numbers. However, St. Vincent and the Grenadines, with a total population size roughly the same as Grenada, had the largest number of cases for the four countries over the period. The total numbers of gonorrhoea cases in project countries over the entire period are 2,109 in Dominica, 2,741 in Grenada, 4,676 in St. Lucia and 5,966 in St. Vincent and the Grenadines. Between 1996 and 2005, CAREC reports that the countries that reported the greatest numbers of gonorrhoea cases were Jamaica [43 percent], Trinidad and Tobago [16 percent], Bahamas [11 percent] and Suriname [9 percent]. St. Vincent and the Grenadines, Belize, Bermuda and the Cayman Islands each reported approximately 2 percent to 4 percent of the total. Barbados did not report any cases for this period; the remaining countries each reported less than 2 percent of the total.

Figure 2: Number of gonorrhoea cases reported to CAREC, 1980-2005, in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines



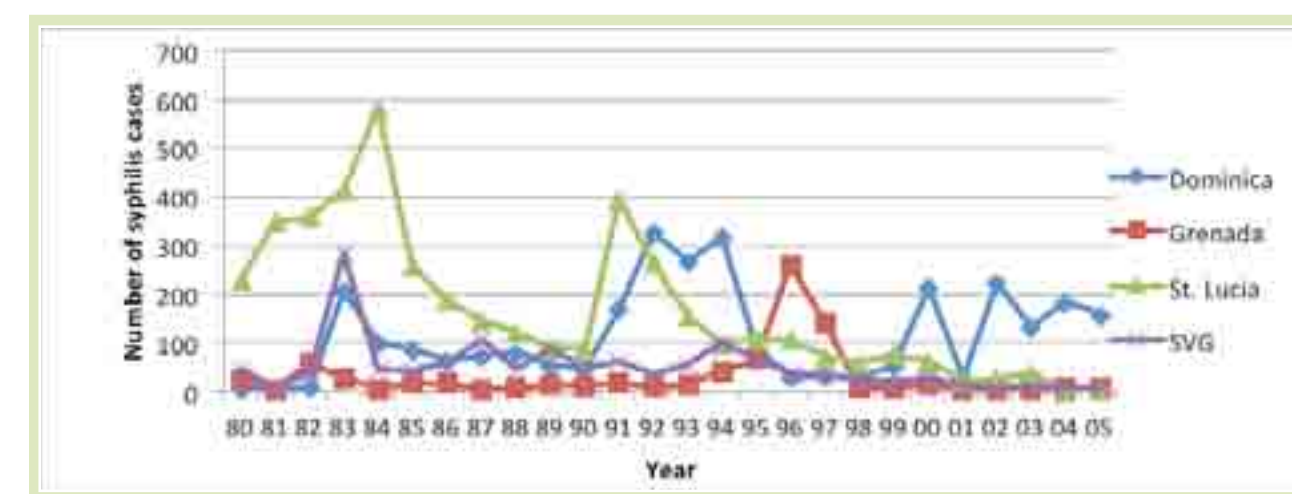
Source: [www.carec.org](http://www.carec.org)

### 2.2.2 SYPHILIS

Syphilis is a highly treatable bacterial disease, but can become chronic if not treated in the early stages, spreading through the body and causing irreversible damage to the cardiovascular and nervous systems. Syphilis infection during pregnancy can cause miscarriage, stillbirth or congenital syphilis in the child.

The pattern of wide fluctuation in numbers over time seen in Fig. 2 below appears to be consistent with a disease that is rapidly spread but easily brought under control. The largest numbers of syphilis cases in the four countries were in St. Lucia which also has the largest population. Dominica has the smallest population of the four project countries but nevertheless high numbers of cases were seen between 1991 and 1994 with further spikes in 2000, 2002 and 2004. Total numbers of cases over the period were 2,963 for Dominica, 822 for Grenada, 4,326 for St. Lucia and 1,281 for St. Vincent and the Grenadines [Caribbean Epidemiology Centre Undated].

Figure 3: Number of syphilis cases reported to CAREC, 1980-2005, in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines



Source: [www.carec.org](http://www.carec.org)

For CAREC member countries as a whole for the 26-year period, most cases were reported from Jamaica [40 percent], Trinidad and Tobago [20 percent], Bahamas [11 percent], St. Lucia [6 percent], Cayman Islands [4 percent] and Dominica [2 percent] [Caribbean Epidemiology Centre Undated].

### 2.2.3 STI SURVEILLANCE IN THE CARIBBEAN

During the period 2002-2005, there was a major review and revision of the regional communicable disease surveillance system for CAREC member countries. The main reasons for the revision of the system were to improve communicable disease prevention and control efforts in countries; and to strengthen national and regional capacity for timely and appropriate response to public health emergencies, as would be required under the revised International Health Regulations [IHR (2005)]. Implementation of the revised regional communicable disease surveillance system occurred in January 2006. One of the changes was that syndromes such as genital ulcers and genital discharge became reportable rather than just relying on diagnosed cases of STI.

According to CAREC, considerable challenges remain in the establishment of a reliable sexually transmitted infection [STI] surveillance system in the Caribbean. Since 2006, CAREC has issued countries with an STI reporting form and has conducted various training exercises to assist with its completion. This requests:

- The total number of STI cases in the year;
- The STI rates found in studies with blood donors, men who have sex with men, sex workers, pregnant women and other groups;



- Syndrome: Number of people with Genital Discharge, Genital Ulcers or with no syndrome, but for whom the laboratory test is serology positive;
- For each syndrome, the number of people with specific aetiologies: chlamydia, gonorrhea, other (for genital discharge); syphilis or other (for genital ulcer); syphilis or chlamydia (for those without symptoms); and
- For each aetiology, the number of males, females and unknown for different age groups (10-14, 15-19, 20-24, over 24 and unknown).

Reporting has been patchy, with some countries reporting incomplete data, some reporting only in some years and some not reporting at all. Special studies with blood donors, men who have sex with men etc. are extremely rare. CAREC is now planning to move to a web-based STI data capture system in which the data on individual cases will be entered. It is hoped that this will facilitate reporting by countries [Boisson 2011].

CAREC Annual Reports collate STI data provided by member countries for the previous year. The following table presents data from the four countries for 2006-9. More recent data have not yet been published. A notable finding from these data is the large numbers of cases of genital discharge and syphilis reported in Grenada.

Table 5: Numbers of reported cases of sexually transmitted infection in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines, 2006 to 2009

		Dominica	Grenada	St. Lucia	SVG
Chlamydial infection	2006	7	0	na	0
	2007	na	0	na	0
	2008	0	2	na	0
	2009	0	0	na	24
Genital discharge syndrome	2006	908	853	na	24
	2007	na	451	na	10
	2008	44	579	na	19
	2009	13	556	na	9
Genital ulcer syndrome	2006	12	0	na	4
	2007	na	32	na	0
	2008	0	129	na	0
	2009	0	0	na	0
Gonococcal infections	2006	95	35	na	20
	2007	na	7	na	10
	2008	19	9	na	19
	2009	13	9	na	9
Syphilis	2006	4	564	na	8
	2007	na	496	na	0
	2008	128	239	na	180
	2009	131	290	na	136

Source: Caribbean Epidemiology Centre ([www.carec.org](http://www.carec.org)). 2006 data from 2007 CAREC Annual Report; 2007 data from 2008 CAREC Annual Report; 2008 data from 2009 CAREC Annual Report; 2009 data from 2009 CAREC Annual Report.

The following page shows data from the Ministry of Health in Dominica on the numbers of reported cases of STI among 10-24-year olds from 2000 to 2010. The numbers are small, not exceeding 5 in any one year for gonorrhea, 6 for syphilis and 3 for trichomonas.

Table 6: Dominica: Number of reported cases of sexually transmitted infection among 10 – 24-year olds, 2000 to 2010

		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Gonorrhea	Male	3	0	0	0	1	0	0	3	5	2	2
	Female	0	0	0	1	1	0	0	1	0	0	3
	TOTAL	3	0	0	1	2	0	0	4	5	2	5
RPR positive syphilis	Male	1	1	0	0	0	1	0	0	0	0	0
	Female	1	1	2	0	6	1	2	2	3	5	5
	TOTAL	2	2	2	0	6	2	2	2	3	5	5
Trichomonas	Female	1	0	0	1	0	1	3	0	1	3	3

[Source: Health Information Unit, Ministry of Health, Dominica]

2.2.4 SELF-REPORTED STI SYMPTOMS

Self-reports of STI symptoms were collected during the 2005-6 Behavioural Surveillance Surveys in Organisation of Eastern Caribbean States countries [Ogunnaike-Cooke, Kabore et al. 2006]. Following is a table comparing the results from the surveys of 15-24-year olds with those for 25-49-year olds for the four countries in our study. The table also offers comparisons between males and females.

Table 7: Self reported Sexually Transmitted Infection Symptoms in the last 12 months, OECS BSS, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Age of Respondents	Sex of Respondents	# of respondents who had sex in the last 12 months	Percent who had genital discharge in the last 12 months	Percent who had a genital ulcer/sore in the last 12 months
Dominica	15-24	Male	285	<1	<1
		Female	257	1	<1
		Total	542	1	<1
	25-49	Male	260	1	<1
		Female	243	3	0
		Total	503	2	<1
Grenada	15-24	Male	239	1	<1
		Female	281	4	3
		Total	520	3	2
	25-49	Male	225	2	<1
		Female	238	9	2
		Total	463	6	1
St. Lucia	15-24	Male	332	4	1
		Female	290	14	2
		Total	622	9	1
	25-49	Male	238	3	2
		Female	231	9	3
		Total	469	6	2
St. Vincent & the Grenadines	15-24	Male	225	2	1
		Female	331	6	<1
		Total	556	4	1
	25-49	Male	224	<1	<1
		Female	238	3	1
		Total	462	2	1

Source: [Ogunnaike-Cooke, Kabore et al. 2006]



The low number of self-reported rates in the table carry a high likelihood of bias, especially underreporting due to the sensitive nature of the questions, and should not be used to represent national STI prevalence. However, under the assumption that all the figures may be biased in roughly the same way, useful comparisons may be made.

Among male youths ages 15-24, the reported prevalence rates ranged from less than 1 percent to 4 percent for genital discharge and less than 1 percent to 1 percent for genital ulcers/sores. Among females, the prevalence of genital discharge ranged from 1 percent to 14 percent while for genital ulcers/sore, the prevalence was reported to be between 0 percent and 3 percent. The gender difference in the range of genital discharge may have been due to females reporting normal genital discharge as an abnormal one. However, it may also indicate the use of vaginal practices such as douching that could contribute to discharge (see the section on biological risks below).

Comparing the age groups, no clear pattern emerged as to whether STI symptoms were more or less prevalent among the 25-49-year olds than among youth age 15-24. Females were more likely than males to report genital discharge in both age groups. The prevalence of self-reported discharge was generally higher than the prevalence of ulceration.

In a study conducted at venues where people meet new sexual partners in St. Lucia, percentages of participants who said they had symptoms of STI over the past four weeks were higher than in the BSS study that asked about genital discharge or sores over the past year. The percentages among youth aged 15-24 were 3.0 per cent among males and 13.6 per cent among females. For the sample as a whole, 2.6 per cent of males and 14.0 per cent of females reported STI symptoms in the past four weeks [National AIDS Program Secretariat and MEASURE Evaluation 2007]. The higher proportions may be associated with the fact that the study was conducted in “hot spots” where people meet sexual partners. See section 2.5.2.2 for further details of this study.

In 2010-11, HIV Knowledge, Attitudes, Beliefs and Practices (KABP) surveys were conducted in Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis on behalf of the OECS HIV/ AIDS Programme Unit [Organisation of Eastern Caribbean States and Health Economics Unit 2011a]. The following table provides data on self-reported STI symptoms in Dominica and Grenada from that survey. The survey reports do not disaggregate these data by age group or sex.

Table 8: Dominica and Grenada: self-reported genital discharge and genital ulcer in the past 12 months, 2010

	Dominica				Grenada			
	Genital Discharge		Genital Ulcer		Genital Discharge		Genital Ulcer	
	Number		Number		Number		Number	
Today, last 24 hours	13	1.1	4	.4	8	.9	0	0
Happened last 30 days, but not today	21	1.8	0	0	27	3.1	1	.1
Happened but not in last 30 days	64	5.4	11	.9	36	4.2	9	1.1
No, has never happened	942	79.9	1090	92.5	752	86.2	844	96.6
Don't know	89	7.6	31	2.7	28	3.2	9	1.0
NA	49	4.1	42	3.5	21	2.4	10	1.2
Total	1178	100.0	1178	100.0	873	100.0	873	100.0

The majority of those surveyed in Dominica and Grenada (80 per cent or more) had never had genital discharge or a genital ulcer. As in the 2005-6 BSS studies, more participants reported genital discharge than genital ulcer. Higher rates of symptoms were reported in the more recent study, but it should be noted that the questions were asked in a different way so the figures may not reflect real increases in prevalence. Over the past year, in Dominica a total of 8.3 per cent of respondents reported genital discharge and 1.3 per cent genital ulcer, while the corresponding figures for Grenada were 8.2 and 1.2 per cent respectively.

2.3 PREGNANCY AND MATERNAL HEALTH IN WOMEN AND GIRLS UNDER 25

Maternal mortality rates are relatively low in the Eastern Caribbean (UNICEF 2007). This is the result of widespread access to prenatal care and care at the time of delivery. There is also wide access to family planning services with contraceptive prevalence rates at about 50 per cent (UNICEF 2007). The countries in the sub-region seem on track to meet MDG targets with respect to maternal mortality, antenatal coverage and the presence of skilled attendants at birth (UNICEF 2007). It should be noted that according to the World Health Organization Grenada, along with Japan and Mauritius, is among the three countries with the lowest Maternal Mortality Ratios (MMR) in the world. (High Commission for Grenada 2011). In Dominica there were six maternal deaths between 2000-2010, of which one was an adolescent aged 17 in 2001 and one a young woman age 23 in 2008 (Ministry of Health Dominica 2011).

Although access to prenatal care is nearly universal, it would be better if more women started receiving this care earlier in their pregnancies (UNICEF 2007). In Dominica, only 36 per cent of women seen for prenatal care at a health centre in 1995 were seen before the 16th week of pregnancy. In Grenada, it is estimated that 78 per cent of pregnant women attend prenatal clinics held in community health facilities but that only about five per cent of these women make their first visit before the twelfth week of pregnancy, while 80 per cent do not come until after their fifteenth week. In St. Lucia, an estimated 50 per cent of pregnant women use the public health clinics for prenatal care, and only 10 to 15 per cent of these women register before the 6th week of pregnancy (UNICEF 2007).

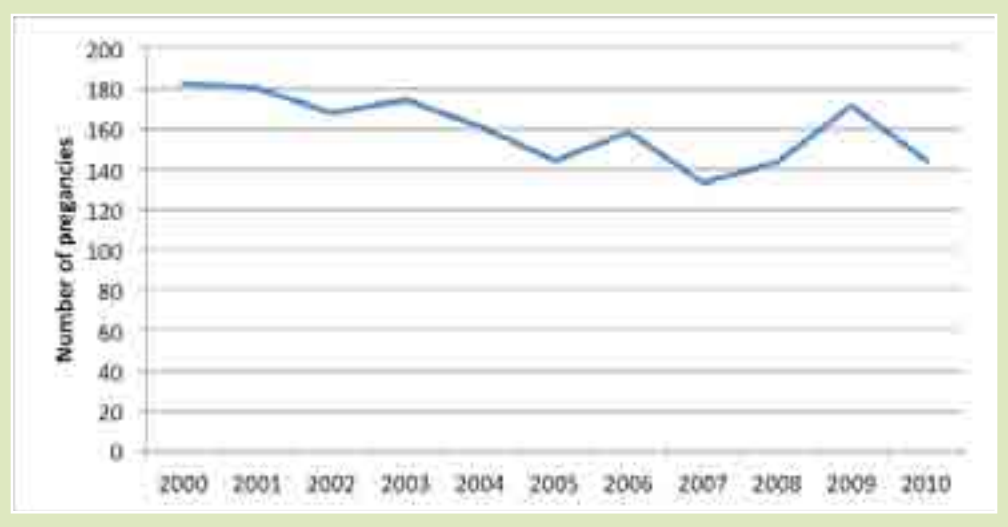
Teenage pregnancy is a concern in all countries of the sub-region and raises a number of human rights issues. According to a report by UNICEF (2007), teenage mothers account for between 10 to 20 per cent of live births in Dominica, St. Kitts and Nevis, St. Lucia and the Turks and Caicos Islands. Teenage pregnancy results in health problems for the mother and a disproportionate share of maternal deaths, in part because teenagers are less likely to seek appropriate care. In addition, teenage pregnancy is more likely to result in health problems for the baby. Meeting the MDGs for infant and maternal mortality is integrally linked to reducing teenage pregnancy. In addition, teen mothers find it more difficult to access their right to education and development. Stakeholders report that when a girl becomes pregnant, more frequently than not, her education stops. The economic cost of adolescent pregnancy – both the immediate costs related to the birth period and the long-term financial costs related to lower lifetime earnings of the mother – is significant. Teen mothers tend to have larger families, are more likely to be poor (they work more and earn less) and are more likely to have children who themselves become teenage parents (UNICEF 2007).

Efforts to inform young people about the consequences of unsafe sex, which include pregnancy, STIs and HIV, have been relatively successful in providing information but have not resulted in concomitant behavioural change. In addition, adolescents do not have access to confidential health services, particularly reproductive health services (UNICEF 2007).

2.3.1 DOMINICA

In Dominica between 2000 and 2010, the absolute numbers of teenage pregnancies decreased, except for a spike in 2009 (Ministry of Health Dominica 2011). The percentage of teenage in all pregnancies fluctuated with an increase in 2009 and a drop in 2010. Teenage mothers have accounted for between 14 and 18 percent of all births since the year 2000. It appears that the apparent general trend to reduced teenage pregnancies may be associated with a decline in the number of pregnancies in the population as a whole, since the percentage of teenagers among all pregnant women has not declined.

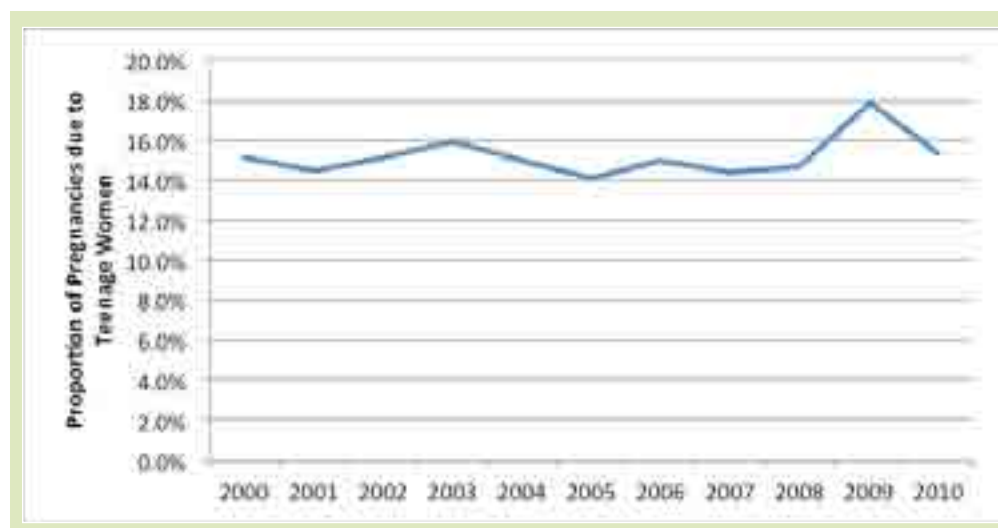
Figure 4: Dominica:  
Number of  
pregnancies among  
females ages 10-19,  
2000 to 2010



[Source: Health Information Unit, Ministry of Health, Dominica]



Figure 5: Dominica:  
Proportion of pregnancies due to 10-19-year olds, 2000 to 2010



[Source: Health Information Unit, Ministry of Health, Dominica]

### 2.3.2 GRENADA

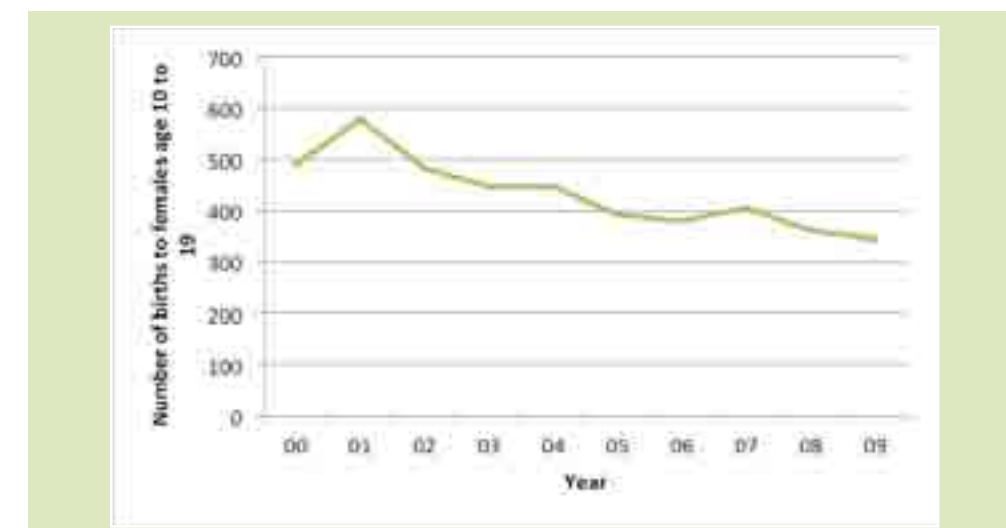
In Grenada, an alarming 40.3 percent of females of ages 15-49 are reported to have had their first child between the ages of 15-19 [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. Of some concern is the 4 percent of females who reported having their first child under the age of 15. The percentage of females having their first birth during their teenage years is associated with socioeconomic status; 57.8 percent of these births are in the lowest economic quintile as compared with 25 percent in the highest income quintile [Kairi Consultants Limited and National Assessment Team of Grenada 2008].

According the Grenada Country Poverty Assessment [2008], teenage pregnancy appears to be a phenomenon in some households and residents in some of the communities identified it as a problem. In spite of this it appears there is little acknowledgement that men who impregnate teenage girls are breaking the law and there is little evidence that such males had been arrested or convicted of statutory rape [Kairi Consultants Limited and National Assessment Team of Grenada 2008]

### 2.3.3 ST. LUCIA

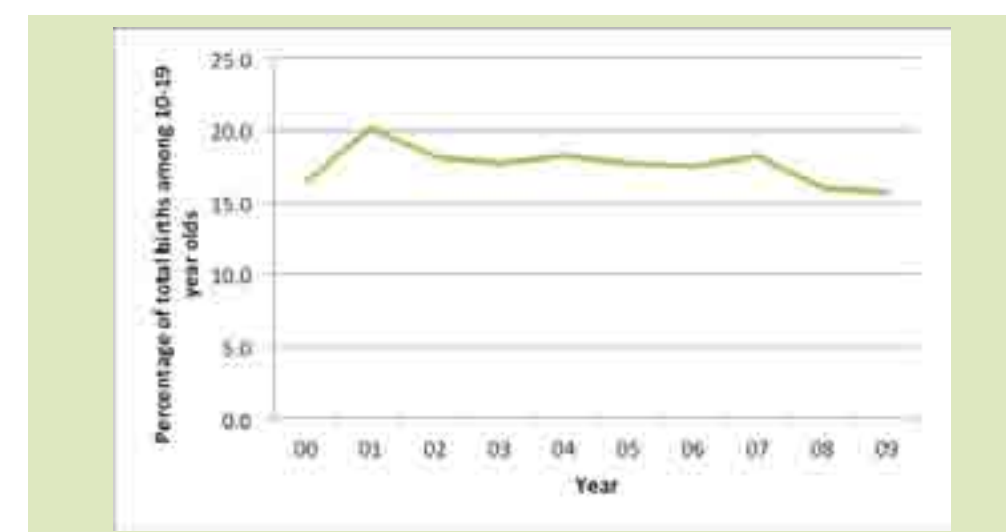
The St. Lucia Fertility Report for 2009 shows that a significant number of mothers [42.8 per cent of total births] were below 25 years old. The number of teenage pregnancies has declined since 2001, reflecting a general pattern of reduced overall numbers of pregnancies per woman in St. Lucia. However, similar to the pattern found in Dominica, the percentage of total births among 10-19-year olds

Figure 6: St. Lucia:  
Number of births among 10-19-year olds, 2000 to 2009



Source: [St. Lucia Ministry of Health Epidemiology Unit 2011]

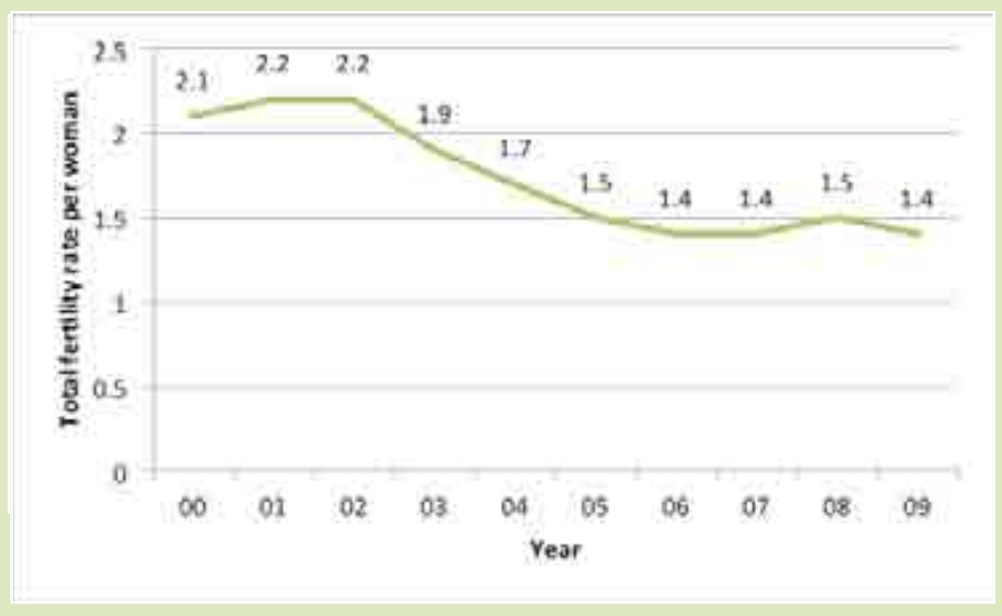
Figure 7: St. Lucia:  
Percentage of total births among 10-19-year olds, 2000 to 2009



Source: [St. Lucia Ministry of Health Epidemiology Unit 2011]

has remained steady around an average of 17.5 per cent between 2000 and 2009, declining to 15.8 per cent in 2008 and 15.6 per cent in 2009 [Fig. 5 and Fig. 6]. There has been a large decline in overall numbers of pregnancies per woman in St. Lucia since the early 1990s. The number of births per woman fell by 55 per cent between 1992 and 2009, from 3.1 to 1.4. The following chart shows the downward trend in fertility between 2000 and 2009. As shown above, this decline has been reflected in declining numbers of teenage pregnancies but the overall percentage of pregnancies accounted for by females under 20 years old has not changed significantly.

Figure 8: St. Lucia:  
Total Fertility Rate  
per Woman, 2000 to  
2009



St. Lucia Ministry of Health Epidemiology Unit 2011

Turning to infant health, low birth weight babies represented an average of 10.9 per cent of total births between 1989 and 2009, and between 10 and 13 per cent of total births every year for the same period. Among babies born to young mothers aged 10 to 19, the prevalence of low birth weight was higher, at 13.3 per cent. The infant mortality rate for 2005 was calculated to be 15.0 per 1,000 live births – a decrease of 16.2 per cent over the rate in 1991. Between 1996 and 2005 the infant mortality rate ranged from 13.2 to 18.7 [St. Lucia Ministry of Health Epidemiology Unit 2011]. In 2006 the infant mortality rate jumped to 25.8, declining to 15.9 in 2007 and 13.9 in 2008 [data supplied by the National Epidemiologist, St. Lucia].

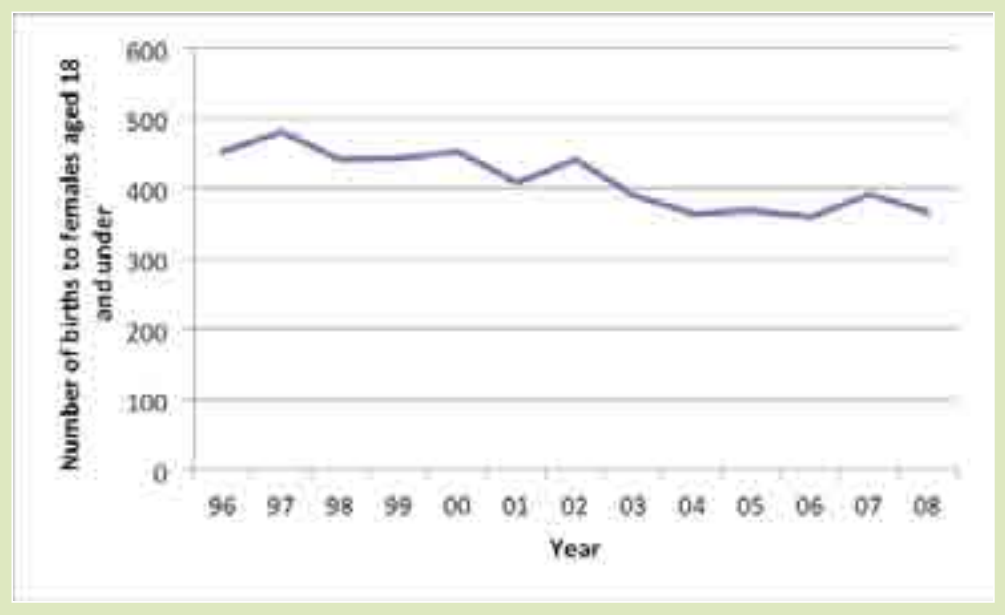
Between 1989 and 2007 there were 24 maternal deaths, ranging from zero to six per year [St. Lucia Ministry of Health Epidemiology Unit 2011]. The maternal mortality rate was 1.4 in 2006 and 2.7 in 2007, with no maternal deaths reported in St. Lucia in 2008 [data supplied by the National Epidemiologist, St. Lucia].

According to an assessment, primary health care is well institutionalized with relative ease of access to 32 health centres across the island. Antenatal services are readily available to women. While \$100 is charged as an admittance fee, no one is denied access to hospital for delivery of babies. The vast majority of births are attended by skilled health personnel [Kairi Consultants Limited 2007].

### 2.3.4 ST. VINCENT AND THE GRENADINES

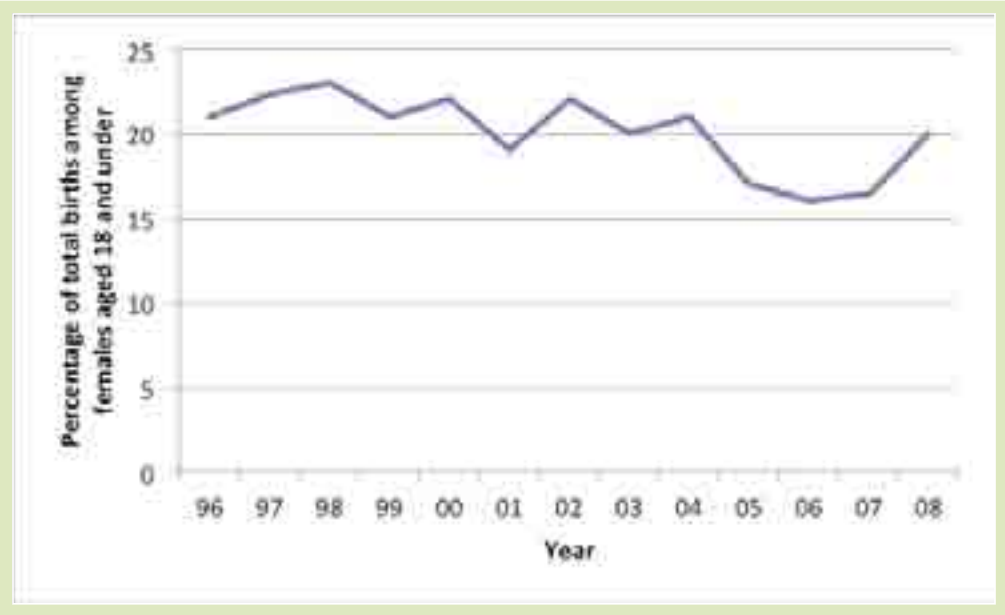
Figures 8 and 9 are based on pregnancy data from the main hospital in St. Vincent and the Grenadines. As in Dominica and St. Lucia, they show a gradual decline in the numbers of pregnancies among teenagers. In St. Vincent and the Grenadines there also seems to be a slight decline in pregnancies among teenagers as a percentage of all pregnancies. The average percentage over the 13 years covered by the data was 20.1 per cent. The percentage dipped between 2005 and 2007 but went back to 20 per cent in 2008. The average percentage is higher than in St. Lucia [17.5 per cent for 2000-9] and Dominica [15.1 per cent for 2000 to 2010].

Figure 9: St.  
Vincent and the  
Grenadines: Number  
of pregnancies  
at Milton Cato  
Memorial Hospital to  
females aged 18 and  
under, 1996-2008



Source: St.  
Vincent and  
the Grenadines  
Ministry of Health

Figure 10: St.  
Vincent and  
the Grenadines:  
Percentage of  
total pregnancies  
at Milton Cato  
Memorial Hospital  
among females  
aged 18 and under



Source: St.  
Vincent and  
the Grenadines  
Ministry of Health



The maternal mortality ratio in 2007 was 1 per 1000 live births. A quantitative survey of living conditions and household budgetary survey was conducted in St. Vincent and the Grenadines as part of the Country Poverty Report (2007/2008). The number of surveys obtained was 1019. The survey revealed that nearly 50 percent of females reported having had their first birth between the ages of 15-19; 2.5 percent had their child before their 15th birthday (Kairi Consultants Limited 2009). Discussions with a number of school principals and the records from a selection of secondary schools confirm that teenage girls generally become pregnant for older rather than younger men; and their mothers appear to approve and/or encourage the girls' activity in order to supplement household income (Kairi Consultants Limited 2009). Many of these girls are under the age of 15.

## 2.4 SOCIAL AND ECONOMIC STATUS OF YOUTH

### 2.4.1 DOMINICA

#### Basic demographic data

With an estimated population of 71,898 at the end of the first decade of the 21st Century, Dominica has experienced declines in or near zero population growth over the past three decades (Caribbean Development Bank Government of the Commonwealth of Dominica and Harlow Group Limited 2003). High emigration rates have been a major feature of the country's demography since the 1940s and many more Dominicans live overseas than in Dominica itself.

Children (aged 0-14 years) accounted for 26.5 percent of the population, and youths (aged 15-24 years) accounted for 16.3 percent of the population, a total of 42.8 percent of children and youths together (Kairi Consultants Limited and The National Assessment Team of Dominica 2010).

The Dominica Census defined youth as persons aged 15-24 years. Youths face various challenges, including access to tertiary education, employment, access to appropriate financing for those who want to begin their own businesses or even get involved in starting a family and a home. Census data show that 6,679 and 4,488 youths were in the 15-19 and 20-24 age groups respectively (Caricom Capacity Development Programme [CCDP]. 2009).

#### School Enrolment

At the time of the 2001 Census, 4,853 young persons or 43.4 of all youths (aged 15-24) in Dominica were attending school (Caricom Capacity Development Programme [CCDP]. 2009). This number comprised 2,287 males and 2,566 females. The data show that the proportion of young females attending schools was higher than the proportion of young males. Of those in female headed

households, 38.8 percent of young males and 48.7 percent of young females were attending school. Sex of household head did not make a substantial difference in school attendance.

Approximately 19,888 or 31.2 percent of all Dominicans five years old and over were attending school at the time of the census. This comprised 9,791 males and 10,097 females representing 30.5 percent and 31.9 percent of the male and female populations, respectively. Of the 19,888 persons recorded, 11,150 were attending primary schools (including primary and senior primary/junior secondary), 6,626 attending secondary schools (including secondary and sixth form) and 405 university (Caricom Capacity Development Programme [CCDP]. 2009).

An analysis of the data by sex informs that a higher proportion of males than females were attending primary school, but a higher proportion of females were attending secondary school. Primary education is usually compulsory but advanced secondary and tertiary are optional and the data show that 3.3 percent of females compared to 1.4 percent of males were attending sixth form schools. Some 1.8 percent of females and 2.3 percent of males were reported to be attending university (Caricom Capacity Development Programme [CCDP]. 2009).

In the 2010-11 academic year, attendance of students at Dominica secondary schools ranged from 82 per cent to 97 per cent, or an approximate average of 92 per cent (data supplied by the Education Planning Unit, Ministry of Education and Human Resource Development). This indicates a rate of absenteeism of around 8 per cent. The data were not disaggregated by sex.

#### Employment

The data show that 3,487 or 32 percent of all young persons in Dominica were reported to have worked at the time of the 2001 Census (Caricom Capacity Development Programme [CCDP]. 2009).

Young persons with a pre-university, post secondary or college education were by far more likely to have worked; of these 55 percent reported having worked. The next highest category was "Primary Grade/Standard (4-6 years)" with 40 percent reporting having worked. It is interesting to note that relatively small proportions of young persons with no education as well as those with a university education were reported to have worked. Among 20 to 24-year olds, while 78 percent of those with a pre-university, post secondary or college were working, only 27 percent of those with no education worked (Caricom Capacity Development Programme [CCDP]. 2009).

When age is taken into consideration, it can be observed that while a mere 14 percent of young persons in the 15-19 age group were reported to have worked, 58 percent of those aged 20-24 were working. It can be assumed that a large

proportion of those aged 15-19 were still attending school [Caricom Capacity Development Programme [CCDP]. 2009].

When the sex of the youth was taken into consideration, 37 percent of young men compared with 26 percent of young women were working [Caricom Capacity Development Programme [CCDP]. 2009]. There was a general increase in the proportions working as the level of educational attainment increased for males as well as females. When the age of the young persons is taken into consideration along with their sex, it is seen that a mere 10 percent of young females in the 15-19 age group compared with 18 percent of males were working. In the 20-24 age group, much higher proportions of both young males (63 percent) and young females (52 percent) were reported to have worked. Employment is slightly higher among males and this is consistent with their leaving school earlier. However, it may also indicate discrimination against young women seeking jobs and the limited number of job options for females.

#### **Family Poverty**

Persons 0-24 years of age, i.e. children and youth, are disproportionately represented among the poor, accounting for 52.1 percent of all poor persons. Children under the age of 14 are the cohort most likely to be poor [Kairi Consultants Limited and The National Assessment Team of Dominica 2010]. With respect to gender, there was nothing in the data to suggest higher levels of poverty among males or females. The percentages of poor males and females were almost the same, at 28.8 and 28.9 per cent respectively. The poverty line is based on an estimate of the minimum cost of basic food and non-food needs, and for Dominica was estimated to be EC\$6,230 per annum per adult [Kairi Consultants Limited and The National Assessment Team of Dominica 2010].

#### **Gender-based Violence**

Given the extent of underreporting, very little can be concluded from police records on the prevalence of all forms of violence against women. The data from the police are generally not disaggregated or analysed in such a way as to capture the extent of inter-personal violence in the family or household setting. Police records will generally only reflect the nature of the offence as opposed to the relationship between perpetrator and victim. There has been an increase in reports with strong indications that this is an achievement based on increased advocacy and support for victims.

A study undertaken in 2001 in Dominica found that that 32 percent of those interviewed had experienced abuse in a spousal or intimate relationship. Two thirds of that group were female and while the men reported experiencing verbal abuse, the vast majority of women had been physically abused. In many cases, this abuse was inter-generational as a significant number of abused women (36 percent) had also witnessed the abuse of their own mothers. The persons abused offered a variety of reasons to explain why they stayed in abusive relationships

including, for the sake of children, financial need, fear of losing property and contrition of the abuser. Abusers were seen as being largely unapologetic and unreflective, unable to communicate, having low self-esteem and having substance abuse problems.

This survey was not the first study of its kind in Dominica and two previous surveys obtained similar results. It is with an appreciation of the magnitude of the issue that much of what exists by way of a programme to address domestic violence was formulated [The Economic Commission for Latin America and the Caribbean [ECLAC] and United Nations Development Fund for Women [UNIFEM] 2003].

### **2.4.2 GRENADA**

#### **Basic demographic data**

The enumerated population of Grenada, Carriacou and Petit Martinique on Census Day, 12th May 2001 stood at 103,137 persons [Caricom Capacity Development Programme [CCDP] 2009b] comprising 51,795 females (50.2 percent) and 51,342 males (49.8 percent). This was an increase of 21.2 percent over the population in the 1991 census [Caricom Capacity Development Programme [CCDP] 2009b]. The population might since have fallen as a result of a larger than usual external migration in the light of the major hurricanes that the country experienced [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. Unlike some of the Leeward Islands, Grenada has not attracted large numbers from neighbouring countries, and has remained a sending country, with many of its citizens migrating since the middle of the 20th century to other islands in the region, especially Trinidad & Tobago, and to the North Atlantic countries [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. Grenada has a youthful population with 50 per cent of its residents being less than 25 years. One third of Grenada's population was less than 15 years and 43 per cent less than 20 years.

#### **School Enrolment**

Of the 78,096 persons aged 5 years or older, 26,750 or 34.3 percent were attending school at the time of the 2001 Population and Housing Census [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. The Parish of St. Mark's had the highest percentage of persons 5 years or older attending school (38.0 percent), followed by the parishes of St. Andrew's and St. Patrick's. When compared to all other parishes in Grenada, the Town of St. George's and Carriacou had the lowest percentages of school attendance among persons aged 5 years or older, the respective percentages being 29.6 percent and 31.4 percent.



### Employment

The majority of persons 15-19 years old were attending school (64.8 percent). The activities of the remaining 31.2 percent included those who did paid work - 18.6 percent; those who looked for work - 6.2 percent; those who wanted work - 1.7 percent; and those who had a job but did not work - 0.1 percent. Home duties, or unpaid work, were performed by 7.5 percent, while less than one percent of persons 15-19 years old were disabled or performed other economic activities [Kairi Consultants Limited and National Assessment Team of Grenada 2008].

### Gender-based Violence

The police are expected to investigate in situations of abuse of children, including cases of adolescent pregnancy, which result from the rape of a minor [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. The Social Services Department is expected to investigate in upholding the laws relating to child protection, and to establish the circumstances surrounding each case. There was little evidence that the Police have pursued prosecution of any fathers of children by adolescent girls. In addition, there is still ambivalence in some quarters over the rights of girls to return to the formal school system.

According to the Immigrant and Refugee Board of Canada, national government and human rights reports have noted that domestic violence in Grenada remains an issue of serious concern and that incidents of violence against women are rarely reported [Immigration and Refugee Board of Canada 2004]. Moreover, cases of domestic violence that were reported tended to be settled out of court [Immigration and Refugee Board of Canada 2004]. According to a government report entitled Crime Reduction Strategy for Grenada, published in October 2003, the hesitation to report domestic violence could be attributed to the inadequate capacity and organization of services for victims [Immigration and Refugee Board of Canada 2004].

### Family Poverty

Children (persons aged 0-14) and youths (persons aged 15-24) together account for 66.4 percent of the poor [Kairi Consultants Limited and National Assessment Team of Grenada 2008]. These two groups are disproportionately represented among the poor: children account for 29.2 percent of the population, but 39.4 percent of the poor; while youths account for 21.4 percent of the population, but 27.0 percent of the country's poor. This reflects the underlying fact that poorer people are likely to have more children than those who are better off. The data suggest that more males are poor relative to females: 39.5 percent of all males were deemed to be poor, compared to 36.2 percent of all females [Kairi Consultants Limited and National Assessment Team of Grenada 2008].

## 2.4.3 ST. LUCIA

### Basic demographic data

During the 2001 Population and Housing Census, Saint Lucia's population was enumerated at 156,734 persons, of which 51 per cent were female. Of the total population in 2001, 29.9 per cent (46,843 persons) were aged 10-24 [Caricom Capacity Development Programme (CCDP) 2009c]. The St. Lucia Fertility report for 2009 gives a population estimate for that year of 172,370, of which 51 per cent were female [St. Lucia Ministry of Health Epidemiology Unit 2011].

### School Enrolment

The 2001 Population and Housing Census shows 29.9 percent of male youth and 38.3 percent of female youth aged 15-24 years still attending school.

Approximately 40.6 percent of the age group 15-19 completed 4-7 years of primary schooling, 44.2 percent completed secondary level, and less than 1 percent proceeded to university level. In the case of the group 20-24 years, 29.6 percent had completed 4-7 years of schooling, 46.7 percent had completed secondary level and 1.6 percent had achieved university level.

Comparing education level by sex in the 15-24 age group, 7,522 females had completed secondary level education as against 6,198 of males. Ninety-five males and 140 females had a university education [Caricom Capacity Development Programme (CCDP) 2009c].

More recent data show the picture across the four countries, with females being more numerous in secondary schools and in post-secondary academic institutions. Boys predominated among school dropouts in 2008-9, making up 67 per cent of dropouts at primary level and 69 per cent at secondary level. The majority of primary school repeaters were also boys (59 per cent). In contrast, most teachers were female at primary (86 per cent) and secondary level (68 per cent).

Enrolment in secondary schools in St. Lucia rose from 76 per cent of the eligible population in 2005-6 to 94 per cent in 2009-10 following the introduction of universal secondary education in 2006-7.

In 2009-10, 35 per cent of the public primary students benefitted from the School Feeding Programme designed for needy children. Sixteen per cent of secondary school students benefitted from the Transportation Subsidy. These statistics may be regarded as indicators of economic need in the country [Ministry of Education and Culture St. Lucia 2010].

### Employment

In the age-group 20- 24 years 57.9 percent had jobs, more than double the 24.8 percent of the 15-19 age group for both males and females [Caricom Capacity Development Programme [CCDP] 2009c]. The majority of youths seen in the category “worked” had attained secondary level schooling, irrespective of sex, the proportions being 41.9 percent in the case of males and 51.8 percent in the case of females. The respective proportions having a university education were 0.9 percent and 1.4 percent. For youths who worked but had no education, the respective proportions for males and females were 1.0 percent and 0.6 percent. Youths are largely employed as service workers in shop and market sales [18.9 percent], as craft and related workers [13.1 percent] and as clerks [12.5 percent]. Additionally, 10.1 percent are engaged in elementary occupations.

In terms of general distribution among industry groups, higher proportions of males can be seen in wholesale and retail [12.9 percent], construction [11.1 percent], hotels and restaurants [8.2 percent] and manufacturing [6.7 percent] than in other industries [Caricom Capacity Development Programme [CCDP] 2009c]. In terms of females, a similar distribution among industries obtains with 14.2 percent being in wholesale and retail, 9.2 percent in hotels and restaurants and 7.7 percent in manufacturing.

### Gender Based Violence

Break up of families, domestic violence and abuse of women and children were identified as common problems in many of the poorer households in St. Lucia. A few young girls were concerned about becoming pregnant or being victims of sexual abuse and incest and they were aware that adults who should be protecting them could abuse them [Kairi Consultants Limited 2007].

### Family Poverty

The estimate of the indigence line for St. Lucia in 2005 was EC\$3.40 [US\$1.27] per day or EC\$131 [US\$46.06] per month or EC\$1,570 [US\$588.02] annually [Kairi Consultants Limited 2007]. The data reveal that 1.2 percent of households (or 1.6 percent of individuals) consumed at levels below the indigence line. The poverty line was estimated to be EC\$13.93 [US\$5.22] per day [EC\$423.83/US\$158.74 per month] or EC\$ 5,086 [US\$ 1,904.87] per annum. The data reveal that 21.4 percent of households fell below the poverty line. This corresponds to a headcount of 28.8 percent. The vulnerability line, estimated at 125 percent of the poverty line [i.e. 25 more] [Kairi Consultants Limited 2007], applies to those in the population who, given their current consumption patterns, are at risk of falling into poverty should any adverse natural disaster or economic shock occur. An estimated 40.3 percent of the population were consuming at levels below this line [Kairi Consultants Limited 2007]. Data from the participatory poverty assessment revealed the existence of chronic poverty in several multi-generational households. Moreover, many of these households were headed by grandmothers and included large numbers of children, the result of high numbers of births to

their female members. As has been found in most other Caribbean countries, the data reveal disproportionate numbers of young people living below the poverty line. Of those living below the poverty line, some 51 percent are below the age of 20, compared to 37 percent among the non-poor [Kairi Consultants Limited 2007].

## 2.4.4 ST. VINCENT AND THE GRENADINES

### Basic demographic data

In 2001, the enumerated population of St. Vincent and the Grenadines was 109,022 [Caricom Capacity Development Programme [CCDP] 2009d]. This represents an increase of 1,424 persons and an average annual growth rate of only 0.13 percent over the 1991/2001 intercensal period. In 2001, there were 21,001 youths [15 to 24 years] in the population, of whom 50.7 per cent were male and 49.3 per cent female. The 15 to 19 age group accounted for 53.8 per cent of 15-24-year olds [Caricom Capacity Development Programme [CCDP] 2009d].

In 2001, children under age 15 years accounted for 30.6 per cent of the population, while the youth sub-population [15 to 24 years] accounted for 19.8 percent [Caricom Capacity Development Programme [CCDP] 2009d]. Therefore, approximately one half of the population comprised children and youth. Those in the 25 to 44 years and the 45 to 64 years age groups accounted for 29.1 per cent and 13.2 percent respectively while those 65 years or older accounted for 7.3 percent [Caricom Capacity Development Programme [CCDP] 2009d].

The numbers of youth in St. Vincent and the Grenadines fell in the intercensal period. Females in the 15-19 age cohort lost 31.5 percent of their population and their male counterparts lost 29.2 percent. Additionally, females in the 20-24 age cohort lost 22.7 percent of their population while their male counterparts \lost 19.6 percent. The losses are mainly due to migration for education and economic opportunities. It is argued that females in the Caribbean are more likely than males to pursue higher education, and St. Vincent and the Grenadines is no exception [Caricom Capacity Development Programme [CCDP] 2009d]. Since there is no university it is expected that persons would migrate to get university degrees.

### School Enrolment

There were 28,190 persons or 29.3 per cent of the population age five years or older who attended school in 2001. The percentage of females [30.5 percent] who attended school was slightly higher than the percentage of males [28.1] [Caricom Capacity Development Programme [CCDP] 2009d].

Figures provided by the Ministry of Education for 2008 to 2009 show that 5,604 males and 5,821 females aged 10 to 19 were enrolled in government secondary



schools. A further 2,344 males and 1,934 females aged 10 to 13 were enrolled in government primary schools (comprising 30.0 and 27.1 per cent of the primary school population respectively).

### Employment

The youth population in 2001 accounted for 28.5 per cent of the working age population, with similar percentages for male and female youths (Caricom Capacity Development Programme [CCDP] 2009d).

In the 15 to 19 age group, the participation rate among the males was more than twice that for the females, 46.4 and 22.0 respectively (Caricom Capacity Development Programme [CCDP] 2009d). The wide gap between males and females in this age group signifies the earlier entrance of males into the labour force, which could be due to the failure of the males to complete a secondary or higher level of education. The data on school attendance indicate that a higher percentage of females (55.1 percent) compared to males (42.9 percent) in this age group attended school (Caricom Capacity Development Programme [CCDP] 2009d). Evidently females in this age group are staying in school longer than the males and delaying their entrance into the labour force.

The population of the youngest age group experienced the highest unemployment rate (Caricom Capacity Development Programme [CCDP] 2009d). Those in the 15 to 19 age group had an unemployment rate of 51.4 per cent, with the rate being even higher among the females (54.2 per cent) compared to males (50.2 per cent) in this age group. These figures reveal that there were more people in this age group that wanted work and looked for work compared to those who had a job. This is the only age group that had more unemployed than employed persons in the labour force and higher female compared to male unemployment rate.

### Gender-based Violence

According to the Immigration and Refugee Board of Canada, violence against women is a “major problem” in St. Vincent and the Grenadines (Immigration and Refugee Board of Canada 2008). According to statistics cited by the United Nations Office on Drugs and Crime (UNODC) in a March 2007 report, St. Vincent and the Grenadines has the third highest rate of reported incidents of rape in the world (United Nations Office on Drugs and Crime and Latin American and the Caribbean Region of the World Bank 2008). The data, which were gathered by UNODC from a survey of police statistics in 102 countries, indicate a recorded rate of 112 incidents of rape per 100,000 people in Saint Vincent and the Grenadines. The average rate among all 102 countries surveyed was 15 recorded incidents of rape per 100,000 people.

The United States [US] Country Reports on Human Rights Practices for 2007 reported that the police in St. Vincent and the Grenadines investigated 47 cases of rape and eight cases of attempted rape, but only 18 of these cases

were brought to trial. The law does not criminalize domestic violence but rather provides protection for victims (United States Department of State 2007). Cases involving domestic violence were normally charged under assault, battery, or other similar laws. The St. Vincent and the Grenadines Human Rights Association reported that, in many instances, domestic violence went unpunished due to a culture in which victims choose not to seek assistance from the police or the prosecution of offenders. Furthermore, a number of victims decide not to press charges once domestic tensions cool down after having already complained to the police. For this reason, police were often reluctant to follow up on domestic violence cases (United States Department of State 2007).

### Family Poverty

The headcount index, which measures the percentage of the population that is poor based on the estimated poverty line, is the most commonly used measure of the incidence of poverty. A study revealed that 30.2 percent of the population is poor, not meeting the minimum annual consumption expenditure of EC\$5,523, required to satisfy the basic food and non-food requirements (Kairi Consultants Limited 2009).

### Survey of youth on the block

In 2009, UNFPA collaborated with the Youth Affairs Department of St. Vincent and the Grenadines to conduct a survey of “Youth on the Bloc” (Allen 2010). Semi-structured interviews were conducted in afternoons or evenings at times and places that young people gather in the streets. Participants were 350 young people (of whom 88 per cent were male) in 21 communities around the country. Participants included individuals known to staff of the Department as well as others who volunteered to be interviewed. There may thus be some selection bias towards youth in contact with the Youth Affairs Department and people who are willing to volunteer. The data nevertheless provide a useful picture of the social and economic status of young people who are to be found on most evenings in the streets in St. Vincent and the Grenadines, as in many other parts of the Caribbean.

Fifty-four per cent of participants were 10-24 years old; the rest were older. Over a quarter (28.9 per cent) had achieved only primary education (grades 2 to 9). More than a third (34.3 per cent) had incomplete secondary education, while 27.7 per cent had completed form 5 of secondary school. Education beyond Form 5 was completed by 6.6 per cent of participants, while 2.7 per cent had only a Junior 2 to 5 education.

Among 10-15-year olds, the majority were studying as expected, but 21.3 per cent said they were working and 21.3 per cent said they were unemployed. Among 16 to 20-year olds, 22.1 per cent were studying; this dropped to 2.5 per cent among 20-24-year olds. Sixteen to 20-year olds had a higher rate of unemployment (41.1 per cent) than 21 to 24-year olds (24.3 per cent). The unemployment rate was

38.1 per cent for youth as a whole. Only 22 per cent of respondents said they had any special skill or training.

Most participants lived in households with one or both parents (87.7 per cent); about half (40.8 per cent) lived with one parent only. When asked to assess the income of the persons they live with, 42.6 per cent said it was “too little” or “barely manageable”.

Most respondents (85.4 per cent) reported that they met with people on the “bloc” every night. An open-ended question asked participants to identify five things that happen “on the bloc.” The most frequently occurring responses were smoking marijuana, drinking alcohol, playing games, cooking, arguing and fighting. Nevertheless, most participants (65.4 per cent) believed the “bloc” serves a useful purpose: 21.8 per cent thought it “helps to keep us together and interact”, 12.9 per cent thought that it enabled them to “share problems with friends”; and that it is “a place to relax.” Those who thought that the “bloc” does not serve a purpose were concerned that it “harbours violence” (25.6 per cent), that “you can get into trouble there” (18.3 per cent) and that “it promotes laziness” (17.1 per cent). Most participants (65.1 per cent) thought the “bloc” helped the community, for example by creating a sense of togetherness, by cleaning and beautifying the area and keeping people out of trouble.

Some participants (28.9 per cent) were not in a relationship. Most of the rest described their relationship as “good” or “very good” (55.4 per cent). Almost one fifth (17.1 per cent) had experienced violence in a relationship as victim or perpetrator. Of the females in the study, 26.1 per cent had experienced violence. Both males and females said they perpetrated the violence, usually in response to partner infidelity or partner jealousy.

Around one third (34.5 per cent) of participants had attended sessions on sexual and reproductive health or HIV. Around half (51.0 per cent) said they used a condom every time they had sex.

#### 2.4.5 GENERAL FINDINGS ON THE SOCIAL AND ECONOMIC STATUS OF YOUTH IN PROJECT COUNTRIES

The following general patterns emerge from the above review of the social and economic status of youth in project countries.

The populations of these countries are young, with around 45 to 50 percent under the age of 25 and around 30 percent of the population attending school. Higher proportions of females than males attend secondary school and further education, while males aged 15-24 participate in the labour force at higher rates than females. Employment rates were very low among those with no education. There is substantial poverty in each of the countries, with young people

particularly likely to be poor.

Gender based violence is a substantial problem in these countries.

The survey of youth on the block in St. Vincent and the Grenadines showed low levels of education and high unemployment, but also gave the sense that “block culture” in most cases provides important social support and relaxation for young people in difficult circumstances.

## 2.5 RISK AND PROTECTIVE FACTORS FOR SEXUAL AND REPRODUCTIVE HEALTH AMONG YOUNG PEOPLE

Since sex is the main mode of HIV transmission in the Caribbean, age at initiation of sex, number of partners and unprotected sex are critical and direct influences on HIV incidence, STIs and teenage pregnancies. In addition biological factors can affect the likelihood of transmission of HIV and STI in any given sexual act. These direct determinants are in their turn influenced by social, economic and cultural environmental factors and by health service provision and policies. Some factors in all these categories (behavioural, biological and environmental) may be protective against HIV, STI and pregnancy, decreasing the likelihood of occurrence. This section reviews the evidence for the four countries in our study. It thus delineates the scope of the prevention challenge but also offers the prospect of “combined prevention”, combining biological, behavioural and structural interventions for maximum impact at the population level (Padian, McCoy et al. 2011).

### 2.5.1 BEHAVIOURAL FACTORS

In this section we review Caribbean evidence on sexual behaviours that are associated with HIV transmission among youth. A limited number of sexual behavioural studies were found for individual countries covered by the current project. In this section we review these and also examine some multi-country studies that included the project countries. Descriptive information is provided from surveys conducted in the Eastern Caribbean, notably the Global School-Based Student Health Surveys (Centers for Disease Control and Prevention 2009), the OECS Behavioural Surveillance Surveys (BSS) (Ogunnaike-Cooke, Kabore et al. 2006) and the OECS KABP surveys (Organisation of Eastern Caribbean States and Health Economics Unit 2011a).



## 2.5.2 AGE AT SEXUAL DEBUT AND EARLY SEXUAL EXPERIENCES

### 2.5.2.1 STUDY OF SEXUAL ACTIVITY AND CONDOM USE AMONG HIGH-SCHOOL GIRLS IN DOMINICA

A cross-sectional study was conducted at five high-schools in Dominica in 2000 to assess behaviour that might put high-school girls at risk for HIV (George, Alary et al. 2007). The convenience sample consisted of 204 girls (median age 16 years). The main outcome variable, sexual activity, was defined as vaginal or anal sex, and inconsistent condom use defined as none to infrequent condom use. Forty-one percent of girls reported at least one episode of sexual activity. Sexual intercourse was associated with past sexual coercion (odds ratio [OR] = 7.2, 95 percent confidence interval [CI] 2.4, 21.8), oral sex [OR = 8.0, 95 percent CI 3.0, 21.0] and smoking marijuana [OR = 8.2, 95 percent CI 2.9, 23.0]. Among sexually active girls, 59 percent were inconsistent condom users. Variables associated with inconsistent condom use were being coerced [OR 2.8, 95 percent CI 0.9, 8.2] and low socio-economic status [OR 3.3, 95 percent CI 1.1, 9.6].

It was concluded that sexual activity and inconsistent condom use occur frequently among high-school girls in Dominica. Therefore, strategies directed at delaying the onset of sexual activities and promoting condom use among the sexually active are necessary, taking into account the economic and social conditions of their daily lives. As noted in section 2.4, children and young people are disproportionately represented among the poor in Dominica, and this study provides evidence that low socio-economic status is associated with inconsistent condom use and thus vulnerability to HIV. Both sexual intercourse and sexual activity among these young women were associated with sexual coercion, drawing attention to the importance of gender-based violence in increasing the vulnerability of young women. Drug use was also significantly associated with sexual activity. The importance of gender-based violence and drug use to HIV risk is explored in more detail in sections 2.7.3 and 2.7.4. Sexual coercion and low socio-economic status must be addressed by the state and include adequate law enforcement and community sensitization on the factors that prevent girls from using condoms (George, Alary et al. 2007).

The need for intervention to address sexual coercion and peer pressure was reinforced by qualitative data from the same study. A qualitative question was included in the questionnaire, where participants were asked to write comments on issues relating to sexual relationships, sexuality or to comment on sexual behaviour. The 87 girls who responded to this question said that sexual coercion by boys was common. Both physical and psychological abuses were mentioned by the girls. A majority also experienced pressure from other girls to conform to the norm of sexual behaviour. In quantitative data from the study, 23 percent of all girls reported that they were coerced into sex and 38 percent reported unwanted sexual touching (George, Alary et al. 2002).

### 2.5.2.2 PLACE STUDY IN ST. LUCIA

In 2007, the St. Lucia National AIDS Programme Secretariat collaborated with MEASURE Evaluation to conduct a Priorities for Local AIDS Control Efforts (PLACE) study in St. Lucia. PLACE studies are based on the premise that HIV prevention programmes should focus on areas likely to have a higher incidence of infection. Within these areas, PLACE identifies venues where AIDS prevention programmes should be focused in order to reach those most at risk of acquiring and transmitting HIV, provides indicators that monitor HIV prevention programmes and identifies gaps in prevention programmes. A local Steering Committee selected three Priority Prevention Areas, Anse la Raye, Castries, and Gros Islet, based on contextual factors such as tourism, poverty, incidence of sexually transmitted infections, high population density and HIV prevalence. Within these Areas, 883 interviews with patrons were conducted at 35 venues sampled from 686 venues identified by community informants. Venues included bars, restaurants, clubs, street parties, beaches, sports venues and other public places.

Of patrons interviewed at the venues, 37.2 per cent of the men and 51.2 per cent of the females were aged 15-24. The numbers of new partnerships among male youth were higher than among older males: 37.3 per cent of male youth reported having at least one new partner or two partners in the past four weeks as compared with 32.5 per cent of the full sample of males. The percentages of male and female youth with new partners in the past twelve months were also higher than among older people. These results are important since HIV viral load peaks in the early stages of infection, and new partnerships increase the likelihood of sex with someone recently infected. On the other hand, more of the young people used a condom the first time they had sex with their most recent partner; 72.1 per cent of male youth and 67.0 per cent of female youth did so as compared with 64.0 per cent of males and 62.9 per cent of females in the sample as a whole. Higher percentages of male and female youth also used a condom at last sex. The percentages who had a partner 10 or more years older in the past year were similar between young people and older people; this applied to 9.0 per cent of male and 15.9 per cent of female youth as against 7.6 per cent of males and 17.8 per cent of females in the sample as a whole (National AIDS Program Secretariat and MEASURE Evaluation 2007).

### 2.5.2.3 WHO GLOBAL SCHOOL-BASED HEALTH SURVEY AMONG 13-15-YEAR OLDS

The following table presents data from the countries in our project from the Global School-Based Student Health Surveys, conducted primarily among students aged 13-15 years and developed by the World Health Organization (WHO) in collaboration with UNICEF, UNESCO, and UNAIDS; with technical assistance from CDC.

Table 9: Sexual Behaviours of students aged 13-15 years, Global School-based Student Health Survey, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Percentage of Students who ever had sexual intercourse	Among students who ever had sexual intercourse, the percentage who had sexual intercourse for the first time before age 14 years	Percentage of students who ever had sexual intercourse with two or more people during their life	Among students who ever had sexual intercourse, the percentage who used a condom the last time they had sexual intercourse
Dominica				
Girls	36.9	60.3	No data	68.2
Boys	57	85.1	No data	63
Total	46.9	75.5	No data	65.1
Grenada				
Girls	14.8	No data	11.4	*
Boys	42.9	No data	34.9	57.0
Total	26.5	No data	21.7	57.0
Saint Lucia				
Girls	16.8	No data	8.9	*
Boys	38.0	No data	32.8	48.0
Total	26.1	No data	19.6	53.5
Saint Vincent				
Girls	12.6	No data	8.6	*
Boys	52.4	No data	43.1	59.2
Total	30.4	No data	24.9	60.0

\* Less than 100 students

NOTES:

Dates of GSHS in each country: Dominica 2009, Grenada 2008, St. Lucia 2007, St. Vincent and the Grenadines 2007.

Sample sizes: Dominica 1,642, Grenada 1,542, St. Lucia 1,276, Saint Vincent and the Grenadines 1,333

Students self-reported their responses to each question on a computer scannable answer sheet.

For comparison purposes, only students aged 13-15 years are included in the analyses for the fact sheets from which the data in this table are drawn.

The percentage of students age 13-15 who said they had sexual intercourse ranged from 26 percent (1 in 4 students) in St. Lucia to 47 percent (almost half) in Dominica. In Dominica, 36.9 percent of girls of this age group said they had ever had sexual intercourse; this seems consistent with the finding from the 2000 high-school study (George, Alary et al. 2007) with slightly older girls in which 41 percent said they had ever had sex.

In every country, considerably more boys than girls said they had had sex. In every country except Dominica, more than twice as many boys than girls said they had had sex. Furthermore, in Dominica, with the highest rates of self-reported sexual activity, the majority of sexually active students (76 percent) said they first had sex before the age of 14 years, again with higher rates among boys. This indicator was not measured in the other countries.

This is a common pattern seen in sexual behaviour surveys with youth in the Caribbean, that boys tend to report sex at an earlier age than girls, but the extent to which this represents reporting bias is unknown (with boys tending to over-report and girls to under-report because of gendered expectations) (Bombereau and Allen 2008). The figures also beg the question of the age of the partners that the boys are having sex with – the figures suggest that, to the extent that the boys are telling the truth, their sexual relationships with females are to a large degree with people outside their age bracket.

The percentage of students who had ever had more than one partner was not shown on the fact sheet for Dominica. In Grenada, the percentage was 22 percent, in St. Lucia 20 percent and in St. Vincent and the Grenadines 25 percent. In these three countries roughly three to four times as many boys as girls reported they had more than one partner, confirming the social norm that Caribbean males should have multiple partners, even at young ages (Bombereau and Allen 2008). Reported condom use at last sex ranged from 54 percent in St. Lucia to 65 percent in Dominica. Thus the Dominican students were apparently more sexually active but also more likely to use condoms. The 2009 result for Dominica that 68 percent of 13-15 year old females used a condom suggests that condom use may have risen over time, since in the 2000 school survey only 41 percent of girls reported consistent condom use.

2.5.2.4 OECS BEHAVIOURAL SURVEILLANCE SURVEY, 2005-6: AGE AND AGE MIXING AT FIRST SEX

The following table for the age group 15-24, from the Organisation of Eastern Caribbean States Behavioural Surveillance Survey (OECS BSS), shows in comparison with the discussion above that by the age of 24 the numbers of those who reported ever having sex was much higher, ranging from two-thirds (67 percent) in Grenada to three-quarters (74 percent) in St. Lucia. The table also shows median ages at first sex of 15 or 16 in all countries, with a median of 15 for



males and 16 for females in three of the countries. The range of ages at first sex is from 5 years old to 23 years old. The lowest age at sexual debut was reported as 5 for boys and 8 years old for girls. The patterns repeat those from a number of sexual behaviour surveys in the Caribbean [Allen, Samiel et al. 2001; Allen 2002], and contrast with many regions of the world where females tend to report sex at an earlier age than boys. The figures highlight the need to address child abuse and early sex among boys as well as girls. Early sexual initiation may be one explanation of higher rates of HIV among males in these countries.

Table 10: Age at first sex, OECS BSS with 15-24-year olds, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Sex of Respondents	# Surveyed	Percentage who ever had sex	Median age at first sex (years)	Range for age at first sex (years)
Dominica	Male	456	82	15	5-21
	Female	532	62	16	8-23
	Total	988	71	15	5-23
Grenada	Male	438	73	15	5-20
	Female	533	62	15	8-21
	Total	971	67	15	5-21
St. Lucia	Male	466	82	15	7-20
	Female	522	67	16	8-23
	Total	988	74	16	7-23
St. Vincent & the Grenadines	Male	451	69	15	6-22
	Female	528	75	16	10-21
	Total	979	72	15	6-22

Source: [Ogunnaike-Cooke, Kabore et al. 2006]

Further insight may be offered by results from the Dominica survey with men who have sex with men described in section 2.1.1. Among participants in that survey, first sex with either a female or male took place under the age of 10 for 10.1 percent of the sample and between the ages of 10 and 15 for the majority, 65.2 percent of the sample. Only 18.8 percent of participants had their first sexual experience after 16, the legal age of consent. Yet 91.0 percent of participants said that their first sexual experience was consensual. This suggests that there is substantial consensual sexual activity under the legal age of consent among males and that this may be either with males or females. The sex of the first partner was not included in the study report. However the data imply that first partners may be male or female, since the majority of participants in the survey had had sex with at least one woman in the past 6 months (77.0 percent). Most

[71.2 percent] had sex with a regular male partner and 63.6 percent had had sex with a non-regular male partner in the last six months.

Additionally, the data suggest that much of early sexual activity among MSM in this study is with peers but for a substantial minority it is with older people: 53.1 percent of respondents said their first sexual experience was with someone of the same age or younger while for 30.7 percent it was with someone more than five years older than they were [Dominica Ministry of Health, Public Health Agency of Canada et al. 2011].

The following table gives data for males and females on age mixing at first sex and may give an indication of sexual abuse of children by older people. The percentages reporting that their partners were 5 to 9 years older than them when they first had sex ranged from 9 percent in Dominica to 20 percent in Grenada. The percentages reporting that their first partners were 10 or more years older ranged from 3 percent in Dominica and Grenada to 5 percent in St. Lucia. In every country, a substantially larger percentage of girls than boys reported first partners 5 or more years older. The figures seem to suggest that females are particularly likely to have older partners, confirming qualitative studies including those that have noted the “sugar daddy syndrome” [girls having older partners for access to material resources] [Barrow 2005]. However, the data are puzzling once compared with those in previous tables that suggested that lower ages at sexual debut among boys. A couple of explanations are possible:

1. Boys’ first sexual experience is often with someone of roughly their own age. Given that girls generally report higher ages at first sex, a possible explanation is that just a few girls of similar age have sex with a lot of boys.
2. A substantial number of males are not telling the truth, either about their age at first sex or about the age gap between them and their first partners. Given the social pressure on males to be sexually active, it is easy to suspect that estimates of self-reported age at first sex among males are lower than true age at first sex.

Table 11: Age mixing at first sex, OECS BSS with 15-24-year olds, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Sex of Respondents	# of respondents who had ever had sex	percent whose first sexual partner was 5 to 9 years older	percent whose first sexual partner was 10 or more years older
Dominica	Male	370	3	1
	Female	331	16	6
	Total	701	9	3
Grenada	Male	320	7	1
	Female	332	33	5
	Total	652	20	3
St. Lucia	Male	381	9	2
	Female	352	28	9
	Total	733	18	5
St. Vincent & the Grenadines	Male	309	4	2
	Female	397	28	7
	Total	706	17	4

2.5.2.4 OECS KNOWLEDGE, ATTITUDES, BELIEFS AND PRACTICES SURVEY, 2010-11

As noted above, in 2010-11, HIV KABP studies were conducted with 15-49-year olds in Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis [Organisation of Eastern Caribbean States and Health Economics Unit 2011a]. The report includes presentation of some key United Nations General Assembly Special Session (UNGASS) indicators relating to young people. For instance, the table below presents the percentages of young people in Dominica and Grenada who had sex by the age of 15.

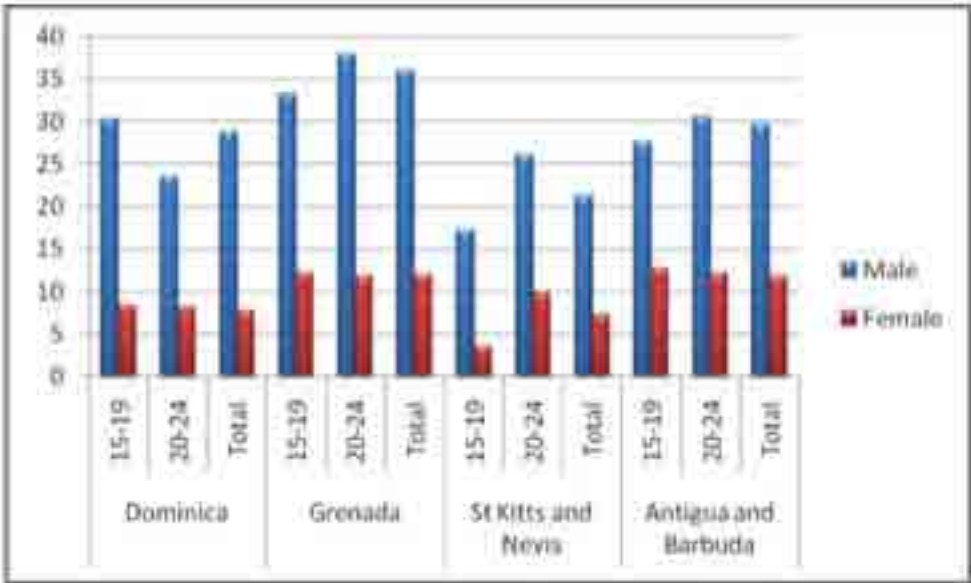
Table 12: Dominica and Grenada: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15, 2011

Country	Age Groups	Male	Female	Total
Dominica	15-19	30.3	8.2	17.5
	20-24	23.4	8.1	12.7
	Total	28.7	7.7	15.4
Grenada	15-19	33.3	12.2	20.3
	20-24	37.9	11.7	22.5
	Total	35.9	11.9	21.5

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011a]

The data confirm the picture above, with higher percentages of males in both countries having sex at an early age. This survey shows higher early sexual activity in Grenada than Dominica. The WHO Global School Health Survey data shown above for 13 to 15-year olds showed higher sexual activity in Dominica in 2009 and lower in Grenada in 2008. The diagram below compares data for the project countries with data from Antigua and Barbuda and St. Kitts and Nevis, showing higher levels of early sexual activity in the project countries.

Figure 11: Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15, 2011



Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011a]

The following chart enables comparisons between Dominica and Grenada and the other two countries in the OECS KABP studies. Percentages of males with multiple partners are consistently higher than among females. The rates of multiple partnerships among 15-19 year old males in Dominica and 20-24 year old males in Grenada are particularly high.



Table 13: Dominica: Age difference with first sex partner, 2011

		Age group	15-19 %	20-24 %
Male	Age Of Person With Whom You Had First Sexual Experience	10 or more years older	.0	.0
		5-10 years Older	.0	10.3
		Less than 5 years older	28.1	50.8
		Less than 5 years younger	35.6	13.4
		5-10 years younger	6.1	.0
		Don't know	27.3	13.3
		Not stated	2.9	12.2
Female	Age Of Person With Whom You Had First Sexual Experience	10 or more years older	.0	12.6
		5-10 years Older	26.4	36.9
		Less than 5 years older	50.0	39.8
		Less than 5 years younger	6.6	4.3
		5-10 years younger	0	.0
		Don't know	17.1	4.3
		Not stated	.0	2.1
Total	Age Of Person With Whom You Had First Sexual Experience	10 or more years older	.0	8.9
		5-10 years older	12.7	29.0
		Less than 5 years older	38.6	43.0
		Less than 5 years younger	21.6	7.0
		5-10 years younger	3.2	.0
		Don't know	22.4	7.0
		Not stated	1.5	5.1

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011]

The following table shows age differences with first partners for males and females among young people in Dominica. The Grenada report does not present these data disaggregated by age group and sex.

None of the Dominican males and females in the table above reported that their first sexual experience was with a person ten or more years older. This differs from the OECS BSS with 15-24-year olds which found that 3 per cent of males and females in Dominica had a first sexual partner who was 10 or more years older [See Table 11 above]. Males in the 15-19 year old age group were less likely than females in the same age group to have a partner five to ten years older [.0 per cent and 26.4 per cent respectively]. The same was true for males and females in the 20-24 age group [10.4 per cent and 36.9 per cent respectively]. This is also consistent with the OECS BSS with 15-24-year olds which found that 3 per cent of males compared to 16 per cent of females had a their first sexual experience with a partner who was 5-9 years older.

2.5.3 NUMBER OF PARTNERS

The following table gives reported numbers of non-commercial sex partners for the age group 15-24 in project countries. It shows that at least half of 15-24-year olds reported that they had had one or two partners in the past 12 months, with

Table 14: Number of non-commercial sex partners in the past 12 months: OECS BSS with 15-24-year olds, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Sex of Respondents	# of respondents who had sex in the past 12 months	Median number of non-commercial sex partners	Range for number of non-commercial sex partners
Dominica	Male	285	1	1 to 24
	Female	257	1	1 to 5
	Total	542	1	1 to 24
Grenada	Male	239	2	1 to 11
	Female	281	1	1 to 6
	Total	520	1	1 to 11
St. Lucia	Male	332	2	1 to 10
	Female	290	1	1 to 10
	Total	622	1	1 to 10
St. Vincent & the Grenadines	Male	225	2	1 to 12
	Female	331	1	1 to 4
	Total	556	1	1 to 12

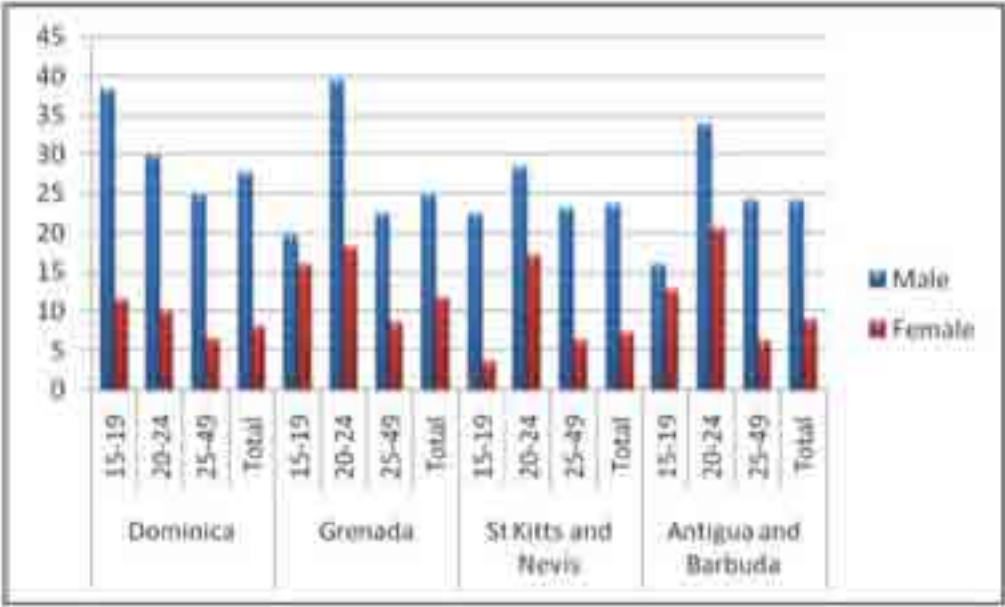
Source: [Ogunnaike-Cooke, Kabore et al. 2006]

most males reporting two partners. The range of numbers of partners was wider for men, with up to 24 partners reported. In contrast, a maximum 10 partners in the past year was reported by females.

Table 15: Dominica, Grenada, St. Kitts and Nevis and Antigua and Barbuda: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months, 2011

Count	Age Groups	Sex Of Respondent		
		Male	Female	Total
Dominica	15-19	38.2	11.5	22.7
	20-24	29.8	9.9	15.8
	25-49	24.7	6.4	14.9
	Total	27.6	7.9	16.5
Grenada	15-19	19.6	15.9	17.3
	20-24	39.4	18.1	26.9
	25-49	22.3	8.5	14.0
	Total	24.9	11.6	16.9
St Kitts and Nevis	15-19	22.4	3.5	13.0
	20-24	28.3	17.1	24.1
	25-49	23.0	6.2	12.0
	Total	23.6	7.1	13.5
Antigua and Barbuda	15-19	15.9	12.7	14.0
	20-24	33.9	20.5	25.9
	25-49	24.0	6.1	13.9
	Total	24.0	8.8	15.3
Total	15-19	25.5	11.6	17.5
	20-24	33.5	16.1	23.0
	25-49	23.7	6.7	13.8
	Total	25.2	8.8	15.7

Figure 12: Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past twelve months, 2011



The following chart enables comparisons between Dominica and Grenada and the other two countries in the OECS KABP studies. Percentages of males with multiple partners are consistently higher than among females. The rates of multiple partnerships among 15-19 year old males in Dominica and 20-24 year old males in Grenada are particularly high.

Table 16: Dominica, Grenada, St. Kitts and Nevis and Antigua and Barbuda: Average number of Sexual Partners in the Last 12 Months, 2011

	Dominica	Grenada	St. Kitts and Nevis	Antigua and Barbuda
Male	2.03	1.85	1.88	2.6
Female	1.27	1.22	1.40	1.25
Total	1.60	1.47	1.57	1.69

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011]



The following table presents average numbers of partners by sex, reinforcing the point that multiple partnerships are more common among males. These data were not disaggregated by age group in the study report so they represent the situation for 15-49-year olds.

Table 17: Condom use with commercial sex partners, OECS BSS, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Age of Respondents	Sex of Respondents	# of respondents with commercial sex partner[s] in the last 12 months	Percent who used condom at last sex with commercial partner	Percent reporting consistent condom use with commercial sex partner[s]
Dominica	15-24	Male	15	100	100
		Female	0		
		Total	15	100	100
Grenada	15-24	Male	14	79	50
		Female	16	56	6
		Total	30	67	27
St. Lucia	15-24	Male	26	69	46
		Female	54	83	24
		Total	80	79	31
St. Vincent & the Grenadines	15-24	Male	24	92	63
		Female	6	67	33
		Total	30	87	57
St. Vincent & the Grenadines	25-49	Male	21	95	57
		Female			
		Total			

Source: [Ogunnaike-Cooke, Kabore et al. 2006]

2.5.4 CONDOM USE

The OECS BSS provides figures on only one measure of condom use, condom use with commercial sex partners, on the basis that these partnerships are higher risk than other sorts of partnerships. This was measured in both 15-24-year olds and 25-49-year olds, and the following table provides the figures. Note that for the age group 25-49 the OECS BSS report states the figures for men only.

There were generally small numbers of people who said they had commercial sex in the past 12 months, the highest number being 101 in St. Lucia. The difference

in numbers by sex of those who reported commercial sex may not be significant since the numbers are small and may relate to different sample sizes for men and women. Among women, condom use at last sex was reported to be high, ranging from 67 percent in Grenada to 100 percent in Dominica. St. Lucia, where the highest number reported commercial sex, had the lowest prevalence of consistent condom use with a commercial partner – 31 percent. In St. Lucia and St. Vincent and the Grenadines condom use during commercial sex was higher in the older age group 25-49 than among the younger people.

In the 2010-11 OECS KABP surveys, there was greater attention to condom use. The following table gives data for Dominica and Grenada on the UNGASS indicator of condom use among people with multiple partners. It shows that condom use at last sex was highest among 15-19-year olds and dropped in older age groups.

Table 18: Dominica and Grenada: Percentage of men and women who had more than one partner in the past 12 months who used a condom at last sexual intercourse

Country		Male	Females	Total
Dominica	15-19	73.5	85.7	79.2
	20-24	64.3	36.4	52.0
	25-49	62.9	46.2	59.1
	Total	65.7	56.9	63.3
Grenada	15-19	80.0	92.3	82.6
	20-24	76.9	76.5	76.7
	25-49	64.0	44.8	57.0
	Total	69.4	63.3	66.9

More of the 15-19-year old females than males of the same age group used a condom. There is still substantial room for improvement, with between one fifth and half of young people not using a condom at last sex even though they had more than one partner.

A review of Caribbean HIV BSS and Knowledge, Attitudes, Practices and Belief [KAPB] surveys [Bombereau 2007] found eight surveys conducted between 2000 and 2006 in which young people aged 15-24 reported on condom use at first sex. In five out of the eight surveys<sup>1</sup>, over half of respondents reported

1 The eight studies were conducted in seven countries.

using a condom during their first sexual encounter. The percentage of youth who reported using a condom at first sex ranged from 35 percent in St Vincent [2006] to 76 percent in Dominica [2006]. Note that the relatively high use of condoms at first sex in Dominica is consistent with the high rate among 13-15-year olds in Dominica reported in the table above on the Global School-Based Student Health Survey.

The same review of eight surveys showed that more males than females knew a place to find condoms. The highest gap was found in Haiti, where only 6 out of 10 females aged 15-19 years old knew a place to find condom compared to 9 out of 10 males [Bombereau, 2007].

Thirteen surveys with young people asked them about consistent condom use over the past 12 months<sup>2</sup>. In 10 of these 13 surveys, less than half of the surveyed youths indicated that they used condoms every time they had sex in the past 12 months. In eight of the surveys, a third or less of the youth indicated using a condom consistently. In Haiti, St Kitts and Nevis, St Vincent and the Grenadines and St Lucia, only about one in every five youths, regardless of gender, declared having used a condom every time they had sex with a non-regular, non-commercial sex partner.

Similar findings were found in reviewing seven surveys among adults<sup>3</sup>. Across all seven, over half of the respondents indicated that they did not use a condom every time they had sex in the past 12 months.

Available evidence suggests that at first sex, condom use is more common among girls than boys. The reverse can be observed among young adults and adults, where condom use [at last sex and consistently] is greater among males and within non-regular relationships [Norman 2003; Bombereau 2007; Bombereau and Allen 2008].

## 2.6 BIOLOGICAL RISK FACTORS

Biological risk and protective factors have often been overlooked by sexual and reproductive health decision-makers concerned with prevention in the Caribbean. Interventions such as antiretroviral therapy have usually been seen as medical issues to do with treatment rather than prevention. However, there is increasing

<sup>2</sup> Data were from 13 surveys in 10 countries: 6 OECS, 20063; Guyana, in-school-youth, 15-19 years, 2004; Guyana, out-of-school youth, 15-24 years, 2004; Jamaica, in-school and out-of-school youth, 15-19 years, 2000; Haiti, household survey 15-19 and 20-24 years old, 2000; Barbados, 15-29 years old, 2001.

<sup>3</sup> Data were from seven surveys in seven countries: six OECS, 25-29 years old, 2006; Haiti, males, 25-49 years old, 2000.

evidence that biological interventions can also be effective in prevention of HIV and STIs. Biological factors influencing transmission include:

- **Biological sex.** per vaginal sex act, females are more susceptible to HIV transmission than males and young women and girls whose genital organs have not yet matured are especially vulnerable. Male-to-female transmission during sex is about twice as likely to occur as female-to-male transmission if no other sexually transmitted infections are present [Joint United Nations Programme on HIV/AIDS [UNAIDS] 2004].
- **HIV virus** sub-types.
- **Presence of other STIs** can influence susceptibility to HIV [Korenromp, White et al. 2005].
- **Stage of infection.** viral load and thus the potential for infection is high during the immediate post-infection phase and also during advanced HIV infection or AIDS [Pisani 2011].
- **Prevalence of HIV/STIs.** The higher these are the greater the chance of infection. Also, the extent of concentration of the epidemic among sub-groups such as men who have sex with men and sex workers and the size of the populations who have sex with people in these groups affect HIV and STI susceptibility.
- **HIV treatment.** A recent clinical trial [the HPTN-052 trial] has shown that treating HIV “early” - when the CD4 count was between 350 and 550 cells/mm2 – reduced the likelihood of HIV transmission by 96 percent as compared with the control group who received antiretroviral therapy [ART] only when CD4 went down to 250-200 cells/mm2 [Cohen, Chen et al. 2011]. See <http://www.niaid.nih.gov/news/QA/Pages/HPTN052qa.aspx>. Other observational studies with HIV discordant couples have also shown lower HIV incidence among those whose HIV positive partners are taking ART.
- **Male circumcision.** Several clinical trials as well as observational studies have demonstrated that male circumcision reduces the likelihood of HIV transmission from females to males by around 60 percent per act of vaginal intercourse [Weiss, Quigley et al. 2000; Weiss, Halperin et al. 2008]. See <http://malecircumcision.org/>
- **Vaginal practices.** Some vaginal hygiene practices such as douching and use of herbs inside the vagina for cleanliness or for sexual



enhancement such as dry sex have been shown to increase risks of reproductive tract infections and STIs [especially bacterial vaginosis] *[Zhang, Thomas et al. 1997; Fonck, Kaul et al. 2001; Cherpes, Meyn et al. 2003]*. The evidence that they increase risk of HIV is inconclusive, partly because it depends on the nature of the practices *[Allen, Desmond et al. 2010]*. In sub-Saharan Africa, cross-sectional studies have shown associations between IVP and HIV prevalence *[Mann, Nzilambi et al. 1988; Gresenguet, Kreiss et al. 1996; Brown and Brown 2000; Myer, Denny et al. 2004]*, but evidence from prospective studies is conflicting *[Myer, Kuhn et al. 2005; McClelland, Lavreys et al. 2006; Myer, Denny et al. 2006; Van de Wijgert, Morrison et al. 2006; van de Wijgert, Morrison et al. 2008]*. Studies have varied in the degree to which they have controlled for potential confounding variables *[Myer, Kuhn et al. 2005]*. Impact may depend on frequency, chemical and physical properties of substances and how they are applied or inserted.

- **Male genital hygiene.** There is some limited evidence that among uncircumcised males, penile hygiene, involving in particular cleaning inside the foreskin, can reduce risk of HIV, but the reduction in risk is minor as compared with male circumcision *[Meier, Bukusi et al. 2006; O'Farrell, Morison et al. 2006]*.
- **Menstrual practices** adopted by poor women, such as using cloths to absorb blood without adequate facilities to sterilize them before re-use, may also increase risks of reproductive tract and sexually transmitted infection *[Francis, Allen et al. 2007]*.

To date, there is little data on biological risk and protective factors in the Caribbean. The extent of male circumcision, for instance, is not known, but it is widely thought that the majority of younger men are not circumcised because the trend has moved away from infant male circumcision since around the 1960s. There are no published studies on male circumcision or male or female genital hygiene practices in the four countries in our study. With the exception of a couple of studies in the Northern Caribbean *[Sobo 1997; Brito, Caso et al. 2009]*, there has been little research interest in this area in the region. We do not know the extent to which beliefs about genital practices and male circumcision are culturally embedded and the extent to which they are amenable to change.

## 2.7 SOCIAL, ECONOMIC AND CULTURAL FACTORS INFLUENCING SEXUAL BEHAVIOUR

Sexual behaviours and biological risk and protective factors may be influenced by the social, economic and cultural environment. Social and gender norms, economic inequalities, political decisions, laws and health policies are among a

wide variety of issues that can influence HIV incidence and prevalence via their effects on sexual behaviour or on biological risk. This section looks at some of the most important of these, considering evidence wherever possible from young people in the four countries in our study, but supplementing this with studies from the wider Caribbean and further abroad as necessary.

### 2.7.1 GENDER-RELATED NORMS AND TRANSACTIONAL SEX

Gender norms are important in reinforcing youth vulnerability. Qualitative studies have shown a strong pressure on boys from both peers and family members to be sexually active, in part to dispel fears of homosexuality *[Chevannes 2001; George, Alary et al. 2002; Hutchinson, Jemmott et al. 2007; Hope 2010]*. There is also pressure on young men to have more than one partner. In two single-sex focus groups with 14-18-year olds in St. Vincent, both sets of respondents agreed that Caribbean men prefer to have more than one girlfriend. When asked why, the girls said that it is important that they demonstrate publicly that they are involved with more than one woman. The males said this was important to prevent being alone if one of the girlfriends found somebody else *[Avant Garde Media 2008]*. Girls are under increasing peer pressure to demonstrate their attractiveness by having a sexual partner *[Kempadoo and Dunn 2001; George, Alary et al. 2002; Barrow 2007]*.

There is also an important transactional element to many relationships and encounters. To access economic resources men and, to a greater extent, women put themselves at risk by accepting multiple partnerships, not negotiating condom use and/or trading sex for money and goods. Adolescent girls and some boys may accept unprotected sexual relations with older men in order to access resources. A Caribbean literature review found that these practices are supported by the cultural norm that men should provide financially for their sexual partners *[Bombereau and Allen 2008]*.

Qualitative research supports the idea that many young people are effectively trading sex for money or gifts but quantitative studies, where people are asked to state clearly whether or not they do so, tend to produce results suggesting that few people actually do trade sex for money or gifts, as shown in the table below. It should be noted, however, that quantitative estimates may underestimate the true extent of transactional or commercial sex because people do not wish to admit to being associated with commercial sex, or they may not associate their actions (in, for example, expecting gifts from their boyfriend) with transactional sex. Another important point is that those who *are* engaged in these activities are at high risk and, especially in the context of a concentrated epidemic, we should concentrate resources on those people who are at high risk rather than at people as a whole. Thus interventions should seek out those who engage in these high risk activities.

Table 19: Commercial and transactional sex among those who had sex in the past 12 months, OECS BSS, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Age of Respondents	Sex of Respondents	# of respondents who had sex in the last 12 months	Percent who had sex with a commercial partner in the last 12 months	Percent received money/gifts for sex in the last 12 months
Dominica	15-24	Male	285	5	3
		Female	257	0	1
		Total	542	3	2
	25-49	Male	297	9	0
		Female	295	0	0
		Total	592	4	0
Grenada	15-24	Male	239	6	5
		Female	281	6	5
		Total	520	6	5
	25-49	Male	277		1
		Female	299		2
		Total	576		2
St Lucia	15-24	Male	332	8	7
		Female	290	19	26
		Total	622	13	15
	25-49	Male	291	7	0
		Female	287	7	6
		Total	578	7	3
St. Vincent & the Grenadines	15-24	Male	225	11	8
		Female	331	2	2
		Total	556	5	5
	25-49	Male	291	7	2
		Female	298	1	1
		Total	589	4	2

Source: [Ogunnaike-Cooke, Kabore et al. 2006]

Among those in the 15-24 age group who had sex, Table 8 shows that the percentage who had sex with a commercial partner in the past 12 months ranged from 3 percent in Dominica to 13 percent in St. Lucia. Among sexually active 25-49-year olds, the percentages ranged from 4 percent in Dominica to 7 percent in St. Lucia. There was no data from Grenada on this indicator. Note that according to Table 7, St. Lucia was also the country with the largest number of survey

respondents who had a commercial sex partner. In every country except in St. Lucia, the percentage among 15-24-year olds who reported having sex with a commercial partner was higher among men than women.

Among sexually active 15-24-year olds, the percentage who received money or gifts for sex in the last 12 months ranged from 2 percent in Dominica to 15 percent in St. Lucia. In the 25-49 age group, the equivalent percentages ranged from zero in Dominica to 3 percent in St. Lucia. Thus young people were more likely to be paid for sex than older people. Gender-related patterns were not consistent. Among young people in St. Lucia, considerably more females than males reported having received money or gifts for sex. However, in Dominica and St. Vincent and the Grenadines, more males than females reported this practice, while in Grenada the percentages were equivalent. The data show a small but substantial minority of young people are willing to report having been paid for sex, and that both males and females are being paid for sex. Males selling sex may be an important part of the explanation of the high proportions of male cases of HIV.

2.7.2 “CLUSTERING” OF RISK FACTORS AMONG A MINORITY OF YOUTH

The largest English-Speaking Caribbean youth health survey to date was carried out among 15,695 in-school youth aged 10-18 in nine countries, including Dominica, Grenada and St. Lucia. Data for individual countries was not disaggregated. About a sixth of all respondents stated they had been physically abused [15.1 percent of females and 16.9 percent of males], and one-tenth reported sexual abuse [10.9 percent of females and 9.1 percent of males]. Abuse, either physical or sexual, was found to be a significant predictor of sexual activity, raising the odds of having had intercourse by 1.36 among boys and 2.14 among girls [Blum and Ireland 2004]. Furthermore, young people who had early sexual intercourse, defined as initiating sexual intercourse at or before thirteen years of age [representing over 22 percent of respondents], were significantly more likely to be involved in other practices that are potentially damaging to health, including carrying or fighting with a weapon, smoking, alcohol use, marijuana use, gang membership, running away from home and skipping school [Ohene, Ireland et al. 2005]. Thus vulnerability may be associated with a “cluster” of risk factors that include being out-of-school. On the other hand, feelings of school connectedness and family connectedness were shown to be protective factors, decreasing the likelihood of sexual intercourse [Blum and Ireland 2004]. There appears to be a difference, then, in the levels of vulnerability of those who attend school and who feel contented in that environment and those youth who are out-of-school and may be involved in a number of risky activities.



2.7.3 GENDER-BASED VIOLENCE AND CHILD SEXUAL ABUSE

As we saw in section 2.4, the four countries in our study experience considerable levels of gender-based violence. Violence is a regular feature of the lives of many Caribbean children and women. It is also a feature of many homes, schools, institutions and communities. Research indicates that children are exposed to a variety of different kinds of violence [physical, sexual, emotional, verbal] and that there is a high level of tolerance of violence – especially in the home, in the school and within the context of discipline and punishment [UNICEF 2007]. Violence between young people at school and in their communities is also common.

2.7.3.1 GENDER-BASED VIOLENCE

Available Caribbean data suggest the **vulnerability of young women to violence may be particularly high**. In Jamaica, a study among 750 females aged 15-17 years found that 49 percent of these young women had ever experienced sexual coercion or violence [Baumgartner, Waszak Geary et al. 2009] – a much higher percentage than the approximately 30 percent found in studies covering a one year period among the general population of women in Caribbean countries [Inter-American Commission of Women 2009]. As shown for project countries in Table 5 above, some girls are sexually initiated by older men, and age differences between girls and young women and their older male partners are often substantial, [Allen, Samiel et al. 2001; Allen, Martinez et al. 2002; Barrow 2003; Barrow 2004; Barrow 2007; CAREC 2007; Hutchinson, Jemmott et al. 2007]. **Incest** is an important factor. In a study in which Jamaican girls and boys were asked the question “Who do you think young girls have sex with the first time?” Most responses referred to someone in the family as girls’ first partners: father, step-father, cousins, uncles and brothers. The first partners of boys were also thought to be family members, such as sisters or cousins [Ramlal, Champagnie et al. 1985; Kempadoo and Dunn 2001].

In a review of evidence linking violence against women and HIV in the Caribbean, Allen and Odlum [2011] found a number of quantitative studies that showed associations between indicators of violence against women or child abuse and risk factors for HIV such as non-use of condoms or early sexual intercourse. Two such studies referred to in previous sections were the Dominica in-school survey conducted in 2000 in which engagement in sexual activity and inconsistency in condom use were found to be associated with sexual coercion [George, Alary et al. 2007] and the Caribbean Youth Survey in which sexual activity among 10-18-year olds was found to be associated with physical or sexual abuse [Blum and Ireland 2004]. Table 7 summarizes results of some other Caribbean studies that showed links between violence against women and HIV risk factors.

Table 20: Caribbean studies showing links between violence and HIV risk factors

Country of study [Authors]	Population	Violence indicator	Associated HIV risk factor
Haiti and Dominican Republic [Kishor and Johnson 2006]	Women aged 15-49	Ever experienced spousal violence	Sexually transmitted infection in past 12 months
Jamaica [Locke, Wyatt et al. 2004]	Women aged 15 to 50	Childhood sexual abuse	Lower use of condoms
Haiti [Smith Fawzi, Lamberta et al. 2005]	Women accessing a women’s health clinic	Forced sex	Symptoms of sexually transmitted infection

Source: [Allen and Odlum 2011]

A contributing factor is the **widespread acceptance of violence against women** as a taken-for-granted aspect of life in the Caribbean. In a focus group study with survivors of domestic violence in Barbados, participants believed that the “lackadaisical” attitude of the public and law enforcement officials was the most important factor impeding the containment of domestic violence [CADRES 2009]. Other studies in the Caribbean have shown that, despite the widespread nature of violence against women, it is regarded by many as shameful, is seldom discussed and is often hidden from public view. This means that many cases are unreported and there is a lack of law enforcement [Caribbean HIV&AIDS Alliance and University of California San Francisco 2010; Inter-American Commission of Women [OAS/ CIM] 2011]. **Disabled youth** are anecdotally reported throughout the Caribbean to be at high risk of sexual and other forms of abuse and thus of HIV, STI and teen pregnancy, but data on this are lacking.

With regard to policy to address violence against women [including domestic and sexual violence], major strides have been made in the adoption of CARICOM model legislation in several Caribbean countries [Clarke and Sealy-Burke 2005]. However, legislative reform is still needed in a number of areas to promote a safer environment for women. Some of these reforms can assist women in protecting themselves from HIV/STI transmission and in protecting female PLHIV from violence. According to the Inter-American Commission of Women, these include:

- Making marital rape a criminal offence (not just in cases of legal separation or divorce as exists presently).
- Including an arrest clause in domestic violence legislation, making it possible to arrest someone as soon as violence is reported.

Provision also needs to be made to authorize police to remove one of the partners in a domestic violence situation.

- A Batterer Intervention Program is needed, along with a place to take the perpetrator before trial.
- The introduction of mandatory reporting to police of child sexual abuse cases known to health care workers and teachers [Inter-American Commission of Women [CIM/OAS] 2009].

There is also evidence that the existing legislation is inadequately enforced by some law enforcement officials who are inadequately committed to combating violence against women [Inter-American Commission of Women [OAS/ CIM] 2011].

UNFPA has supported the St. Lucia Planned Parenthood Association in conducting a study of **intimate partner violence and contraceptive choice in St. Lucia** [Bray 2011]. In-depth interviews were conducted with 24 women, who were survivors of domestic violence or currently in an abusive relationship. There were also focus group discussions, two of which were with healthcare professionals and one with eight survivors of domestic violence. Most of the women (60 per cent) also self-identified as survivors of child sexual abuse, pointing to the importance of inter-generational abuse. Most [83 per cent] said that their partners affected their method of contraception. Three-quarters [75 per cent] indicated that their partner wanted them to get off contraceptives entirely, and tried getting them pregnant when they did not want to. Most of these women therefore used injectable contraceptives or intrauterine devices without their partner's knowledge, but the partners mostly found out eventually and some verbally or physically abused them at that point. Most participants had become disinterested in sex as a result of the sexual and physical abuse. Some reported that their partners had told them myths about the ineffectiveness or side effects of contraception to discourage use. Those who had been pregnant gave examples of ways that their partners sought to control the outcome, either to terminate it or carry it to term. Recommendations from the report included:

- Development of a domestic violence screening tool for front-line health care providers.
- Regular screening for domestic violence at all government and non-governmental clinics.
- Training of front-line service providers in screening and handling domestic violence cases, especially as regards confidentiality.
- A nationwide media campaign to highlight the issues surrounding domestic violence.

- Workshops on sexual and reproductive health and rights, especially for women, emphasising self-esteem, assertiveness, recognition of abuse and sexual enjoyment.
- Establishment of efficient referral systems between agencies concerned with domestic violence and sexual and reproductive health.
- Strengthening of linkages between services addressing child abuse and domestic violence.

### 2.7.3.3 CHILD SEXUAL ABUSE IN THE EASTERN CARIBBEAN

A UNICEF-funded study examined child sexual abuse in the Eastern Caribbean; Anguilla, Barbados, Dominica, Grenada, Montserrat and St. Kitts and Nevis [Jones 2009; Jones 2010; Jones 2010]. A mixed-methods approach was used to gather data from about 1,400 individuals from five stakeholder groups: the general population, professionals in relevant fields, policy makers, adult survivors of sexual abuse, and parents. The study report [Jones and Trotman Jemmott 2010] contains a lot of detail on child sexual abuse in the region and it will only be possible to summarize some key issues here.

According to participants, child sexual abuse in the Eastern Caribbean is a major contributor to teenage pregnancy and sexually transmitted infection, including HIV. In fact any sexual intercourse or pregnancy among girls under the age of 16 entails sexual abuse of a minor. However, there was some ambivalence about the status of teenage mothers, with some participants believing that through motherhood they became adult women. Some participants pointed to the difficulties for the girls in assuming adult responsibilities while they were still children, including disruptions to their education. It was noted that there is an important inter-generational element in teen pregnancies, with a considerable number of the mothers of teenage mothers having themselves become pregnant at an early age. There were also variations in the definition of childhood. Though most people believed that a person was a child at least until the age of sexual consent, some believed that childhood ends when a girl becomes a teenager. Thus in the focus group discussions, some men indicated that they considered girls to be 'legitimate sexual targets' once they reach their teens.

According to the findings, girls continue to outnumber boys among children subjected to sexual abuse, though cases among boys were said to be rising. Most of the perpetrators are male. The study shows that the major contribution that women make to the problem is in failing to protect children even when they are aware that abuse is going on by disbelieving the child, putting male partners before the protection of the child, minimising the harm that abuse does, physically abusing children and, in some instances, permitting or actively



encouraging abuse to take place for material gain. Among the many factors responsible for the abuse were said to be:

- Patriarchal values typified by men's sense of entitlement to sexually abuse the children of their partners because they are the breadwinners;
- The commodification of sex within society; and
- Poverty - single mothers who are economically dependent on men remain silent to abuse within the home in order to ensure the family's economic survival.

At the same time it was found that child sexual abuse occurred at all socio-economic levels and that the behaviour of perpetrators and people who turn a blind eye to it could not be attributed solely to economic status or level of education. In interviewing survivors, the study team found that strength and resilience were enabled by talking about the abuse, support and understanding, counselling and religion.

Some sexual abuse was said to be transactional. This involved primarily older men and teenage girls, but increasingly boys were involved in seeking or providing sexual favours in return for money or goods. There are isolated examples of women targeting young girls and boys. Transactional sex is often carried out openly, is sometimes widely known about and in some cases is socially sanctioned. Some highly prestigious and well-resourced older men were said to be involved in the practice and received little or no social censure as a result. Some parents and guardians turned a blind eye to the abuse of girls in this way because of the prospects for social or economic advancement. It was noted that some young people were engaging in transactional sex so that they could obtain cell phones, which were seen as a vital accessory by young people. Sex for access to other material goods such as clothes and fast food meals was also mentioned.

Incest was frequently mentioned. There was the commonly expressed view that fathers and step-fathers who committed incest were of the opinion that sex with their daughters was their right. The men, it was believed, thought that being the ones feeding and clothing the girls gave them the right to their sexual initiation. Focus group discussion participants in Dominica thought that this type of child sexual abuse was the most insidious but that it was traditional views and the inordinate power of men in families that gave men permission to commit these acts and to society to tolerate it.

Some important recent trends were said to be:

- **Cell phone pornography.** Children are using their cell phone cameras to take sexually suggestive images of themselves or others and to distribute them

- **Internet abuse.** Some predators access young people via social networking sites. Pornographic images of young people are also distributed.
- **Child sex tourism.** There was evidence of a growing market for child sex tourism. Specific examples were given such as the existence of an organized paedophile network set up to service cruise ships.
- **Opportunistic abuse linked to natural disasters.** Natural disasters often result in families being relocated to temporary shelters where children share living space with adults who take advantage of them, or where families are disrupted and focused on survival, lead to children being left unsupervised; or children may have to fend for themselves and their siblings, increasing their risk of being sexually exploited in return for money.
- **Sexual aggression by girls.** There was evidence from several countries of girls engaging in sexually aggressive behaviour in which groups of girls gang up on individual boys and sexually abuse them.
- **Transactional sex between children.** This issue was reported as a problem across all countries with young girls agreeing to sex with teenage boys for money and material goods [Jones and Trotman Jemmott 2010].

The following table provides data from the Welfare Department in Dominica on child sexual abuse cases reported to them in 2010. This shows a large number of cases [216], of which the majority were sexual abuse [71.3 per cent] and/or among females [81.9 per cent]. Eighteen of the cases were identified as incestuous and 13 resulted in pregnancy. Data for the first six months of 2011 were also provided, indicating that from January to June 130 child abuse cases were identified, of which 61.5 per cent were sexual and 74.6 per cent were female. The age breakdown [only provided for 2011] showed that 11.5 per cent of cases were 0 to 5 years old, 23.1 per cent were 6 to 10 years old, 59.2 per cent were 11 to 15 years old and 6.1 per cent were 16 to 17 years old.

Given the high levels of sexual abuse shown in this section it is surprising that the numbers of reported HIV and STI cases among young people are not higher. Explanations may lie in two factors:

- HIV and STI are not widely present in the general population, so they are unlikely to be spread to children.
- HIV and STI in the Caribbean are generally diagnosed at late stages in the disease, so are less likely to be detected in children.

Table 21: Dominica: Child abuse cases reported to the Welfare Department in 2010

MONTHS	Grand Total per Individual Months	Sexual Abuse	Physical Abuse	Emo- tional Abuse	Neglect /Aban- don- ment	Sexual Abuse & Neglect	Incest Cases per Month	Preg- nancy cases per month	Male cases per month	Female cases per month
JANUARY	12	11	1				1	2	1	11
FEBRUARY	11	10	1					2	2	9
MARCH	23	15	3		5		1		10	13
APRIL	23	16	6	1				2	5	18
MAY	14	8	3	1	2			1	3	11
JUNE	26	19	4	3			4		4	22
JULY	14	10	3			1	1		3	11
AUGUST	19	9	3		4	3	3	3	2	17
SEPTEMBER	20	11		4	5			2	2	18
OCTOBER	15	11	1		3		1		1	14
NOVEMBER	20	16	3		1		5		4	16
DECEMBER	19	18			1		2	1	2	17
GRAND TOTAL	216	154	28	9	21	4	18	13	39	177

Source: Welfare Department, Dominica

2.7.3.4 INDICATORS OF SEXUAL VIOLENCE IN THE OECS KABP SURVEYS

The three tables below show data on forced intercourse and sexual molestation among young people in Dominica and Grenada.

Rates of sexual abuse of young people in these countries are considerable, particularly among young women. There are also small but important minorities of young men [one in twenty in the 20 to 24 age group in Dominica] who were forced to have sexual intercourse, or raped, the first time they had sex. Over a quarter of young women aged 15 to 19 in both countries had been sexually molested.

Table 22: Dominica and Grenada: Percentage of young persons forced to have sexual intercourse the first time by age and sex, 2011

	Dominica		Grenada	
Age group	15-19 %	20-24 %	15-19 %	20-24%
Male	3.8	5.0	0	1.8
Female	8.6	11.4	14.4	20.1
Total	6.1	9.5	9.0	12.2

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011; Organisation of Eastern Caribbean States and Health Economics Unit 2011]

Table 23: Dominica and Grenada: Percentage of Young Persons Forced to Have Sexual Intercourse in last 12 months by Age and Sex, 2011

	Dominica		Grenada	
Age group	15-19 %	20-24 %	15-19 %	20-24%
Male	0.0	0.0	10.4	7.4
Female	10.7	2.6	9.4	7.6
Total	4.5	1.8	9.7	7.5

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011; Organisation of Eastern Caribbean States and Health Economics Unit 2011]

Table 24: Dominica and Grenada: Percentage of Young Persons who have been Sexually Molested, by Age and Sex, 2011

	Dominica		Grenada	
Age group	15-19 %	20-24 %	15-19 %	20-24%
Male	0.0	6.3	16.4	4.5
Female	27.1	17.7	26.3	14.9
Total	11.4	14.4	23.2	10.6

Source: [Organisation of Eastern Caribbean States and Health Economics Unit 2011; Organisation of Eastern Caribbean States and Health Economics Unit 2011]

2.7.4 DRUG AND ALCOHOL USE

As shown in the section on clustering of risk behaviours, a minority of young people may be engaged in a number of practices that put them at high risk of HIV. Among these are drug and alcohol use, which may reduce the ability of people to make sexual decisions in the interest of their health. They may also be associated with a cluster of other risk practices and with social marginalisation. In Jamaica, for instance, a study showed that marijuana smoking before sex was associated with STI and also that it was associated with high risk sexual and other behaviours and with lower education, unmarried status and unemployment [Simeon, Bain et al. 1996]. The following table presents data on young adolescents age 13 to 15.

Table 25: Alcohol and Other Drug Use of students aged 13-15 years, from Global School-Based Student Health Surveys, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Percentage of students who had at least one drink containing alcohol on one or more days during the past 30 days	Percentage of students who drank so much alcohol that they were really drunk one or more times during their life	Percentage of students who had a hang-over, felt sick, got into trouble with family or friends, missed school, or got into fights one or more times as a result of drinking alcohol during their life	Among students who ever had a drink of alcohol [other than a few sips], the percentage who had their first drink of alcohol before age 14 years	Percentage of students who used drugs one or more times during their life
Dominica					
Girls	54				
Boys	54.9				
Total	54.5				
Grenada					
Girls	43.0	22.1	13.1		7.8
Boys	49.1	33.9	19.2		21.9
Total	45.6	27.4	15.7		13.9
Saint Lucia					
Girls	52.2	30.0	14.1		15.8
Boys	59.2	41.5	15.4		29.7
Total	55.4	35.3	14.7		22.0
Saint Vincent					
Girls	53.5	30.0	14.6		13.4
Boys	52.6	40.3	18.1		26.9
Total	53.2	35.1	16.5		19.9

Source: [Centers for Disease Control and Prevention 2009]

The prevalence of alcohol use in the last 30 days ranged from 46 percent in Grenada to 55 percent in Dominica. Alcohol use was roughly the same among boys and girls in each country. The prevalence of drunkenness in the young people's lifetime was lowest in Grenada [27 percent] and highest in St. Vincent and the Grenadines [35 percent]. In Dominica, of students who had ever drunk alcohol, 88 percent had done so before the age of 14. In all countries, higher percentages of boys than girls had been “really drunk” in their lifetimes.

The third column of the table shows the percentages of 13-15 year old students who had got into various sorts of trouble as a result of drinking alcohol. This was not reported in the Dominica fact sheet. In the other countries, the percentages range between about 15 percent and 17 percent, with slightly higher percentages among boys.

Use of drugs was not reported in the Dominica Fact Sheet. In Grenada, 14 percent had used drugs, in St. Lucia 22 percent and in St. Vincent and the Grenadines 20 percent. In each of the three countries, the prevalence of drug use was higher among boys than girls.

An area of concern is the association between drug and alcohol and transactional sex, with both practices tending to reduce the likelihood that people will practice safer sex. Following are data from the OECS BSS showing the extent of self-reported exchange of sex for drugs among 15-24-year olds.

Table 26: Exchange of Drugs for Sex Among Respondents who had sex in the past 12 months, General population aged 15-24, OECS BSS, Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines

Country	Sex of Respondents	# of respondents who had sex in the last 12 months	Percentage who gave drugs for sex in the past 12 months	Percentage who received drugs for sex in the last 12 months
Dominica	Male	285	0	1
	Female	257	0	11
	Total	542	0	6
Grenada	Male	239	0	34
	Female	281	0	8
	Total	520	0	20
St Lucia	Male	332	1	7
	Female	290	1	10
	Total	622	1	9
St. Vincent & the Grenadines	Male	225	8	3
	Female	331	0	2
	Total	556	3	3

Source: [Ogunnaike-Cooke, Kabore et al. 2006]

No respondents in Dominica or Grenada reported giving drugs for sex, while 1 percent of both males and females in St. Lucia did so and 8 percent of males in St. Vincent and the Grenadines did so. However, larger proportions reported having received drugs for sex, ranging from 3 percent in St. Vincent and the Grenadines to 20 percent in Grenada, indicating the vulnerability of young people to exploitation by people who have drugs. In Dominica and St. Lucia there were clearly more females than males engaged in this practice, but the opposite was



the case in Grenada. The findings for Grenada were noticeably higher than other countries with one-fifth (20 percent) of sexually active respondents reporting that they had received drugs in exchange for sex. Anecdotal reports have suggested that this may have been related to difficult economic situations and/or psychological stresses in the aftermath of the hurricanes in 2005 [Ogunnaike-Cooke, Kabore et al. 2006].

A 1998 survey in **Grenada** based on the WHO Alcohol Use Disorders Identification Test [AUDIT] of 824 working adults aged 17 years and over found that 3 percent of male and 1 percent of female students drink four or more times per week [World Health Organization 2004]. Also in Grenada, a 2000–2001 study among 14 to 20 year old adolescents in secondary schools found that alcohol proved to be the drug of first choice for young people. The lifetime prevalence of alcohol use was found to be 87.7 percent of male and 70 percent of female students [Alexander 2004; World Health Organization 2004].

Surveys conducted in **St. Vincent and the Grenadines** suggest that among young people the most prevalent drug of choice is alcohol followed by marijuana [Drug Information Network St. Vincent and the Grenadines 2003]. The Adolescent Health Survey (2001) revealed lifetime prevalence rates for alcohol at 56 percent, marijuana 8 percent, cigarettes 7 percent and inhalants 11 percent. The Global Youth Tobacco Survey (2001) showed that 24 percent of the students currently used some form of tobacco and 15 percent currently smoke cigarettes. Most of the arrests in St. Vincent and the Grenadines are for marijuana. The majority of the individuals are male in the age group of 20-29 years followed by the 30-39-year old age group [Drug Information Network St. Vincent and the Grenadines 2003].

**Saint Lucia** is among several recognized as a transit point for drugs. Cocaine arrives by sea, primarily from Venezuela, and is offloaded to smaller local vessels along the coasts for onward shipment to Europe via the French territory of Martinique. As with the rest of the Caribbean it is increasingly common that with each shipment some percentage of the goods stays behind as a payment in kind and “dumped” on the local market. In Castries, a “crack rock” costs less than US\$2.

In St. Lucia, the drug culture appears to have become a “normal” activity and large numbers of young people, both male and female but larger numbers of the former, are involved in trafficking and use of illegal drugs. Not only has there been an increase in the use of illegal drugs, including cocaine, in all of the communities, but smoking of marijuana in particular is now done in the open. Interviews with young people revealed that some young people who still live with their parents are in a better position than their peers who in order to survive and to buy the things that they want become involved in illegal and criminal activities. Several admitted to using and selling drugs, and to being involved in

gangs and crime and saw these activities as providing them with the money they needed to get the things they wanted [Kairi Consultants Limited 2007].

As noted in the section on HIV, a behavioural and seroprevalence study found that 4.6 percent of homeless and poor crack cocaine users in St. Lucia were HIV positive. About 82 percent of study participants reported having unprotected sex, 28 percent doing so consistently (“always”) and just below half doing it “sometimes”. In the same study and among those who had vaginal and anal sex during the past 30 days 67 percent also reported not using a condom during sex; 72 percent did not use a condom in last “sex for money” or “money for sex” exchange [Day 2009]. According to Day [2009], it is important to understand the underlying mechanisms by which cocaine is linked to the HIV epidemic in the Caribbean in order to know how to use the information in HIV prevention strategies. As noted above, the majority of participants in this study were over 25, but the study is important in illustrating the increased risks of HIV transmission associated with drug use.

In another study, seventy-four homeless, out-of-treatment drug users were recruited from drop-in centres in Castries, Saint Lucia [n=26] and Port-of-Spain, Trinidad [n=48] [Day 2004]. Drug use and treatment experiences were assessed in this sample. Lifetime crack use was reported by 96 percent of the sample; 95 percent of the sample reported use within the past 30 days. Lifetime use of the following substances was as follows: 26 percent reported using tobacco, 54 percent used alcohol, and 64 percent used marijuana. More than 75 percent of the sample obtained their first “rock” from a friend, although they normally purchased the drug from an unrelated drug dealer. The first experimentation with crack was free for 85 percent of those who had used the drug. Evidence of crack’s strong addictive quality is highlighted by the time to regular use among this sample: 43 percent of the sample reported the onset of regular crack use “immediately,” or “within days,” of first use and 61 percent reported they were addicted to crack within two weeks of first use. This shows how easy it may be for youth to become addicted to crack cocaine if they experiment with it, as they may be more likely to do if they have used alcohol and “softer” drugs such as marijuana. Homelessness appears to have been directly caused by crack use for most of the sample, with less than 6 percent reporting homelessness prior to the onset of crack cocaine use [Day 2004].

#### 2.7.5 STIGMA AND DISCRIMINATION

Stigma and discrimination pose enormous challenges to the prevention of HIV, STI and teenage pregnancy. Stigmatisation and denial of young people’s sexuality can lead to denial of needed services and to poor health-seeking behaviour. In the context of concentrated epidemics, as appear to exist in the four countries in this study, discrimination against vulnerable groups, including men who have sex with men [MSM] and sex workers, likewise and even more severely restricts

access to services. Caribbean culture tends to reject homosexuality via extreme and frequently violent social disapproval. Local communities are generally homophobic, threatening MSM with social and economic marginalization, and sometimes violence or even death. In addition, MSM behavior is illegal in most of the Anglophone Caribbean [Averett 2011]. HIV-related stigma and discrimination result in low levels of testing and treatment, and non-use of condoms because of their association with HIV.

The Caribbean HIV&AIDS Alliance conducted a study of faith-based organizations in St. Vincent and the Grenadines and other countries in the Eastern Caribbean that are not included in the present study. The church leaders who were interviewed expressed welcoming attitudes towards PLHIV, based on Christian notions of compassion. However, the extent of their sympathy towards PLHIV was shown to be conditional on the extent to which they were either unengaged or willing to disengage in sexual activity that was regarded as sinful. Top of the list of sinful practices was homosexual sex, closely followed by commercial sex. This restricted the ability of the faith-based organizations to provide a comprehensive response to HIV in the context of a concentrated epidemic, and it was suggested that there was a need for them to collaborate with agencies willing to provide comprehensive services to vulnerable populations [Caribbean HIV&AIDS Alliance and University of California San Francisco 2010]. These findings are important since many young people in the Caribbean are involved in churches and these organizations can influence their attitudes and practices in relation to sex, HIV and STI.

The following table compares OECS BSS results for 2005-6 for 15-24-year olds and 25-49-year olds as regards accepting attitudes towards PLHIV. In general, slightly larger percentages of older people reported accepting attitudes than young people. Most people across countries were willing to care for an infected male or female relative and to allow an HIV-infected teacher to teach or an infected student to stay in school. However, a small minority were willing to buy food from an HIV-infected shopkeeper and only about half were willing to share food with someone who was HIV positive. This fear of infection or contamination via food was likewise found in the Caribbean HIV&AIDS Alliance survey with faith-based leaders [Caribbean HIV&AIDS Alliance and University of California San Francisco 2010].

The 2010-2011 OECS KABP studies included two project countries, Dominica and Grenada in addition to St. Kitts and Nevis and Antigua and Barbuda. Results from the Dominican and Grenadian respondents of the surveys are presented in Table 28.

Table 27: Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines: Respondents with accepting attitudes towards people living with HIV infection, OECS BSS, 2005-6

Country	Age of Respon- dents	Sex of Respon- dents	a) Care for an infected male relative %	b) Care for an infected female relative %	(c) Allow HIV- infected teacher to teach %	d) Buy food from an infected shopkeeper %	(e) Not want to keep HIV status of relative secret %	(f) Allow an infected student to stay in school %	(g) Share a meal with an infected person %
Dominica	15-24	Male	76	77	63	11	38	66	56
		Female	79	82	79	19	36	85	51
		Total	77	80	72	15	37	76	53
	25-49	Male	85	85	63	11	53	66	70
		Female	82	81	77	20	50	82	59
		Total	83	83	70	16	51	74	65
Grenada	15-24	Male	63	62	58	19	42	61	46
		Female	76	81	69	14	27	73	51
		Total	70	72	64	16	34	68	49
	25-49	Male	72	74	76	16	52	75	65
		Female	67	70	71	21	40	78	58
		Total	70	72	73	18	46	77	61
St Lucia	15-24	Male	57	57	59	23	26	72	37
		Female	56	66	67	10	34	76	43
		Total	57	62	63	17	30	74	40
	25-49	Male	61	67	68	26	45	72	37
		Female	73	77	77	11	40	83	58
		Total	66	72	72	18	42	79	47
St. Vincent & the Grenadines	15-24	Male	86	84	62	16	27	72	49
		Female	64	73	75	14	45	74	73
		Total	74	78	69	15	37	73	62
	25-49	Male	79	81	64	20	41	73	65
		Female	62	67	69	15	55	70	66
		Total	71	74	66	18	48	71	66

Source: [Ogunnaike-Cooke, Kabore et al. 2006]

The majority of surveyed people seemed willing to care for HIV infected relatives. Females were more willing than males in most age groups in the 2011 study, whereas in the 2005-2006 OECS Behavioural Survey females were more willing only in the younger age group aged 15-24. In Dominica, willingness to allow

asymptomatic HIV positive teachers or students to continue with their school-related activities was lowest in the 15-19 year age group – the age with most contact with students and teachers. In both countries, youth aged 15-24 were more likely than older age groups to keep the HIV status of a relative secret. Consistent with the 2005-2006 survey, there was low willingness for food-related contact that might reflect persistent fear of HIV transmission through food, with these attitudes particularly prevalent at younger ages.

As part of a study of the *Response of Caribbean Youth to HIV/AIDS Prevention Messages and Campaigns*, six single-sex focus group discussions were carried out with 14-18-year olds in Barbados, St. Kitts and Nevis and St. Vincent and the Grenadines. Among the findings were the low levels of accurate knowledge of HIV transmission that led to fears of casual contact and consequently stigma. For instance, in St. Vincent a girl said that teachers with HIV should not be allowed to continue working because they might sneeze and transmit the virus to students. Another girl in that group believed that HIV could be transmitted by an HIV positive student who “scraped” another student. There were also beliefs that HIV positive people deliberately spread the virus. A boy in St. Vincent said that HIV positive teachers should not continue because they will want to have sex with the students to pass on HIV [Avant Garde Media 2008]. These responses seem to substantiate the finding from the OECS BSS survey that young people have lower levels of acceptance of PLHIV and that there is a need for education to combat stigma and discrimination among them.

A study in Barbados, Grenada and Trinidad and Tobago found that while many people involved in various aspects of social work and health care believed that they were sympathetic to PLHIV, some still believed in some of the discredited popular myths about the way the disease is transmitted. Most of the service providers were reluctant to get tested because they were afraid that this could lead to discrimination. Participants generally agreed that PLWHA didn’t care if they infected others and were neutral regarding whether PLWHA were responsible for their condition [Abell, Rutledge et al. 2007]. Improving attitudes and practices among health care workers vis-à-vis people living with HIV has been a major focus of the Champions for Change initiative of the Pan-Caribbean Partnership Against HIV/ AIDS [Pan Caribbean Partnership Against HIV/ AIDS, Caribbean Community et al. 2005], as well as its Law, Ethics and Human Rights project.

2.7.6 VULNERABLE POPULATIONS AND DISCRIMINATION

The HIV epidemic in the Caribbean has been described as ‘mixed’ in that there is generally medium to high prevalence in the general population along with a high concentration in so-called most at-risk populations such as sex workers and men who have sex with men, many of whom are adolescents and young

Table 28: Dominica and Grenada: Respondents with accepting attitudes towards people living with HIV infection.

Country	Age of Respon- dents	Sex of Respon- dents	[a] Care for an infected male relative %	b) Care for an infected female relative %	[c] Would attend school with male teacher with HIV %	d) Buy food from an infected shopkeeper %	[e] Not want to keep HIV status of relative secret %	[f] Would attend school with student with HIV %	[g] Share a meal with an infected person %
Dominica	15-19	Male	75	75	61	13	34	67	42
		Female	61	68	78	23	32	78	57
		Total	67	71	71	19	32	73	51
	20-24	Male	57	57	71	11	27	77	60
		Female	72	65	86	31	33	88	53
		Total	67	63	82	25	31	85	55
	25-39	Male	72	71	84	31	45	85	62
		Female	72	83	88	27	45	92	70
		Total	72	77	86	29	45	89	66
	40-49	Male	69	69	72	23	60	69	56
		Female	75	79	81	23	45	85	58
		Total	72	74	77	23	52	78	57
Grenada	15-19	Male	77	77	83	42	41	83	56
		Female	73	76	88	41	42	87	63
		Total	74	76	86	41	42	86	60
	20-24	Male	73	73	82	40	39	84	62
		Female	77	79	87	36	36	87	64
		Total	75.7	76.5	84.8	37.6	37	85.9	63.3
	25-39	Male	79.1	76.1	81.0	32.5	55.1	82.0	63.3
		Female	79.2	79.8	89.5	38.2	37.9	90.3	68.0
		Total	79.2	78.4	86.3	36.1	44.4	87.2	66.2
	40-49	Male	75.0	75.2	83.7	39.5	52	84.6	74.0
		Female	73.3	74.0	80.6	32.3	52.9	81.6	65.3
		Total	74.0	74.5	81.9	35.4	52.6	82.9	69.0

OECS KABP surveys, 2010-11



people. In the countries in this project HIV levels in the general population are indicated to be low. However, as noted above, in Dominica among MSM a high prevalence rate was recently found, indicating a more concentrated epidemic. Recent surveys in other Caribbean countries show HIV prevalence levels of up to 32 percent in men who have sex with men and 27 percent among sex workers [UNAIDS 2009]. Research in Eastern Caribbean countries has shown that there are important class and other social divisions between MSM, with differing levels of openness about sexual orientation and practices, posing difficulties for outreach and involvement in activities that might publicly identify them as homosexual [Russell-Brown and Sealey 1998; Caribbean HIV&AIDS Alliance and University of California San Francisco 2010]. As for men who have sex with men, discrimination and violence against sex workers is associated with their social marginalization and the illegality of their activities. Violence is perpetrated not only by clients and partners, but by some law enforcement officials and sex work business operators [Kempadoo 2010]. These factors make it difficult for men who have sex with men and sex workers to adopt safer sexual practices.

An exploratory focus group study was conducted in Grenada and five other Caribbean countries to gather information around felt and enacted HIV-related stigma among community members in the effort to determine the perception of stigma in the Caribbean context [Royes 2007]. Two focus groups with adolescents were conducted in Grenada; one consisting of adolescent males and another adolescent females.

Participants in both groups were much more sympathetic to wives and husbands, and even sex workers who were HIV positive than to men who have sex with men. A male focus group participant said, *“I would want to kill the homosexuals who contracted the virus, but pitied the wife or husband who got it because of infidelity”*. Both groups felt that people living with HIV should be treated fairly but they emphasized that they should be given instructions regarding prevention of onward transmission. With regards to employing people living with HIV, they felt that they should be given work, but when questioned further several members of the male group indicated that this should be restricted to *“office work with little contact to people”*. Both groups expressed the feeling that persons who are HIV+ should not be handling food, confirming the taboo around food-handling by people living with HIV.

2.7.7 HIV KNOWLEDGE AMONG YOUTH

Table 29 reports the results from Dominica and Grenada from the 2010-2011 OECS KABP surveys on a key UNGASS indicator, the percentage of young people who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV. In both countries, more than half of respondents were successful in these skills (53% and 62% respectively). In Dominica, females in both the 15-19 and 20-24 age groups were more successful

in this area than their male counterparts. In Grenada, males in the 15-19 age group were more successful than their female counterparts. However in the 20-24 age group females were more successful. There is substantial room for improvement since in both countries substantial percentages of young people have incorrect knowledge and beliefs.

In the 2005-2006 OECS Behavioral Surveillance Survey, it was found that among those aged 15-24, most people surveyed, regardless of their gender, knew that a healthy-looking person could have HIV (92% to 99% of interviewees). Similar proportions of respondents rejected myths about HIV transmission via mosquito bites and by sharing a meal with an HIV infected person. Overall, the results indicate that across the countries in the study between 3 and 5 people out of 10

Table 29: Dominica and Grenada: Percentage of young people aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV transmission

Country	Age Groups	Sex Of Respondent		
		Male	Female	Total
Dominica	15-19	39.3	49.2	45.0
	20-24	61.7	64.0	63.9
	Total	47.8	56.2	53.0
Grenada	15-19	66.7	58.5	62.4
	20-24	54.5	70.2	63.8
	Total	59.8	64.8	62.8

still have some misconceptions about HIV and/or how it can be spread. Results from Dominica and Grenada for youth in 2011 seem to be slightly poorer than this since in Dominica 5 out of 10 and in Grenada 4 out of 10 were unable to both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.

2.8 MAJOR FINDINGS FROM THE DESK REVIEW

Before proceeding to analyse results from primary data collection with youth and stakeholders in project countries, it is useful to take stock of the major findings of this lengthy analysis of the existing data and research on sexual and reproductive health. The challenges facing youth in the Eastern Caribbean are numerous and varied. One is the economic conditions, meaning that many young people live in conditions of poverty with little prospect of employment during their youth. School completion is lower and absenteeism higher among males. The lower academic performance of males is reflected in lower levels of accurate knowledge and higher levels of misconceptions about HIV, as well as

higher levels of HIV stigma among them. Greater percentages of young than older people have stigmatising attitudes to people living with HIV. Fears of contamination through food and drink are particularly high, as are stigmatising attitudes relating to homophobia and prejudice against sex work. In the context of an HIV epidemic in project countries largely concentrated among vulnerable groups, it is important that the levels of accurate knowledge be improved and the levels of prejudice reduced.

There are high levels of transactional sex, sexual abuse and exploitation of children and young people, resulting in high levels of teenage pregnancy. Condom use is not sufficiently high, especially among males, to prevent HIV, STI and teen pregnancy. While overall numbers of pregnancies per woman in project countries have fallen over time, the percentage of those pregnancies among teenagers has remained relatively stable, ranging from 14 per cent to 23 per cent over the past ten years. The numbers of teenage pregnancies are very high relative to rates of HIV and other STI, meaning that the risk of pregnancy is a more immediate concern than STI to many young people, and that contraceptive needs are high.

The HIV epidemic appears to be largely concentrated among vulnerable populations, and reported cases of STI among youth are low. However, many cases of HIV and STI may be undiagnosed at young ages, and factors such as poverty, transactional sex, teen pregnancy, insufficient condom use, sexual abuse, poor knowledge and stigma and discrimination suggest that the risks of rapid spread among youth are high. Among teens, diagnosed cases of HIV are higher among women, suggesting their vulnerability through sexual abuse and via relationships with older men.

We now turn to analysis of responses to youth sexual and reproductive health in project countries, based on stakeholder interviews. This will be followed by analysis of the focus group discussions to find out the perspective of young people on the challenges described in the desk review, what brings them about and what may be done to address them.





# STAKEHOLDER INTERVIEWS



**A total of 73 stakeholders were interviewed or consulted, 20 in Dominica, 17 in Grenada, 20 in St. Lucia, and 16 in St. Vincent and the Grenadines.** This section provides an overview of the services provided to address sexual and reproductive health. A list of agencies represented by stakeholders included in the study is presented in Appendix 10.

From interviews across the four countries the following features are apparent.

## STAKEHOLDER INTERVIEWS: RESPONSES TO YOUTH 'SEXUAL & REPRODUCTIVE HEALTH IN THE EASTERN CARIBBEAN

### 3.

#### 3.1 TEENAGE PREGNANCY

Teenage pregnancy was viewed by stakeholders as substantial both in terms of numbers and impact on young peoples' lives. Girls are legally able to go back to school if they get pregnant, but many do not because of lack of adequate support, including child care, or because of the stigma and ridicule they might face. Special supportive services exist in Grenada and St. Vincent and the Grenadines. In Grenada, the Programme for Adolescent Mothers (PAM) provides academic and vocational education and life skills over a two-year period for mothers aged 11-18. PAM is a charity and receives funding from the government and private donors. Counsellors are available for the students and a nursery for their babies. In St. Vincent and the Grenadines, an innovative programme of support for teenage mothers exists whereby assistance is provided with skills building and job seeking, including some job placements. The Gender Affairs Department and the Youth Affairs Division of the Ministry of National Mobilization lead this initiative with support from UNFPA. The Guadeloupe Home for Girls also provides some assistance.

#### 3.2 PEER EDUCATION AND YOUTH FRIENDLY HEALTH SERVICES

The Red Cross conducts peer education in project countries via groups formed in schools but meeting outside. In St. Lucia they are partnering with the Community Paediatrician at the Ministry of Health and with UNFPA to develop and pilot youth-friendly health centres. The National Youth Council and National AIDS Programme are among several organizations that have participated in consultations on the design of youth-friendly health services throughout St. Lucia. The Ministry of Health is supporting and tracking the results of this pilot. Pilot projects have been set up in three areas through the work of the NGO RISE St. Lucia.

The St. Lucia Planned Parenthood Association, in partnership with RISE St. Lucia, is setting up a Mobile Youth Clinic. This was donated by Rotary and will offer sexual and reproductive health services in hard to reach communities, along with job prospects and funding opportunities/training by the national skills training agency.



In Dominica the Red Cross had a youth peer educator programme that was supported by the World Bank, but this ceased when the funding from the World Bank stopped. Youth are employed in various capacities by the Red Cross, including in their emergency relief programmes, and youth volunteers receive sexual and reproductive health education as part of their training.

The Young Women's Christian Association (YWCA) in Grenada includes HIV, sexual and reproductive health and gender in every outreach project or event. Consistent with its status as a Christian organization, young people aged under 20 are given "abstinence packages." These include a prayer and literature that focuses on behaviour, attitude and alcohol use. The people aged 20 and older are given safer sex packages, which are similar but also include a male and a female condom.

In St. Vincent and the Grenadines the Red Cross are conducting community consultations to orient their programmes and are increasingly realising that their peer support for youth should be supplemented by economic empowerment initiatives. St. Vincent and the Grenadines Planned Parenthood is looking at the feasibility of establishing separate youth-friendly services. The Health Promotion Unit of the Ministry of Health runs 13-week programmes in some schools called "Youth Guidance Centres". Topics discussed in the course include self-esteem, values clarification, growth and development, STIs, HIV/AIDS, conflict resolution, child abuse, drug abuse, diabetes, environmental health, hypertension, cancer and discipline. Once the young people have graduated from the YGC they are eligible to become part of HELTA groups, standing for Health Education for Life through Adolescents. The groups meet outside the school setting, usually after school, and out-of-school youth are welcome to join. Lately the HELTA groups have started to work with parents, aiming to improve communication and support between parents and children. The Family Planning Unit in the Ministry of Health also conducts adolescent programmes at the district clinics for youths between ages 12-18. Sessions are done after school for in- and out-of-school youths. Annually, a vacation camp focuses on reproductive health, communicable diseases, the environment and effective communication.

In St. Lucia, Several NGOs have youth peer outreach initiatives, including the Caribbean Association for Feminist Research and Action (CAFRA) Youth League, the Red Cross, Planned Parenthood, RISE and AIDS Action Foundation. Most of these recruit from schools with some out-of-school recruitment as well. The peer meetings generally take place in out-of-school settings, except those of the Youth Advocacy Movement of Planned Parenthood that take place in school as well. One organization, United and Strong, brings together gay, lesbian, bisexual and transsexual people for peer outreach and mutual support. CAFRA's Youth League involves young women in education and advocacy around gender-based violence, sexual and reproductive health and self-esteem.

### 3.3 VOCATIONAL EDUCATION AND THE NEEDS OF OUT-OF-SCHOOL YOUTH

In each country various governmental and non-governmental agencies seek to address the educational and skills-building needs of young people who have dropped out or not performed well in mainstream education.

In Dominica, the Youth Development Division in the Ministry of Education, Human Resource Development, Sports and Youth Affairs has shifted from welfare provision to providing skills training, enterprise development and interventions with "at-risk and marginalized" youth. Its strategic plan 2009-2013 includes the aim of increasing youth participation to reduce youth engagement in violent and antisocial behaviour. Other goals are to document youth success stories and establish a database on youth.

Also in Dominica, the Social Centre provides out-of-school youth, including teen mothers, with education and child care facilities. A life-skills approach to learning includes sessions on HIV and STI. The Child Fund conducts outreach to vulnerable communities, including young people who are out-of-school. Young people have been involved in the Roving Caregivers Programme through which they provide infants and their mothers in poor communities with direction on how to play with children and stimulate them intellectually, which has been shown in research to have long-term benefits to the academic and social performance of children. In Grenada, the Ministry of Youth Empowerment and Sport is responsible for four major areas: youth service and leadership; the apprenticeship programme to address youth unemployment; youth rehabilitation programme for youth at risk with the law; and the small business component, which is the entrepreneurship programme. The youth service and leadership programme is focused on the community and has a liaison person responsible for HIV/AIDS education. His role is to develop awareness about HIV/AIDS and collaborate with other organizations on HIV/AIDS projects. The youth rehabilitation programme is for males only and includes a focus on how to respect women as well as sexual and reproductive health education.

The New Life Organization (NewLO) in Grenada is a life skills and vocational training centre for those who dropped out-of-school or who never had a chance to go to secondary school. Before vocational training begins, each student must complete the adolescent development programme known as the "Spiceys Programme." This programme focuses on six different aspects of the individual: the physical, spiritual, intellectual, creative, emotional and social. Parenting skills are an aspect of the programme.

In St. Lucia, The Upton Gardens Girls' Centre provides education and support to continue their education for girls who have dropped out or been expelled from school. Sexual and reproductive health is taught alongside skills such as gardening/farming and sewing. Staff believe there is need to provide overnight

accommodation since the girls tend not to reach their full potential as they have to spend the evenings/nights in the same social environments, characterized by poverty and lack of parental discipline, that led to their being admitted to the Centre. Also in St. Lucia, the Social Development Fund and the Ministry of Youth and Sports both undertake considerable work in communities and develop infrastructures to access out-of-school youth as well as to offer them increased leisure, training and work opportunities.

In St. Vincent and the Grenadines, the Youth Department in the Ministry of National Mobilization has an important initiative focussing on the sexual and reproductive health of young heterosexual men. This involves outreach to young men “on the block”, training peer educators, and running “edu-tainment” sessions. The Youth Empowerment Service Programme (YES SVG) provides opportunities for out-of-school youth to experience the world of work through practical attachment to governmental and non-governmental institutions for a twelve-month period, while receiving a stipend and skills training in areas such as budgeting, micro-enterprise development, effective communication, workplace safety and ethics. An NGO, Marion House, is another major source of counselling support and skills building for out-of-school youth. Adult and Continuing Education (ACE) in the Ministry of Education also caters for out-of-school youth in the area of skill development through its evening classes which are conducted in seven zones across the island.

### 3.4 HEALTH AND FAMILY LIFE EDUCATION

Health and Family Life Education (HFLE) is carried out in school under the purview of Ministries responsible for education, and is said to follow the Caribbean Community HFLE guidelines. Teacher training is provided by these Ministries. In each country, a variety of organizations supplement the work of teachers, visiting schools to provide special sessions. In St. Lucia, guest speakers have included representatives from the National AIDS Programme, the Division of Gender Relations, RISE St. Lucia, Red Cross, AIDS Action Foundation, Caribbean Drug and Alcohol Research Institute and the St. Lucia Planned Parenthood Association. In St. Vincent and the Grenadines, the Caribbean Healthy Lifestyle Programme (CHLP), CARE SVG, The US Peace Corps Volunteers and Planned Parenthood all complement the ministries in helping with HFLE in and out of school.

In Grenada, in the Ministry of Education and Human Resource Development, the HFLE Coordinator directs teacher training and curriculum. HFLE subject leader posts have been established. About two are in each school, and are specially trained and chosen teachers who are available to deliver sex and sexuality topics which may be uncomfortable for some teachers. The Ministry of Education HIV/AIDS Response Unit also aims to create focal points for HIV education in each school.

### 3.5 GENDER-BASED VIOLENCE

In Dominica, The Welfare Department is the main referral agency in cases of child abuse. The Gender Affairs Department also sometimes refer cases of domestic violence there. There is no counsellor at Gender Affairs, and the few social workers at the Welfare Department have a heavy workload. The Dominica National Council of Women has a small room where women and children who are survivors of gender-based violence can stay. The Council also assists in finding refuge accommodation for survivors in the houses of friends and colleagues. Representatives of many agencies identified that counselling was in need of strengthening.

The St. Vincent and the Grenadines Human Rights Association has conducted research as part of PANCAP’s Law, Ethics and Human Rights initiative. They were instrumental in the establishment of the Family Court and laws to address gender-based violence. The National Council of Women has also played a major role in bringing to light the plight of women in the country.

The Grenada Legal Aid and Counselling Clinic provides legal and counselling services for people on low incomes. Its psycho-education programmes include one for perpetrators of violence against women (Partnership for Peace). The Clinic provides training for police and social workers on child abuse and domestic violence.

### 3.6 VULNERABLE POPULATIONS

#### 3.6.1 YOUNG PEOPLE WITH DISABILITIES

Each country has an NGO representing people with disabilities, but specialized attention to the sexual and reproductive health needs of youth varies. In St. Vincent and the Grenadines, the National Council for People with Disabilities provides educational sessions and workshops at their headquarters concerning sexual and reproductive health of adolescents with disabilities. Some of these are provided for adolescents themselves and some for their parents on ways to manage their children’s sexuality. The headquarters serves as a place for young disabled people to meet and receive additional educational and skills support. Other activities are conducted at the Council’s affiliate headquarters (National Association of and for the Blind, School for Children with Special Needs, Helping Hands).

The National Council for Persons with Disabilities in St. Lucia runs many workshops for people with disabilities and their carers. The St. Lucia government has a policy of integrating children with disabilities in mainstream schools where possible, and the children receive Health and Family Life Education there. Sexual and reproductive health of youth has not been a major focus of the Council in



St. Lucia.

Young people with disabilities appear to be especially vulnerable in Dominica as there is no policy of mainstream education for them. There are a few specialized schools but insufficient places to accommodate all those in need. Many young people with disabilities are at home and their isolation makes them vulnerable to exploitation. The National Council for Persons with Disabilities does not have a specialist youth programme but there is interest in doing so.

### 3.6.2 INDIGENOUS YOUTH: KALINAGO IN DOMINICA

In each country, youth descended from the original inhabitants, or “first people” of the Caribbean, are now part of ethnic minority populations and may be at particular disadvantage. In Dominica, specialized staff attend to the needs of the Kalinago Territory. A Field Officer from the Ministry of Carib Affairs liaises with youth and other organizations in the territory to assist in accessing agencies and services. Education of Kalinago youth is heavily supported by the Ministry, through grants and scholarships from primary to university level. Some who have benefitted from this educational support later returned to provide their professional expertise in the Territory, including regular medical clinics. Many governmental and non-governmental agencies conduct outreach to the territory including sexual and reproductive health education, with The Committee of Concern Women, the Catholic church and Church of the Nazarene providing a great deal of support. The University of Manitoba conducted a health survey in 2011 that may be used as a basis for planning.

### 3.6.3 POPULATIONS VULNERABLE TO HIV

NGOs provide the bulk of specialized services relating to key populations in HIV prevention, care and support, including drug users, MSM and sex workers.

The Caribbean HIV&AIDS Alliance [CHAA] has funding from USAID for the Eastern Caribbean Community Action Project 2 [EC-CAP 2], that began in 2011. It has recently set up offices in St. Lucia, Dominica and Grenada, while the St. Vincent and the Grenadines office was set up under the previous project [EC-CAP 1]. They specialize in outreach, care and support for key populations, especially sex workers, gay men and people living with HIV, training peers, known as animators, to conduct the outreach and counselling. Community-based voluntary counselling and testing is a feature of their programme and the organization operates at venues and events where high-risk behaviour takes place.

The Grenada chapter of the HIV/AIDS Partnership [GrenCHAP] is a small organization that provides services for marginalized populations including MSM and sex workers. The staff includes two Voluntary Counselling and Testing counsellors and a parenting facilitator. Parenting classes include information on talking about sex with children. Forums are facilitated by staff and include

discussions of homophobia and stigma and discrimination. GrenCHAP has a holistic approach to HIV prevention, including empowerment, relationship issues, spirituality, and general issues that persons face. Also in Grenada, Helping Our People Lead Productive Lives [Hope Pals Foundation] represents people living with and affected by HIV. Primary services include housing and support, home care, nutritional support, advocacy, lobbying and access to treatment. Human rights and reduction of stigma and discrimination are a major priority.

In St. Lucia, CAFRA is the main organization providing counselling, social support and access to health care for sex workers. They have also developed educational materials on safer sex for sex workers with assistance from UNAIDS and UNFPA. Sex work in St. Lucia is thought to be more professionalized than in other project countries, though there are also many young women who are involved in transactional sex. The Caribbean Drug and Alcohol Research Institute provides a social support venue for drug and alcohol users and assists them in accessing other services. The Director of the Institute also provides office space for the AIDS Action Foundation and United and Strong in the lower floor of his own home.

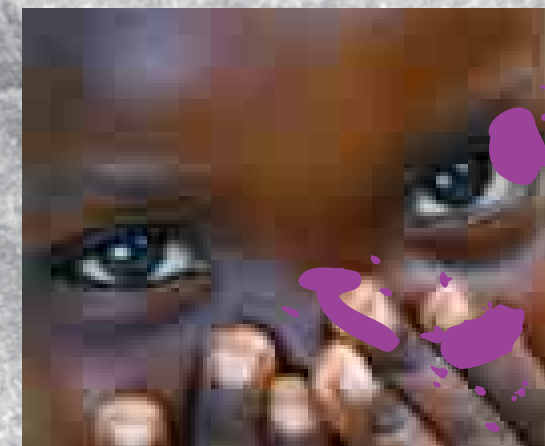
## 3.7 GOVERNMENT RESPONSES TO HIV

World Bank funding for HIV programmes in several Eastern Caribbean countries came to an end in 2010. The National AIDS Programmes in St. Vincent and the Grenadines and St. Lucia have since had to cut staff and programmes. For instance in St. Lucia, under the World Bank grant they had the Clinical Care Coordinator, the Civil Society Coordinator, a Monitoring and Evaluation Officer and Assistant, the Voluntary Counselling and Testing/ Prevention of Mother to Child Transmission [VCT/ PMTCT] Coordinator as well as focal points in NGOs and government Ministries. They now have a Biostatistician, a Data Collection Officer, the VCT/ PMTCT Coordinator, the Director and a secretary. They are working increasingly through ministerial focal points and NGOs, as well as forging new partnerships. Community-based voluntary counselling and testing is provided.

In Dominica, the National HIV/AIDS Response Programme has provided specialist health education for young people, for example staging plays, an HIV poster competition, booths at events and participating in the HFLE programme. The Programme hosted a National Youth Summit on HIV. It also provides voluntary counselling and testing at its headquarters and through outreach and access to clinical services. It has often provided support to people living with HIV and their organization, Life Goes On, through provision of office space, funding and involvement in a variety of activities. It has strong links with several governmental departments and NGOs and runs joint initiatives with them.

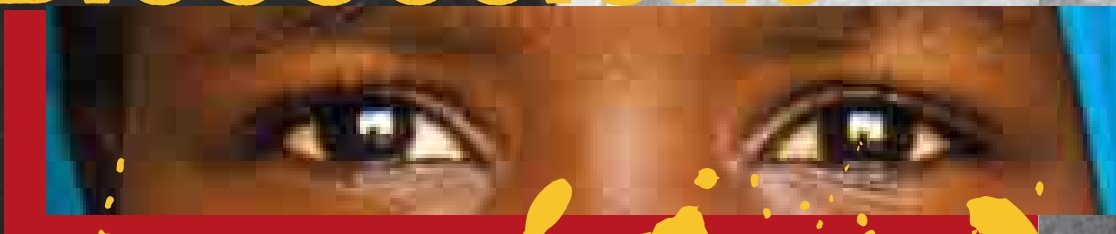
In Grenada, The Ministry of Education HIV/AIDS Response Unit coordinates all activities related to HIV/AIDS education for the Ministry. The Unit has one staff

member who coordinates all activities. The Coordinator conducts classes and talks with teachers, students and parents in an effort to develop new strategies around HIV/AIDS. Limited capacity makes it difficult to cover all schools. Other activities include gathering data, obtaining supplemental educational materials for schools, applying for programme funding and implementing programmes such as training teachers in how to deliver HFLE.





# FOCUS GROUP DISCUSSIONS



**In this chapter we report on youth sexual and reproductive health and rights from the point of view of young people themselves.** Focus group discussions (FGDs) were conducted with 15-17-year olds in the four project countries.

Within each country, UNFPA partners including Ministry and other governmental and non-governmental personnel kindly assisted with obtaining lists of suitable potential participants and making logistical arrangements for the FGDs. Given the length of time taken to obtain in-country ethical approval for the research before this process could begin, combined with budgetary constraints meaning that data collection had to end in 2011, the time available for FGD organization and data collection was more limited than planned. In the available time, challenges faced by

## FOCUS GROUP DISCUSSIONS WITH YOUNG PEOPLE

### 4.

partners in identifying out-of-school youth from whom to select potential FGD participants were the main reason that fewer than the six planned FGDs were conducted in Dominica and St. Lucia. There were also challenges in securing the approval of schools to conduct the research with students, in receiving lists of students, in contacting parents or guardians to complete the informed consent process and in assembling potential participants on the day scheduled for the discussion. For each FGD, at least five and up to ten young people were selected to participate, but as few as three attended to participate in three of the FGDs; for some there were challenges relating to the organization and timing of the groups.

#### 4.1 CHARACTERISTICS OF PARTICIPANTS IN THE FGDS

A total of 100 young people participated in the FGDs across the four countries, of whom 51 were male and 49 female.

Table 30: Number of FGD Participants by Country and Sex

Country	Males	Females	Total
Dominica	12	13	25
Grenada	16	8	24
St. Lucia	3	7	10
St. Vincent	20	21	41
Total	51	49	100



Table 31: FGDs conducted, by country, location and sex of participants

		In-school (number of participants)	Out-of-school (number of participants)	Other area (number of participants)	Total number of participants
Dominica	Male	Dominica Grammar School	--	Kalinago territory [5]	12
		[7]			
	Female	Dominica Grammar School	--	Kalinago territory [5]	13
Grenada	Male	Happy Hill Secondary School [5]	Various [3] <sup>1</sup>	Carriacou [8]	16
	Female		Various [3] <sup>1</sup>	Carriacou [5]	8
St. Lucia	Male	Castries Comprehensive Secondary School [3]	--	--	3
	Female	Castries Comprehensive Secondary School [7]	--	--	7
St. Vincent & the Grenadines	Male	Intermediate High School [9]	Various <sup>1</sup> [5]	Bequia [6]	20
	Female	Intermediate High School [7]	Various <sup>1</sup> [6]	Bequia [8]	21
Total number of participants		46	17	37	100

NOTE: 1.The participants in out-of-school FGDs in were drawn from various locations because of challenges in identifying sufficient numbers of out-of-school youth for sampling in any one village.

The table above shows the FGDs that were conducted in each country.

Among the 100 participants, 98 had received secondary education, while 2 males had received technical or vocational education. The following table gives the breakdown by country and employment status. The majority of participants were school students, reflecting the recruitment of most via schools and the difficulties in identifying out-of-school youth in the time available for fieldwork.

Table 32: Employment status of FGD participants

	Student, not employed Males	Student, not employed Females	Paid, full time employed Males	Paid, full time employed Females	Self employed Males	Self employed Females	Un employed Males	Unemployed Females
Dominica	12	13	0	0	0	0	0	0
Grenada	13	5	0	0	0	0	3	3
St. Lucia	3	7	0	0	0	0	0	0
St. Vincent	15	15	1	0	0	1	4	5
Total	43	40	1	0	0	1	7	8

The following sections address the research questions of the FGD component of this project, drawing on the responses of young people during the discussions. Throughout, differences by sex, country and between in-school and out-of-school youth are presented.

4.2 WHAT ARE THE FACTORS THAT DRIVE YOUTH VULNERABILITY, OR PROTECT YOUTH FROM HIV/STI/ TEEN PREGNANCY?

The discussions began by asking young people their perceptions of the opportunities and challenges of living as young people in their countries, and about the amount of power they believed that they had in relation to school, parents, government, work, relationships and religious leaders. Answers to these questions provide important contextual information about how young people are living and some key constraints on their abilities to control their sexual and reproductive health and rights.

Some of the responses reflected the general status of adolescence, being at once a time of perceived freedom and opportunity and also one in which they recognize, confront and contest various restrictions before being accepted as adults. Other responses were more locally specific, pointing to features of their countries that they liked or disliked and the reasons why.

4.2.1 ADOLESCENCE AS A TIME OF FREEDOM AND OPPORTUNITY

When asked about the opportunities for young people in their countries, several respondents immediately pointed to the freedom they felt they enjoyed, saying that they were “free to go anywhere” (Dominica male in-school) or “You have freedom to do whatever you want” (Grenada female out-of-school). This was a time when there was a “lot of pleasure time” (Dominica Kalinago male), in which young people did not face the responsibility of meeting all their subsistence

needs. Some pointed to the fact that their parents still did the majority of the household chores as well as earning to support the household, hinting that they sometimes took advantage of this at the expense of parents.

VFI1: We here young right. We don't have any much responsibility, we don't really have to worry about work and buy clothes and pay bills and all them thing there, you just live your life.

I: Live your life? What do you mean by that?

VFI1: Like go parties, hang out with friends, go beach, you know, have fun while you young.....

VFI2: When you young, you don't work, you depend on what your parents get.

VFI3: You just sit down and cock up [put up] your foot and your parents bring in the money and you spend.

*(St. Vincent and the Grenadines in-school females)*

Some declared that they were now able to look after themselves while others highlighted their continued dependency on their parents, even among out-of-school youth who were now employed.

VMO1: You could take care of yourself.

I: Okay, at that, at his age you could take care of yourself? Okay, anybody else?

VMO2: Man, me can't take care ah myself, dread

VMO3: And you ah work [are working]? (Boys laugh)

VMO2: My mummy still have fuh give me thing fuh eat.

*(St. Vincent and the Grenadines out-of-school males)*

It was also noted that the freedom often involved an element of rebellion against the restrictions that parents and others tried to impose.

My freedom is you could go and come back, when you come back you will get licks [from parents] and the next day you go again. When you go again, that is where freedom starts. So you could go and then you come in but you just tell you mother where you going. That is my freedom.

*(Grenada, out-of-school female)*

Some pointed to the physical abilities associated with youth and the opportunities for enjoyment that these offered.

We have a lot of energy to do things that grown people can't do, like going to the beach and jump around whole day and still have energy for later on to go and do more stuff.

*(Grenada, in-school male)*

Several pointed to this being a time of potential and possibility, while adulthood

was seen as a time when options were progressively closed. Young people were able to learn from the mistakes of previous generations:

VFI1: When you young, right, you could see how the world going today, see how the world going nah, the good and the bad, make way. You could avoid mistakes when you young so when you get older you know better what to do exactly, and learn from your parents mistake. 'Cause your parents could probably, say for example, get pregnant at age 15, and when you get older you would know better than that, to not follow in that same footstep.

VFI2: Cause you would have seen how she struggled, like to buy pampers and baby milk and you well want to buy clothes.

*(St. Vincent and the Grenadines, in-school females)*

The relatively plentiful opportunities available to this generation of young people were noted.

Choices that our parents did not have to make we can make.

*(St. Lucia male, in-school)*

These included educational opportunities. Participants valued the opportunities provided by free health care and education in their countries.

It have more schools, more campuses, more universities you can go to. Like my grandmother. My grandmother doh go high school, and my mother did not get the chance to go to university when she was younger so she going to university now. But me, I in high school now so after I can just go university one time. Go college.

*(Dominica in-school female)*

New technologies such as laptop computers and the internet were also highlighted as potentially expanding opportunities for young people, though the time-wasting potential of the internet was also noted.

As young men living in the twenty-first century we are faced with choices our parents didn't have to make. There are a lot of advantages and disadvantages. The internet we use for Facebook and projects like at the science lab. The disadvantage is wasting time on Facebook so getting up late for school.

*(St. Lucia in-school male)*



#### 4.2.2 ISLAND LIFE

The small islands of the Eastern Caribbean were portrayed as having the potential of living “a nice life, a simple life” (Grenada, out-of-school male). People were seen as generally treating each other well and there are very attractive features with the beach frequently mentioned. The availability of public education was also highlighted.

Living in Carriacou, it is very nice. I would say it is very nice. Because you get to enjoy the sandy beaches, and other activities, good education and a higher standard. Because when you leave from Carriacou to go to the States or somewhere else, (laughter) you do not get the opportunity as you get in Carriacou.

*(Grenada Carriacou male).*

The high quality of local food was praised, such as “crayfish and crab” (Dominica in-school male). A girl in Dominica noted the availability and efficacy of local traditional medicine relative to Western medicine.

Some of the sickness can be cured with local bush and ting, local medicine. They will want to give you how much medicine, with plenty chemical and thing that will maybe make you sick.

*(Dominica female in-school)*

It was noted that the climate and land quality made it possible to grow one's own food such as corn and peas (Grenada male from Carriacou). Other male participants from Carriacou however believed that the facilities in the island were generally not of high quality.

GMT1: The disadvantage is I don't like things. It not up to standard. Ah fine [I find], ah fine things is just kind of downgrade-able.

GMT2: Yeah, he right in truth. Yeah. Yeah, you could do an amount of things but it don't have places, you can't really do it.

Participants also noted that things were expensive and that there were few structured activities available to young people.

DMI1: It's boring.

I: It's boring? And when you say it's boring, can you say a little more about that?

DMI1: Well on some days and some weekends, I have nowhere to go and nothing to do.

*(Dominica in-school male)*

A few however noted that while they were young they could be involved in sporting activities.

The absence of privacy and limitations in one's freedom to express one's individuality were expressed as concerns.

GMO1: Miss, sometimes when you go out, people doh like how you dress and they beat you for that. They don't like the scarf that you wear.

I: What is important about the scarf? Is it the colour?

GMO1: Yes miss. Miss, like how they say it. Too many fast people, minding one another business.

*(Grenada male out-of-school)*

#### 4.2.3 ECONOMIC CONSTRAINTS

Several participants noted that there were few jobs available to young people so that they could make the most of the opportunities offered by the attractive surroundings and availability of public education in their countries. There was also little choice in the types of jobs available, in finding “the work you want” (Dominica female in-school). In Carriacou, one boy said that his island was “too much a dependency” and “they need to activate some more work and so for the youths.” It was not clear whether he was referring to Carriacou being too much of a dependency of Grenada or of other, metropolitan countries. Among out-of-school females in Grenada, the view was expressed that finding work meant more red tape and formality than in the past.

These days young teenagers like tend to don't have jobs. You know before you could go in a store and get a little work. Now to work in a store, you have to have ID card, you have to have papers.

Some also faced poverty at home, with two female participants in Bequia, St. Vincent and the Grenadines saying that young people sometimes get depressed because they do not have enough money to get to school.

#### 4.2.4 RULES AND RESTRICTIONS

In common with adolescents and young adults worldwide, FGD participants complained about the rules and restrictions they faced, though, as noted above, there were economic and other advantages to the absence of responsibility implied by these restrictions. Parents and schools were seen as the major source of these restrictions. It was also acknowledged that there would not be unlimited freedom when they entered the world of work (Dominica Kalinago females). Some participants, especially in the male FGDs, expressed their dislike of almost all sorts of regulation:

DFT1: I don't like the punishments, detentions and suspensions.

DFT2: Being able to do what you want.

I: Being able to do what you want at school like what? What do you want to

do at school that school does not allow you?  
DFT2: Talk freely in the class, use of cell phones, going to the washroom.  
(Dominica Kalinago males)

Among males in Carriacou, several participants grumbled about clothing regulations in school. Another participant however rebuked them, saying that dressing decoratively in school served no useful purpose.

GMT1: Let me say something. You all coming in school with clothing, jewelleries and so. Are the clothing getting your education?  
GMT6: What?  
GMT8: What?  
GMT1: The clothing getting your education?  
GMT4: Nah but is like...  
GMT1: The jewellery, your education? What purpose it serving?  
(Background mumbling)  
GMT1: You come to school to learn not for fashion style.

His colleagues in the group replied that some relaxation of rules would be useful to enable students to wear hats to protect them from the hot sun.

Among girls, there appeared to be less concern about rules per se than about perceived interference in their abilities to make their own choices, and the lack of respect that this implied.

VFI1: There's a lot of stress. People want to dictate your life, you understand. I mean, talk to me, not at me! You understand, right? They want to, like, run my life.  
VFI6: Lock them in.  
VFI1: OK, talk to me, tell me what to do. But don't talk down to me.  
(St. Vincent and the Grenadines females in-school)

#### 4.2.5 SAFETY AND VIOLENCE

In St. Lucia, when asked about the disadvantages of living as a young person in the country, the first thing mentioned was crime [St. Lucia girls in-school]. However, in Dominica, some young women perceived that relative to other places, they were able to go out at night without much fear of violence:

I: Is there any advantage you feel as a young person or you see with your peers?  
DFI1: You can go out whatever time you want, like leave your house and come back, actually come back, unlike other places when you go you don't know if you going to come back because somebody might kill you.  
(Dominica, in-school female)

Another participant in this FGD, however, pointed out that while relatively safe in terms of levels of crime, young people may still be at risk owing to peer pressure that could put them at risk:

I: So, share with us, tell us about the power that young people have in terms of decision making.  
DFI2: OK, it's like most times you'd want to go somewhere, you'd feel that it's safe and your parents would tell you, no, it is not safe because it have a lot of bad influence where your friends and them might influence you to do something you don't want to do.  
(Dominica, in-school female)

Males in school in Dominica cited young people involved in drugs as negative influences.

I: Is there anything else that you see as a disadvantage of living here?  
DMI1: Plenty bad influence. Fellas taking drugs and them things.  
INT: Ah, fellas taking drugs. And who are those fellas? They are young boys or what kind of fellas?  
MI1: 18, 20 (murmur)  
INT: So they take drugs and they are a bad influence on whom?  
MI1: On the rest of young people.  
(Dominica in-school male)

Attention was also drawn to the risk of violence through child abuse and sexual violence from partners. Among in-school males in St. Vincent and the Grenadines, child abuse was the first thing mentioned when participants were asked about the advantages and disadvantages for young people of living in the country. This theme was taken up by females in the Bequia group in St. Vincent and the Grenadines in relation to bullying:

VFT4: A disadvantage could be like, sometimes how you small you can't defend yourself.  
I: Defend yourself against what?  
VFT4: Like, violence.  
I: Violence from?  
VFT4: Older people. Like when you getting bully and so.  
I: Bully from who?  
VFT6: School children and other people.  
I: Like your age- older than you?  
VFT8: Older.

In Grenada, out-of-school females mentioned beatings and physical restrictions from parents: one even mentioned being put in an animal coop.



GFO3: Even though you tell them where you are going, they will agree, but it have some of them does want to give you their time to come home. And when you don't come home on their time they does want to beat you, they may lock you outside. [Inaudible]. I know that is how I grow up with my mother and them. When my father ain't beat me, then he lock me outside.  
 GFO1: I use to sleep in coop and all [laughs].  
 GFO3: I would go the next day, when I come back they wouldn't talk to me. It had a day my father get real mad, and he find me where I was. It was licks from right there to home, oui.

This group of girls comprised teenage mothers, and they also recounted their experiences of abuse from partners, including from older men. At their young age they already expressed considerable disillusionment about men, viewing them as exploitative as well as prone to violence.

GFO2: Some men tend to abuse like young girls like my age so. Because they look at us like we not mature, like we don't have enough brain. Like, if they tell us something... like, it have some girls when a man speak in their ears, they go one time. It have some again they put up with it. Some men tend to think like when they talk in your ears you will go. Yeah, 'I will get you anytime.'  
 GFO1: Yeah, you have soft head.  
 GFO3: Yeah it have some of them when they tell you they love you, you does fall for it.  
 GFO1: Ah tired fall for it oui, ah tired.  
 GFO3: That is where they does take advantage. They tell you they love you but when you do catch it, it is use they using you.  
 GFO2: And they like to beat their girlfriend.  
 GFO3: Yes, their hand too fast. When they tell you do that and you don't do that, prepare yourself to get lash, oui. I never experience it like that. I use to put up until I get fed-up one day. [Baby fussing] My child father, he like to raise his hand, he like to hit. It have some of them, they wicked.

In Carriacou, girls found boys “annoying”, referring to the harassment they faced when they tried to look their best.

GFT5: The guys, they annoying... If you have on something nice, they there behind you.  
 GFT3: The disadvantages now something about the boys... Anywhere you go and you meet a boy they want to know what's your name and all kind of thing disturbing from your school work, because we now as fifth formers we need to focus, and them boys nagging nagging.

This theme will be taken up in the section on sexual violence below.

#### 4.2.6 PERCEPTIONS OF YOUTH POWER AND SELF-DETERMINATION

Participants were asked, “Do you think that young men/women [depending on sex of FGD] such as yourselves have enough power to make their own decisions?”, followed by a series of prompts regarding their power in relation to types of people and institutions.

##### 4.2.6.1 GOVERNMENT

Few young people felt that they have power in relation to their government, partly because they were not yet old enough to vote. There was a perception that when they reached the age of majority things would change for the better.

Just now, just now, couple years from now we going to get ID card, we going start we life.  
*(St. Vincent and the Grenadines male in-school)*

There was also the sense that governments did not listen to young people or take their views seriously.

I: Do you have a voice like in government politics, or government decisions?  
 DMI1: I don't think so.  
 I: You don't think so?  
 DMI3: And even if we say something, nobody will take us on.... They think they bigger than us, know more than us.  
 INT: Ok, so they think they're bigger, they know more. Ok. What about you?  
 DMI2: I support him....  
 INT: So would you go to the government and all those people and think that they could work together with you?  
 DMI1: They might say yes and it never happen  
 DMI6: For the young adults to know. They might say yes, miss, and nothing not coming to play, na miss. And they might not be serious too.  
 INT: So you think that they might not be serious about doing it.  
 MI6, MI3, MI1, MI2, MI4: Yes  
*(Dominica in-school males)*

On the other hand, a male in Carriacou felt it was possible for young people to protest so that the government would listen to them.

Few of the participants mentioned specific government policies or actions they would like to change. Remarkably, though, the single mothers in the Grenada out-of-school group gave details of such policies and demonstrated a high level of political engagement. Their complaints included the availability of fish and the accessibility and quality of health care. The local health centre had apparently been closed down and the new government had not yet replaced it, meaning

that people had to travel long distances to receive health services.

GFO1: Since that government come in power, everything just change. Right now, you ain't see fish scarce and all? Yes, because since they come, like man can't catch fish now to make a little dollar. Serious. Before time you have catch all kind of things. They use to have tittiray in the river and man use to go and make their little dollar. Can't do that again because NDC there. So nothing can't go on. NNP coming back.

GFO2: [singing political ditty]

GFO1: They say they building a health centre in Gouyave. They break down them people health centre. [overlap of comments] Actually, when NNP was in power they decided what them building but NDC come now so they say they inventing their own thing. So up to now the health centre break down and up to this blessed day they can't build it back up.

LM: And how does that affect you as a young person?

GFO1: Well, I mean it kind of hard for everybody up there because some of them, like it hardly have nurse [GFO2 comments]. It hardly have people there. You have to take bus to go in Grand Roy or we have to come way down here to do stuff like that. And it kind of affecting up we health.

GFO2: Like the doctor now attend to less people now because of the small space [baby fussing] because the clinic small [baby fussing].

GFO1: I mean they close up a year now. Before time, they used to have there open all kind of hours. We use to have a nurse and a doctor up there. Right now it don't have that. So like if a man get a chop he can't go nowhere, you have to fight to get a vehicle to go down from where the chop is.

#### 4.2.6.2 PARENTS

It was generally felt that “parents make the decision for you” [Dominica Kalinago male]. This was usually seen as appropriate, “because parents know better” [Grenada in-school male]. For example, parents' efforts to stop their children from staying out very late were seen as appropriate [Dominica in-school male]. Even some young men who had dropped out-of-school were accepting of parental authority.

I: In relation to your parents, your household, would you say that you have enough say as to what decisions are being made in the household, whether it is for yourself or not?

GM03: Miss, I'm cool.

GM01: Well it is up to the parents you know. It's not up to us. If they say this has to be done, then it has to be done.

I: So would you say that your parents have more power than you in the household?

GM01: Well, yes, it is obvious.

GM02: Dem is the boss. Dem is the world force. I can't go and tell my mother go and sweep the yard.

*(Grenada out-of-school males)*

However, later in this discussion with the out-of-school males, a sense of disempowerment came across, with the sense that they were never really involved in decisions that affected their lives. After stating that they never took any decisions at school either, one of the group remarked,

GM01: You see, it starts from home too, eh. If you can't make the decisions at home, you can't make it nowhere. It's obvious. When you're at school and you cannot make a simple decision then what sense does it make? Sometimes things will just come in your way and you cannot handle it, so it's obvious that it starts from home and if you cannot handle it at home, you cannot handle it nowhere.

Males in school in St. Lucia felt that they were old enough to make more of the decisions for themselves.

LMI2: Parents are too involved in the decision-making of their children. We already growing and we are practically adults. We need to learn from our mistakes. I get the point that they want to supervise us but let us get our own experience.

Males in school in Dominica thought that young people should be allowed to make decisions in cases where there would be no negative consequences to those decisions.

There was some evidence of a generation gap in terms of lack of understanding. A St. Lucian school girl said, “It's hard to understand my parents.” Among girls in Bequia, it was said that parents “don't want us to speak out” and “don't wanna listen to us 'cause we young an thing.” The girls felt that they could not discuss their relationships with their parents, because of lack of understanding and discomfort discussing sexual matters or that the parents were too busy. One noted that young people sometimes therefore needed to rely on their peers for advice.

VFT7: Like if you go to them with a situation wit a boy and stuff like that, they don't wanna understand that.

I: These are your parents you are talking about?

VFT4: Yea.

VFT3: Mothers.

VFT8: My mother is a single mother.

VFT2: Me too.

VFT4: Me three.



I: OK

VFT8: And sometimes she don't be around to talk about those stuff. So you have to go find somebody else- like your friend, na.

#### 4.2.6.3 SCHOOL

As noted above, some young people expressed the feeling that they should be free to do as they pleased at school and elsewhere. However, several felt that the decisions they were allowed to make at school were the appropriate ones; for example, choosing their exam subjects (St. Vincent and the Grenadines and Dominica females in school) or choosing which class they want to go into (Bequia females, St. Vincent and the Grenadines). In Carriacou, a girl felt that if they concentrated on their studies and were "patient" they would be respected and listened to both at school and in her village.

I: But your voice is listened to? If you have opinions, people listen to what you have to say? They consider it?

GFT3: Yes. Once is patient young ladies, they will look up to you. Like home in my village, certain times I does get fed up with people but again they like to hear when I'm speaking.

Boys in several groups said they did not have enough power at school because of "rules" or "rules and regulations" (Grenada males out-of-school and in Carriacou; St. Vincent and the Grenadines males in-school and out-of-school). There appears to be a gender difference in the willingness to conform at school.

#### 4.2.6.4 RELATIONSHIPS

Among males in several groups, the view was expressed that they had the power to decide whether or not to have a girlfriend. In-school males in St. Vincent and the Grenadines noted that parents were not with their children all the time so they had the power to have relationships without their parents' knowledge.

Females did not mention anything about power to have relationships; they seemed more concerned about abuse within relationships and power to say no to sex. Among Kalinago girls in Dominica, it was noted that either males or females could physically abuse their partners. Among in-school girls in Dominica, concern was expressed about the ability of girls to refuse sex given the threat that their partners would abandon them for another woman or given the seductive tactics used by men.

DFI3: Some of them don't feel like they can tell their boyfriend 'No' when it comes to having sex with him, so they give him every time he ask for it.

I: Why do you feel young girls are not able to tell their boyfriends no?

DFI3: Because they think he will go somewhere else for it..

I: So the fear of losing the boyfriend makes them lose their power to saying yes or no?

DFI2: Some of them doing like is one man alone it have in the world.

DFI1: Well I have a friend, she told me that she told her boyfriend over the phone that she not coming by him to have sex. When she went he start kissing her all over and turning her on and she end up having sex and regretted it.

Girls in the in-school FGD in St. Vincent and the Grenadines emphasized the difficulty of finding a partner who would not be abusive as well as the risks and restrictions of being with a controlling partner, especially one who is older.

VFI3: You have to grow up, and you have to go through people, learn your mistakes and all them thing there.

VFI6: Until you get that perfect one, special one, you know, 'Mr. Right'. Mr. Right is the one that will propose to you, the one that you spend the rest of your life with.

I: OK.

VFI2: And the one who won't abuse you.

I: When you say abuse, what do you mean?

VFI2: Like beating you and telling you you can't go down the road and talk to no man. Controlling freaks

I: Controlling freaks? I don't know, explain that for me?

VFI3: Everything that you do, you have to tell them. Anything you do it's like they want to be behind you, even like you going to the bathroom they wanna be like your shadow following you around.

I: OK, how... OK, do you think that differs between people your age or people or...

VFI2: When you young. 'Cause like you see for instance, like how a young girl might be in school. Now ah these days you might be with someone out there who working, and because you going school the man going say, you have man in school, and don't trouble and everywhere you go have to make sure tell him an exactly way going on in school today.

VFI1: Even if you go to the shop he will follow you.

I: So give me one sentence how you would say that's a disadvantage, or why is it a disadvantage?"

VFI5: I would say it's a disadvantage because – you young, right, and being in the relationship, you have to explore life, enjoy life as it is, and being in a relationship with a control freak you ain't getting to explore the real world. It's like you in a place just locked up, you alone.

#### 4.2.6.5 RELIGIOUS LEADERS

Young people did not feel that they had power in relation to religious leaders. In Dominica, a predominantly Catholic country, a Kalinago girl said that the clergy would preach but that there was little opportunity for dialogue and understanding with any young person. Even during Confession, they would preach and quote from the Bible but “they would not really go down to your level, like, understand you.”

#### 4.2.7 WHO HAS MORE POWER, YOUTH IN-SCHOOL OR OUT-OF-SCHOOL?

Many participants thought that young people in-school had more power because of the opportunities available to them, including social as well as educational opportunities. Those who spoke about the power of youth who were out-of-school generally emphasized the fact that fewer restrictions were placed on their actions. At the same time it was acknowledged that there were few jobs available for youth with few or no qualifications.

Girls in school in St. Lucia were asked if those who had left school had more power than those who were in school. They thought the out-of-school youth “have the freedom to do what they want” and noted, They always boast in our faces telling us that they have finished school and that the stress [of school] is for us.

The St. Lucian girls may have been referring to those who have finished school rather than those that had dropped out. Their male counterparts also thought that out-of-school youth had more power and that they no longer had to submit to parental authority once they had left school. One noted that some out-of-school youth become involved in criminal activity and therefore parents are afraid to try to restrict them.

I: Under the age of 18, who do you think have more power, in school or those who have left?

LMI2, 3, 1: Those who are out of school

I: OK, why?

LMI1: Because they can do what they want. They can go out when they want. You are not under their parents’ rules no more. The parents don’t take decisions for you, because after all you out of school.

LMI2: To me adults feel more intimidated that you are out of school because most time it leads to criminal life style and the adults are somehow afraid of them so they just let them do what they want.

During the discussion with females in Bequia, the distinction was made between youth who had graduated from school and those who had dropped out. The participants thought that those who had graduated had more power than in-school youth, but that those who had dropped out did not. Their power was conditioned by their educational skills and qualifications.

VFT7: Like if they get back plenty subjects , they can choose what kinda career they want and like which college they want to go.

I: OK... lets also take the out-of-school who may have dropped out - who do you think have more power those who are in school or those who have dropped out and they are out-of-school?

VFT5: In-school

I: Why you said that?

VFT5: [Out-of school have] no education

VFT7: If you drop out you ain’t go get the same privileges like the set that in school cause you ain’t going know how to read and write or spell. So when you go for a job application and stuff like that they have to spoon-feed you and the one them in school have the advantage, and the kinda job way you want you might have to go back school in order to get it.

*(St. Vincent and the Grenadines females in Bequia)*

The males in Bequia also thought that in-school youth had more power because their educational opportunities would enable them to get better jobs and have people working for them rather than just being employees.

VMT5: We could get a better education than those who left. I mean.... like those who left, right, say them dey want work by Knights [a pharmacy] or some kind of supermarket or something. We could aim in school, we could work hard in school now fuh get a better job than working by Knights or by a supermarket or something. We could work hard and open our own business or something.

I: OK, this side over here. Who do you think have more power?

VMT2: I think in school ‘cause we could watch their life and make something better.

VMT3: Them who working by Knights and thing, when you in school you watch their life, you say well I don’t want drop out of school; I want to make something good of my life, right? And when your parents hear you talking like that they go try to encourage you and nurture you to become that person....

VMT5: I getting what I want through school and when I done school, I work hard for what I want. I go open my own business. He working for people. I could get people to work for me.

I: OK.

VMT5: So we going get more power.

*(Males in Bequia, St. Vincent and the Grenadines)*

Females in school in St. Vincent shared this view, adding that those out-of-school had already made choices while for those in-school there was a world of opportunity in front of them.



VFI5: We ain experience the outside world yet- and when we start experiencing that outside world there we could choose to do this or choose to do that. People out there working and employed and thing like that. Them, they done make up their minds – done make their decision - to do this and do that and done make their choice. They done choose.

Like the boys in St. Lucia, these girls noted that out-of-school youth could become involved in illegal activity, adding that poverty was a driving factor in this. Poverty may drive them to leave school in the first place.

VFI5: It's the people in the road who cause the most trouble now ah these days.

VFI1: Sometimes it don't really be their fault, is poverty.

I: Poverty? What do you mean by that?

VFI1: Some parents can't afford to provide for them and send them school and thing like that, and they have no choice 'cause they have nobody else.

VFI5: That's what the majority young people doing these days. They stopping school because of their parents' lack of money and those things. Because you will have to go out in the real world and stock up yourself while you young, start to make money by making a little hustle, sell weed. But at the end of the day you could get hurt, because all them ting include illegal, you know, and you could get dead from selling weed, thieving, sticking up people, robbing.

*(St. Vincent and the Grenadines in-school females)*

Girls noted that young women without qualifications were more vulnerable to sexual exploitation because they found it more difficult to get jobs without submitting to sexual encounters with employers.

VFI6: The young girl them outside the school, it go hard. They probably want have sex with you, just to get the work, cause you ain't have no subjects. Cause when you have a subject, all you have to show the man the paper and you get the work.

VFI1: Based on when you have your qualification sometimes, it's because they want a promotion or something because they want a promotion. Other people might have like a higher qualification than you so they will want to abuse you.

I: Abuse you - explain what you mean by abuse.

VFI1: Like, sexually. If you want the job you have to do such and such.

*(St. Vincent and the Grenadines in-school females)*

St. Vincent males in-school started by saying that out-of-school youth had more power, "caw dem could do wah dem want" but then moved on to saying that in-school youth had more power because they could get better jobs via greater qualifications.

Dominican females in-school thought that out-of-school youth had more power because they could make more decisions and make lives for themselves, and were free from parental authority. However, youth in school had more social activities in terms of clubs and hobbies. Among Dominican males in-school, most thought that in-school youth had more power because of the opportunity to shape their lives, while one participant emphasized freedom from parental authority among out-of-school youth. Dominican Kalinago females thought that youth in-school had more decision-making power but that economic power was greater for out-of-school youth because they often had jobs. Dominican Kalinago males thought that out-of-school youth were more powerful because they were on their own, did not have to abide by so many rules, could decide whether to work, did not have to submit to their parents and could attend parties without having to be home by a certain time. However, one participant noted that if they were working they would have to take orders from their bosses. Grenadian males in-school also thought that out-of-school youth had more choices because they could stay up later.

Interestingly, participants in the FGDs that were conducted with out-of-school youth overwhelmingly thought that in-school youth had more power than out-of-school youth. This view was encapsulated by a boy from Grenada who pointed to unemployment and said, "When we finish school it doh have no work and when we going to school, we have everything." However, another out-of-school boy in Grenada said that even for those who had dropped out of school there was the possibility of owning a business; achievements would depend on the drive and motivation of the person. Another noted that families would meet the economic needs of youth in-school but not out-of-school.

GM02: If you're in school and you say you want pants, you will get pants. If you're out of school and you say you want pants, you have to work for your pants.

*(Grenada male out-of-school)*

Grenadian females out-of school shared the view that in-school youth had more opportunities ahead of them.

GFO2: Well, those in school, actually well they have their papers. They getting the amount of education they need. They get more opportunities to travel and get work.

However they also noted that some did not make the most of these qualifications and "just sit down at home." Additionally, there were few jobs to choose from in Grenada whether or not you had qualifications.

Out-of-school males in St. Vincent and the Grenadines emphasized that there was little in terms of productive occupations for out-of-school youth.

VMO1: Them deh who deh by the road side nah want nothing, just deh a walk up and down ah road ah kick bottle (boys laugh).

VMO5: And when them out deh just ah walk up and down, ah smoke a load ah weed...

VMO1: And kick bottle (boys laugh).

Vincentian out-of-school females mostly stressed the value of education in terms of attainment in future, believing that in-school youth were more powerful.

VF03: It's up to them to hold up their head and reach far.

One participant in the same group made the point that some made an active choice in leaving school so in that sense were powerful. Another responded that out-of-school youth tended to end up "liming" (relaxing and enjoying themselves with no particular goal in mind).

#### 4.2.8 SEX AND RELATIONSHIP EDUCATION

Against this background of the enormous potential but the limited opportunities available to youth, it is important to understand how they are educated in terms of sex and relationships so that they can lead satisfying emotional and sexual lives while retaining choices in terms of employment and other domains. Participants were asked what they were taught at school and by their parents and families about sex and relationships and whether they thought that this teaching was adequate. In the course of discussing this, the participants often talked about other ways they had found out about sex and relationships.

##### 4.2.8.1 SCHOOL-BASED SEX AND RELATIONSHIP EDUCATION

Education on sex and relationships in school seemed, from the responses of participants, to concentrate on the biology of sex, on telling young people to abstain until married or use a condom, and on the negative consequences of sex such as teen pregnancy and HIV/STIs. There was a general feeling that the number of hours allocated to these subjects was insufficient and that relationship education was lacking. Several suggested more interactive teaching methods and discussions to enable youth to understand and tackle the challenges they were facing.

Dominica in-school females thought that they already knew the basic facts about sex that they were taught in school and that the time allocated to teaching about the subject was not enough. They had classes once a week for fifty minutes and thought a longer discussion each time would be useful. They said they were told about contraceptives and the risks of getting an STI or HIV, "but it just giving us the basic information about it still." They found it difficult to relate this to the situations they were facing and suggested that people should come and

present their own stories and scenarios and how they addressed them, as well as providing better explanations.

DFI2: They should give us more things we can relate to.

I: OK, more things you can relate to. All right, things like what?

DFI2: Like their life history. The way they talking about is... not really like something that happen in Dominica. It kinda boring too.

I: OK so you find some of the situations are not relevant. You cannot really relate to it. OK. Yes, what about you? Do you think its adequate, do you want more in your school?

DFI1: Yes, because now they will tell you, umm... the reason why is to protect yourself from teenage pregnancy or the STDs but they doesn't really tell you the benefits behind it.

DFI2: And why we shouldn't have sex.

Boys from the same school said that they were taught about HIV, STIs and to abstain, but "they wouldn't go in depth." They are told to abstain to avoid STI, HIV and getting somebody pregnant. They noted that the abstinence only message was not useful in a situation where a young person starts having sex, and that education on condom use was necessary. It was noted that they had been told about condoms at school but were warned that they may not be effective and may burst.

DMI2: You never know it [sex] might happen to you or whatever, so all you going to think about is you getting AIDS, you ain't going to think about nothing else.

I: OK, so you think that that is negative for you?

DMI2: Yes.

INT: So you think they should tell you more like...

DMI2: Yeah, like if you doing it, use a condom or something like that.

INT: Oh, so they tell you to abstain and that's it. They don't tell you if you cannot abstain, then use a condom. They don't tell you those things?

DMI1: They does still tell us condoms going to burst.

All Participants: (Laughter and agreement).

I: Oh, they still tell you condoms going to burst?

DMI4: They say it not 100%.

INT: So do you feel scared by all this?

All Participants: No.

*(Dominica males in school)*

One gathers from the participants' "no" that they were not scared into abstinence by the messages they received at school and that they needed more information and guidance on how to protect themselves.



Girls in the Kalinago territory in Dominica said that they were taught about STIs and “the proper use of protection” (presumably condom use). They were apparently told,

DFT1: Don't have boyfriends when you are going to school.

INT: Oh, so they tell you don't have boyfriends while you are going to school? (Some chuckles heard in background) OK. That's what they tell young people?

DFT5: They say take your education seriously and put your education first.  
(Dominica Kalinago females)

The girls thought they should also be told “about the circumstances you face when you get pregnant,” echoing the call from other participants in Dominica for education based on real-life scenarios. Kalinago boys reported being told the “basics” - to abstain and to use a condom to prevent STIs and pregnancy. As regards relationships, they were taught that these could take them away from their schoolwork. They could not recall ever having been told anything positive about relationships by a teacher. They noted that teachers,

do not want to use the name penis , vagina; they use the words sex organs.  
But we mature enough to know about that.  
(Dominica Kalinago males)

Grenada males in-school reported that they were told that taking care of a child was not easy and that they should “be careful and use condoms and safeguard.” Males in Carriacou said that they were taught to abstain and that having a child young brought financial responsibilities that probably could not be met.

GMT1: Because in indulging in sexual activities, you are not working, that is part one. You are not living on your own to responsibility and in case of an accident, you go and have sex with someone young child, you not working, you don't have a house on your own , you don't know, you can't even change pampers (background chuckling), where will you get the money?  
Where will you get the money to mind the people children?  
(Grenada Carriacou male)

This participant went on to point out that young people often did not use “proper protection” (condoms) to prevent this. Another participant then remarked, “They don't provide us with it!” highlighting a lack of access to condoms among young people. Among out-of-school males in Grenada, it was noted that they were taught about abstinence and STIs but many young people did not heed the abstinence message and that young people themselves should pay more attention to what they were taught. Out-of-school females in Grenada noted that at their schools nurses or personnel from NGOs would visit to provide sex education, but that this service seemed no longer to be available.

I: When you were in school, were you taught about sex and relationships and stuff?

GFO2: Yes, well, we actually had this group that always used to come when we reach Form 1. They went to all secondary schools. They tell you about sex, they show you the female condom, the male. They tell you how to use it and they give you little advice and yeah.

I: What about you, you had that experience in school?

GFO1: Uhh hmmm[murmured assent].

I: People came as well?

GFO3: Yes, is the same thing. Just the nurse.

I: Okay, okay.

GFO2: But right now, like I have a brother and thing in school. Right now when I ask them if the people and them does come, they tell me they hardly come. They doesn't really tell them children about sex and they not telling them what is good about sex, what is bad. They don't, they don't. Them children don't even know what is a condom. Some of them don't know what is a condom.

Among schoolgirls in St. Lucia, it was said that school-based sex education focussed on abstinence and condom use. As was said by participants in other groups, they believed that more should be done to enable young people to understand the consequences of their sexual actions. Their male counterparts also said that at school they were told to abstain until age 18 or until they are married. They said they learned more in school about sex and relationships from their peers, by talking at break time and lunch time and by text messaging, given that teachers did not share their own experiences.

In St. Vincent and the Grenadines, schoolgirls said that they were taught about abstinence and that condoms were not 100 per cent effective. They were also told about the family planning programme to prevent pregnancies. These participants thought that what they were taught was adequate but that it could not prevent teen pregnancies by itself because of other negative influences in society. Boys from the same school said they were taught about STI prevention and condom use and told to protect themselves if they were sexually active. Like the girls, they noted that people could “break the regulations” and have sex regardless of whatever they were taught. In Bequia, females said they were taught about “reproductive parts and functions”, about “the condom to go on the guy” and that “we must use protection.” Neither males nor females in Bequia thought that this approach was adequate. Out-of-school Vincentian girls said they were told to abstain until they were adults or married. They did not think this was adequate and noted that education and relationships should be continued up until Form 5. They also said they were told that having a boyfriend could prevent them from doing well in school; they disagreed, saying they could still do well in school if they had a boyfriend.

VFO4: Teachers does say you can't study boyfriend and school, but it doesn't make sense.

I: Why it doesn't make sense?

VF04: 'Cause people does get boyfriend and still ah go ah school, and do good in school.

I: OK.

VF03: And the teachers say book before boys.

I: Book before boys - that's the triple B's.

Out-of-school Vincentian boys did not think that the information provided about sex was adequate, especially given that small children were sexually active.

#### 4.2.8.2 EDUCATION FROM PARENTS ON SEX AND RELATIONSHIPS

Levels of communication about sex and relationships from parents seemed to vary. They focussed more on the risks of pregnancy than HIV/STI, and this is consistent with the statistical finding that teenage pregnancies are far more plentiful than diagnosed HIV/STI cases. Parents advised their children not to have sex, and seemed to be more likely to advise boys than girls to use a condom. Some parents drew on their own experiences to advise their children about relationships.

In Dominica among schoolgirls, it was said that they had learnt "nothing" from parents and "the the only way they knowing about it is if we doing it and they find out," indicating that they tended to speak about sex only after the fact. Parents would also comment if one of their friends was known to be having sex.

DFI2: If your friend get in trouble too and if they find one of your friends doing it they want to give you how much talk about your friend.

DFI3: I know, and want to know if you doing it too!

I: Oh, ok, so that's the only time they talk about it, they wait for something to happen.

DFI2: Or hear something, or something happen in the neighbourhood, about your neighbour. The neighbour child get pregnant or something, now they have talk!

Participants said that they knew young girls who got pregnant and that mothers used these examples to warn them not to have sex and to concentrate on their studies. They would then recount their experience, such as with the girl's father.

DFI4: Yes, they telling you, 'See how she spoil her life. Doh do like her eh, doh do like her!'

DFI2: 'I working too hard to send you to school!'

DFI4: And 'I working too hard to send you to school' and la la la la la about your father.

These girls were also concerned that parents would tend to spread the news about what they regarded as their private business.

DMI2: If you tell them you start having sex is a another long story.

DMI1: They'll tell the aunty, the aunty going an tell the uncle and when you do check it next thing everybody hear.

DMI4: Oh, they does do that for true.

I: So you don't think you can go to your parents and trust them with the information.

DMI2: No!

DMI3: No.

It was also said that mothers would give advice when they were annoyed, such as times when the girls were not concentrating on their school work because of a boyfriend.

DMI4: When she vex she does give the advice, or when you see is during exams and she see you not studying and you in your phone, you does hear, 'Tell the little boyfriend I say if you fail I'll send you and meet him for him to pay the school fee.'

Males in school in Dominica said their parents told them to "use protection" [condoms]. One said that his father warned him by saying that in his time HIV was not around, while another's father told him not to make the same mistakes he had made. Another said, "They just say keep away from it." Interestingly, none of these boys spoke about their mothers as a source of sex education. One felt uncomfortable in talking to his parents about sex, preferring to talk to his peers. Among Kalinago females, it was said that they were told not to bring a child to the house, meaning that they should not expect support if they got pregnant. Kalinago males reported that they were told not to have sex, or "Do not go after people children," and about the negative consequences of getting a girl pregnant. They expressed a wish for their parents and grandparents to tell them about their past and about their experiences. They said they wanted more communication and the "ability to give your own opinion."

Males in school in Grenada said they were taught about STIs and the need to condomise to prevent pregnancy. In Carriacou, males said they were told to avoid sex until they finished school and always to use protection. One said that this did not really help him in learning to "control" his sexual urges.

GMT5: In this age where we growing up now the drive is stronger than normally when you older. So you have to be ready to control yourself and thing.

I: And did they tell you how you control, how you suppose to control yourself?

GMT5: No, not really.

Among out-of-school males in Grenada, one participant said his mother does not talk or ask him about sex. Another said his mother simply told him not to have sex, while a third was told to be faithful to whatever girl he was with.

GM02: *She will tell me if I dey with one, stay with one.*

In contrast with the boys in Dominica, these out-of-school boys did not talk about fathers providing any of their sex education. The out-of-school girl participants in Grenada, all of whom had been pregnant, said that their mothers used to tell them not to have sex but they didn't listen. One said that three of her four sisters had also had babies and, though they warned her against this, she went ahead.

GFO1: *My mother used to pound me, 'Don't go there, do this, do that.' But I making my head hard. I just doing my own thing. I ain't want to hear what she saying, I want to do my stuff.*

LM: *But you were taught about sex at home.*

GFO1: *Yes.*

GFO3: *Same goes for me.*

GFO1: *She used to tell me, don't go through the same thing she go through.*

GFO3: *I have three sisters, well four sisters. And out of four, three have babies. One has five, one has five, and the next have one. They used to always talk to me about it but I never used to listen. Playing my own woman, doing what I want. Until I meet it. As my mother used to tell me, I always used to say if I did know.*

It seems in these cases that the verbal warning and the experiences of their mothers and sisters were not sufficiently powerful.

In St. Lucia, schoolgirls reported that they were told that "sex is not good" and that they should abstain or use a condom. Similarly, St. Lucian schoolboys said that they were told to abstain, use a condom if they had sex and to "know your partner," which they explained meant knowing if they were promiscuous or had HIV.

Schoolboys in St. Vincent and the Grenadines said that the primary message from parents was, "Don't have sex." A secondary message was to protect themselves and "don't breed anybody girl children" (don't get any girls pregnant). One boy noted that his father, not his mother, advised him to use a condom. The father of another had told him he was allowed to have girlfriends so long as he continued to study.

VM14: *My father go tell me that how, he go allow me with the skin them, the girl them nah, but you ha fuh study you book still.*

Among schoolgirls in St. Vincent and the Grenadines there was the feeling that

parents did not feel comfortable talking to them about sex and that consequently they received little guidance. They said that the advice they received was restricted to simple messages such as, "Don't have sex, you will get pregnant." They believed that their parents should discuss it more because they could be trusted to tell them the truth as compared with outsiders who might deliberately twist the information. At the same time it was clear that some of them did receive advice on relationships. Mostly this concerned the potential for abandonment if they get pregnant.

VFI3: *Some parents would tell their children, 'When the young boy them done get the sex they gone. Let me tell alyo straight, because if you get pregnant for a young boy now an he ain't there, you ain't have no one to mine the child.'*

I: *So who is a young boy anyway?*

VFI1: *Like, our age.*

VFI3: *Like them school boy them – they is children themselves.*

VFI5: *And, miss, they say, 'Little children can't make children. You ain't going know what to do.'*

VFI1: *'Pampers - them ain't even know how to put on the Pampers.'*

Out-of-school females in St. Vincent and the Grenadines said that their parents also warned them that boys sometimes forced girls into sex. The parents said they could have boyfriends but they must know what they are doing, and retain their dignity.

VF03: *They say, 'Hold up yo head nah.'*

VF05: *'Don't let the boy force you.'*

I: *Don't let the boy?*

VF05: *Force you to have sex.*

VF03 also said that when she had her first period her mother sat and talked with her and warned her of the dangers of getting pregnant. Overall, these girls felt they got some good information and advice from their parents, though it was not enough. In contrast, the out-of-school boys in St. Vincent and the Grenadines did not feel they were told anything by their parents about sex and relationships except not to have sex until they were 18 or married or to use a condom. These boys lived with their mothers, not their fathers and their mothers had not advised them about relationships.

Like the out-of-school females, the girls in Bequia thought that their parents talked to them about sex and relationships and would also share their experiences with the girls. They noted that their mothers had told them that boys often had more than one girlfriend and some were only interested in sex. Mothers who had been pregnant at a young age would tell their daughters about the difficulties they had faced and advise them not to do the same thing. Their daughters would be advised to avoid pregnancy and complete their education. Males in Bequia had



been advised to stay away from sex or to use a condom and were warned that if they got a girl pregnant it would “mash up my whole life right deh.” Parents emphasized the economic consequences of getting a girl pregnant.

VMT3: Especially the girl, I might have nowhere to put her, so I should wait until I have a job, I have a house and I could get money to help myself.

#### 4.2.8.3 FINDING OUT ABOUT SEX AND RELATIONSHIPS FROM PEERS, THE INTERNET AND READING

In the course of reporting what they had learned from school, parents and family about sex, FGD participants often pointed out that they had also learned from their friends and other young people. Sometimes peers, along with internet searches and reading, filled in gaps in information left by school and family. Young people were concerned about the trustworthiness of the information they received from these sources and thought it would be better if school and family provided more of the information needed and communicated with them better. Some of them had also learned about sex from pornography. This will be further explored in a later section.

St. Lucian males, as noted above, thought they got more of their information about sex from fellow students during school breaks and via cellphones than from their teachers. Three of the participants in the St. Lucia female in-school FGD said that they got information about sex from reading. Grenadian in-school males got most of their information from “older friends on the block.” They noted that the information they got from this source sometimes conflicted with that they received at school and that they preferred to rely on the school as a source of information. Two of the Dominica in-school males said that sometimes the information they got from parents about sex was “too much” and they felt more comfortable talking to peers about some sensitive matters. Others in that FGD disagreed, saying that they preferred to talk to their fathers or siblings.

#### 4.3 WHY AND HOW DOES YOUTH VULNERABILITY OCCUR? WHY AND HOW ARE SOME YOUTH PROTECTED?

In this section we explore risk and protective factors for youth sexual and reproductive health, and explore their accounts of how these factors have impacted on their lives. We start with a detailed exploration of influences on sexual activity or abstinence among youth, drawing on data from questions on the types of young people who have not yet had sex and the degree of choice that young men and women have as to whether to have sex. We then explore the influences on condom use and drug or alcohol use and how they affect sexual behaviour. Genital hygiene practices and attitudes to voluntary medical male circumcision are explored in an examination of biological risk and protective factors. We then look at how young people experience and perceive teenage

pregnancy. Finally, we examine youth perceptions of health service responses to the issues identified.

#### 4.3.1 INFLUENCES ON ABSTINENCE AMONG YOUNG PEOPLE

Question 6 of the topic guide on the types of young people who had not yet had sex revealed a lot about the norms surrounding and driving sexual activity among youth. It was generally felt that a minority of 15-17-year olds were virgins and that abstinence was not socially acceptable for boys in particular. It was also seen as difficult to maintain among girls given multiple social influences. These qualitative results are consistent with survey results such as the BSS in the OECS that showed that half of males had sex by the age of 15 and half of females by age 15 or 16 in project countries. The pressures on boys are also shown in several other surveys showing lower ages at sexual debut among males (see the desk review).

##### 4.3.1.1 TYPES OF YOUNG PEOPLE WHO HAVE NOT HAD SEX

The types of young people believed not to have had sex included: youth involved in the church, those with controlling parents, those who had decided to wait, those focussing on their studies, those who were afraid, those who were “nerds” or not attractive, people with disabilities, drug users, homosexuals, tomboys, immature children and those who masturbated instead.

The immediate response to this question for both boys and girls was often to mention young people heavily involved in Christian faith-based organizations, so-called “church girls” or “church boys.” The influence of religious teachings about waiting for sex until marriage was seen to be strong. However, participants in several groups quickly moved on to make the joke that many church girls were in fact as sexually active or more so than other young people.

In St. Lucia, males in school said that church girls were “on lock” (not allowed or allowing themselves to have sex), not only because of the influence of the church but because of heavy parental supervision. These girls would not be able to escape church and the family in order to have sex. Reflecting that St. Lucia is predominantly a Catholic country, they also mentioned that “daughters of Mary” would not have sex.

LMI1: Well, the kind of people, them really they on lock. Maybe that person is a church girl and one of the descendants of Mary.

[Everyone laughs]

LMI1: She would not engage into those activities. She would refrain from boys and stay around girls. You know that person not going to have sex.

I: Someone else - what types of girls have not yet had sex?

LMI2: Girls with heavy religious influence, parental supervision. They lack the resources to exploit that avenue.

Similarly, girls in all three female FGDs in St. Vincent and the Grenadines said that parental involvement combined with churchgoing prevented some girls from having sex. For example,

VFI7: Say your parents are Christians and, and you start to have boyfriend and sex, you know parents ain't going talk, she going sit down with you and start to preach.

*(St. Vincent and the Grenadines in-school female)*

Boys in all but one of the male FGDs also mentioned that “church girls” were among those unlikely to have sex, especially those who had strict parents. However, it was pointed out in five male FGDs that some of them did have sex and the boys found this entertaining.

VMT3: Some ah them church girl they breed the same now as any other people, you know. Some ah them does go church and play Christian in church, baptize and thing and when they reach in school is a different thing.

VMT4: Let me make a point and don't call no name eh. It have a church girl in we class and ....she is the baddest thing in our class right now (boys snickering). No name to call. Cause she go and wine up on anybody. She ah want go and kiss anybody.

VMT1: Talk it man!

*(Males in Bequia, St. Vincent and the Grenadines)*

Church and religion were mentioned less frequently as reasons for boys not having sex than for girls. “Church boys” or “religious fellas” were mentioned by males in-school in Dominica and Grenada and females in-school in St. Lucia. The boys seemed to respect other boys who made this choice, but some of the girls in St. Lucia adopted a mocking tone when talking about boys who had not had sex, calling them “decent boy”, and “Mummy's boy” as well as “a Christian,” providing an example of the sort of mockery that can push boys to have sex.

I: What types of boys have not had sex?

LF1: A decent boy.

I: When you say a decent boy...

LF5: Mummy's boy.

LF5: Daddy's boy.

LF2: Mummy's boy.

LF1: A Christian.

Research backs up the view of the participants in the FGDs that religion and parental involvement can reduce the occurrence of sexual activity among youth. The Caribbean Youth Health Survey found that religion and family connectedness significantly reduced the likelihood of sexual activity among 10-18-year olds, and these findings held true for both girls and boys, though the impact was

greater in terms of parental involvement for girls. The measure of religion was based on two questions addressing religious attendance and the extent to which they saw themselves as a religious or spiritual person. The measure of parental connectedness was based on five items: “family pays attention to you”, “family understands you”, “can tell mom/ dad your problems”, “mom/ dad cares about you” and “other family members care”. Responses were along a three point scale: from “very little”, “some” to “a lot” [Blum and Ireland 2004]. Thus religion and parental involvement may indeed be important reasons that some children are protected from sexual activity.

People who concentrated on their school work were also seen as likely to stay away from sex. Some groups lauded this behaviour in terms of what could be achieved through studying, but studious girls and boys were described by others as “nerds” and seen as unattractive. The “nerd” label was particularly likely to be applied to boys.

Participants in some groups expressed admiration for young people who studied hard and did not have sex. This behaviour was said to be with a higher goal in mind, including deciding to wait (in line with religious teaching), having self-respect and aiming to get qualifications and good jobs. Dominica schoolboys said that “smart people” and “people who want to wait” were among the boys who did not have sex. Dominica schoolgirls mentioned “those with a high self esteem”. Grenada out-of-school girls observed that those who did not have sex “will always be home sit down or they always there in their books”. Grenada out-of-school boys noted the important role of parents in motivating girls to concentrate on reaching their goals.

GM01: These parents look out for their kids so that they grow up in certain way so that they can be somebody. Those are the ones that you would hardly find in that.

St. Vincent and the Grenadines out-of-school males emphasized that girls who had not had sex were often heavily controlled by their parents and were concentrating on schoolwork.

VMO4: Them don't really walk out so much. Them ah stay home and deh in them book.

VMO3: Everywhere them go them dey with them parents, them weh does deh home with their parents.

Males in Bequia said that an “educated girl”, “church girl” and “a girl who keep she head up” (who respects herself) were less likely to have sex.

Notably, studying was rarely mentioned as a reason for boys not having had sex. Data from the FGDs throw light on the ways in which social norms reflect and

reinforce the lower academic achievement of boys. Girls from St. Lucia said that those who thought too much were less likely to have sex.

LF7: They thinking too much about it– they must just do it and finish with it.

The word “nerd” was often applied to males and sometimes females who had not yet had sex. Male nerds were said to be uninterested in females and were shy and awkward in their movements. The following passage reflects this and also shows how some of the participants try to single out and mock the studious boys among them.

VMI4: You does just watch how they does move and talk and thing (boys laugh).

VMI1: They don’t get any.

VMI: Yeah, yeah (boys laugh).

VMI2: They just hitting deh books. Some ah dem deh right here (boys laugh).

I: I didn’t hear that one. Come again.

VMI2: Some ah them, dem deh right here (boys laugh).

*(St. Vincent and the Grenadines in-school males)*

More rarely, respect was shown for males who did not have sex. An out-of-school female in St. Vincent and the Grenadines said that males who had not had sex did so because “they want a good name.”

The Caribbean Youth Health Survey also supports the view that students who are happy in school, and by implication more studious, are less likely to have sex. Among 10 to 18-year olds it was found that “school connectedness” reduced the likelihood of sexual activity among girls by an astonishing 96 per cent and among boys by 74 per cent. School connectedness was measured by two questions: “Do you get along with teachers”, “Do you like school?” [Blum and Ireland 2004]. While the participants in our FGDs seemed to have a certain amount of respect for girls who studied and did not have sex, they did not generally show the same respect for boys, and they also less frequently mentioned studying as a reason for not having sex among boys. Among boys, the social norm that regards studious boys as “nerds” seems to be an important factor placing them at risk of HIV, STI and becoming fathers at a young age.

In addition to studiousness being regarded as unattractive as a trait among males, a number of other terms were used to portray the unattractiveness or social deviance of young males who did not have sex. These included “fat boys,” “retarded,” “handicap,” “girlish,” “not interested in females,” “gay,” “talkish.” It was also thought that some had not matured sufficiently, implying that as soon as males felt the sex urge, they should start having sex.

I: So do you think that there are young men your age who have not had sex as yet?

GM03: They have to be retarded. They don’t have feelings. They don’t know about that.

*(Grenada out-of-school males)*

It was also said that boys who grew up surrounded by lots of females would become “girly” and not know how to attract the opposite sex.

VFI3: When you raise around girls you would act like the girl an them.

VFI5: Remember you don’t really know how to talk to a girl and thing and want give sweet talks and thing.

And it going be hard for you in the world, cause you going war [want] talk to a girl and because you just accustom to the girl and them in your house, you ain’t going know what to tell the girl them out there because the kinda joke joke allyuh make in the house, you can’t make them kinda joke dey. The girl might want curse you or slap you or box you up or something like that.

*(St. Vincent and the Grenadines female in-school)*

Notably, most of the disparaging remarks about virginity were directed at males, though some females who had not had sex would also be called “nerds” or “geeks” and these terms, as for males, were usually directed at girls who spent a lot of time studying. For in-school girls in St. Vincent and the Grenadines, the “nerd” label applied to girls who did not have sex who were heavily controlled by their parents and who spent a lot of their time with “old people.” These people would also orient the girl to be involved in the church.

I: Ok, so what types of girls you think have not had sex?

VFI2: The nerdy kind.

I: I don’t know what you mean. Explain it to me”

[Laughter]

VFI1: The one whose parents, basically that is them only child, and then they want to please their mommy, so they don’t really study them thing deh. Sex don’t bother them.

VFI4: And when you grow up around old people.

I: When you grow up around old people? I don’t know. Explain that for me.

VFI6: Some young girls , when they grow up around old people, them does get the old people thing inside of them, so they ain’t go really study them things they. They just want think about church, going church and Sunday school, and all in the home news an gospel channel, and they ain’t go really teach you about the outside world. So you ain’t go really study them thing deh cause you not explore the world. Going party, nite time and them thing deh, you just lock down inside the house, just going church, and from church, home.



There was also, as for boys, the suggestion of homosexuality. Both females in school and males out of school in St. Vincent and the Grenadines said that girls who were “tomboys” would not have sex, with the males adding that these girls were “afraid lolo [penis].”

For both boys and girls, fear was also said to stop them from having sex. Girls were said to be afraid of the consequences of sex, such as pain and bleeding from first intercourse, parents finding out and pregnancy.

DFI2: They are afraid of the pain.

I: The pain. What kind of pain?

DFI2: Well they have friends doing it already so they come and talk to them and tell them it does hurt the first time, and how it does bleed and next thing your mother have to see you with blood in your panty.

*(Dominica in-school female)*

Males were also said to be afraid of losing control, getting a girl pregnant and not being able to take up the responsibility.

I: Those that abstain, why do you think they abstain?

DMO3: I don’t know, maybe they scared. They do not want to put themselves in a situation where they cannot help themselves.

DMO4: Like have sex and get a child and they have to go out of school and they don’t have nothing to give the child.

*(Dominica males out-of-school)*

Both males and females were also said to be afraid of contracting HIV/ AIDS, especially if they did not have a condom with them (females in Bequia and males in school, St. Vincent and the Grenadines). The out-of-school boys in the St. Vincent and the Grenadines group added that boys who did not have sex may be “cowards”.

All this having been said about the traits of sexually inactive youth, some participants cautioned about generalising, saying that some young people who one would expect to be sexually active were not and vice versa.

VFI6: You can’t judge a book by the cover. So you never know who from who ain’t tinging [having sex]. People who you expect ain’t go do them things is who doing it. Them is the one is who you see later down in life with belly [pregnant], and you say, ‘What, me ain’t know them use to do them thing dey!’

*(St. Vincent and the Grenadines in-school female)*

Similarly, out-of-school females in St. Vincent and the Grenadines said that girls who were most “vulgar” and “them with the most mouth on the road” were often those who had never had sex.

#### 4.3.2 DO YOUNG PEOPLE AGE 15-17 YEARS HAVE CHOICES ABOUT WHETHER TO HAVE SEX? INFLUENCES ON SEXUAL ACTIVITY

The questions, “Do young men of around your age have choices about whether to have sex?” and “Do young women of around your age have choices about whether to have sex?” revealed gender-based notions of power and control.

##### 4.3.2.1 MALE CONTROL AND THE OBLIGATION TO HAVE SEX

It was felt that males had choice about whether to have sex, since they were goal-oriented and ideally could control sexual situations.

I: Do young men of around your age have choices about whether to have sex?

VMT4: Yeah.

I: Why?

VMT5: They more focus on what they want, more focus on their goal.

*(Males in Bequia, St. Vincent and the Grenadines)*

Grenadian males in Carriacou thought they were “smart enough” to control when sex took place.

I: Do you think you have choices about whether to have sex or not?

In Unison: Yes.

GMT4: Yes, I have my own choice man.

GMT7: Yes, I have mine too.

GMT4: I smart enough.

GMT5: I smart enough too.

GMT1: I have my own choice.

I: Wait, wait, wait now. You said you are smart enough. Define what you mean by being smart enough, please,

GMT8: I have my own choice and I have my parent’s choice.

GMT5: Because I know when to do it and I...I know when to do it and we know when to do it.

Boys in the out-of-school group in St. Vincent and the Grenadines noted that when a girl wanted sex they were able to refuse it. But some in the group found it difficult to accept that a male would refuse or not want sex, and said this would only happen if the girl was ugly or had a serious disease such as AIDS. Girls in Carriacou, Grenada said that they thought all boys had sex by their age, or at least they boasted about it and spread stories about girls with whom they said they’d had sex.

GFT4: Yeah, that’s the only thing they [boys] could talk about... yeah, because they have the experience... GFT5: Some of them they does discriminate the girls too.

LM: In what way? Can you explain?

GFT5: Okay, like, if a guy go and have sex with me right, and he might go and say like how we had sex, where we had it, time and stuff. Yeah, so real discriminate them girls and them.

#### 4.3.2.2 SEXUAL PERSUASION, COERCION AND VIOLENCE

Girls were generally portrayed in a relatively passive role in sexual encounters, being persuaded, coerced or forced to have sex, with a few still managing to abstain as noted above. Male participants acknowledged that women could be raped and in these circumstances had no choice, but also emphasized that girls had to make the choice to refuse sex to maintain their good name. Thus they highlighted one of the contradictions of femininity, that chastity must be guarded but that men can force them to have sex. Dominica out-of-school boys said that females sometimes do not have a choice “because they can get raped” and that “the young men cannot be so easily raped”. Males in Carriacou said that females needed to make choices to avoid negative consequences such as loss of reputation. Girls aged 15 to 18 should not be having sex, should act to avoid pregnancy if they do have sex and should finish their education.

GMT4: They should make their choice for themselves.

GMT2: Yeah, ah feel.

GMT4: Because if they know what go, the outcome of it!

GMT2: Yeah, disrespect after.

GMT4: If they know the effects after, best they stay out of it. At a young age eh. If they big and they done grow up already and they feel they could handle things, then go ahead but not when you 15 to 18.

GMT2: If they know they really have to do it, use protection because they know if anything happen then they want to know where the money coming out, the clothes and them thing.

GMT1: Go and finish your education.

The same group of boys, however, acknowledged that girls could also be put under pressure by their boyfriends and may have sex with them to prevent them from going with other girls. They also can be charmed by older men.

GMT2: I feel they does do it if they want to give their boyfriend because if they don't want to do it the boy might get vex and they might want another girl.

GMT7: They might want to leave they girl too.

GMT2: Yeah, so.

LM: Yeah, so. What about you, do you think that the young women have the same kind of choices you have?

GMT5: Not really, no. You see, them young ladies does have a thing for bigger boys and thing and them bigger boys does have a way they treating

them ladies.

GMT4: True, true, smart man!

GMT4: That is a smart man there! That is what going on!

Dominica schoolgirls corroborated the view that girls sometimes had sex to try to prevent their boyfriends from finding another partner. One participant pointed out that this was misguided since boys who harassed their girlfriends could also be replaced.

DMI2: Some of them doing like is one man alone it have in the world.

Another tactic used by males to persuade girls to have sex was to refer to how long they had been seeing each other, implying that sex was necessary for the relationship to be serious and sustained. Boys would also refer to friends who were having sex in order to persuade their partner to do so.

GFO2: Some does actually force you. Like, how you and me together long and we still can't have sex?

GFO3: They does say is time to have sex because look how long we there together. How dey friends and them do it before.

*(Grenada out-of-school females)*

Kalinago females in Dominica noted that girls could be raped and also spoke of incidents of incest between older male relatives and girls. This often happened when the mother went out and left the daughter with her father or uncle. It was also an outcome of living with many relatives in the same house.

DFT2: There's the case of this girl. She had a child. And it wasn't her fault. Her father was having incest with her and she got pregnant. And the girls start talking about her, like, 'What is that young girl doing with a child?' And my friend came up to me and was like, 'That young girl have a child?' I told her it's not her fault. Her father was committing incest with her...

INT: And people don't know that and she was still judged because she had a child. Do you think incest happens a lot?

Participants: [All] Yes

INT: A lot of it happens in your area?

DFT5: Most people...like your parents want to go out a lot. And you are always (or they send you) by your father...

DFT2: Uncles...

DFT5: Incest happens a lot when you have under the same roof.

I: So like mother, father, uncle, grandfather, everybody living in the same house?

DFT5: Yes

I: So there is a greater possibility it will happen?

FT1, FT2, FT5: Yes.

In Carriacou, girls noted that some children became sexually active even at primary school age because they had seen sex acts. An out-of-school girl in Grenada said very young children were imitating sex acts because they had seen people having sex. Sometimes exposing young children to seeing sex was not regarded as intentional but resulted from neglect on the part of the parents.

GFT3: Yeah, [they are sexually active in] primary school ‘cause, you see, they exposed to many things. You see, that’s why I say that how the children that come out from school, them little ones now seeing what they doing and they interpreting. You see them little ones now, they mind now developing.

GFT4: And them parent’s too, they not taking care of them children. So they letting them go anyway they want.

GFT5: It could be what they see in the house or in the environment they in. They start adopt what they are hearing in the environment.

GFT3: And sometimes the parents do it in front of them cause they really think that they don’t know what they doing, and they may fully well know what is that, but through they mind they thinking that they don’t care, they’re small.

*(Carriacou girls, Grenada)*

GFO3: My niece is a year and ten months, and she come when Mammy come home the other day, she say, ‘Gramma,’ (she does kind of talk...), ‘Gramma, I see Mama and Dada having sex you know’. Mommy say, ‘You sure?’ ‘Yeah, in front of me.’ ‘So what they do?’ She see Daddy climbing on Mommy and they start to do their thing. And next time we catch she and my nephew doing it on the bed.

*(Grenada out-of-school female)*

As in other social contexts, girls wearing revealing clothing were seen as provocative and this was thought to possibly lead to rape.

VF03: [Some girls] dress up in the shortest thing and walk down the road-belly out, short top, short short pants. Because they get the boys and dem attention they could get rape.

*(St. Vincent and the Grenadines out-of-school female)*

Again, we see a subtext of females being at least to some extent responsible for the behaviour of males. A phenomenon referred to in three FGDs from three countries was that of group sex or gang rape of girls. There were many nuances in what participants said about these and full understanding would require a more focussed study. However, some important features were apparent from what the groups said about this. One is that gang rape was conceptualized as an outcome of unacceptable female behaviour and was therefore in a sense thought to be deserved. Secondly, it was a humiliation, partly because several people

would have observed the girl having sex and could publicize the information to further humiliate her. For example, in the following passage it was said that it was “good for” the speaker’s cousin to be “gangbanged” and then have the details called out in public because “she don’t want to listen when people talk to her”.

Actually meh cousin...It kind of good for her...She don’t want to listen when people talk to her. Them boys and them, a whole set of them gangbang her and a day she was passing and they call out to her and because she refuse to answer, they start to call her name and say who did get her and who did not get her, and who she give blowjob and who she don’t give and them kind of drama, oui!

*(Grenada out-of-school female)*

Thirdly, it was a result of low self-esteem among girls and a misguided desire to fit in. In Dominica, the phenomenon of “line up” was mentioned, whereby boys would line up to have sex with a girl. This was said sometimes to happen to lonely girls who were under peer pressure to have sex and who somehow believed this would help them be accepted by their peers. Boys were said to pick on those girls they saw as weak and did not care if they got them pregnant. It is worth quoting the passage relating to “line up” at length as it shows how it appears to result from male exploitation of young women with low self-esteem who are searching for a way to be accepted. Of course the experience has the opposite effect, and girls who were inexperienced were also vulnerable to pregnancy because they did not know about contraception. Line up was said to be perpetrated by gangs of males.

I: The young people say peer pressure takes away the choices. Anybody have anything else to share on that? Yes, you, shaking your head.

DFI4: Well, not they don’t have a choice, but their choice becomes limited because they so want to be part of who their friends are, so they would just do anything to fit in.

I: To fit in, to be part of that crowd. So they will be amongst a group of girls who are sexually active and..

DFI4: and because they are not the only one, some friends will tell you...

DFI2: does come and tell you how nice it was.

DFI4: “Girl you not in that yet...oh you missing out on the world” and ... [mumbling].

DFI2: They want to be in the great enjoyment too, so they’ll do it.

DFI1: And at times get pregnant faster than the rest.

DFI3: When they end up pregnant faster than the rest and they do it when they under pressure is because they do not know how to do it and... [voice fades]

DFI2: They don’t know about contraceptives and things.

INT: So they’re so anxious to fit in. Is like they don’t know how to.



DFI3: And some of the boys that do it with them are wicked too!  
 DFI2: Exactly!  
 DFI3: They know the girl will want to do it because her friend pressuring her so they'll just go and do it with her, and they will make her get pregnant and doh worry.  
 DFI1: It have some and like when they see those girls stand up doing nothing with themselves they will call that friend, their friend will call that friend and they'll make a line up on the person child.  
 I: Oh, so they do line up on girls that are like weak?  
 DFI4: Yes  
 I: The girls who are trying to fit in.  
 DFI2: Yes.  
 I: OK, line up is a common thing? Line up is common?  
 DFI2: Yes.  
 I: It happens a lot?  
 DFI2: Yes, when they in a gang too...  
 DFI2: And when you in a gang too. It have some fellas they in gang and they say if you have to come by me and you have to have sex, all my partners have to pass on you too because they like to share. They live the dog life and when they see a female dog on the road all male dog want to hump it. That's the explanation I get for that reason.  
 (Dominica in-school females)

This passage ends by saying that, in addition to “line up,” boys in gangs would demand that their girlfriends have sex with others in the gang to show allegiance to the gang. This is an extreme example of how peer pressure leads to sexual encounters devoid of empathy, regard or respect for women and girls. It is unclear the extent to which the girls consent to these group sex acts, but it does appear that lack of self-esteem plays a major part, and it is clear that these encounters present immense physical and psychological risks.

The collective pressure to group sex or gang rape is illustrated further in the following passage where boys laugh about the prospect of forcing a girl to have sex, and also seek to shift responsibility for the action to the girl who is trying to prove her attractiveness.

I: Do young women around your age have choices about whether to have sex or not? Do you think they have choices? Do you think they have choices to have sex or not, around your age?  
 VMI 4: They get choice and they ain't get no choice, caw it ha man who done ah rape and uh nah dread (boys laugh).  
 VMI7: Some man don't care.  
 VMI4: You overs! So then they ain't get no choice, they have to tek. It could be four or all ah we in here pon one woman, she ain't got no choice (boys laugh).

I: Okay, okay. Do you think she won't have a choice because of peer pressure? Proof of attractiveness, or she wants to be Ms. Thing?  
 VMI: When they want play Ms. Thing that is how they does get rape.  
 VMI: And get breed [become pregnant](boys laugh).  
*[St. Vincent and the Grenadines males in school]*

#### 4.3.2.3 PEER PRESSURE, MATERIALISM AND TRANSACTIONAL SEX

The previous section presented some extreme examples of how peer pressure on both females and males can lead to violence and highly risky sexual activity. Here we explore other facets of peer pressure.

Pressure often came from peers who said that they had sex and how enjoyable it was. It was noted that the consequences would be neglected while promoting the joys of sex.

GFT3: And she say that how she try it already so it go be good. When you go now is like, 'What the hell she say it is good?' When you go there now you go and get yourself pregnant and she didn't get pregnant, you go be exposed to many diseases and stuff like that. Then you hear them cry now your name there all about the place, and you go be like, 'Oh, is she that force me to do it, what I was thinking?'  
*(Carriacou female, Grenada)*

A young mother from Grenada noted sadly that “Friends does carry you, they does not bring you back” [Grenada out-of-school female], meaning that friends can lead you astray and not help you when you get into trouble.

Boys often had sex to avoid the disparaging labels that would be attached to males who were abstinent, particularly accusations of homosexuality. In Dominica, a boy in the out-of-school group noted that boys should resist peer pressure since if they studied hard and earned good money they would have enough attention from females when they got older.

DMO4: Like sometimes you so deep in your studies, you in school and just because you not talking to the girl or chat them they call you “batty man.”... [So you have sex] if you doe want them to call you batty man...  
 DMO5: It have an escape though. If you get the education and you making money girls always like men with money.  
*(Dominica out-of-school boys)*

Some of the boys were also aware that some of the stories boys told them about their sexual exploits were untrue, but nevertheless said that the stories added to the pressures to have sex [St. Vincent and the Grenadines out-of-school males]. An important aspect of peer pressure lay in consumerism, the perception that to be socially accepted it was necessary to acquire material things, especially

flashy brand-name items, referred to as “bling”. Girls referred to seeing friends with these things but knowing that their parents cannot afford to give them.

VF04: Sometimes some of the girls and them feel that them friend get certain things and them nah get, because their parents can’t afford it. Them could use that as a factor to go and do that [have sex] so that they could get the same thing as them friend get.

*(St. Vincent and the Grenadines out-of-school female)*

Boys noted how girls would envy others and have sex to acquire similar goods.

DMO4: Some of them like clothes, chains, shoes. So they have sex for that.  
DMO5: Greed.

I: greed. Anything else?

DMO2: Jealousy.

I: Jealousy. When you say jealousy, jealous of who?

DMO2: If you see somebody with that and you want that too, and you don’t know how they get it but you want that. Like if you see someone with a Blackberry and you want that Blackberry and the android.

*(Dominica out-of-school male)*

Top of the list of desirable items among young people appeared to be Blackberry cell phones. Several FGDs mentioned that girls would have sex in order to acquire mobile phones from their partners or even to receive phone credit or “top-ups.” In the following passage a girl acknowledges the risks of this.

I: OK – so what you all think about transactional sex? You all know what that term means? Sex for money.

VFT4: Prostitution.

VFT7: Those are the worst kind.

I: OK, what do you mean by that – why you said that?

VFT3: Miss, because for instance, your friend go have something, especially a Blackberry, and you want one, and this man just tell you, ‘Come nah man, you ain’t want the Blackberry tomorrow? Come go down between the bush an’ have....’ Miss you gone full speed ahead. They hear you lose your mind, and get AIDS one time – no Blackberry for you.

*(Females in Bequia, St. Vincent and the Grenadines)*

Dominica males in-school also said that girls would have sex to obtain a Blackberry in order to “fit in” with friends that also had one. Doing this was not solely because of poverty; some girls were said not to be poor but just wanted a Blackberry. However, sometimes it did result from poverty including following the example of mothers who did the same thing.

GFT4: Like she mother, all of them just doing things for money then, like they can’t maintain themselves.

*(Female in Carriacou, Grenada)*

FGD participants also said that girls had sex for shoes, clothes and brand-name fast food (such as Subway). Grenada out-of-school males also referred to a young man who had sex “to get stuff.” It was noted that girls often chose older partners and even drug dealers in order to have access to these items.

DFI2: They’ll go behind big man, them drug dealers, so they can get more than one [phone], and [the drug dealers will] send top up for them and put service every month.

*(Dominica in-school female)*

Among both male and female participants there was the perception that girls would choose older partners because the material things these partners could provide would make them feel valued.

VFI5: Them go say, ‘Well, you know I young and he old and he working and thing like that, let me don’t go with no little boy, cause he can’t mind me and spoil me and give me everything I want.’ So they prefer to be with the older man and have sex with them.

*(St. Vincent and the Grenadines in-school females)*

Boys noted that boys their age were often rejected in favour of older men for this reason.

VMO2: Them deh want big man with money and vehicle and thing. They nah study boys in school and thing.

VMO3: Them ah say you too young, me want old man.

VMO4: They want big stick [penis].

VMO2: But when the big man leave them they come back to the small man. [Boys laugh].

*(St. Vincent and the Grenadines out-of-school males)*

VMT1: The young girl now ah these days nah, them nah want no school boys. Them want man, you overs, so them get man....

VMT2: You know, dem say school boy lunch money done 12 o’clock.

VMT3: They want man who gwine get them Nike shoes.....and brand thing and all them thing deh.

*(Males in Bequia, St. Vincent and the Grenadines)*

Two girls in the Dominica in-school group noted that some drug dealers were even giving out Blackberry cell phones to young people without demanding sex in return; she was under the illusion that this was a generous gesture, thus further highlighting the vulnerability to exploitation of young people in a materialist culture.

DFI4: That point you make there about drug dealers, is not all of them that like that, because well where I from I know people that up my side that doing it and they just downright generous...

DFI3: Some of them just generous, because first of all you have all that money what you gonna do with it? Is not because they giving them the thing for the sex, they just give it to them.

*(Dominica in-school females)*

Kalinago girls in Dominica also noted that some girls looked for an older partner not only for material things but because they lacked emotional support at home.

DFT2: In some cases, some girls feel like their family not there for them emotionally so they look for a shoulder to lean on.

#### 4.3.2.4 POPULAR CULTURE AND PORNOGRAPHY

FGD participants noted the influence on sexual behaviour of popular culture, especially Jamaican dancehall music. They also noted that young people were now exposed to pornography via new technologies such as DVDs, the internet and cell phones.

Schoolgirls in Dominica said that popular singers could have a negative influence on young women by their revealing outfits.

DFI6: Like, the way they act. The singer presents themselves, it might not be in a pleasant way and some girls choose the unpleasant way to go and want to be just like the unpleasant singers.

I: Ah hah, ok, and when you say unpleasant, just define that a little bit for me or give me some example of what you think is unpleasant.

DFI6: Like the way they dress, with parts of their body outside.

*(Dominica in-school female)*

As noted above, dressing revealingly was noted as one of the pretexts for sexual violence against girls, and here we see that such styles of dress are a product of popular culture. Kalinago girls in Dominica noted that music videos sometimes contained sexual language and pornographic images that could influence young people. Participants in both male and female FGDs in St. Vincent and the Grenadines mentioned dance hall lyrics and videos and especially those of Vyb Kartzel.

VFI1: Some of the lyrics, like especially dance hall music, they famous for that.... Like a whole set of girls wining up and all kinda things, thing like that. Basically if you don't do it, basically you is a 'batty man,' something wrong with you. Like if a boy say, 'Oh gosh, I'm a virgin,' they would get on like you dying.

VFI7: Know what I'm saying, music does really influence them, especially Kartzel.

VFI4: [Imitating Kartzel] 'Give she harder.'

*(St. Vincent and the Grenadines in school females)*

Pornography is now highly accessible to young people, and participants noted that girls as well as boys made use of it.

DFI4: Some of them, some boys don't know porn sites. But some girls they know every single thing. Which link to click on, every web link, everything all websites to type in and what to do to see whatever. So, yes, some of those young girls more into it than those boys.

DFI2: Yeah, that memory card full porn.

I: Memory card for the phone?

DFI2: Yes.

*(Dominica in-school females)*

Belying the image of female passivity noted above, Dominica schoolgirls stated that some young girls were actively involved in the production and transmission of pornographic material, sometimes under the noses of adults who did not suspect they were doing so.

DFI1: There was a scenario... a young lady went with her boyfriend, she made three porn videos. Another one saw one, that same young lady she watch it, she decide she gan make her own by herself for the boys in my village. So now she end up lending a boy her phone and the boy start emailing the porn videos of herself to everybody and it start going to all the high schools.

I: Really?

DFI1: Yeah. And they say the funny thing about it is as she doing it her mother was in the kitchen asking her if she want fish and she telling her mother, 'Yes mammy.' All how they say they watching that, they checking, they never thought she would have do that and she end up doing that.

DFT4: The things people do today, eh!

That boys and/or girls were influenced by pornographic films ["blues"] was a belief held by participants in the following FGDs: Dominica in-school girls, Kalinago girls in Dominica, Dominica in-school boys, all three male FGDs in Grenada, all three female FGDs in St. Vincent and the Grenadines, out-of-school boys in St. Vincent and the Grenadines and boys in Bequia, St. Vincent and the Grenadines. Other groups did not mention this but it may be that pornography existed as an influence in their social milieux too.



### 4.3.3 CONDOM USE

The analysis thus far indicates that there are multiple normative, economic and social pressures on young people to have sex. Gender norms dictate that young men should be sexually active and pursue their own pleasure, and females are under pressure and subjected to violence from males to have sex. The culture of materialism and exposure to pornography are important recent influences on sexual activity. It should come as no surprise that all these influences are also brought to bear on condom use among those who become sexually active.

It was generally agreed that only some young people used condoms and that most of them did so inconsistently. This chimes with research findings reported in the desk review. FGD participants said that the main reason for use was to prevent pregnancy. Male condoms were known by participants in all FGDs and were generally believed to reduce sexual pleasure. The terms “raw” or “bare” were widely used to describe unprotected sex and both males and females were said to “want it raw.” Males tended to say that females wanted “raw” sex, while females said that it was males that wanted this. A teenage mother in Grenada had direct experience from the father of her child who did not want to use a condom.

GFO3: Some of them does say they does get a different feeling or they doesn’t get the vibes. So that is what they want to do to get the vibes, to feel inside you and how inside you warm, and them kind of dramas. That is what my child father used to tell me... That’s how I end up getting pregnant.

Not all participants agreed, however. Some said that females experienced just as much enjoyment if a condom was used [Kalinago females in Dominica]. One male in the FGD in Bequia, St. Vincent and the Grenadines also said that the sexual experience was equally good with a condom.

It was noted that in the heat of the moment people would not focus in condom use because they were enjoying sex. Boys would sometimes use the withdrawal method to try to avoid getting a girl pregnant [Dominica in-school females]. Some held on to the belief that they were somehow invincible and would not be infected with STI or cause a pregnancy [Grenada in-school males]. Some boys were said not to care if they contracted HIV or got someone pregnant because they were just focussed on getting sex [St. Lucia males in school]. They were said to deny responsibility if they did get a girl pregnant.

GFT5: Some of them don’t want to get diseases or get the girl pregnant. But some of them they don’t care if they get AIDS or if they get the girl pregnant, they doing it.

GFT3: Some of them does say like, ‘Oh, you won’t get pregnant,’ and stuff like that and in the back of their mind they well know that what they doing is wrong and they can easily make you get pregnant. When all that has been

done and when you hear that you pregnant and stuff and when the results come out and you go and tell them they is the father, they does say, ‘Oh, me is not the father, me is not the father.’

*(Girls in Carriacou, Grenada)*

Girls in Carriacou also said that some males who have HIV do not disclose this and deceive girls by saying they should trust them and have unprotected sex.

There was a widespread belief articulated in several FGDs that some young men would resist condom use or would damage condoms by putting holes in them. Sometimes this was because they were infected with an STI or actually wanted to get a girl pregnant. More often damaging condoms appeared to happen because they just wanted to assert their power over females by refusing to concede to this act of protection. Some were also said not to take care of their condoms; for instance they left it in a hot car so that it became defective. On the other hand, some who were using condoms were under the mistaken impression that if they used two at the same time, this would offer them extra protection.

VMO1: But, you have fuh use ah condom.... If you use one condom that condom deh could burst so you have fuh use two.

*(Out-of-school male, St. Vincent and the Grenadines)*

Transactional sex could also prevent condoms from being used. Males were said sometimes to threaten withdrawal of gifts such as Blackberries if the girl insisted on condom use.

I: Do you believe that, some young girls, their choices in using condoms are affected by their fear of losing resources from their sex partner?

DMI4: Yes, because sometimes the boy might tell them, ‘The Blackberry I give you there, if you see I taking it back, so if you want to keep it you have to let me go without.’

*(Dominica in-school female)*

Kalinago girls agreed with the view that girls might agree to unprotected sex for access to resources and added that low self-esteem among girls was another reason that they allowed their partners to have sex without a condom.

Participants did not think that male condoms were associated with homosexual sex and believed that all kinds of males could use them. They were not thought to be associated with sex work either, though schoolboys in St. Lucia noted that sex workers would be more likely than other women to have their own condoms and to refuse sex if a condom was unavailable. It was said that condoms would be used if a person had more than one partner [out-of-school females, St. Vincent and the Grenadines]. On the other hand, Kalinago females in Dominica thought that it would be easier to negotiate for condom use if you

were in a serious relationship than if you had a “fling” or one-night stand. This view was counteracted in several FGDs where it was indicated that condom use was associated with mistrust in relationships and therefore stopping condom use was seen as showing that the relationship had become regular and serious. Within relationships believed to be monogamous, condom use was seen as unnecessary.

DFI3: Some of them will have sex without condom because they feel the person they doing it with not going nowhere and they self they know they not going nowhere.  
(Dominica in-school female)

Thus it was said that males would not use condoms with their “main” partner but would use them with their other partners [St. Lucia in-school males]. One young man said, “If is a girl you really like you go do it without condom.” [St. Vincent and the Grenadines in-school male].

Few participants had seen or used a female condom. Some of them had learned about them at school or via a session hosted by NGOs such as the Red Cross or Family Planning Associations. In Dominica, a schoolgirl had been taught by the Family Planning Association how to insert the condom and was told it could be inserted up to three hours before the sex act. Another in the same group said she did not know where to obtain a female condom. It was said that girls took oral contraceptives in preference to the female condom. One girl said boys at her school were selling female condoms [Dominica in-school females]. In the Kalinago territory in Dominica, girls said that girls did not use female condoms because of “the size of it.” Kalinago boys said that they did not know much about it and that it was “not popular.” One said there had been a female condom demonstration using a model at his school.

In Grenada, out-of-school girls said that when they were at school they were told about the female condom but there was no demonstration of how to use it, though demonstrations showed how to use the male condom. An out-of-school male said he would be willing to use a female condom if a woman asked him to. In Carriacou, some boys said they knew about the female condoms but others did not. Three of the five girls in the Carriacou group said they had heard of the female condom, of which one had seen it on television and another in her biology textbook at school.

In St. Lucia, girls had heard about the female condoms and one had learned that it is provided free of charge. Boys said that male condoms were more frequently used than female because, “Women don’t have sex every day so men will use condoms more.”

In St. Vincent and the Grenadines, one schoolgirl said she had learned about

female condoms from a book she had acquired, but the majority in her group did not know much about female condoms and asked her what they were like. The out-of-school girls had not been taught about female condoms but from hearsay had learned the following.

VFO4: They say the woman one don’t make no sense.  
I: You said it don’t make sense, to use it. OK - based on what?  
VF04: Miss, a what me hear. Me does hear people a say that I think you have to push it up inside you. Me don’t know what they mean by that.  
(St. Vincent and the Grenadines out-of-school female)

In Bequia, one of the girls had seen a female condom demonstration while others had learned some facts about the female condom from conversations. Boys in school in St. Vincent and in Bequia had seen a female condom and knew that it was “big” and “stronger” than the male condoms. Out-of-school boys knew that the condom was “big” and that it goes inside the vagina and one of them had seen one.

There was no evidence from any of the FGDs that female condoms had been used by participants. However, the FGD methodology is not designed to collect data on individual behaviour so it may be that some were using it but not reporting this.

The question of access to condoms will be explored in the section on health services below.

#### 4.3.4 DRUG AND ALCOHOL USE

Males were said to be the main consumers of alcohol and drugs, though some females would also drink excessively and occasionally use drugs. Alcohol was discussed in all FGDs, while marijuana and Spanish Fly (an aphrodisiac) were mentioned in some.

In Carriacou, girls said that females were light users of alcohol and their behaviour would rarely get out of control as a result of drunkenness. They might drink a light lager such as Carib or soft drinks such as Malta, Busta or Chubby. In contrast, they thought that boys’ drunkenness presented a problem for them as the boys would harass and disrespect them while drunk, leering at girls and groping them and losing control of what they were doing. Some would also deceive girls, persuading them to have sex then claiming the next day that they were drunk and did not remember having sex with them. Boys in Carriacou agreed that alcohol made males forget what they were doing because “they head bad” and went on to say that if a girl refused sex to a drunk man or boy he might rape her. Some boys also gave Spanish Fly to girls to persuade them to have sex. Girls who got drunk could be easily persuaded to have sex and by the

time they realized what had happened it would be too late. Out-of-school boys in Grenada agreed that local girls infrequently got drunk. Schoolboys in Grenada said that girls who drank alcohol were likely to be sexually active already but that alcohol loosened their inhibitions and made them think “that they could do anything that they want on the road so they does just go out and have sex.” An out-of-school girl in Grenada said that she had already given up alcohol because of the irresponsible things it made her do.

*GFO3: That used to happen to me but I stop drink alcohol...Like, you drink, you get high, you get stupidly, you may not know the person, you just go and have sex with them and the next day you wondering like, what am I doing here or how I reach here? When you see the next person is like, ‘Who is you? ...I don’t know you.’ Then again the person would say, ‘We was together in some dance.’*

In St. Lucia, schoolgirls similarly said that alcohol led to poor self control by both sexes and added that it decreased the likelihood of condom use. They noted, “Somebody may take advantage of you.” St. Lucian boys said alcohol increased the urge to have sex and made boys “bold and reckless”. They said that most girls do not drink or smoke.

In Dominica, schoolgirls said that alcohol affected the sexual behaviour of girls, “because when you are drunk you are easy.... They can do what they want.” They thought that drunken girls were more likely to participate in group sex or “line up” as described above. Schoolboys said that females under the influence of alcohol could not make their own decisions and could easily be led astray. They also mentioned drugs that could be put in girls’ drinks and were used to enable males to have sex with them. Kalinago girls said that alcohol could make girls more sexually assertive, so those who did not dare say they wanted sex under normal circumstances would go and do so. Out-of-school boys said alcohol made boys “go behind” girls and that some boys tried to make girls drunk so that they could have sex with them.

Vincentian schoolgirls said that alcohol can make girls “play more than one man” (have multiple partners) and even get pregnant and not know who the father is. One described the scenario of a girl getting drunk at a night club and blotting out what is going on in the world.

*VFI5: When a young girl our age, ummm... when they go clubs and thing and they drink alcohol and smoke, they go to this place where they don’t really know themselves.... Young girls...have sex by different men, just because they ain’t themself and they don’t really know wha going on to them. They deadin’ the world.*

Out-of-school girls focussed on males, saying that drunkenness was associated

with committing rape. Girls who were not accustomed to drink could be easily persuaded to have sex. Girls in Bequia said that males who were drunk were prone to abusing their partners, but girls rarely drank. Vincentian schoolboys said that alcohol made girls and boys lose control of their thoughts and increase their sex urges. Out-of-school boys and boys in Bequia mentioned the possibility of boys raping while drunk. Bequia boys mentioned that drunken women might be more inclined to try to seduce a man.

Marijuana was mentioned in seven FGDs. Out-of-school boys in Dominica said that marijuana “makes them weak” and was thus not associated with risky sex. There was a difference of opinion among out-of-school boys in Grenada, some of whom thought marijuana would make you “knock out” (unconscious) and others who said it increased sexual stamina. Vincentian schoolboys and boys from Bequia said that marijuana as well as alcohol led to lack of control of sexual behaviour. Girls in-school and in the Kalinago territory in Dominica and out-of-school girls in Grenada also mentioned marijuana use but did not discuss its impact on sexual behaviour.

While the FGD methodology cannot give a picture of prevalence of drug and alcohol use, from the results above it is clear that alcohol especially is a part of the social landscape for young people in project countries and that they are already very familiar with its impact on personal and sexual behaviour among their peers. In particular, they were concerned about how it was loosening control of sexual behaviour by boys and girls, putting them at risk of pregnancy, STI and sexual violence. See the desk review for data on prevalence of alcohol and drug use in project countries.

#### 4.3.5 GENITAL HYGIENE PRACTICES

Questions 13 to 17 of the FGD topic guide explored an area that has received little attention in Caribbean research: genital practices used to maintain hygiene.

##### 4.3.5.1 VAGINAL PRACTICES

Very few participants had heard of the word, “douching,” though a few were familiar with Summer’s Eve and similar products whereby liquid is squirted into the vagina to cleanse it. Few girls were said to use these products, but in discussion it emerged that there were other vaginal practices for hygiene or for sexual enhancement.

Schoolgirls in Dominica said that some girls used douching products to rinse away sperm after sex. They also stood up after sex so that gravity would make the sperm come out. They were said to view this as a supplement or alternative to the “morning after” pill when they had had unprotected sex. Girls also used rolled up toilet paper or twisted up “rag” (washcloths) to clean inside their



vaginas. They were not taught this by their mothers or other relatives since elders did not want them to have sex. Mothers would actually discourage them from inserting anything inside the vagina, including using tampons when they first had their periods, perhaps because they wanted their hymens to be intact to signify virginity. Girls did not insert anything into the vagina for regular hygiene purposes as they believed that the vagina cleaned itself.

DFI2: Miss, your body does clean out the inside for you already with the discharge and what not.

I: OK. So you heard that the body self cleans ?

DFI2: Yeah. That is why it have the discharge. Discharge is like a waste product.

Boys in school in Dominica were not asked about vaginal practices as the discussion focussed on male hygiene practices.

Girls in the Kalinago territory said that douches were not used and there were no intravaginal hygiene practices. Girls would use soap, body wash, water and rags to clean their external genitalia. Their mothers would teach them to do this. Participants said it was important to do this to wash away bacteria and odours and prevent diseases. Kalinago boys had never heard of practices to clean the vagina.

Schoolboys in Grenada and in Carriacou and Grenadian out-of-school boys similarly had not heard of douching. However, out-of-school boys referred to another vaginal practice, putting blue soap into the vagina so that it would seem tighter. Out-of-school girls said that some girls used commercial douching products after their period or after a vaginal infection to get rid of any remaining smell. One noted that the product may be ineffective in removing infection or odour.

GFO3: When I got pregnant I got an infection. I used to use it but it didn't use to work. It used to give me a sweet smell for a while, and after it just used to have a different smell. And then they give me tablets to take for it.

They knew of girls who used vinegar or hand sanitizer intravaginally to remove sperm after sex. However, like the girls in Dominica, they knew that the vagina could clean itself. One had learned at a workshop in Carriacou that drying the vagina could increase risk of infection. Girls from Carriacou said that commercial douching products were not used but that they drank a tea made of St. John's bush after their period to wash away the remaining blood. No other vaginal practices were mentioned.

In St. Lucia, schoolgirls said that they did not use any douching products and seemed knowledgeable about the ability of the vagina to clean itself.

LFI7: Something that cleans the inside of your vagina? It wouldn't be good to do that because the vagina makes bacteria...not bacteria, some kind of antigen. And whenever there is some kind of bacteria which comes in it, it kills it. So if you remove that, then you might remove the antigen.

Boys in St. Lucia did not think that girls used douching products. They said that girls used rags to clean the genital area and noted that it was important for girls to do this to avoid bad odours and be known as "the smelling girl" in class or via publicity on Facebook.

Vincentian schoolgirls did not know of girls their age using commercial douching products but noted that some used vinegar to clean inside the vagina. They had also heard of some girls using a cleaning product, Black Jade, in and around the genital area to clean and tighten the vagina. Sea water was also said to have the effect of making the vagina seem tighter. They spoke of using herbal steam to make blood from the vagina clot after sex so that it would not be apparent that the girl had had sex.

VFI3: They say, say you having sex, right, and you ain't suppose to. You don't want your parents to know, and you hear your parents going carry you doctor. Boil some kinda peas bush and let the water cool off a little, when it warm you go over it and it does clot up the blood inside.

For hygiene they reported using soap, bath scrub and fingers to clean the external genitalia. They said their mothers did not teach them about this.

Out-of-school girls in St. Vincent said that girls their age did not use commercial douching products but sometimes health clinics would provide devices that squirted medication into the vagina. They said some girls used vinegar on the external genitalia to remove smells. Normally girls used rags and fingers to clean the genital area. Mothers or other relatives taught them to do this.

Girls in Bequia said that some girls used commercial douching products if they had multiple partners. There was also the hint that they would use them if they knew their partner had other partners such as tourists.

I: Do you know of young women or do you know of young women your age who use that type of product for personal hygiene?

VFT7: Miss, yeah, I know.

I: OK, so why do they use them?

VFT7: Because they with plenty guy and they figure, 'Well, you know, up in there you going so that good.'

I: So you would have to explain...

VFT7: Miss it have girls who don't wanna stick with one man. Especially if them boyfriend working on tourist and thing - them sticky.

*(Females in Bequia, St. Vincent and the Grenadines)*

As in other groups they said that soap and rags were used to clean the external genitalia. Female relatives taught them to do this.

Schoolboys in St. Vincent believed that some girls used commercial douching products to remove smells. Girls were also said to use bleaching soap, laundry soap as well as bath soap, rags and fingers to clean the genital area. Out-of-school boys did not know of the use of commercial douching products but said that girls would use cloth or toilet paper to clean inside of the vagina after sex. Girls used soap, water and sometimes baby oil to clean the external genitalia. In Bequia, boys had not heard of douching. They said that some girls used blue soap or sea water to make the vagina tighter. Girls were reported to use water, fingers, body wash, cotton wool and cloth to clean externally. They did not know whether relatives taught them to do this.

Thus, while douching was uncommon, there is cause for concern as it may be used in high risk situations such as multiple partnerships or to wash away sperm. There are also important sexual enhancement practices such as the use of blue soap or sea water to tighten the vagina and that could disturb the chemical balance or vaginal flora. Most girls just cleaned the external genitalia using some combination of water, soap, cloths, rags and occasionally other products. The use of household cleaning products such as bleach and Black Jade to clean the genital area gives cause for concern.

#### 4.3.5.2 MALE CIRCUMCISION

Most participants knew what male circumcision was but few knew young people of their age who had been circumcised. Most were unaware of the research that shows that circumcision reduces the risk of female to male HIV infection by approximately 60 per cent. Participants generally felt that some young men would be interested in accessing safe, voluntary medical male circumcision (VMMC) services if they were offered, in order to be protected against HIV. However, they also said that some young men would be anxious about the pain of the operation and about people operating on their private parts.

Some participants knew of young men who had been circumcised when they were babies. This was reported by Kalinago females in Dominica, in-school and out-of-school males in Dominica, out-of-school females in Grenada, males in Carriacou, in-school females in St. Vincent and females in Bequia.

Participants were asked, “If young men were educated about the HIV prevention benefits of male circumcision and it was offered to them in a safe way on an entirely voluntary basis, do you think they would want to get circumcised?” Responses varied. Kalinago females thought that they would, “because nobody wants to get diseases,” but also noted that “they might think it will hurt” and “they might feel it might look weird” (referring to the penis without the foreskin).

Kalinago males also thought some young men would do it for the prevention benefits. Among males in school in Dominica, some thought that young men would do it for the protective benefit, while some were not so sure. One suggested it might be better to circumcise at birth, before the child knew what was happening. Some young men would be worried about safety.

DMI4: Like they afraid of a knife or something or whatever they using.

DMI2: If you make a mistake, its like, yah!

DMI1: Next thing you seeing your penis on the floor.

I: Next thing you seeing your penis on the floor?

Participants: (laughter, some agreement).

DMI4: Or if you get an infection when they cut it, and it start to rotten.

(Dominica in-school males)

This group also pointed out that some young men do not think that they personally are at risk of HIV and would not take up the service for that reason.

Grenadian out-of-school males thought males would be unlikely to accept VMMC, thinking it should be done at birth or not at all. Grenadian out-of-school females thought that young men would want it for the protective benefit. Males in Carriacou noted that males would like the option of VMMC but one wanted to know if it was still necessary to use a condom if one was circumcised. He thus pointed to the public health concern about “risk compensation,” that men would abandon other protective behaviour such as condom use and partner reduction if they were circumcised to prevent HIV.

In St. Lucia, girls thought that young men had “too much pride” to present themselves for circumcision, presumably referring to the general unwillingness of males to refer themselves for health care unless very ill. One of the boys in St. Lucia said that now he knew the protective benefits, he would be willing to be circumcised. However, one of the other boys in the group disagreed, saying that young men would be embarrassed to go to a doctor and show their private part. Among in-school males in St. Vincent, opinion was divided. One participant was very enthusiastic, saying “real man would want to do that” if they knew of the preventive benefit. Another referred to the pain the operation might cause. One noted that removal of the foreskin might reduce sexual pleasure for men and their partners.

VMI7: Well, sir, well, ahh, how I should put it? Some ah them, some ah them just don’t want do that, you understand? The girl does want pull it back and just (hand jerking motion) (boys laugh).

I: Uh hmm, in other words them want the skin then?

VMI7: Yeah (boys laugh and talking).

Out-of-school boys also had mixed views, with some saying young men would

do it to be protected, but another saying that they would want to leave their penis just the way they were born with it.

VMO5: ‘Cause it get some who just care about them self. It have some who go say, ‘Man, me leave my thing just so eh. Me born so, me dead so.’

In Bequia, it was said that some young men would be “interested in that 60 per cent you talking about.” Girls in all three FGDs in St. Vincent and the Grenadines thought that some young men would want to be circumcised, but a schoolgirl pointed out that some might refuse to let any other man touch them to do the operation because of the fear of homosexuality. She explained that some young men only wanted their penis to be seen by girls they were going to have sex with.

The data suggest a high degree of interest in having the option of VMMC for HIV prevention. However, uptake may not be high given fears about safety, low use of preventative health services by men and resistance to anything that might involve other men operating on their penises.

To date there have been no studies of the prevalence of male circumcision in these countries. Discussions with health care workers suggest that infant male circumcision was quite widespread about 30 to 40 years ago in the region, but then fell out of favour following trends away from infant circumcision in the major metropolitan countries, the UK and US, where many doctors in the Caribbean receive their training. The strong recent research evidence on the efficacy of male circumcision in preventing HIV, the relatively high HIV rates among men in the Caribbean, along with the evidence above that young men in project countries may be interested in having the option of VMMC, suggest there is a need for debate and rethinking the approach in existence for the past few decades.

#### 4.3.5.3 GENITAL HYGIENE AS AN STI PREVENTION STRATEGY

Participants were asked about their personal hygiene strategies and the extent to which they thought that these could protect them from HIV/STI.

Female genital hygiene strategies have been described at length above. Males were generally said to have been taught by their parents to pull back or “skin back” the foreskin of the penis and use soap and water to clean underneath, removing any discharge or dirt.

Participants generally knew that HIV infection did not depend on how clean or dirty a person was, but depended mostly on the HIV status of the person they had sex with. A male in St. Lucia agreed with others in his group when he said, “You can be the cleanest person in the world but if your partner has HIV you can get it.” This view was shared by participants in the following FGDs: Kalinago females and males, in-school males in Dominica, out-of-school females and

males in Grenada, in-school females in St. Lucia, in-school females and out-of-school males in St. Vincent, and males and females in Carriacou. It was generally agreed across FGDs that lack of hygiene could not cause HIV but some, including schoolboys in St. Vincent and girls in Bequia, correctly thought other genital or sexually transmitted infections could increase risk.

Responses to this question suggest that young people know that HIV is not caused by lack of cleanliness and that the HIV status of sex partners is the most important factor. A few also knew that genital hygiene plays a relatively minor role in the risk of HIV infection.

#### 4.3.6 TEENAGE PREGNANCY

Participants in all groups knew of at least one girl who had become pregnant. The experiences of these girls were generally portrayed in negative terms. In Dominica, schoolgirls said that the girls became “ashamed” and “depressed.” Participants in several groups pointed out that teenage mothers often had to stop their education, with Kalinago males in Dominica pointing out that this had an intergenerational impact since the children were raised in poor households and often became involved in crime. Schoolgirls in St. Vincent pointed out that girls who became pregnant often had no idea how to look after a child and made mistakes that damaged the health of the children. Many teenage mothers were abandoned by the fathers and, less frequently, by parents as well. A few had experienced complications of pregnancy and childbirth as a result of their young age. The negative impact of teen pregnancy was summed up by a schoolgirl from St. Vincent as follows.

VFI1: Pregnancy to me is like suicide, like I just kill my life there, kill my own self there. Pregnant! I mean, I give up my freedom, I give out my future, my financial life. I war money for myself, have to buy Pampers and all them thing there. They give up they education, they whole future right there basically ‘cause you have to catch up on a whole.

It was noted in several FGDs that some of the fathers of babies resulting from teenage pregnancies were teenagers themselves. They could not meet the financial and other responsibilities of parenthood, and would often abandon their partners. Some would become frightened and tell the girl to abort the child before others found out about the pregnancy. The prospect of becoming a father when still in school and not working was immensely stressful for some boys.

DMI1: Well, I have a friend, he told me that it had a Christmas time when he and his girlfriend they go sans capot [did not use a condom]. Then he break [ejaculated] inside her and he thought she had got pregnant and his Christmas didn’t go well... Until she tell him her period come, that was till after Christmas, all he was doing was just sleeping and crying.

*(Dominica in-school female)*



Schoolgirls in Dominica said that one of the advantages of having older partners was that they could offer some support in the event of pregnancy of a girl. However, older partners often abandon the girls too because “they afraid they take jail,” i.e., they are afraid of legal sanction for having sex with someone below the age of consent. Some girls who became pregnant were rejected by their parents and had to turn to their partners for support. Boyfriends placed in the position of having to support the girl and child would often mistreat the girl and turn to violence, according to schoolgirls in Dominica. Most parents, after the initial shock and disappointment, provided support for the mother and often child care to enable her to return to studies or get a job. Occasionally a girl’s parents would throw her out of the house and in some cases the father’s parents would provide support.

Access to education for teenage mothers appeared to vary. Research participants told only of pregnant young women that they knew and their responses may not be representative of each entire country. Kalinago girls said that the teenage mothers they knew went back to school. Schoolgirls in Dominica said that some teenage mothers went back to school and others did not, with the outcome partly dependent on whether a grandparent was willing to look after the baby. Schoolboys in Dominica said that some dropped out of school because they were ashamed. One teenage mother dropped out of her school but then was provided with a place at the school the father of her child attended. Grenada out-of-school girls said that teenage mothers they knew had to leave school, but there was the possibility of continuing their education with an NGO, the Programme for Adolescent Mothers (PAM). Boys and girls in Carriacou said teenage mothers left school partly because they were not allowed to return after the baby was born and also because they did not have anyone to look after the baby. Schoolboys in St. Lucia said that girls did not go back to school partly because they faced heavy social criticism for having become pregnant. Out-of-school girls and boys in St. Vincent and the Grenadines and both boys and girls in Bequia said girls did not continue their schooling following pregnancy.

Faced with dim prospects for the future, some pregnant teens sought abortions, known as “throwing” the child. Participants in Dominica mentioned drinking hot Coca-Cola or taking paracetamol as a way to cause a miscarriage, while in St. Vincent and the Grenadines they would drink hot Guinness and Epsom salts for the same purpose. Abortions are illegal in project countries but it seems that some young women were able to obtain them. However it was acknowledged that they posed risks to the health of mothers. Some girls who went through with the pregnancy still tried to keep it secret by wearing baggy clothing or banding down their bellies. The Welfare Department would arrange for adoption or foster care of unwanted babies.

Experiences of health service support by teenage mothers varied. A few teenage mothers received no help from any governmental or non-governmental

organizations (NGOs). Some said that health care workers were quick to judge and make comments about teenage mothers. St. Lucian boys said that nurses gave out brochures on how young mothers can take care of themselves and the medical tests. They also advised her on classes she could do and counselling was made available. Vincentian schoolgirls and schoolboys said that the Welfare Department or Salvation Army would give a small amount of money to purchase food and clothes for the child.

#### 4.3.7 HEALTH SERVICE RESPONSES

Participants noted varying levels of support for young people by health care workers. The gender and age of patients were said to condition the response of health care workers. Some participants were especially concerned about levels of confidentiality in public services and chose to avoid them or use private organizations instead.

Health care workers were generally regarded as resistant to providing condoms to young people aged 15 to 17. Dominican schoolgirls said that they would provide them but ask them many questions, including their age and whether their parents knew that they were seeking condoms. “Because of pride” some young people would choose not to seek condoms from public clinics.

DFI3: Sometimes when you go and get the condoms they does ask you what you need that for and if you not in church and why you in that. They’ll ask you too much questions that will make you want to come out there.

I: So we were talking about restriction from obtaining condoms from family planning or healthcare providers, what about without parental consent, do they give you a hard time?

DFI3: Yes. They does want to ask too much questions.

I: Like what?

DMI3: About your sex life and who you doing it with and if your mother know and who you doing it with in your same age. That causes you not to go back.

I: So if you do not have parental consent they do not give you the condom is that what you are saying?

CI3: They will give it to you but they will ask a lot of questions.

I: OK... Do you think healthcare providers in Dominica are friendly and helpful to young people?

CLIENTS: No.

I: To obtain condoms?

DMI4: They more busy to mind your business.

Similarly, Kalinago girls said that in some places health care workers were helpful, but in some when young people ask for condoms, “they asking you what you going to do with that? They always have something to tell you.” Girls in Carriacou commented,

GFT3: Some of them fast because they want to know what you do and who you do it with and some of them just want to know your business.

Out-of-school girls in Grenada pointed out that the age of consent to sex was 16, yet at ages 16 and 17, young people were legally mandated to get parental consent to health care, including accessing condoms. St. Lucian girls said that the attitudes of health care workers were different for young people under 18 “Because they’d faster ask us questions than the older ones.” They also believed, in common with girls in several other FGDs,

LF13: It’s easier for boys to get condoms. Girls...the people watch girls differently. Like girls are supposed to protect themselves, but at the age they are, they’re not supposed to be coming to look for condoms.  
(St. Lucia in-school female)

Similarly, a girl in Bequia observed that the legal requirement of parental consent was applied more strictly for girls.

VFT1: When a young woman go to the hospital and ask for condoms, they would ask a lot of questions and you will have to bring your mother and you have to explain to your mother why you want condoms. So the boys they get away easier than the girls.

Male respondents tended to corroborate this view that boys were treated differently by health care workers. A schoolboys in Dominica said, “Most of the times they will tell the girl not to have sex and they will tell the boy to use protection.” In the view of these boys, this actually represented discrimination in favour of girls as they thought they were not protecting the boys sufficiently.

DMI6: They more concerned about the girls.

I: They are more concerned about the girls?

DMI1, DMI6: Aha.

I: So they will tell the girls not to have sex and they will tell the boys to use a condom?

MI6: Yes, they sending us to have sex.

INT: They send the boys to have sex?

MI6: Yes.

INT: And the young girls they telling them don’t?

DMI6: Yes. They more educating the women, miss.

Schoolboys in Grenada, however, suggested that when they asked for condoms at health centres they would not always get them and that health care providers would use an unpleasant “tone of voice” to them. Schoolboys in St. Vincent said they could obtain condoms from health centres but some health care workers would comment that they are too young and “want to know where you going with

it”. On the other hand, in Bequia, boys said that health care workers were happy to give them condoms because they were “doing the right thing” by seeking protection. Some boys noted that condoms were distributed for free at some public events such as concerts and during Carnival.

Girls generally felt that health care workers wanted to know too much about their personal lives, and in addition were concerned about a perceived lack of confidentiality among health care workers.

VFT8: They does wah go down in your business in Bequia.

VFT7: If them know your parents and thing, they go talk, yeah, talk your name. And talk ‘bout stuff ‘bout, ‘Her mother ain’t protective at all, she there let she have sex,’ and thing like that, ‘Do weh she feel like and them cah talk to she.’

I: OK, so are health care providers friendly towards young people?

VFT3: No. Because they would go in the streets with the rest of your friends and spread it and next thing everybody in the community know.

(Females in Bequia, St. Vincent and the Grenadines)

Some girls however thought that some health care workers were genuinely concerned and would maintain patient confidentiality.

Males also thought that the degree of youth friendliness among health care workers varied. Some would provide useful advice as well as educational sessions and discussions for young people, for example around special events such as World AIDS Day. In-school males in Grenada observed that the attitude of health care workers was less friendly if a person of his age was seeking contraception than if he was seeking another type of service. Repeating the concern expressed by some girls, a boy in Carriacou said that health care workers were not friendly,

GMT1: Because they are not confidential. Before you have, if something like AIDS and you go to the hospital and they finalize that, before you reach in the road, Miss, it is out on the road. They don’t keep things confidential. They don’t keep it private. In a business place you not suppose to be letting your bus...people business outside... And they talk you bad. They sit down in the place and they talk people bad, very, very bad.

Boys in St. Lucia believed that younger health care workers were more helpful than the older ones, who were quick to pass judgement.

In terms of teen pregnancy, out-of-school girls in St. Vincent and the Grenadines observed that health care workers would try to help the girl with advice but may also seek to report the incident to the police.

I: Do you think they treat young people differently to how they will treat

someone over 18?

VF04: Miss, in terms of teenage pregnancy, them go more treat the younger one better 'cause she na go really know about pregnancies but the older one go done know.

VF03: Miss, some of them... go look to blame the parents...

VF04: So when you underage and you go clinic for pregnancy, them go wah call police and all them kinda thing dey,.... when you 14 and when you 15 and maybe when you 16.

Because of perceived lack of confidentiality and unwillingness to provide condoms to young people under 18 in the public sector, many young people sought their condoms from private pharmacies. There was the perception that store staff would be more willing to provide them to males than females, so that some females would either obtain them from a male they knew or pretend that they were buying the condoms for a male relative. Boys would also be given judgemental remarks by store staff, so some pretended they were getting condoms for an older male. Some young men were said to have supplies of condoms that they sold to younger males.

For HIV testing, some young people were willing to use government facilities, but many were afraid of being seen at HIV testing sites or were concerned about lack of confidentiality among health service staff. Many young people who wanted to be tested for HIV would therefore go to private doctors or clinics. Others would not be tested at all, partly because they could not afford private testing. Schoolboys in Dominica said that some young people who could afford it went abroad for HIV testing. Schoolgirls in Dominica said that some young people went to the Planned Parenthood Association for HIV testing while others went to the offices of the National AIDS Programme. They noted that concerns about privacy were amplified now that personal business and rumours could be spread on Facebook.

I: Oh. So you worry about privacy in Dominica?

CLIENTS: Yeah.

I: You think it's a problem here?

DMI3: Yup. Of course is a problem.

DMI2: People talking too much.

DMI1: They doesn't mind their business.

DMI2: If Grammar School children see me go and take AIDS test and you come back school the Monday, when you come back school the Monday everybody know your business.

DMI4: Monday! The Friday night they update your status on Facebook, what you talking about, nuh, girl?

#### 4.4 HOW WOULD YOUNG PEOPLE LIKE THINGS TO CHANGE TO REDUCE THEIR VULNERABILITIES?

Since young people aged 15 to 17 have not had much exposure to the world of policy-making, many of the suggestions they put forward to improve youth sexual and reproductive health focussed on the people they knew best; young people, their families and their teachers. They also had suggestions for other service providers, especially health care workers.

Some of the suggestions reiterated messages they had been taught at school and at home, such as urging young people to abstain or use condoms and be faithful if they were sexually active. The preceding sections show that existing methods to teach these messages were ineffective for many young people, so many of the participants put forward suggestions of different ways that young people might be empowered to protect themselves.

A major theme in these suggestions was the greater involvement of young people and greater interactivity in teaching methods, accompanied by greater respect for the voices of youth.

LF11: People have to be allowed to express themselves. People are too judgemental of children. They always prefer bigger people who are more mature and know everything.  
*(St. Lucia in-school female)*

Participants in several groups called for discussions of sex, sexuality and methods of protection, in contrast to the one-way, didactic teaching style adopted at school. They wanted "more talk about sex in school and at home" and also on the television [females in Bequia, St. Vincent and the Grenadines] and on the radio [in-school males, Dominica]. It was suggested that learning had become too individualistic and there was a need to go back to the days when groups used to sit down and debate things together.

VMT5: It have people back then eh, teachers go tell you long ago, they use to get together in a group and talk all thing together. That is where, that is where we going wrong, I believe, eh, because sometimes people hardly thinking of being in a group and talking, they rather be by theyself. So I believe if everybody come together in a group and get a group discussion everything go be better than how it running now.

VMT3: Yeah, I mean it could get a sex talk every Monday and every Friday you talk about sex.

*(Males in Bequia, St. Vincent and the Grenadines)*

Girls in Carriacou supported the idea of more teaching and discussions in groups. Schoolboys in Dominica suggested clubs at school that could have meetings and guest speakers to discuss sexual and reproductive health.



There were also calls for people who wanted to promote the sexual and reproductive health of young people to draw on the sexual experiences of themselves and others, using personal scenarios and stories to engage young people, catch their interest and get them to imagine how they would respond to a similar situation, thus sharpening their problem-solving skills. Peers and people not much older than the youth themselves should play a major role in sharing their stories and in education. A few participants had experienced educational sessions involving young people and NGOs in discussions and demonstrations of protective methods and said that these were useful. Participants said they would also value discussions with experts including nurses, doctors and government officials so long as young people could be active participants in these discussions. DMI4: Have more discussions, like on AIDS, on sex and ting.

INT: Have more discussions on sex. Who should have more discussions on sex?

DMI2: The young people.

I: Young people with who?

DMI5: Nurses, doctors.

DMI2: Government officials, Ministry of Education.

DMI3: Youth groups.

*(Dominica in-school females)*

Schoolboys from Dominica said they would appreciate nurses, doctors and other experts visiting school as frequently as fortnightly to host discussions on sex. Workshop formats should also be used:

LFI3: They should have more workshops for the youth to encourage them on what is important in having sex and what to avoid.

LFI5: All those teenagers, the young teenagers that want to have sex, they should be made more knowledgeable about it. There should be special classes for them to either try to make them stop, but if they want to continue – because they like their business – try to give them more aiding sessions about it.

*(St. Lucia in-school female)*

Schoolboys from St. Vincent suggested that television advertisements should be developed showing realistic scenarios to persuade young people to take their sexual and reproductive health seriously.

VMI1: Like do some advertisement on T.V., about them sexual thing, people getting throw out ah school, show that they can work and abstain and them thing deh.

VMI2: Knock sense in your head sometimes, nah.

I: Knock sense how?

VMI2: Show them, like whenever news going start, right, you does see

LIME commercial and thing every minute pop up, like when news going break and thing, like if they could like cut out some ah them commercial and put in like them kind ah advertisement deh.

VMI3: You know, how life is real serious!

Participants in several groups called for better communication with parents, who should also be encouraged or even trained to use their own experiences to teach their children. They indicated that parents should not be so quick to judge and condemn but should engage in discussions with children and respect their opinions and wishes.

Reaching young people would also involve community outreach, and this would need to be supported by announcements in advance that educational sessions would be taking place, included targeted promotion to youth. Posters, radio announcements, text and Facebook messages should be used. Schoolgirls in St. Lucia suggested various bodies or professionals already involved in community activities could contribute to outreach, including Village Councils, the Child Fund and Welfare Officers. Out-of-school female youth in St. Vincent also suggested that people from churches could provide education through outreach to people beyond their own congregations, given the effectiveness of the church in preventing sexual activity among some young people. Out-of-school females in Grenada suggested that HIV testing should also be extended into the community using outreach methods.

Counselling was suggested as another interactive method to include young people in addressing their own challenges. Participants bemoaned the lack of counsellors who could enable them to develop and share methods to confront such challenges as partner violence and teenage pregnancy. A girl in Carriacou suggested that counsellors should be available within communities as well as more readily available in schools.

GFT5: We need to have more counsellors, not 2 and 3 and 4, not only in them schools like in them communities. They need to have more counsellors.

Given the call for experience-based learning, the need for confidentiality of personal information becomes all the more pressing. All people, including young people, who are involved in delivering sexual and reproductive health education and other services to youth should undergo training stressing the human right to privacy and the duty to protect confidentiality. Sanctions should be applied, including dismissal, for personnel who break confidentiality. Girls in Carriacou suggested that workshop formats would be useful in teaching health care workers the skills they need to improve their care of young people. Boys in school in Grenada recommended employing “more helpful people in the health care facilities [who are] interested in helping young people.”



Another suggestion from girls in Carriacou was for women to raise funds to support campaigns to promote protection and abstinence, in which young people would be involved on a regular basis. Thus they acknowledged responsibility of communities to help themselves to overcome sexual and reproductive health challenges.

GFT1: Well, yeah, they could raise funds and something like that. Like, all women in the country, they could come together and raise funds.

I: Raise funds for the purpose of?

GFT2: Protection and abstinence.

I: You mean campaigns?

GFT2: Yeah, every Sunday or something. It would be kinda fun.

I: A fun day to educate?

GFT3: Yeah, the government doesn't want to stretch forth their hands. They go say they don't have time for little children.

A second major suggestion was to improve condom access for young people. As noted above, health care workers did provide condoms to young people aged 15 to 17, despite the law saying that parental consent to health care was necessary, but tended to ask questions that young people regarded as intrusive and judgemental. Many therefore sought condoms from pharmacies or from other private sources. Participants suggested that young people should have more involvement in the provision and distribution of condoms and this would remove the perception that older people were judging them and trying to restrict them.

DMI2: They will have to like select some people to do youth work who could sit down and discuss how to use a condom.

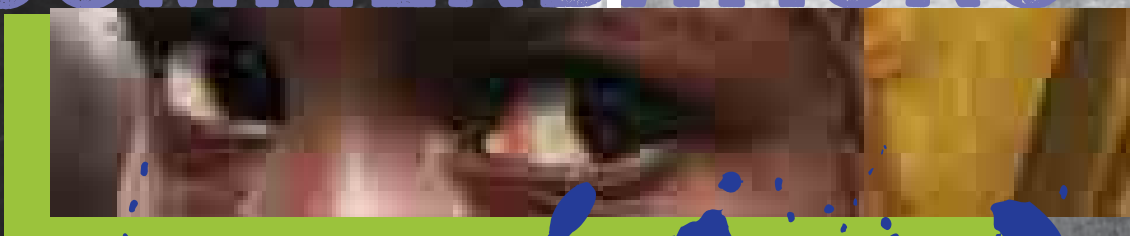
*(Dominica in-school female)*

Thirdly, in support of teenage mothers it was suggested that the right to education should be assured in all countries and that this should be supplemented by special facilities such as nursery care and business training centres for young mothers or simply good advice on child care and how to access existing services and get back to school. They should be assisted in attending another school if they feel uncomfortable attending the school they were at when they became pregnant [Kalinago females, Dominica].





# DISCUSSIONS & RECOMMENDATIONS



**This study has included secondary and primary data collection and analysis in four countries on a wide range of dimensions of sexual and reproductive health and rights.** The challenges facing youth have been shown in quantitative and qualitative research to be numerous. At the macro level, economic conditions are not promising in terms of young people obtaining gainful and fulfilling work opportunities, while consumer culture and technological innovation have bred new temptations and aspirations. Sexual behaviour and crime are conditioned by this context, with new challenges posed by easy access to the internet and pornography. The research has shown that many young people are not being equipped with the skills they need to navigate these challenges and enjoy a brighter future with safe and fulfilling sexual relationships and reproductive health.

## DISCUSSIONS & RECOMMENDATIONS

### 5.

We now summarize the recommendations put forward by young people and add a few more relating to policy. Given the multiple challenges identified in this report it is difficult to be comprehensive with regard to recommendations and the following may be regarded as preliminary and may be supplemented by others through discussion with stakeholders and experts.

#### 5.1 CHARACTERISTICS OF PARTICIPANTS IN THE FGDS

A total of 100 young people participated in the FGDS across the four countries, of whom 51 were male and 49 female.

##### 5.1.1 GREATER INVOLVEMENT AND GREATER RESPECT FOR YOUNG PEOPLE

1. Parents, teachers, religious leaders, the media and all professionals involved with youth should discuss sex and sexuality on a regular basis with them.
2. Interactive and experiential communication and teaching methods should be used, with full participation of youth.
3. **Community outreach** should be undertaken for especially vulnerable and out-of-school youth with regard to sexual and reproductive health education and services.
4. More **counsellors** should be available in school and community settings.
5. **Specialist youth health services** should be developed.
6. Young people should be assisted in **forming organizations and carrying out fund-raising** to develop campaigns to improve sexual and reproductive health.



### 5.1.2 GREATER CONFIDENTIALITY

1. All people, including young people, who are involved in delivering sexual and reproductive health education and other services to youth should undergo **training stressing the human right to privacy and the duty to protect confidentiality**.
2. **Sanctions**, including dismissal, should be applied for personnel who break confidentiality.

### 5.1.3 IMPROVE ACCESS TO BIOLOGICAL PREVENTION METHODS

1. **Young people should have more involvement in the provision and distribution of condoms** and this would remove the perception that older people were judging them and trying to restrict them.
2. Community outreach should include HIV testing and provision of male and female condoms at events and through non-traditional outlets.
3. Girls at high risk should be provided with **education about the risks of douching** as well as about condoms and contraceptives. Community workers should assist in identifying girls at high risk who may be involved in activities such as alcohol consumption and transactional sex as well as multiple partnerships.
4. **Voluntary medical male circumcision** should be among the services offered in a comprehensive package of sexual and reproductive health care services for men. This would necessitate thorough training and quality control with respect to service safety, as well as awareness campaigns, following guidelines developed by the WHO and UNAIDS.

### 5.1.4 IMPROVE SUPPORT FOR TEENAGE MOTHERS

1. **The right to education for girls who become pregnant should be assured in all countries.**
2. Special facilities such as nursery care and business training centres for young mothers should be provided alongside good advice on child care and how to access existing services and get back to school.
3. Teenage mothers should be **assisted in attending another school** if they feel uncomfortable attending the school they were at when they became pregnant.

### 5.1.5 PRIORITIZE EMPLOYMENT OF YOUTH

1. Special attention should be paid to the provision of **attractive income-earning and career opportunities** for youth.
2. **For young men**, support for income-earning opportunities should supplement focus on more interactive methods to study for academic or vocational qualifications accompanied by interactive education on the consequences of multiple sexual partnerships and violence against women and girls.
3. Males should be engaged in further discussions of the challenges they face and how these relate to issues of **masculinity**, while being presented with alternative opportunities and role models.

### 5.1.6 VIOLENCE AGAINST WOMEN AND CHILDREN

1. Existing **laws relating to sexual and domestic violence should be better enforced**, with attention being paid to the long-term welfare of children as survivors or perpetrators.
2. Laws should be developed regarding child **pornography**.
3. Protocols should be developed for the management of **child abuse and neglect**.

### 5.1.7 SUPPORT FOR KEY INSTITUTIONS: PARENTS, SCHOOLS AND CHURCHES

1. Parents, teachers and religious leaders should seek closer, more trusting and respectful relationships with children, especially with regard to discussion of sexual matters.
2. Experts in adolescent development and communications should assist and train parents, teachers and religious leaders in ways to improve communication and dialogue with young people, especially around sensitive issues such as sex among youth.

### 5.1.8 HIV KNOWLEDGE, STIGMA AND DISCRIMINATION

1. Attention should be paid in schools to improve **HIV knowledge** using the teaching and communications methods recommended at 4.1.1.
2. Interactive methods should also be used to **discuss how HIV stigma relates to personal moral values and especially compassion**, with a view to develop more helpful and less discriminatory attitudes to vulnerable populations.



# APPENDICES



## APPENDIX 1: RESEARCH PROJECT INFORMATION DOCUMENT

### Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

#### RESEARCH PROJECT INFORMATION DOCUMENT

The United Nations Population Fund (UNFPA) Regional Office for the Caribbean/Barbados is working to strengthen the evidence base on adolescent and youth sexual and reproductive health and rights in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. The research project described in this introductory document aims to: Assist project countries with the development and strengthening of policies and programmes on adolescent and youth sexual and reproductive health and rights.

## APPENDICES

### 5.

Inform the development of UNFPA's 2012 – 2016 Programme of Assistance to the Eastern Caribbean, of which the primary objective is to support countries with the development and strengthening of policies and programmes on adolescent and youth sexual and reproductive health and rights.

Inform the development of targeted advocacy and communications campaigns on adolescent and youth sexual and reproductive health and rights.

#### OBJECTIVES OF THE RESEARCH

The objectives for the research in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines are:

- To collate and present existing data on sexual and reproductive health in the age group 10-24 with a focus on STIs, HIV and unintended pregnancies
- To identify vulnerabilities of youth to STIs, HIV and unintended pregnancies
- In both governmental and non-governmental sectors, to assess the appropriateness of policies and access to services to address sexual and reproductive health challenges.

#### METHODOLOGY

Three principal methods will be used to meet these objectives:

- Desk review
- Interviews with key stakeholders
- Focus group discussions with young people

#### Desk review

The desk review will seek to collate and present existing information on the sexual and reproductive health of young people aged 10-24 in the four project



countries. By collecting documents through online searches and consultations with stakeholders in each country and reviewing them, the available evidence will be presented in relation to the following questions, thus providing a baseline for further action and research:

- What is the status of youth sexual and reproductive health? Epidemiological and research data and statistics on HIV, STI, pregnancy and maternal death will be sought, presenting trends over a ten year period where data permit.
- What is the existing evidence on the risk and protective factors for sexual and reproductive health among adolescents and young people? What are the social and economic vulnerabilities that have been identified in research to date?
- What are the existing health and social services and policies relating to youth sexual and reproductive health?

#### Interviews with key stakeholders

An interview guide will be administered to stakeholders in each country involved in or with an interest in the design and delivery of sexual and reproductive health services to youth. Open-ended questions will be used to generate descriptions of services, policies and protocols, youth access to services, views on the vulnerabilities and protective factors for young people and recommendations for action.

#### Focus group discussions with young people

It is important that the voices and opinions of adolescents and youth be reflected in any project designed to benefit them, and that projects are built on understanding of their experiences and challenges. In addition to including youth advocates among stakeholder interviewees and collating existing information on adolescents and young people age 10-24, the project will collect primary data among young people in an especially vulnerable age group; 15 to 17 years. The rationale for focusing on this demographic is that they are often engaged in or contemplating sexual activity, yet do not have full access to sexual and reproductive health services, mainly because they have not yet reached the age of legal majority [18].

The research will collect primary data with 15 to 17-year olds via twenty-four focus group discussions. In each country, three male only and three female only discussions will be conducted, organized as follows:

- In-school youth [one male and one female group]
- Out-of-school youth [one male and one female group]
- Culturally distinct area [one male and one female group]. The culturally distinct areas have been identified by Project Advisory Teams in each

country, and comprise the Kalinago Territory in Dominica, Carriacou in Grenada, a hurricane-affected area in St. Lucia, and a Grenadine island in St. Vincent and the Grenadines.

Parental consent and the assent of individual young people will be obtained prior to the focus group discussions. The discussions along with introductions and refreshments will last up to two hours and will be facilitated by same-sex individuals with a track record of working with youth and maintaining confidentiality of personal information. Discussions will cover the following topics:

- Overview of opportunities and challenges facing young people
- Evaluation of what young people were taught about sex and relationships by their teachers, parents or others
- Characteristics of young people who abstain from sex
- Degree of choice available to young women and men about whether to have sex
- Reasons for use or non-use of male and female condoms
- Impact of drug and alcohol use on sexual behaviour
- Use of douching and other vaginal hygiene practices by young women
- Knowledge of and attitudes towards voluntary medical male circumcision to prevent HIV
- Beliefs concerning the role of personal hygiene in preventing HIV/STI
- Experiences of young women who become pregnant
- Youth-friendliness of health care providers as regards facilitating access to contraceptives and advice on sex and relationships
- Accessibility of HIV testing for young women and men
- Recommendations to improve sexual and reproductive health
- Identification of stakeholders to involve in the process of implementing recommendations.

The focus group discussions will be digitally recorded and fully transcribed. Following transcription, the digital recordings of the discussions will be destroyed. To maintain confidentiality and protect participants, no information about the identities of the individual participants in the focus group discussions will be included in any reports from the research.

#### How to get further information

If you have any questions or concerns about the project, please get in touch as follows:

**Ms. De-Jane Gibbons** - Assistant Representative, UNFPA Sub-Regional Office for the Caribbean/Barbados, UN House, Marine Gardens, Hastings, Christ Church, Barbados.

T: 246-467-6135      F: 246-435-3243      Email: gibbons@unfpa.org



**Dr. Caroline Allen** - Lead Researcher  
T: 246-228-0852      Email: allen.carolinef@gmail.com

**APPENDIX 2: INTRODUCTORY VERBAL STATEMENT FOR STAKEHOLDER INTERVIEWS**

**Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean**

Introductory verbal statement for stakeholder interviews

NOTE: The following statement will be preceded by providing the potential interviewee with the information document above. If the potential interviewee is already familiar with the research project [e.g. through membership of the Project Advisory Team], it may be summarized rather than read out verbatim.

I am here carrying out work on behalf of the United Nations Population Fund (UNFPA). The aim of our project is to strengthen the evidence base on adolescent and youth sexual and reproductive health and rights in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. I am carrying out research in [name of country] to consult key stakeholders about the status of youth sexual and reproductive health, the relevant policies and sorts of services provided and find out people’s views about ways to strengthen existing approaches.

I would like to interview you for the project. I have an interview guide and most of the questions are open-ended which means that you are free to describe things and offer your views in the way you want. There are also some questions where I will be asking you to tell me whether certain sorts of services are provided. The interview may take up to an hour.

Descriptions of each agency represented by interviewees will be provided in the final report of the study. Views expressed will be referred to by the gender of the interviewee and the name of the agency he or she works for. The intention is to keep the identities of interviewees confidential. If you would prefer your agency not to be named when you talk about your own views, please let me know and this wish will be respected. The names of interviewees will not appear in the study report.

We do not believe that this research poses any great risks to participants. We will not be asking you for any information about your private life, and will not be divulging your identity in reporting on the research. However, there is a risk that people will be able to work out who said what. This may be harmful if, for example, a work colleague or boss does not agree with the views expressed.

The report from this research will be shared with UNFPA and its Project Advisory Committees in each country. After finalization it will be disseminated electronically to stakeholders and subsequently in UNFPA’s Annual Programme Review Meeting.

We would like to record this interview using a digital voice recorder. This is so that we have an accurate record of what was said, since we may miss something if we rely on my notes. You may request that the recording be switched off at any time. Do you agree to voice recording of this interview? [IF NO, TAKE NOTES INSTEAD]

Are there any questions about the research at this point? [ANSWER QUESTIONS]  
Do you agree to be interviewed? [IF NO, THANK THE PERSON FOR THEIR TIME AND ASK IF THEY CAN RECOMMEND ANOTHER PERSON FROM THE AGENCY WHO MAY BE AVAILABLE AND WILLING TO PARTICIPATE]

APPENDIX 3: GUIDE FOR STAKEHOLDER INTERVIEWS

Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

Interview Guide for Stakeholders

Country: Dominica [ ] Grenada [ ] Questionnaire number:

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St. Lucia [ ] SVG [ ]

A: Participant characteristics

Name of Agency/Ministry/Organization

-----

Job Title

-----

-----

Sex M / F

Age Group 15-24 [ ]  
25-34 [ ]  
35-44 [ ]  
45-54 [ ]  
55-64 [ ]  
65+ [ ]

B: Services

Please **describe the services** that are provided by your agency and how they relate to the sexual and reproductive health of young people

PROMPTS

HIV prevention, care and treatment services

STI prevention, care and treatment services

Prevention of teenage pregnancy/ contraceptive provision/ social support for young mothers

Youth empowerment/ advocacy

Health and family life education

Skills building, employment and income-generation

Services to address child abuse or gender-based violence

Gender and women's empowerment

Substance abuse

Counselling and psychosocial support

Monitoring, evaluation and research

What human and other **resources** do you have to carry out this work?

- human resource capacity (number of staff)
- physical infrastructure (buildings)
- other equipment and supplies, e.g. diagnostic equipment, condoms, testing kits
- source(s) of funding
- referral system/ coordination and collaboration with other service providers

Is your work guided by a **policy or protocol**? [If yes] Please describe this. If yes, request copy.

PROMPT on whether the guidance is:

- facility/ organization-based,
- national government
- Caribbean regional
- and/ or based on international protocols such as the Declaration of Commitment on HIV/AIDS (outcome of the UN General Assembly Special Session on HIV/AIDS) or the Inter-American Convention for the Prevention, Punishment and Eradication of Violence against Women (Convention of Belem do Para)

Do you have any **reports or studies** relating to the work of your organization or on the sexual and reproductive health of adolescents and youth in this country?

If Yes, request copies

Do you think adolescents and young people under the age of 18 have **full access** to the services provided by your organization?

[If Yes] Why?

[If No] Why not? PROMPT about legal, policy, religious or economic barriers.



- C. Vulnerabilities of adolescents and young people
- What do you think are the factors that drive youth vulnerability to HIV/ STI/ teen pregnancy in this country?
  - Encourage the interviewee to give examples/ stories of ways that youth vulnerability occurs.
  - What do you think are the factors that protect some youth from HIV/ STI/ teen pregnancy?
  - Encourage the interviewee to give examples/ stories of ways that youth are protected

Do you think there are gender differences in vulnerabilities? Are there differences in the vulnerabilities of young males and females? Why?

Are there differences in the levels of vulnerability between adolescents and young people who are in school and those who have dropped out-of-school? Why?

Are there differences in the levels of vulnerability in different parts of this country? Why?

PROMPT for urban [capital city]/ rural differences, differences by area [e.g. Kalinago in Dominica, Carriacou in Grenada, hurricane-affected area in St. Lucia, the Grenadines in St. Vincent and the Grenadines]

D. Recommendations

Do you have recommendations to address the vulnerabilities you have identified?

PROMPT: Recommendations for young people/ parents/ community members/ men/ women/ service providers/ policy makers/ NGOs/ lawmakers/ religious leaders/ international or regional organizations/ funders.

- Who are the key stakeholders who should be involved in making the changes you have recommended? What should each of their roles be?

APPENDIX 4: INFORMED CONSENT FORM FOR PARENTS OR GUARDIANS

Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

Parents'/ guardians' consent form

I understand the information given about the reasons for the study, and the procedures that my child is being asked to participate in.  
The questions I had about this study have been answered.  
I clearly understand what my child will be required to do if s/he assents to be part of the study after I have agreed that s/he can participate.  
I know that s/he has the right to stop her participation in the focus group discussion at any time if s/he does not want to continue.  
I know that s/he has the right to refuse to answer questions in the focus group discussion.  
I am aware that the information that s/he gives will be kept confidential.  
I am aware that the information gathered relating to my child [or any other individual in the study] will not be shared with me by the research team.  
I agree that my child may take part in this study.

Name (Block letters please) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX 5: POINTS TO BE COVERED IN THE INTRODUCTORY VERBAL STATEMENT FOR FOCUS GROUP DISCUSSIONS WITH YOUNG PEOPLE

Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

*Introductory verbal statement for young people*

I am here carrying out research on behalf of the United Nations Population Fund (UNFPA). The aim of our project is to find out about the concerns of young people about their health situation so that that we can make recommendations to policy-makers and service providers on how to strengthen existing approaches. The research is being carried out in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines. In each country, young people are being involved in focus group discussions like the one we are going to do today, so that they can share their views on the issues that matter to them. This will help us to develop recommendations based on what young people think.

Each of you has been selected at random from lists of young people in your school or local area age 15 to 17. Because you are under the age of 18, we have approached each of your parents or guardians with information about the study and they have consented for you to take part. However, that does not mean that you have to agree to take part. The information I'm now giving you should help you make up your own mind about whether you want to participate.

As well as the discussions with young people, the research team will be gathering the existing research and statistics about the health of young people in these countries, and interviewing service providers and policy-makers to find out about the services that are in place.

The focus of the research is on the sexual and reproductive health of young people. This means that we are especially interested in information that can help in preventing HIV, sexually transmitted infections and teenage pregnancies, all of which can prevent young people from reaching their potential as well as being harmful to health. We will therefore be asking about some quite sensitive things in the discussion, such as about how young people behave in their relationships with their girlfriends or boyfriends and what young people are taught in school or by their parents about sex. We will not, however, be asking any individual about what s/he or he does or does not do in terms of sex or about their own past experiences.

Before the discussion starts, we would like you each to fill in a short form with some basic information about yourself (age, sex, educational level and employment status). This information will be used to describe the sorts of people who have been included in the focus group discussions but will not be used to identify

particular individuals in the report from the study. Individual names will not be included on this form and will not be used in any of the reporting from the study. We expect the discussion to last about an hour, after which refreshments will be served. We encourage each of you to speak so that your views can be reflected. If the facilitator finds that one or two people are silent most of the time, s/he will encourage those people to speak out.

As we already said, no report from this research will identify individuals and confidentiality will be maintained. The research team will not be sharing any personal information you give us with your parents, teachers or anyone else. At the same time, we would ask that each person in the discussion agrees that they will not tell anyone else any of the information shared by people here today. We won't be asking any of you about your personal behaviour, but nevertheless everyone should respect the privacy of each person who chooses to share information with us today. If we all respect each other in this way, it will remove the greatest risk from this type of research; that sensitivepersonal information will be revealed to someone without a person's consent.

Because we want to be able to base the report on what you say, we would like to record the discussion using a digital voice recorder [show it]. Everything people say in the discussion will be typed into a transcript. The researchers will then read and analyse each transcript to come up with the overall findings of the study.

The report and recommendations from this research will be shared with UNFPA and its Project Advisory Committees in each country. Each Project Advisory Committee includes youth representatives. After finalization it will be disseminated electronically to stakeholders, including youth representatives and policy-makers, and then in UNFPA's Annual Programme Review Meeting.

Are there any questions about the research at this point? [ANSWER QUESTIONS]  
If there are any questions you would like to ask me in person instead of in front of the whole group, I'm available for you to see me now. If not, I'd ask each of you to read through and sign the informed assent form. Before you do so I will quickly read it out to you myself [READ IT OUT]. If you do not want to participate in the discussion after what you have heard today, please just let me know and you are free to leave. We do hope that everyone wants to join in, though.

## Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

I understand the information given about the reasons for the study, and the procedures I am being asked to participate in.

The questions I had about this study have been answered.

I clearly understand what I will be required to do if I agree to be part of the study.

I know that I have the right to stop my participation in the focus group discussion at any time if I do not want to continue.

I know that I have the right to refuse to answer questions in the focus group discussion.

I am aware that the information that I give will be kept confidential.

I agree to take part in this study.

Date \_\_\_\_\_

## Strengthening the Evidence Base on Youth Sexual and Reproductive Health and Rights in the Eastern Caribbean

## FGD ID : \_\_\_\_\_



## APPENDIX 8: FOCUS GROUP DISCUSSION TOPIC GUIDE

Note to facilitator.

The following questions are not designed to be read word-for-word or in the exact order listed. Please ensure nevertheless that the topics highlighted in bold type are covered in the discussion.

1. What are the main **opportunities and challenges** facing young people in [country]?

Probe: “Good” and “bad” things about living as a young person in this country

Do you think that young men/ women [depending on sex of FGD] such as yourselves have enough **power** to make their own decisions?

- Probes: Power in relation to
  - Government
  - Parents
  - School
  - Work/ income earning
  - Relationships with boyfriends or girlfriends
  - Religious leaders
2. Among youth under 18, who do you think have more **power**: those who are still **in school** or **those who have left school**? Why?
  3. What are youth under 18 in this country taught in school about sex and relationships? Do you think this is adequate?
  4. What are youth under 18 in this country **taught by their parents and families about sex and relationships**? Do you think this is adequate?
  5. Do you think some young people of about your age have **not yet had sex**? Why do you say this? What types of girls have not had sex? What types of boys have not had sex? What do you think stops them from having sex?
  6. Do young **men** of around your age have **choices about whether to have sex**? Why/ why not?

Probe:

- Peer pressure
- Proof of manhood
- Transactional sex/ sex work [seeking resources through sex]
- Pressure from partner/ coercion/ rape
- Relationship with older person/ sugar daddy or mummy

7. Do young **women** of around your age have **choices about whether to have sex**? Why/ why not?

Probes:

- Peer pressure
- Proof of attractiveness
- Transactional sex/ sex work [seeking resources through sex]
- Pressure from partner/ coercion/ rape
- Relationship with older person/ sugar daddy or mummy

8. Do young **men** around your age use **condoms** when they have sex? Why/ why not?

Probe:

- Ask about female as well as male condoms
- Restrictions on obtaining condoms from health care providers without parental consent
- Associations of condoms with mistrust in relationships
- Association of condoms with sex work or gay sex
- Loss of sexual sensation
- Poor sexual negotiation skills
- Fear of losing resources from a transactional sex partner or sex work client

9. Do young women around your age use condoms when they have sex? Why/ why not?

Probe:

- Ask about female as well as male condoms
- Restrictions on obtaining condoms from health care providers without parental consent
- Associations of condoms with mistrust in relationships
- Association of condoms with sex work or gay sex
- Loss of sexual sensation
- Poor sexual negotiation skills
- Fear of losing resources from a transactional sex partner or sex work client

10. Do you think **alcohol and drug use** influence the sexual behaviour of young men of about your age? Why/ why not? How does it affect them?

11. Do you think **alcohol and drug use** influence the sexual behaviour of young women of about your age? Why/ why not? How does it affect them?

12. Do young women of around your age use **douches such as Summer's Eve** for personal hygiene? Why/ why not?

If they do not use Summer's Eve or another commercial douching product, do they use **other substances such as soap or herbs to clean inside the vagina**? Why/ why not? What substances do they use? Do they use these inside the vagina or just to clean their private parts on the outside? Do they use cloths, cotton wool, other materials or just their fingers? Do their mothers or other relatives teach them to do this? Do you think it is important to do this?

13. Turning to young men, did you know that recent research has shown that removal of the foreskin of the penis, or circumcision, can reduce the risk of contracting HIV from a female partner by up to 60 percent? Do you know of any young men around your age who have been circumcised, perhaps when they were babies? If young men were educated about the HIV prevention benefits of male circumcision and it was offered to them in a safe way on an entirely voluntary basis, do you think they would want to get circumcised? Why/ why not?

14. What do parents or other family members tell young **boys** about how to maintain **personal hygiene** when they are growing up? Can you describe the hygiene practices they are taught? Do young men maintain these hygiene practices when they get to your age?

15. If you maintain a high level of personal hygiene, can you get infected with HIV or sexually transmitted infection? Why/ why not?

16. Do you know young women or girls of your age or younger who have got **pregnant**? What was the experience like for them?

Probe:

- Did they use or have access to contraception prior to the pregnancy?
- Did they go through with the pregnancy?
- Did they seek or obtain an abortion?
- Was their male partner supportive or did he abandon her?
- How did the family react?
- How did health care providers react?
- Was she able to continue her schooling?
- If she had a job, was she able to continue working?
- Did the government or a non-governmental organization provide support to the mother or child?
- Were the mother and child healthy after the birth?

17. Are **health care providers** in the country **friendly and helpful towards young people** your age who want to obtain condoms, other contraceptives or advice on sex and relationships? Is their attitude to young women different to their attitude to young men? [If Yes] How is it different? Is their attitude to people your age different to how they treat people over 18?

18. If a young person **wants to get tested for HIV** in this country, where would he go? Would s/he go to a government clinic or health centre? Why/ why not? Would a young woman go to a different place from a young man?

19. What would be your **recommendations** to improve youth sexual and reproductive health in this country? Who are the stakeholders who should be involved in discussing and implementing the recommendations?

APPENDIX 9: AGENCIES REPRESENTED IN STAKEHOLDER INTERVIEWS

DOMINICA

Person interviewed or consulted	Position within organization	Organization
Mr. Michael Murphy Mrs. Nathalie Murphy	President Executive Director	Dominica Association of Persons with Disabilities
Mrs. Annie St. Luce	Family Life Educator	Dominica Planned Parenthood Association
Ms. Valencia Webb	Counsellor	Youth Development Division
Ms. Julie Frampton Ms. Angela Desabaye	National AIDS Programme Coordinator PMTCT Coordinator/Health Educator	Ministry of Health
Fenella Wenham Tumpe Trotter	President Executive Member/ Committee Member	National Youth Council
Gelina Fontaine	Programme Manager	ChildFund Caribbean [Dominica and St. Vincent]
Ana Maria Locsin	National Director	
Norma Cyrille	Director	The Social Centre
Mr. Morvan	Acting Asst Chief Welfare Office	Welfare Division
Dr. Paul Ricketts	Epidemiologist	Ministry of Health
Ms Josephine Dublin-Prince	President	Dominica National Council on Women
Ms. Myrtle Prevost	Education Officer for Curriculum	Ministry of Education
Kathleen J. Pinard-Byrne	Director General	Dominica Red Cross
Ms. Rosie Browne	Director	Gender Affairs Bureau
Mr. Christopher Dorsett	President	Life Goes On [PLHIV]
Mrs. Sylvanie Burton	Development Officer	Ministry of Carib Affairs
Nurse Florestine Lewis	Senior Community Health Nurse	Ministry of Health

GRENADA

Person interviewed or consulted	Position within organization	Organization
Yvonne DaBreo	Chief Social Development Officer	Ministry of Social Development
Rachel Charles	Director	HOPE PALS
Nigel Mathlin	President	GrenCHAP
Mr. Tyrone Buckmire	Child/Youth Advocate	Legal Aid & Counselling Clinic
Shonta Duncan	President	YWCA
Mrs. Alva Lawrence	Manager	Programme for Adolescent Mothers [PAM]
Ms. Nester Edwards	Chief Nursing Officer and Family Health Focal Point	Ministry of Health
Kevin Andall	Youth Coordinator	Ministry of Youth, Sport, Culture and Community Development
Sis Margaret Yamoha	Executive Director	Newlo
Ms. Jacqueline Sealy Burke	Director	Legal Aid & Counselling Clinic- LACC
Dr. Jessie Henry	HIV Focal Point	Ministry of Health
Ms. Hermione Baptiste	Curriculum Development Officer	Health & Family Life Education , Min of Education
Arthur Pierre	HIV/AIDS Response Coordinator	Ministry of Education
Deanne Scott	Deputy Director	Planned Parenthood
Ms Elaine Henry-McQueen	Gender Focal Point	Ministry of Social Development
Dr. Alister Antoine	Medical Officer of Health/ Head of Epidemiology Unit	Ministry of Health
Ms. Ann Hopkin	PRO	Grenada National Council of the Disabled



ST LUCIA

Person interviewed or consulted	Position within organization	Organization
Ms. Charms Gaspard Lindy Eristhee	Director Research Officer	Division of Gender Relations
Dr. Marcus Day	Director	Caribbean Drug and Alcohol Research Institute [CDARI]
Dr. Anthony George	Technical Assistance Coordinator, SFA2006 [Special Framework of Assistance], "Poverty Reduction through Community Based Development Planning"	St. Lucia Social Development Fund
Veronica Cenac	Attorney-at-Law	Cenac Law Chambers
Marva Edwards	Communications Officer	St. Lucia Red Cross
Olympia Vitalis	Counsellor	Upton Gardens Girls Centre
Dr. Aline Jaime	National Epidemiologist	Ministry of Health
Ms. Anne Margaret Henry	Principal Nursing Officer	Ministry of Health
Ms. Joan Didier	Coordinator	AIDS Action Foundation
Dr. Jacqueline Bird	The Director [RISE]/ Community Paediatrician, Community Child Health Service, MoH	RISE St. Lucia Inc.
Mr. Nahum Jean-Baptiste	Director	National AIDS Programme
Lancia Isidore	Executive Director	Nat'l Council for Persons with Disabilities
Ms. Claudia Noel	Youth and Sports Officer	Ministry of Social Transformation, Youth & Sports
Ms. Charles	PMTCT/ Counselling and Testing Coordinator/ Health Educator	The National AIDS Programme
Mrs. Sophia Edwards-Gabriel	HFLE Curriculum Specialist	Ministry of Education & Culture
Ms. Flavia Cherry	The Manager	Caribbean Association for Feminist Research and Action [CAFRA]
Ms. Geralda Bray	Programme Manager	St. Lucia Planned Parenthood
Timothy Ferdinand	Second Vice President	National Youth Council
Kenita Placide	Co-Chair/ Programme Manager	United and Strong

ST. VINCENT  
& THE  
GRENADINES

Person interviewed or consulted	Position within organization	Organization
Ms. P. Olliver	Coordinator	Min of Nat'l Mobilization: Gender Affairs
Mr. Marksman Mr. Morgan Ms. Julia Simmons	Director General President Outreach worker	SVG Red Cross
Mrs. Patricia Cumberbatch	President	Nat'l Council for Persons with Disabilities
Jeanie Olliveire	PRO and Education Programme Secretary	St. Vincent and the Grenadines Human Rights Association
Ms. Barbara Matthews	Deputy Director	Marion House
Mrs. Morine Williams	Acting HFLE Coordinator	Ministry of Education
Mr. Philcol Jeffers	Assistant Youth Officer/ Communications, Public Relations and Youth Advocacy Officer	Youth Affairs Department
Ms. Mavis Verlene Saunders	Executive Director	SVG Planned Parenthood
Dr. Kevin Farara	Country Cordinator	Caribbean HIV and AIDS Alliance
Dr. Del Hamilton	Director	National AIDS Secretariat
Dr. Jennifer George	National Epidemiologist	Ministry of Health and the Environment
Mrs. Sandra Augustus	Coordinator of Teen Mothers Programme/ Case Worker	Min of Nat'l Mobilization: Gender Affairs
Mrs. Celoy Nicholls Mr. Harvey Farrel	Health Educator Health Educator	Health Promotion Unit, Ministry of Health and the Environment

BARBADOS

The following person was interviewed as coordinator of the activities of the Caribbean HIV and AIDS Alliance for St. Lucia and Barbados.

Person interviewed or consulted	Position within organization	Organization
Teddy Leon	Senior Programme Officer	Caribbean HIV&AIDS Alliance

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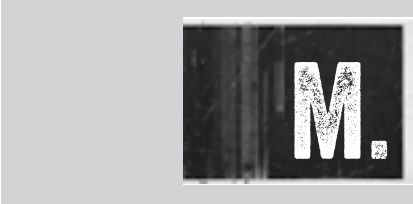
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# NOTES



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