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Authors

Jarrett, Sharlene Beckford
Udell, Wadiya
Sutherland, Sannia
et al.

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Age at sexual initiation and sexual and health risk behaviors among Jamaican adolescents and young adults

Sharlene Beckford Jarrett¹, Wadiya Udell², Sannia Sutherland³, Willi McFarland^{1,4}, Marion Scott⁵, and Nicola Skyers⁵

¹Global Health Sciences, University of California, San Francisco, USA

²School of Interdisciplinary Arts & Sciences, University of Washington, Bothell, USA

³Caribbean Vulnerable Communities Coalition, Kingston, Jamaica

⁴Department of Public Health, San Francisco, California

⁵HIV/STI/Tb Unit, Health Promotion and Protection Branch, Ministry of Health, Kingston, Jamaica

Abstract

Current policies limit access to sexual and reproductive health services for adolescents younger than 16 years in Jamaica. Using data from a national survey, we explored the relationship between age at sexual initiation and subsequent sexual risk behaviors in a random sample of 837 Jamaican adolescents and young adults aged 15 to 24 years. In the sample overall, 21.0% had not yet had sex. Among the 661 sexually active participants, the mean age at first sex was 14.7 years. High percentages of sexually active youth reported engaging in risk behaviors such as inconsistent condom use (58.8%), multiple sex partners (44.5%), and transactional sex (43.0%). Age of sexual initiation for males was unrelated to subsequent sexual risk behaviors. However, earlier sexual debut for females was associated with their number of partners during the preceding year. Findings underscore the potential benefits of access to sexual and reproductive education and services at earlier ages than current policies allow. Interventions before and during the period of sexual debut may reduce sexual risk for Jamaican adolescents and young adults.

Keywords

sexual debut; sexual and reproductive health policy; Jamaica; sexual risk behavior; adolescent sexual health

Correspondence to: Sharlene Beckford Jarrett, Global Health Sciences, University of California San Francisco; 550 16th Street, Third Floor, San Francisco, CA 94158; sharlene.jarrett@ucsf.edu; Phone: 1-876-537-7617.

Conflict of Interest

The authors declare that they have no conflict of interest.

Compliance with Ethical Standards

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

Informed consent

Informed consent was obtained from all individual participants included in the study.

Introduction

Young persons in Jamaica are at risk for unintended pregnancies and contracting sexually transmitted infections (STI), including human immunodeficiency virus (HIV).[1,2] This risk is fueled by a variety of factors, including unprotected sexual activity, multiple sexual partners, substance use, and early age at sexual initiation.[3,4] According to data from the most recent Jamaica Reproductive Health Survey (2008), as many as 62% of adolescents and young adults aged 15 to 19 years were sexually experienced, and 23% reported having had sex before age 15 years.[4] The latter percentage is even higher among adolescents in communities such as Kingston, the capital, where as many as 41% of males and females aged 14 years are sexually active.[2] In addition to early age at sexual initiation, young persons in Jamaica engage in risky sexual practices. For example, 16% of persons aged 15 to 24 years in the Reproductive Health Survey reported using alcohol during their most recent sexual intercourse[4] Additionally, a recent study reported that 47.5% of sexually active Jamaicans between the ages of 15 and 19 years used condoms inconsistently, and 38% (12% of females, 52% of males) had more than 1 sexual partner within the past year.[3]

Despite a substantial number of sexually active adolescents in Jamaica, current policies regarding reproductive and sexual health restrict access to many evidence-based services (eg, HIV testing) for persons younger than 16 years.[5, 6] Although the Jamaican Access to Contraceptives for Minors policy asserts that persons younger than 16 years have a right to access health care without parental consent,[7] laws and policies such as the Sexual Offences Act[8] and the Child Care and Protection Act[9] significantly restrict the implementation of these guidelines. Under the Sexual Offences Act, sexual activity among persons younger than 16 years is illegal, making any person (including minors themselves) who has or intends to have sex with someone younger than age 16 the perpetrator of a crime. The Child Care and Protection Act sanctions health care providers for providing sexual and reproductive health services to minors without first obtaining parental consent. This law puts providers in the position of having to decide whether facilitating access to contraceptive services for persons younger than 16 years is an act of abetting child harm and abuse or an act of reducing STI transmission and unintended pregnancy. As a result of such laws, providers have a legal right to refuse care, given the ambiguity around their role in facilitating sexual offenses of minors. Additionally, young persons may be hesitant to seek sexual and reproductive health care, fearing the legal consequences for themselves and their partners.

Although policies such as the Sexual Offences Act and the Child Care and Protection Act were meant to protect young persons from a range of harms, they are based on a cultural belief that sexual activity among youth should not occur, and the reality is that such activities are commonplace. Jamaican youth are having sex at early ages, and early sexual debut is associated with a host of negative sexual health outcomes, including multiple sex partners and inconsistent condom use.[10,11,12] Providing developmentally appropriate interventions may reduce sexual risk behaviors among adolescents,[13] but laws limiting access to preventive sexual health care do little to reduce such risks among sexually active persons younger than 16 years. Limited resources have resulted in a shift in national HIV/STI campaigns and interventions, from a focus on prevention for the general population

to targeted campaigns and services for the most marginalized groups with the highest HIV prevalence.[14] Taken together, these factors may place Jamaican adolescents at increased risk for sexual and reproductive health problems. Using data from a national survey, this paper examines sociodemographic characteristics, sexual risk behaviors, and the relationship between age at onset of sex and subsequent risk behaviors, among adolescents and young adults aged 15 to 24 years in Jamaica. We hypothesize that early sexual initiation is associated with high-risk behaviors among youth in our study.

Methods

Participants

The current study analyzes data from the Jamaica Ministry of Health household-based Knowledge, Attitudes, Behavior and Practices (KABP) survey conducted in 2012 among a representative national sample. Respondents in the KABP survey were aged 15 to 49 years. A subgroup of 871 respondents aged 15 to 24 years was oversampled to achieve a large sample of sexually active adolescents and young adults. The present analyses include all participants aged 15 to 24 years who had a valid response for age at first sex, including those who were not sexually active up to the time of the interview.

The KABP survey used a multistage approach to obtain a randomly selected, nationally representative sample of 1800 persons, which is described in greater detail in the KABP final report.[15] In brief, the 14 parishes in Jamaica were stratified into constituencies, and each constituency was stratified into parish capitals/main towns and rural areas. Each area was then divided into primary sampling units (PSUs), which consisted of as many as 400 dwellings. A random sample of PSUs was then selected, with probability proportional to size to ensure that the larger PSUs were selected with a greater probability. Twenty-one (21) PSUs were purposively selected in the Kingston metropolitan region and St. James, 12 PSUs in other urban areas, and 29 PSUs in rural areas. Thirty households were then systematically selected in each PSU, using a map of the area, a random starting point, and a predetermined sampling interval. The Kish card method, a preassigned table of random numbers, was used to objectively select 1 member within each household to be interviewed.[16]

Data were collected in confidential, face-to-face interviews in a private area. The interviewer read each question aloud. For questions regarding high-risk sexual activities, participants entered their responses on self-administered cards and placed them in an envelope for privacy. For questions related to sociodemographic variables, HIV/AIDS knowledge, and risk perception, the responses were given verbally to the interviewer.

Measures

Sociodemographic characteristics—Questions were asked to determine a participant's age, highest level of education, employment status, and relationship type. To determine a socioeconomic classification, scores were assigned based on education level completed and occupation.

HIV knowledge and testing—HIV knowledge was measured using 5 questions to assess a participant's understanding of HIV transmission as well as common myths. These

questions were: (1) Can using a condom every time during sex reduce the risk of HIV transmission? (2) Can a healthy-looking person be infected with HIV? (3) Can a person get HIV from mosquito bites? (4) Can a person get HIV by sharing a meal with someone who is infected? (5) Can having sex with only 1 faithful, uninfected partner reduce the risk of HIV transmission?[17]

HIV testing was assessed through self-reported knowledge of where to obtain a confidential HIV test and history of ever having had one.

Sexual debut and HIV risk behaviors—Age of sexual debut (“At what age did you first have sex?”) was measured using a single continuous variable. HIV risk perception (“Following the normal course of your life, what do you think are the chances that you might catch HIV?”) and alcohol use (“In the last 4 weeks, how often did you have a drink that contained alcohol?”) were each measured via a single categorical item. Single dichotomous items were used to assess consistent condom use over the preceding 10 sexual acts, partner concurrency (“Do you believe that [identified main partner] has had sex with another person in the past 6 months?”), and coerced sex (“During the past 12 months, were you forced or pressured by anyone to have sex even though you did not want to have sex?”).

Involvement in transactional and commercial sex was defined as being either the recipient or solicitor of sex. Transactional sex was assessed by first asking the participant: “Other than [spouse or live-in partner], have you helped a person you had sex with in the past year by giving them money for expenses such as food, clothing, entertainment, or bus fare?” A second question asked whether the participant had been helped by a sex partner. To assess involvement in commercial sex, participants were asked: “In the past 12 months, how many times have you paid for sex; that is, had a commercial partner(s) in the past 12 months?” A subsequent question reversed the roles, asking if the participant had been paid for sex in the past year. The major distinction between transactional and commercial sex is that the former is motivated by an exchange of benefits and the latter is considered a service for monetary payment. Both transactional and commercial sex were measured dichotomously (ie, yes/no responses).

To assess their number of sex partners, participants were asked to provide estimates for 3 time periods: the last 4 weeks, the last 3 months, and the last 12 months. Responses were reviewed for inconsistencies, and the higher number was used to estimate the number of partners during the preceding 12 months.

Analysis

Descriptive statistics (n and %) were used to summarize sociodemographic characteristics and risky behaviors by sex. Differences within categories were tested with chi-square tests.

The Kruskal-Wallis test was used to compare the age at sexual debut for youth categorized by sex and risk behavior. Because our data include adolescents in an age range that straddles the onset of sexual activity, the main outcome (sexual debut) was determined by the reported age at onset for those who were already sexually active; for respondents who were not yet sexually active, the data were censored at the respondent’s age at the time of the interview.

Figures and statistical comparisons therefore take into account information from participants who were not yet sexually active. This statistical approach is analogous to survival analysis. Pairwise comparisons were done with Bonferroni adjustment for multiple tests. Data analysis was done with IBM SPSS Statistics for Mac, version 23.0 (Armonk, NY). All tests were 2-tailed, and significance level was defined as $P<.05$.

Ethical considerations

All participants gave verbal consent or assent before completing the study. A parent or adult guardian who was present at the time of data collection gave consent for participants aged 15 to 17 years. Staff members involved in data collection were trained in ethics for the conduct of research involving human subjects. No identifying information was collected in the survey. All interviews were collected in a private space at the participant's home. The KABP protocol is approved by the Ministry of Health Ethics and Medico-Legal Affairs Panel.

Results

The final sample included 837 participants aged 15 to 24 years, with 435 males and 402 females. Thirty-four participants who did not provide their age at their first sex were excluded from the analyses. There was no sex difference in the pattern of missing data.

Comparisons of the sociodemographic characteristics of male and female participants are shown in Table 1. Sex differences were found in age, employment, relationship type, and sexual experience. Females were slightly older ($P=.023$), more likely to be unemployed or employed less than full time ($P<.001$), and more likely to live with a partner and less likely to report having a casual or main (non-cohabiting) partner ($P<.001$). Males were more likely to report that they had had sex ($P=.014$). Overall, a majority of the participants were sexually experienced ($n=661$; 79.0%), and 64.4% of males ($n=280$) and 23.6% of females ($n=95$) reported having had sexual intercourse at age 15 or younger.

Risk behaviors

Significant sex differences in risk behaviors were found among sexually experienced adolescents and young adults (Table 2). The mean age at first sex was 14.7 years (SD 2.6), with males reporting a younger age at first sex (mean=13.5±2.6) than females (mean=16.1±1.8; $P<.001$). Males also reported significantly more sex partners than females. Most men (60.9%) reported having more than 1 sex partner in the preceding 12 months, compared with 25.1% of females, and nearly half of males (47.5%) had 3 or more sex partners in the past 12 months, compared with only 7.3% of females ($P<.001$). Regarding other sexual experiences, more males than females reported transactional sex (52.0% vs 32.3%, respectively; $P<.001$), commercial sex (11.5% vs 1.7%, respectively; $P<.001$), and coerced sex (15.7% vs 9.0%, respectively; $P<.05$). Female participants were more likely than males to report that their partner had other sex partners (34.8% vs 21.5%, respectively; $P<.001$), and less likely to report that they used a condom every time for the last 10 sex acts (30.0% vs 50.6%, respectively; $P<.001$).

Sexual debut and HIV risk

Figures 1A through 1E illustrate the patterns of sexual debut for sexually experienced participants, stratified by sex and behavior. In each model, males had earlier sexual debut compared with females, regardless of subsequent risk or preventive behaviors ($P<.001$). Pairwise comparison among males and among females found no difference in sexual debut regarding HIV testing, current condom use, or frequency of alcohol use. However, a substantial proportion of young women who reported heavy drinking in the last 12 months also reported early sexual debut, at age 15 or 16, compared with young women who reported less frequent drinking (Figure 1E).

Pairwise comparison also showed a lower mean age of sexual debut for females who had had multiple partners, compared with females who had had 0 or 1 partner ($P=.022$). Eighty-three percent of females with multiple partners, compared with 56.1% of females with 0 or 1 partner, had initiated sex by age 16. A similar pattern was observed for transactional sex. Among females, 75.4% who had had transactional sex in the past 12 months reported sexual debut at or before age 16, compared with 58% who had had no transactional sex in the past 12 months ($P=.074$).

Discussion

The present study highlights the need for sexual and reproductive health services for Jamaican youth, as a large proportion of adolescents and young adults in the national KABP survey reported early age at sexual initiation and behaviors that place them at risk for contracting STI and HIV. Similar with other Jamaican studies, we found that a significant percentage of sexually active adolescents and young adults reported early sexual debut (mean age 14.7 years), multiple sex partners in the past year (44.5%), inconsistent condom use (58.8%), and limited HIV knowledge (61.3%).[2,3,18] Our study also found a low rate of testing for HIV (49.9%) and a high rate of transactional sex (43.0%) among sexually active young persons.

In addition to identifying current risk behaviors among Jamaican adolescents and young adults, our study also confirms previous research that found positive associations between early age at sexual debut and subsequent risk behaviors.[10] We found a significant relationship between age at sexual debut and multiple sex partners in the past 12 months for females. Additionally, sexual debut was marginally associated with transactional sex. Taken together, these findings suggest that age at sexual initiation is important to understanding the sexual behaviors of young Jamaican females, for whom early sexual debut may set the stage for continued engagement in high-risk behaviors, such as multiple partnerships and possibly transactional sex. Such behaviors increase a young person's risk for HIV, STI, and unplanned pregnancies.[19] Providing developmentally appropriate sexual-health education and reproductive services before and during the period of sexual debut may delay early onset and reduce sexual risk behavior among adolescents and young adults.[20,21]

No associations were found between age at sexual debut and risk outcome among males in this sample. While the data do not allow for definitive causal interpretations, we hypothesize that sustained social and cultural pressure for boys to prove their masculinity and

heterosexuality through sexual intercourse and multiple partnerships[17,21] is more important in determining sexual risk behaviors than the timing of sexual debut. Young Jamaican males are exposed to and influenced by expectations for sexual behavior at an early age.[22]

Although a high percentage of both males and females engaged in risk behaviors, we found differences in the proportions of those who did. Consistent with previous literature, significantly more males engaged in sexual risk behaviors than females.[3] Jamaican males reported a younger average age at sexual initiation (13.5 years) than Jamaican females (16.1 years), as well as more sexual partners. Similar differences were found with regard to transactional sex and commercial sex. Males also reported more coerced sex. This finding is consistent with gender role expectations for sexual activity among Jamaican youth. The coercion identified in the survey may be related to social pressure for males to have sex to prove their masculinity and/or heterosexuality.[18,22] A reverse pattern was found for condom use, with more females reporting inconsistent use during the last 10 sexual acts, compared with males.

We recognize limitations of the current study. This study found an association between early sexual debut and current risk behaviors among young females; however, cross-sectional data, even when comparing the sequences of events, do not necessarily support conclusions about causality. Direct longitudinal data are needed to improve our understanding of trajectories of risk among adolescents and young adults and rates of early sexual debut in Jamaica. A second key limitation relates to biases associated with self-reporting sensitive information about sexual practices. Cultural expectations for males to prove their masculinity, maturity, and heterosexuality through having sex at an early age and having multiple partners could contribute to young males exaggerating their sexual experiences. Young women, who are expected to be demure to avoid being labeled promiscuous, might underreport their sexual activity.[17,21] However, to minimize social desirability bias and discomfort for participants, the study used self-report cards to collect information on their sexual practices. Additionally, research indicates a general correspondence between biological tests and self-reported sexual and drug behaviors.[23]

Conclusions

Data from this study suggest that Jamaican adolescents and young adults could benefit from access to sexual and reproductive education and services at much earlier ages than current policies allow. According to our data, one third of Jamaican youth have had sex by the age of 14 years, and nearly half have engaged in sexual activity by the age of 16 years. Given these findings, it is apparent that sexual and reproductive health services are not accessible until several years after sexual debut for a significant proportion of young persons. Based on average age at sexual initiation for males and females, the critical ages for preventive intervention would be from 12 to 14 years for males and from 14 to 16 years for females. In addition to highlighting the need for earlier access to services, findings from this study point to important areas for intervention. Jamaican adolescents and young adults should be given access to evidence-based sexual health programs focused on delaying sexual initiation, reducing multiple partnerships, and increasing condom use. Additionally, programs for

Jamaican adolescents and young adults should focus on improving HIV knowledge and testing and on reducing other factors that promote risky sexual activity (eg, alcohol use).

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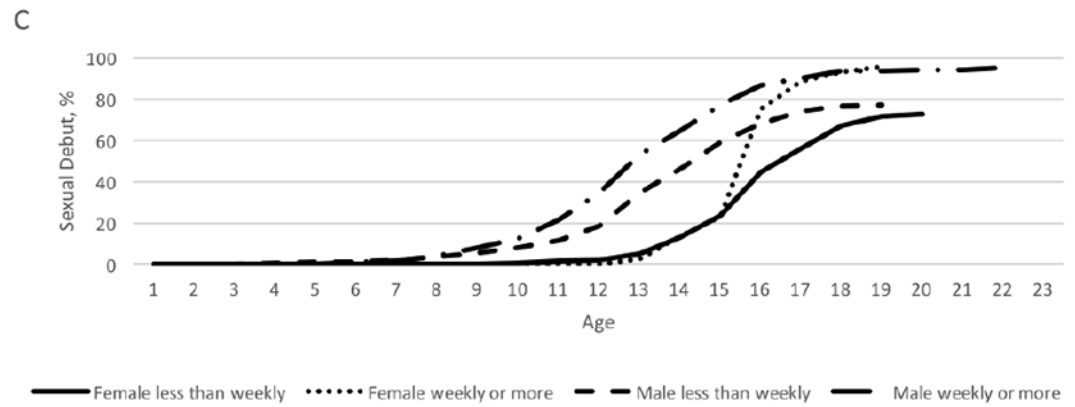
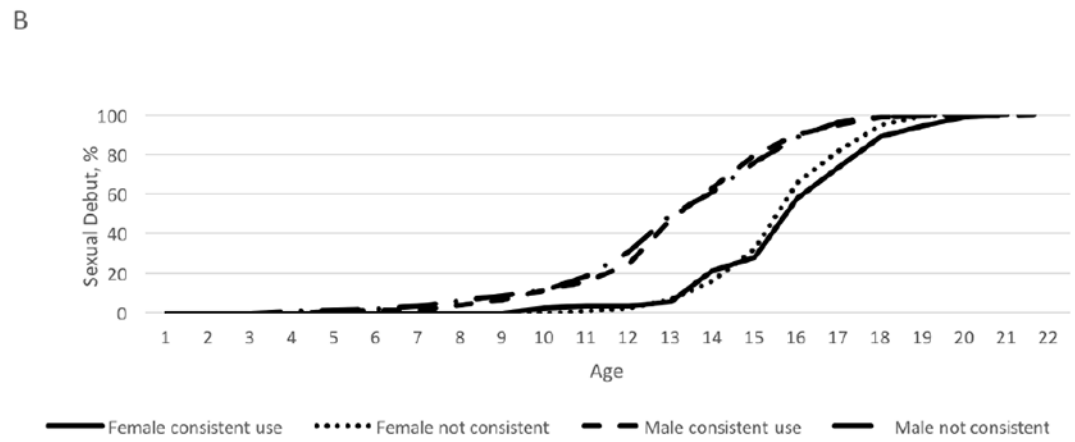
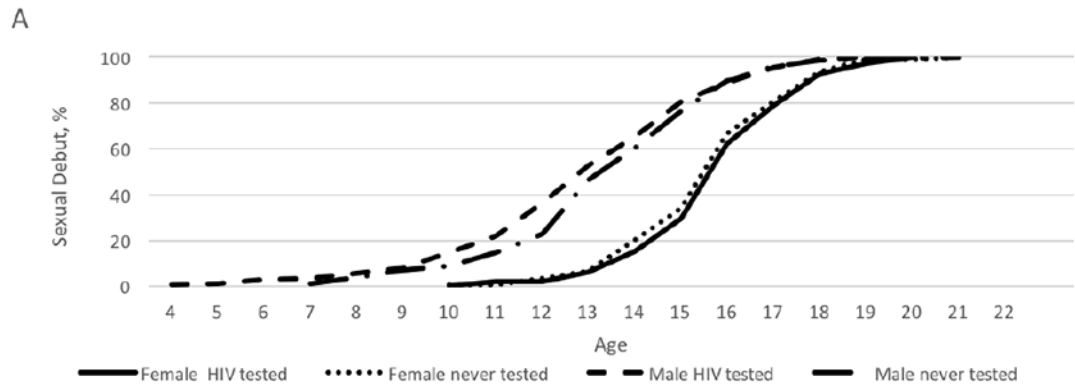
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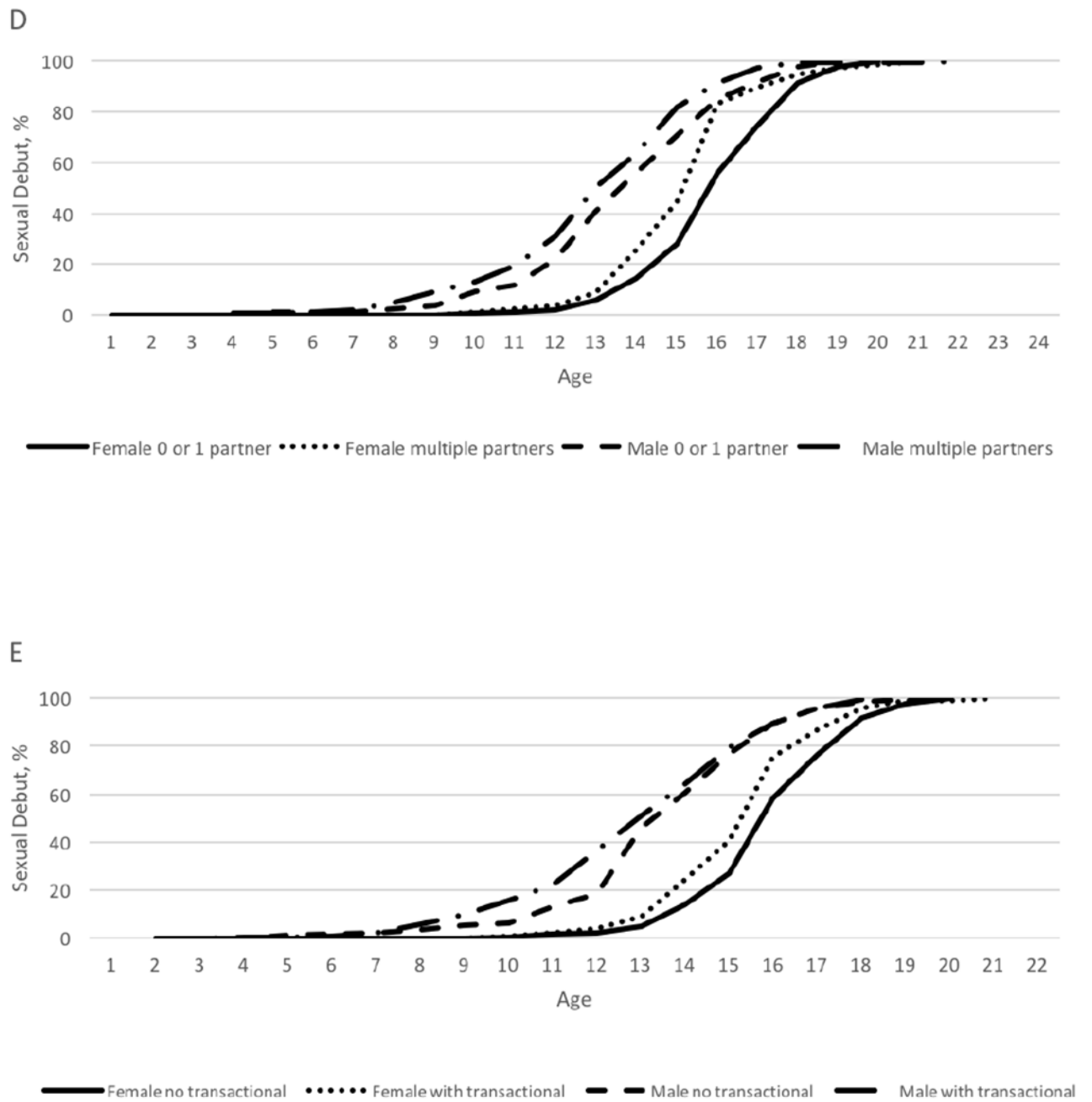


Figure 1.

Comparisons by sex and age of sexual debut among adolescents and young adults for (A) HIV testing,^a (B) condom use,^a (C) frequent drinking,^a (D) multiple partners,^b and (E) transactional sex,^a Jamaica, 2012.

^a Pairwise comparisons did not achieve statistical significance.

^b Female multiple partners – female 0 or 1 partner, $P=.022$

Table 1.

Sociodemographic characteristics of males and females, aged 15-24 years, participating in the Jamaica Knowledge, Attitudes, Behavior and Practices survey, 2012 (n=837).

	Males n=435	%	Females n=402	%	<i>P</i> value
Characteristics					
Mean age in years (SD)	18.9	(2.7)	19.3	(2.8)	.023
Highest level of education ^a					
Some high school or less	128	29.4	131	32.6	.564
High school graduate/or vocational	230	52.9	207	51.5	
Tertiary	77	17.7	64	15.9	
Residence					
Urban	199	45.7	194	48.3	.467
Rural	236	54.3	208	51.7	
Income group					
Lower income	128	29.4	126	31.3	.683
Working class	197	45.3	184	45.8	
Upper/middle income	110	25.3	92	22.9	
Employment status					
Full-time	86	19.8	48	11.9	<.001
Part-time	44	10.1	18	4.5	
Unemployed	116	26.7	165	41.0	
Full-time student	189	43.4	171	42.5	
Relationship status					
Married	1	0.2	7	1.7	<.001
Living with a sexual partner	21	4.8	52	12.9	
Casual or visiting partner	277	63.7	208	51.7	
No partner	136	31.3	135	33.6	
Ever had sex					
Yes	358	82.3	303	75.4	.014
No	77	17.7	99	24.6	

^aMissing = 2.

Table 2.

Prevalence of HIV prevention knowledge, HIV testing, and risk behaviors among adolescents and young adults with a history of sexual activity, in the Jamaica Knowledge, Attitudes, Behavior and Practices survey, 2012.

Variables	Males		Female		P value *
	n	%	n	%	
Mean age at first sex (SD)	13.5	(2.6)	16.1	(1.8)	<.001
Number of sex partners in last 12 months (n=661)					
0	60	16.8	39	12.9	<.001
1	80	22.3	188	62.0	
2	48	13.4	54	17.8	
3 or more	170	47.5	22	7.3	
Type of partners (n=554)					
Any same-sex partner	4	1.4	11	4.2	.063
Heterosexual partners only	289	98.6	250	95.8	
Had transactional sex in last 12 months ^a (n=661)	186	52.0	98	32.3	<.001
Had commercial sex in last 12 months ^b (n=661)	41	11.5	5	1.7	<.001
Has a partner who had other sex partners in last 6 months (N=562)	64	21.5	92	34.8	<.001
Was forced or pressured to have sex in last 12 months (N=566)	47	15.7	24	9.0	.016
Used a condom every time for last 10 sex acts (n=656)	180	50.6	90	30.0	<.001
Alcohol use					
Weekly or more	116	32.4	42	13.9	<.001
Less than weekly	242	67.6	261	86.1	
Has correct comprehensive knowledge of HIV (n=661)	125	34.9	131	43.2	.029
Knows where to get an HIV test (n=661)	308	86.0	273	90.1	.079
Ever tested for HIV (n=661)	135	37.7	195	64.4	<.001
Likelihood of becoming infected with HIV (n=591)					
Little or no chance	281	87.8	224	82.7	.167
Moderate chance	23	7.2	31	11.4	
Good chance	16	5.0	16	5.9	

* Chi-square test.

^aTransactional sex: exchanged sex for help with food, clothing, entertainment, or bus fare.

^bCommercial sex: paid cash to a sex worker or was paid cash as a sex worker.