

HIV and AIDS Legal Assessment Report
for Jamaica

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Glossary of Terms

ABA/ROLI	American Bar Association Rule of Law Initiative
AIDS	Acquired Immunodeficiency Syndrome
ARSH	Adolescent Sexual and Reproductive Health
ARV	Antiretroviral
BCC	Behavior Change Communication
CARICOM	Caribbean Community and Common Market
CBO	Community-based organization
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHARES	Center for HIV/AIDS Research, Education, and Services, University Hospital of the West Indies
CHS	Casual heterosexual sex
CRC	Convention on the Rights of the Child
CRSF	Caribbean Regional Strategic Framework
CSO	Civil society organization
FBO	Faith-based organization
GIPA	Greater Involvement of People Living with AIDS
HFLE	Health and Family Life Education (curriculum)
HIV	Human immunodeficiency virus
HCV	Hepatitis C virus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IDLO	International Development Law Organization
ILO	International Labor Organization
IOM	International Organization on Migration
J-Flag	Jamaica Forum for Lesbians, All-Sexuals, & Gays
JN+	Jamaica Network of Seropositives
LGBT	Lesbian, gay, bisexual and transgender
MARP	Most at-risk populations
MDG	Millennium Development Goals
MSM	Men who have sex with men
MTF	Medium Term (Socio-Economic Policy) Framework
NCDA	National Council on Drug Abuse
NCPI	National Commitments and Policies Instrument
NFPB	National Family Planning Board
NGO	Nongovernmental organization
NHDRRS	National HIV-Related Discrimination Reporting and Redress System
NHP	National HIV/STI Programme
NPGE	National Policy for Gender Equality
OHCHR	Office of the High Commissioner for Human Rights
OI	Opportunistic Infections

OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNIFEM	United Nations Development Fund for Women (now UN Women)
UNODC	United Nations Office of Drug Control
UPR	Universal Periodic Review
USAID	US Agency for International Development
UWI	University of the West Indies
UWI-HARP	University of the West Indies HIV/AIDS Response Programme
VCT	Voluntary counseling and testing
WHO	World Health Organization

Introduction

Jamaica's 2012-2017 National HIV Strategic Plan recognizes the breadth of the epidemic as not just a health problem, but also a development issue requiring multi-sectoral responses, including in areas of governance. The plan speaks to the need to address impediments in the enabling environment including, "Advocating for social policy change and legislation... and raising awareness and changing attitudes towards stigma and discrimination against persons living with HIV and most at risk populations."

The current HIV and AIDS legal assessment of Jamaica is part of an initiative of UNDP Jamaica, with funding support from UNAIDS, and in partnership with the Enabling Environment Component of the National HIV/STI Programme (NHP) of the Ministry of Health, to build capacity for reform of outdated, inconsistent and discriminatory HIV-related laws in Jamaica and to increase access to justice for vulnerable populations.

Using the HIV/AIDS Legal Assessment Tool developed by the American Bar Association's Rule of Law Initiative (ABA ROLI) in 2010, the purposes of this legal assessment in Jamaica are to:

- 1) Generate information on the status of PLHIV's human rights;
- 2) Provide key stakeholders with detailed information on the complex interplay between national laws, policies, and HIV-related services, including prevention, treatment, care, support, and protection from discrimination;
- 3) Provide a roadmap for addressing HIV-related discrimination;
- 4) Facilitate and enable prioritization of legislative reforms;
- 5) Promote programming aimed at improving access to justice for PLHIV;
- 6) Help spearhead local grassroots advocacy initiatives;
- 7) Enhance inter-agency collaboration and international cooperation;
- 8) Facilitate more adequate coverage of the epidemic and related discrimination by the media; and
- 9) Monitor progress in addressing HIV-related discrimination.

The HIV/AIDS Legal Assessment Tool provides a snapshot of Jamaica's compliance with the applicable international legal standards in HIV/AIDS and human rights. In addition, both the Tool and the assessment report can be used to train diverse stakeholders including community-based organizations (CBOs) on how international legal standards can be used to advance human rights in the context of HIV/AIDS through community-driven initiatives. This report targets a wide audience including all stakeholders in the national HIV response, international donors, academics, and CBOs and policy makers in the Caribbean region.

To support the achievement of this assessment, a national multi-sectoral Steering Committee of key stakeholders has been established chaired by the NHP and UNDP Jamaica. The Steering Committee is comprised of representatives of relevant government ministries, department and agencies, civil society organizations and international development partners active in supporting Jamaican initiatives relating to HIV-AIDS. Further, diverse stakeholders have been engaged throughout the process of this initiative through regular workshops and communication. The first two Stakeholder Workshops were held in Kingston on February 19, 2013 and August 20, 2013.

Methodology

An international consultant was engaged between July and November 2013 to conduct the HIV/AIDS legal assessment, followed by drafting a Plan of Action that will provide detailed recommendations on:

- 1) Revisions to statutes, secondary legislation and policies that prohibit access to counseling, care and treatment and/ or support stigma and discrimination against all persons living with and affected by HIV including key populations;
- 2) Accompanying actions in support of the legal revisions including public education, institutional support and national systems;
- 3) Lead and supporting actors for each action (including state, civil society and international partners); and
- 4) Proposed timelines for the actions in order of priority.

The Final Plan of Action will form part of a Cabinet Submission, in anticipation of drafting instructions for the necessary amendments to existing and/or enactment of new legislation.

Data for this legal assessment comes from three main sources:

- 1) Literature review of:
 - Legally binding international human rights treaties;
 - International custom;
 - Non-binding human rights instruments including
 - a) UN General Assembly Resolutions on HIV/AIDS (Millennium Declaration, 2001 UNGASS Declaration of Commitment on HIV/AIDS, and Political Declaration on HIV/AIDS in 2006 and 2011);
 - b) International Guidelines On HIV/AIDS And Human Rights (1996, updated in 2002);
 - d) Standards developed by UNAIDS and its co-sponsors (Joint Action for Results, UNAIDS Outcome Framework 2009-2011 and UNAIDS Getting to Zero: 2011-2015 Strategy);
 - e) Standards developed by treaty-based bodies (Universal Periodic Review (UPR) of Jamaica, general comments or recommendations, concluding observations in consideration of State parties' reports; and other decisions); and
 - f) Other instruments, notably reports by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.¹
 - Jamaican government's periodic reports to various UN treaty bodies and CBO shadow reports; national laws and policies related to HIV and AIDS and key populations;
 - Regional policies and reports; and
 - Other academic and media publications (Appendix 1);
- 2) Stakeholder workshop in Kingston on August 20, 2013 (Appendix 2); and
- 3) Interviews with 36 stakeholders in Kingston between August 19 to 30, 2013 (Appendix 3).

The consultant follows the proposed methodology in the ABA/ROLI HIV/AIDS Legal Assessment Tool in combining *de jure* and *de facto* analyses of all relevant laws, policies, and practices related to HIV/AIDS. Through a comprehensive desk review of Jamaica's laws and policies, pending draft provisions, and secondary materials that

¹ <http://www.ohchr.org/EN/Issues/Health/Pages/SRRRightHealthIndex.aspx> [accessed on September 16 2013].

contain HIV-specific and human rights provisions as well as regulate HIV risk behaviors, the *de jure* (textual) analysis seeks to determine if the country's legal system is sufficiently strong to protect PLHIV and key populations from HIV-related discrimination and other violations of human rights based on real or perceived HIV status. Then the *de facto* (contextual) analysis seeks to determine if "the State has committed appropriate resources and taken concrete steps to reduce HIV-related discrimination" and effectively "protect, promote, and fulfill the human rights of PLHIV and key populations in practice. In addition, initiatives undertaken by non-state actors [are] examined to provide a comprehensive picture on the state of human rights in the context of HIV/AIDS" in Jamaica.²

A compliance gap is analyzed by comparing Jamaica's *de jure* and *de facto* legal and policy practices according to 22 Factor Statements in the ABA ROLI HIV/AIDS Legal Assessment Tool that serve as indicators or principles in four key areas where HIV-related discrimination is likely to occur:

- 1) Access to Essential Services;
- 2) Equality of PLHIV in Public and Private Life;
- 3) Key Populations; and
- 4) Access to Justice.³

In this assessment, HIV-related discrimination is understood as "any measure entailing an arbitrary distinction that results in an unfair and unjust treatment of an individual based on his or her confirmed or perceived HIV status," a definition adopted by the ABA ROLI HIV/AIDS Legal Assessment Tool in line with international guidelines.

² ABA ROLI HIV/AIDS Legal Assessment Tool, http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12_authcheckdam.pdf [accessed on September 3 2013].

³ Ibid.

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This report is dedicated to all Jamaicans living with HIV and AIDS.

Executive Summary

Brief Overview of the Results

The HIV epidemic in Jamaica is generalized (1.7%) and concentrated in four key populations: men who have sex with men (MSM), drug users/homeless, sex workers, and prisoners. The 2013 HIV and AIDS legal assessment for Jamaica presents an overall picture of some very significant gains in the national HIV response including a new governance structure; successes in the prevention of mother to child transmission; dramatic reduction of HIV prevalence among sex workers; continuous provision of free antiretroviral (ARV) treatment; the adoption of the National HIV/AIDS Workplace Policy which prohibits HIV-related discrimination at the workplace; and increased public awareness and discourses on HIV and various vulnerable populations. Several positive legislative developments are also underway e.g. the proposed Public Health (Notifiable Diseases) Order and the Occupational Safety and Health bill, both of which would have the effect of reducing workplace discrimination against people living with HIV and AIDS (PLHIV) and potentially giving PLHIV who have experienced discrimination some legal recourse.

However, Jamaica still faces many challenges in scaling up prevention efforts and achieving universal access to treatment. Crippling debt burden and the most recent IMF Agreement in 2013 put severe fiscal constraints on health sector spending. Classified as a middle-income country in 2010, Jamaica has less access to international funding. New financing sources including from the private sector will have to be explored. The economy is struggling and has only recently emerged from a double-dip recession.⁴ Multisectoral stakeholder engagement remains a real challenge. Criminalization of private, consensual same-sex sexual acts, sex work, and drug use perpetuates stigma and discrimination against the most vulnerable populations and impedes their access to HIV/health information and services. A high-level political declaration in 2011 to address these issues of stigma and discrimination has yet to be translated into concrete legal or policy reforms.

Without a comprehensive HIV and AIDS law, a general anti-discrimination law, or a human rights act/commission to legally enforce non-discrimination against PLHIV, existing HIV and AIDS policies and strategic plans fall short of ensuring equal access to prevention, care, treatment, and support by key populations, as well as the full enjoyment of PLHIV in all aspects of social, cultural, civil, and political life. A significant body of research concerning modes of transmission and various key populations already exists. But more qualitative research needs to be conducted on the social contexts and drivers of HIV vulnerability, especially for the most invisible sub-groups within the key populations that continue to elude existing services. Legal aid, legal literacy, and enforcement of redress remain mostly undeveloped. A human rights approach to HIV puts people living with HIV and AIDS and their support community organizations at the center; and rethinks the current strategy and biomedical model from a rights perspective. HIV-related legal reforms and social change are part and parcel of national development to make “Jamaica, the place of choice to live, work, raise families, and do business.”

Positive Developments Identified in the 2013 Jamaica HIV and AIDS Legal Assessment

- **HIV and National Development.** HIV and AIDS is considered as a priority area under the national priority outcome of “A healthy and stable population” in the second Medium Term Socio-Economic Policy Framework 2012-2015 as part of Jamaica’s first national development plan, Vision 2030. This offers a strategic opportunity to integrate the national HIV and AIDS response into the national development agenda.
- **Governance Structure and Coordination.** Since early 2013, the National HIV/STI Programme has been integrated with the National Family Planning Board (NFPB) under the new Sexual and Reproductive

⁴ Johnston, Jake and Juan A. Montecino, *Update on the Jamaican Economy*, May 2012, <http://www.cepr.net/documents/publications/jamaica-2012-05.pdf> [accessed on September 16 2013].

Health Authority for Jamaica. Until then, the NHP was a unit within the Ministry of Health, lacking independent legal authority and political buy-in from other sectors. The Sexual Reproductive Health Authority is an executive agency with statutory authority and a cross-sectoral Board structure including various line ministries, the private sector, and civil society organizations (CSOs). This is a very significant step forward in the governance structure of the NHP towards implementing the “Three Ones” principle: one AIDS action framework based on the National HIV/AIDS Policy since 2005 and the National HIV/AIDS Strategic Plan (2012-2017); one national AIDS national coordinating authority with a broad-based multisectoral mandate; and one monitoring and evaluation system. While it is too early to see the actual benefits of this new structure, it is expected to facilitate more effective coordination and sustain the NHP by accessing potentially new funding streams including in sexual reproductive health.

- **Financial Sustainability.** Another positive development was the completion of a financial sustainability study of Jamaica’s HIV Program at the end of 2012. A local steering committee was established with World Bank funding to oversee this study to review existing sources and spending patterns on HIV and AIDS and estimate the fiscal burden of the national HIV and AIDS response based on different potential scenarios. The committee is chaired by the Planning Institute of Jamaica, with representatives from the Ministry of Health, Ministry of Finance, UNAIDS, and the World Bank. The study finds that the costs of the national response to HIV and AIDS will increase by 37% from J\$ 1.7 billion (US\$ 20.4 million) in 2010/11 (0.14% of GDP) to about J\$ 2.5 billion (US\$ 28 million) by 2020 as a result of an increasing number of cases needing treatment and the increasing need for second-line drug treatment.

The study also highlights the needs to review new funding sources from both the public and private sectors as well as to assess spending choices across prevention activities. This includes making stronger effort in reaching the most at-risk populations, particularly men who have sex with men (MSM), to prevent HIV transmission. The report clearly indicates that the costs incurred by new infections from sex workers and men who have sex with men are very high and that effective prevention in the short-term will result in lower spending on treatment in the long-term.⁵

- **Prevention.** The Jamaican national HIV and AIDS prevention strategy has achieved two major successes, relating to the prevention of mother to child transmission (PMTCT) and a decrease in infection rates among sex workers. The PMTCT programme was first developed in the Kingston and St. Andrew region in 2002 and then expanded island-wide by 2007. The PMTCT rate has been kept at under 5% since then.⁶ The HIV prevalence rate for sex worker dropped from an estimated 21% in 1990 to 4.1% in 2011.⁷

- **Access to Treatment.** DNA-PCR (a new technology used for HIV early detection testing after recent exposure), CD4, and viral load testing are available free of cost, and ARV treatment has also been made available for persons with advanced HIV and HIV-infected mothers free of charge since 2004. 58% of people living with AIDS who need ARV have access to treatment. HIV management has been integrated into the primary health care system in Jamaica in accordance with the Guidelines for the Clinical Management of HIV/AIDS (updated in 2013).

- **HIV/AIDS Workplace Policy and Legislation.** A National HIV/AIDS Workplace Policy was developed by the Ministry of Labor and Social Security and adopted by the Jamaican Parliament in 2012. It provides guidelines for both the public and private, formal and informal sectors, to develop and implement HIV/AIDS workplace policies and programmes to protect workers living with or affected by HIV and AIDS and help fight against HIV/AIDS-related stigma and discrimination. As of 2013, 116 institutions

⁵ Mziray, Elizabeth; Haacker, Markus; Shiyan Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank.
<http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program>

[accessed on September 3 2013].

⁶ National HIV/AIDS Strategic Plan 2012-2017.

⁷ UNGASS Jamaica Country Report 2012.

have signed the commitment form for the voluntary compliance program under the auspices of the National HIV/AIDS Workplace Policy. Further, an Occupational Safety and Health Act is currently tabled in the Parliament. If passed, it will provide legal protections and sanctions against discrimination of people living with HIV by way of regulations to be appended to the Occupational Safety and Health legislation. A Manual on Life Threatening Illnesses, which treats HIV like other chronic illnesses and prohibits HIV discrimination, is also under discussion.

- **Public Awareness.** There have been increased public discourses on HIV and AIDS as well as issues related to key populations (e.g. MSM or minors' access to sexual and reproductive health information and services) through advertising campaigns and media reporting.

Challenges Identified in the 2013 Jamaica HIV and AIDS Legal Assessment

- **Funding.** Jamaica entered into a new agreement with the International Monetary Fund (IMF) in April 2013. Among various conditionalities are a public sector wage freeze and funding caps, which have a direct impact on health funding including salaries of healthcare professionals. Jamaica's high debt payments (about 56% of the national budget) continue to constrain health sector spending, leaving little fiscal room to scale up HIV prevention and treatment. In addition, since 2010, Jamaica has been reclassified as an Upper-Middle Income country by the World Bank, making it more difficult for Jamaica to secure international aid. As an Upper-Middle Income country, Jamaica is only eligible for the limited Targeted Funding Pool of the Global Fund to Fight AIDS, TB, and Malaria with the requirement of counterpart financing (moving from the current 30% to 60% of domestic share of HIV funding).

Other funding sources such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) are also set to expire over the next few years. In such a tight fiscal environment, the national HIV response of Jamaica will need to explore innovative financing in order to continue prevention strategies among key populations without compromising prevention work among the general population. In particular, Jamaica has to find new funding sources to pay for ARV treatment when Global Fund grants expire.⁸

- **Health System Strengthening and National Development.** Many gaps in the national HIV response such as delays in and undercoverage of testing and treatment or breach of privacy and confidentiality are directly related to a poor health system in general. There is a human resource bottleneck, with insufficient pharmacists, doctors, and nurses; poor data management system (absence of an electronic medical system); and a lack of psychosocial support for patients. Further, larger issues pertaining to national development such as poverty, unemployment, illiteracy, and gender-based violence have a direct impact on key populations' access to prevention and treatment services. Until HIV is tackled within a national development framework, the national response will continue to face significant structural barriers.

- **Lack of Wide Cross-Sectoral Support.** The Ministry of Health remains the lead in the national HIV response, sometimes with little political buy-in from other sectors. There is still a lack of understanding and commitment to promote necessary evidence-based knowledge for HIV prevention among youth. There is also more room for private-sector involvement in promoting testing and funding the HIV response including economic empowerment of PLHIV.

- **Legal Barriers.** Criminalization of private, consensual, same-sex sexual acts, as well as sex work, and drug use makes it more difficult for these populations to access HIV prevention information, services, and treatment. The lack of recognition by political and religious leaders of the relationships between criminalization, discrimination, and HIV vulnerability remains a key challenge in moving HIV-related legal and policy reforms forward. On February 7, 2013, AIDS-Free World filed a complaint with the Jamaica

⁸ Mziray, Elizabeth; Haacker, Markus; Shiyan Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank. <http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program> [accessed on September 3 2013].

Supreme Court on behalf of local lesbian, gay, bisexual and transgender (LGBT) rights activist Javed Jaghai who became the first person to challenge Jamaica's buggery law. The outcome of the case will have significant impact not only in Jamaica, but also throughout the Caribbean.

• **Social Attitudes and Engagement of Faith-Based Organizations.** Despite increased public discourses, HIV awareness has not been fully translated into legal or policy actions. Persistent social attitudes including gender roles and stigma and discrimination towards PLHIV and various key populations present great challenges in HIV prevention in Jamaica. According to the latest Modes of Transmission study in 2012, multiple sexual partnerships remain the key transmission mode for new HIV incidences. The lack of women's ability to negotiate faithfulness and condom use in relationships where men play a dominant role hampers effective HIV prevention.

Religious attitudes towards HIV and certain key populations such as MSM, sex workers, drug users, and prisoners present further challenges in rolling out prevention and treatment to these most-at-risk populations. Despite repeated attempts by the NHP, UNAIDS, and US-funded Health Policy Project to engage leaders of faith-based organizations (FBOs),⁹ various religious denominations have yet to develop HIV and AIDS policy and implement measures to address HIV-related stigma and discrimination.

• **Absence of a Human Rights and GIPA Approach to HIV/AIDS.** While the 2012-2017 National HIV/AIDS Strategic Plan puts human rights and enabling environment as one of the six priority areas, the predominant approach to HIV in Jamaica remains largely a supply-driven biomedical one: test and treat. In contrast, a human rights approach focuses on drivers of HIV vulnerability and the removal of all punitive laws and policies that impede access. The lack of a rights-based approach to prevention strategies and a demand-driven treatment literacy approach account in part for low testing (half of an estimated population of 32,000 living with HIV do not know their status) and low treatment adherence (46%). PLHIV and CBOs suggest that the NHP needs to rethink how it engages PLHIV and key population at the center of the national response.

• **Lack of a Broad, Enforceable Legal Framework to Prevent and Punish HIV-Related Discrimination.** There is not a comprehensive HIV and AIDS law, a general anti-discrimination law, or a human rights commission, or any legally enforceable laws or policies protecting against HIV-related discrimination. At the time of writing, only the Occupational Safety and Health Act (if and when enacted) will provide legal protection against HIV discrimination at the workplace. While the Management of HIV/AIDS in Schools Policy does include non-discrimination, the policy has no legal sanction and has never been reviewed since it was adopted in 2004. A National HIV-Related Discrimination Reporting and Redress System has been operational since 2009, but a 2013 review shows that many people are unaware of the system. The system also lacks an institutional home, sufficient human resources, and adequate technical capacity.¹⁰

• **Lack of Monitoring and Evaluation of Policy Implementation.** Where HIV-related policies exist (e.g. in schools and at workplaces), there is a lack of monitoring and evaluation of the implementation and effectiveness of those policies.

• **Lack of Special Programs and Specific Legislation Directed at Certain Key Populations Affected by HIV.** Populations such as women, children, MSM, and persons who use drugs are particularly vulnerable to the effects of HIV. But, insufficient legislative or programmatic efforts are aimed at addressing their needs. Government responses to HIV are not necessarily targeted at addressing the particular circumstances of

⁹ A Steering Committee for FBO Initiative was formed in 2012 to lead a series of discussions to develop a national FBO platform for partnership in Jamaica's national HIV response after a visit to Jamaica by the UN Special Envoy to the Caribbean for HIV and AIDS, Dr. Edward Greene, in April 2012. Unfortunately, the initiative is currently on hold. See Malaki, Akhil. 2013. "Building Institutional Capacity in HIV and AIDS for Faith-Based Organizations (FBOs) in Jamaica: Project Proceedings, Outcomes and Recommendations."

¹⁰ Gray, Vivian A. 2013. "Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica." Kingston, Jamaica: Futures Group, Health Policy Project.

women or children affected by HIV and AIDS. As previously discussed, social stigma and the illegality of same-sex sex acts has prevented effective government responses to MSMs at risk of infection or affected by HIV and AIDS. Additionally, persons who use drugs would benefit from a government response aimed at harm reduction.

- **Lack of Legal Services Directed at PLHIV.** There are no government-funded legal services aimed specifically at PLHIV. Nor are there legal services aimed specifically at PLHIV by *pro bono* attorneys. Instead, PLHIV who lack adequate financial resources to hire an attorney must rely on Jamaica's underfunded and overburdened legal aid system. Since government-funded legal aid is unable to meet the need for legal assistance in civil cases, PLHIV may be unable to access legal assistance to address discrimination issues, obtain assistance regarding health care, employment, and housing access, or meet basic legal needs such as the drafting of a will. This is especially problematic given the current lack of legal protections aimed specifically at PLHIV, as well as the social stigma associated with the disease. Additionally, there are not legal education programs aimed specifically at PLHIV, or attorneys who might potentially assist them.

- **Lack of qualitative research on vulnerability drivers of key populations.** Many interviewees share the view that there is still insufficient data, especially from qualitative research, concerning vulnerability drivers of HIV. Where such data exists, it is not easily accessible to stakeholders. The lack of data in turn affects Jamaica's ability to attract international funding.

For a summary of all HIV-related legal compliance gaps and recommendations, see Appendix 4.

Jamaica Background

Country Overview: “Out of Many One People”

Jamaica is a Caribbean small island state that gained independence from Britain in 1962. It has a population of 2.7 million (49.3% males and 50.7% females) with an estimated equal number of Jamaicans live outside the country, predominantly in the US, UK, and Canada.¹¹ Remittances, tourism, and bauxite account for over 85% of foreign exchange, making Jamaica extremely vulnerable to external economic shocks. It saw fourteen consecutive quarters of negative growth from 2007-2010 before registering positive real GDP growth of 1.51% in 2011. Total public debt, unemployment, and poverty increased during this period.¹²

Jamaica ranks 79 out of 187 countries and territories in terms of the Human Development Index. Adult literacy is at 86% (2007) while life expectancy is approximately 72 years. It has made good progress in eight out of fourteen Millennium Development Goals (MDG) targets for 2015, achieving targeted reductions in absolute poverty, malnutrition, hunger, and universal primary enrolment. But it lags behind in gender equality, child and maternal mortality, and environmental sustainability targets. Several factors continue to impede MDG progress. Homicidal violence—predominantly male on male, youth on youth, and poor on poor—is a serious social problem. Vulnerable unattached youth, those who are not in school, unemployed and not participating in any training course, comprise roughly 30% of the total youth population. Only a quarter of these youths had attained an education level or grade 9 level or higher, making adolescent pregnancy rates and female youth vulnerability to sexual exploitation a serious societal and health concern. Other factors include the growth of the informal sector, increase in transactional sex due to the economic downturn, and poverty among an increasing urban population living in slum areas.¹³

Jamaica is one of the Caribbean countries that have been caught in a “high debt-low growth trap” for the past two decades.¹⁴ At 111.3%, it has the fourth largest debt-to-GDP ratio in the world (as of 2007), with debt servicing occupying 56.5% of the 2009/10 budget.¹⁵ Jamaica has undergone structural adjustment programs with the IMF and the World Bank since 1977, when Jamaica signed its first two-year Standby Agreement with the IMF. Since then, it has concluded over ten agreements with the IMF and three structural adjustment programs with the World Bank, putting limits on public sector borrowing, considerable public sector contraction, and price deregulation.¹⁶ Jamaica’s silent debt crisis represents the most challenging macroeconomic factor that bears a direct impact on national development, health system strengthening, and the national HIV response. But, classified by the World Bank as an Upper-Middle Income country, Jamaica is not eligible for debt relief. The UN Human Rights Committee noted in the 2011 Report of the Working Group on the Universal Periodic Review of Jamaica, “as one of the most highly indebted countries in the world, Jamaica was worse off than many countries in the low income group.”¹⁷

In 2009, the Jamaican government put forth a bold national development plan with the vision of “Jamaica, the place of choice to live, work, raise families, and do business.” Vision 2030 Jamaica has four strategic goals:

1. Jamaicans are empowered to achieve their fullest potential development;

¹¹ Economic and Social Survey of Jamaica, 2010.

¹² Ibid.

¹³ National Report Of Jamaica on Millennium Development Goals for The UN Economic and Social Council Annual Ministerial Review Geneva, July 2009.

¹⁴ IMF, 2013, Caribbean Small States: Challenges of High Debt and Low Growth. <http://www.imf.org/external/np/pp/eng/2013/022013b.pdf> [accessed on September 4 2013].

¹⁵ Ibid.

¹⁶ Handa, Sudhansu and Damien King. 1996. “Structural Adjustment Policies, Income Distribution and Poverty: A Review of the Jamaican Experience.” Ottawa: International Development Resource Center, <http://idl-bnc.idrc.ca/dspace/bitstream/10625/33344/1/115762.pdf> [accessed on September 4 2013].

¹⁷ UN Human Rights Council. 2011. Report of the Working Group on the Universal Periodic Review (A/HRC/16/14), http://ap.ohchr.org/documents/alldocs.aspx?doc_id=18040

2. The Jamaican society is secure, cohesive and just;
3. Jamaica's economy is prosperous; and
4. Jamaica has a healthy natural environment.¹⁸

These four goals are implemented through a series of Medium Term Socio-Economic Policy Frameworks (MTF), which identify the priority outcomes, strategies, and actions for each three-year period from 2009 to 2030. The current MTF 2012-2015 specifically identifies "A Healthy and Stable Population" as a national priority outcome and HIV and AIDS as a priority area for national development.

Status of the HIV and AIDS Epidemic

Prevalence Rates. Jamaica reported its first case of AIDS in 1982. Between 1982 and 2010, 27,272 persons were reported with HIV/AIDS in Jamaica and the cumulative number of reported AIDS deaths was 8,102. HIV prevalence peaked in 1996. In 2012, an estimated 32,000 persons are living with HIV in Jamaica or 1.7% of the adult population. Together with Haiti and other Caribbean countries, Jamaica has the one of the highest HIV prevalence after sub-Saharan Africa. The HIV epidemic in Jamaica is generalized (above 1% of the general population) and concentrated in four key populations: MSM (32%);¹⁹ drug users/homeless (8.2%); sex workers (4.1%), and prisoners (2.5%). Sentinel surveillance of antenatal clients show a mother to child transmission rate of below 1% since 2007. Approximately half of people living with HIV are unaware of their serostatus. HIV remains a leading cause of death among adults 15-49 years, with over 333 reported deaths due to AIDS in 2010.²⁰

Modes of Transmission. While new HIV infections in Jamaica have declined by 25% over the past decade, approximately 2,500 Jamaicans get HIV infections each year. According to the NHP, the principal drivers of the HIV epidemic have been **multiple partnerships, early sexual debut, high levels of transactional sex, and inadequate condom use.**

HIV case reporting surveillance data indicates that over 90% of new HIV infections among Jamaican men and women are attributed to heterosexual sex. The breakdown of HIV incident rates in 2012 by most-at-risk groups in order of significance is as follows:

- MSM (30%);
- Men engaging in casual heterosexual sex (CHS) (23%);
- Female partners of men engaging in CHS (15%);
- Low-risk heterosexuals (15%);
- Female partners of MSM (7%);
- Clients of sex workers (6%);
- Partners of clients of sex workers (3%), and
- Sex workers (1%).²¹

40% of new HIV cases among men have an unknown designation. Of the remaining 60% for which data is available, 86% indicate only having sexual interactions with women, with 14% report having male partners. This data indicates either under reporting of sexual practices by MSM due to fear of stigma and discrimination or weakness in the surveillance system.²²

Young adults are the most affected by HIV with approximately 79% of all reported AIDS cases in Jamaica

¹⁸ Vision 2030 Jamaica, National Development Plan.

¹⁹ The term MSM is used as part of this population does not self-identify as gay.

²⁰ UNGASS Jamaica Country Report 2012.

²¹ Ibid.

²² Ibid.

occurring in the 20-49 year old age group, and 90% of all reported AIDS cases aged between 20 and 60 years. AIDS case rate among men continue to exceed AIDS case rate among women, though this gap has narrowed over the years.²³

According to the 2012 HIV/AIDS Knowledge Attitudes and Behavior Survey, 53.8% of infected males and 23.6% of infected females engaged in transactional sex, and the rate of condom use in this group was around 60%. Of respondents to the survey, 41% reported having multiple partners in the last 12 months (60.5% of males and 19.4% of females).²⁴

Injection drug use, blood transfusion, and occupational exposure risk groups were not included in the 2012 Modes of Transmission study “as these modes of transmission do not contribute significantly to the Jamaica HIV epidemic based on surveillance data.”²⁵ UNGASS Jamaica Country Reports do not provide HIV transmission data for crack users. The 2009 MDG Progress Report of Jamaica, however, reported an HIV incidence rate among crack/cocaine users at 8%.²⁶

When compared with their estimated group size in Jamaica, HIV incidence rates among various key populations present a stark picture of the predominant modes of transmission of HIV in Jamaica, necessitating targeted prevention interventions in most-at-risk populations as well as bridging populations that may not have been reached by existing prevention efforts, notably men engaging in CHS and their female partners (Fig. 1).

Fig. 1 HIV Prevalence and Incidence Rates in Jamaica, 2012

Most-At-Risk Populations	Estimated Group Size as a Percent of the Total Population	HIV Prevalence Rate	HIV Incidence Rate
MSM	2%	32%	30%
Female partners of MSM	0.8%	N/A	7%
Injecting Drug Users/Homeless	N/A	8.2%	N/A
Partners of DU/Homeless	N/A	N/A	N/A
Sex Workers	1%	4.1%	1%
Clients	3%	N/A	6%

²³ Ibid.

²⁴ 2012 HIV/AIDS Knowledge Attitudes and Behavior Survey.

²⁵ UNAIDS/NHP. 2012. *Modes of Transmission of HIV in Jamaica*. Kingston: UNAIDS/NHP.

²⁶ MDG Progress Report of Jamaica 2008.

Partners of Clients	1.8%	N/A	3%
Prisoners	0.002% (4,600/2,700,000 in 2011)	2.5%	N/A
Men engaging in CHS	60% men; 23% women	N/A	23%
Female Partners of CHS	12%	N/A	15%
Low-risk Heterosexuals	26% men; 27.4% women	N/A	15%

Source: UNAIDS/NHP, 2012 Modes of Transmission of HIV in Jamaica; and UNGASS Jamaica Country Report 2012.

Testing and Treatment. The comprehensive Guidelines for the Clinical Management of HIV/AIDS lay out the national testing and treatment protocol. During 2010, more access to CD4 testing was provided by the introduction of PIMA machines at three treatment sites: Port Antonio Hospital, Black River Hospital, and Jamaica AIDS Support for Life’s Kingston Branch. This new testing methodology eliminates the need to ship all samples to the National Public Health Laboratory in Kingston or the Cornwall Regional Hospital in Montego Bay. Viral Load testing in the public sector is conducted solely at the National Public Health Laboratory, the only public laboratory in Jamaica with this capability. Dried Blood Spot samples for DNA PCR testing of HIV exposed infants, introduced in 2009, has been fully implemented at all treatment sites by the end of 2010. Nearly all pregnant women attending public clinics in 2010 and 2011 were tested for HIV.²⁷

Since 2004, the Jamaican government has rolled out free ARV treatment. In 2011, 23 treatment sites that are integrated in the primary health care system provided multidisciplinary care to PLHIV in Jamaica. By the end of 2011, 9,162 persons with advanced HIV were started on ARV treatment, representing a coverage rate of under 60% of all those in need of ARV treatment. Individual adherence to ARV treatment (at 46%) is a major challenge.²⁸ ARVs are dispensed from treatment site pharmacies and Drug Serv pharmacies. The programme was strengthened by the addition of three private pharmacies as points of access for ARVs to public and private sector clients. For those who prefer to access care in the private sector, the NHP certified practitioners to offer service to PLHIV. These private sector patients can also access ARVs free of cost through the Drug Serv and three private pharmacies involved in the programme. Interviewees reported some incidents of ARV stock outs.

Progress on MDG6 and Other UNGASS Indicators. Jamaica saw the first decline in AIDS deaths in 2005 and in the number of AIDS cases in 2006. In terms of infection and mortality, it is on track with MDG Target 6A (“Have halted by 2015 and begun to reverse the spread of HIV/AIDS”). However, with treatment coverage of 58%, it lags behind Target 6B (“Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it”). The 2012 UNGASS Jamaica Country Report shows progress in several other indicators: youth having sexual debut later; fewer people engaging in multiple partnerships; double uptake of testing; decreased percentage of youth living with HIV (from 1.3% in 2007 to 1% in 2009 and 0.78% in 2011; increased outreach among sex workers; decreased HIV

²⁷ UNGASS Jamaica Country Report 2012.

²⁸ Interview with the Director, Center for HIV/AIDS Research, Education, and Services (CHARES), University Hospital of the West Indies, August 20 2013.

prevalence among sex workers (from 12% 1990 to 9% 2005 and 4% 2011); and increased uptake of testing among MSM. However, gaps remain in numerous areas. There is little youth knowledge of sexual transmission of HIV (approximately 38%); decreased condom use by women (from 52% to 40% between 2008 and 2010); decreased HIV testing among sex workers (from 75% in 2008 to 59.2% in 2012); significantly lower condom use among MSM (25%) and sex workers (15%); stubbornly high prevalence rate among MSM (constant at 33%); and low percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (22%) (Fig. 2).

HIV and AIDS have reversed the health gains that had been achieved in Jamaica over many years. Whereas life expectancy in the country grew at an average rate of 0.2 years annually between 1955/60 and 2005/10, life expectancy was 1.6 years lower in 2005/10 as a result of HIV/AIDS.²⁹

Fig 2. Core Indicators for 2011 Political Declaration on HIV/AIDS, Jamaica Data, January 2010 – December 2011

Target	MDG/ National Goals	Result	On Track?
Target 1. Reduce Sexual Transmission of HIV By 50% Among the General Population By 2015			
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MDG: 95% by 2010	Total: 38.50% Men: 33.86%; Women: 42.64%	No
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		Total: 31.13% Men: 49.69% Women: 13.51%	No
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	National goals: Men: 47% and Women: 15% by 2008	Total: 28.11% Men: 46.77% Women: 13.28%	No
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse		Total: 56.93% Men: 65.38% Women: 40.19%	No
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results		Total: 58.71% Men: 47.24% Women: 67.74%	No
1.6 Percentage of young people aged 15-24 who are living with HIV		0.78% (2011)	No
Target 1. Reduce Sexual Transmission of HIV Among Sex Workers By 50% By 2015			
1.7 Percentage of sex workers reached with HIV prevention programmes		79.7%	No

²⁹ Mziray, Elizabeth; Haacker, Markus; Shiyan Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank. <http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program> [accessed on September 5 2013].

1.8 Percentage of sex workers reporting the use of a condom with their most recent client		85.2%	No
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results		59.2%	No
1.10 Percentage of sex workers who are living with HIV		4.1%	No
1.11 Percentage of men who have sex with men reached with HIV prevention programmes		86.9%	No
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		75.52%	No
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results		68.32%	No
1.14 Percentage of men who have sex with men who are living with HIV		32.77%	
Target 2. Reduce Transmission of HIV Among People Who Inject Drugs By 50% By 2015			
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes		Not provided	
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse		Not provided	
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected		Not provided	
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results		Not provided	
2.5 Percentage of people who inject drugs who are living with HIV		Not provided	
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission		58.68% - 284/484; (2011, Spectrum and PMTCT Prog. Monitoring)	No
3.2 Percentage of infants born to HIV-positive women receiving a		87.1% (2011,	Yes

virological test for HIV within 2 months of birth		PMTCT Prog. Monitoring/ NPHL Lab Data); 58.5% (283/484: 2011, Spectrum/ NPHL Lab Data)	
3.3 Mother-to-child transmission (modeled)		37 new infections (2011); 484 Women needing PMTCT (Spectrum Model); 20 cases or 0.35 (per 1000) (2010 – PMTCT	Yes
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015			
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy		58.6	No
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		75.6	No
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015			
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both HIV and TB.		22.2	No
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low-middle-income countries			
6.1 Domestic and international AIDS spending by categories and financing sources		26.2% domestic funding	No
Target 7. Eliminating gender inequalities			
7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		Completed (NCPI 2012)	Yes
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months. All indicators with sex-disaggregated data can be used to measure progress towards target 7		9.89	No
7.3 Current school attendance among orphans and non-orphans aged 10-14	National Target: >0.9% by 2012	Unavailable (2010/11)	?

7.4 Proportion of the poorest households who received external economic support in the last 3 months		Unavailable (2010/11)	?
Target 8. Eliminating stigma and discrimination Indicator development, Stigma indicator for general population planned to be ready for 2014 reporting			
Target 9. Eliminate travel restrictions Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed			
Target 10. Strengthening HIV integration No data provided			

Source: UNGASS Jamaica Country Progress Reports 2010 and 2012; 2012 HIV/AIDS Knowledge Attitudes and Behavior Survey, Jamaica.

Legal and Infrastructural Framework

Judicial System. Jamaica, like the rest of the Commonwealth Caribbean, inherited a Common Law legal system from England. The judicial system is comprised of five tiers, from lowest to highest:

- i) The Petty Sessions Courts. These are the lowest courts, presided over by Justices of the Peace who do not necessarily have legal training.³⁰ It hears cases involving minor crimes.
- ii) The Resident Magistrate's Courts. One exists in each Parish, and they are divided into a number of divisions, hearing civil and criminal cases.
- iii) The Supreme Court. Like the Resident Magistrate's Courts, it is divided into a number of divisions. It serves as a first instance court and an appellate court in some types of cases.
- iv) The Court of Appeal. It is the court to which all appeals are first referred.
- v) The London-based Judicial Committee of the Privy Council which may recommend confirmation, overturn or variation of the judgment of the Court of Appeal.³¹

Additionally, since 2001, Jamaica has been subject to the jurisdiction of the Caribbean Court of Justice, a regional court for members of the Caribbean Community and Common Market (CARICOM). This Court is charged with applying and interpreting the Treaty which established CARICOM, the Treaty of Chaguarmas.³²

Ratification of International and Regional Human Rights Treaties. Jamaica has signed, ratified, or acceded to most of the core international human rights instruments, including the:

- International Covenant on Civil and Political Rights (ICCPR);
- International Covenant on Economic, Social and Cultural Rights (ICESCR);

³⁰ <http://www.moj.gov.jm/services-and-information/jp> [accessed on September 14 2013].

³¹ http://www.supremecourt.gov.jm/court_structure [accessed on September 5 2013].

³² <http://www.caribbeancourtsofjustice.org/> [accessed on September 14 2003]; Agreement Establishing the Caribbean Court of Justice.

- International Convention on the Elimination of all Forms of Racial Discrimination (ICERD);
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
- Convention on the Rights of the Child (CRC);
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; and
- Convention on the Rights of Persons with Disabilities.

However, Jamaica is not a State Party to a number of Optional Protocols that allow individuals or groups to bring forth complaints regarding member states' treaty violations to the relevant treaty body. For example, Jamaica denounced the First Optional Protocol to the ICCPR in 1997 that it had previously ratified in 1975. Therefore citizens may not bring complaints before the ICCPR Human Rights Committee alleging violations of the Covenant by the Jamaican government. Similarly, it also has not signed the Optional Protocol to CEDAW or the Optional Protocol to the Convention on the Rights of Persons with Disabilities (Fig. 3).

Fig. 3 International Human Rights Treaties Ratified by Jamaica

International Human Rights Treaties	Signature	Ratification
ICCPR	1966	1975
Optional Protocol to ICCPR (individual complaint mechanism)	1966	1975 (denounced in 1997)
ICESCR	1966	1975
ICERD	1966	1971
CEDAW	1980	1984
CRC	1990	1991
Optional Protocol to the CRC on the Involvement of Children in Armed Conflicts	2000	2002
Convention concerning the Prohibition & Immediate Action for the Elimination of the Worst Forms of Child Labour		2003
Convention against Transnational Organized Crime	2001	2003
Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children	2002	2003
Protocol against the Smuggling of Migrants by Land, Sea and Air	2002	2003

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families	2008	2008
Convention on the Rights of Persons with Disabilities	2007	2007
Optional Protocol to the establishing an individual complaint mechanism	2007	Not ratified
Second Optional Protocol to ICCPR on the abolishment of the death penalty	Not signed	
Optional Protocol to CEDAW	Not signed	

Source: UN Convention websites; and University of Minnesota Human Rights Library, Ratification of International Human Rights Treaties – Jamaica. <http://www1.umn.edu/humanrts/research/ratification-jamaica.html>.

In addition, Jamaica is signatory to a number of non-binding international standard-setting documents relevant to the protection of PLHIV, including the 1994 International Conference on Population and Development Programme of Action,³³ the 1995 Beijing Platform for Action,³⁴ the Millennium Declaration (MDG 6 on HIV/AIDS, Tuberculosis, and Malaria);³⁵ UN General Assembly Special Session on HIV/AIDS (UNGASS, 2001);³⁶ the UN General Assembly Political Declaration on HIV/AIDS in 2006³⁷ and 2011;³⁸ and the ILO Code of Practice on HIV and the World of Work.³⁹

In terms of regional agreements, Jamaica is a State Party to the American Convention on Human Rights. It adopted the 2012 Organization of American States (OAS) Resolution 2435 on Human Rights, Sexual Orientation, and Gender Identity.⁴⁰ As a member of the Caribbean Community (CARICOM), it is also a partner to the Pan-Caribbean Partnership against HIV/AIDS and the 2008-2012 Caribbean Regional Strategic Framework on HIV/AIDS.⁴¹

Laws and policies on HIV and AIDS. There is no broad, HIV-specific law in Jamaica. The main regulations and policies pertaining to HIV and AIDS are the:

- Public Health Act. Among other things, this Act classifies HIV as a notifiable disease and empowers medical professionals to isolate an infected person.⁴²

³³ <http://www.un.org/popin/icpd/conference/offeng/poa.html> [accessed on September 5 2013].

³⁴ <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en> [accessed on September 5 2013].

³⁵ <http://www.un.org/millenniumgoals/> [accessed on September 5 2013].

³⁶ <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html> [accessed on September 5 2013].

³⁷ http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf [accessed on September 5 2013].

³⁸ http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf [accessed on September 5 2013].

³⁹ http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_113783.pdf [accessed on September 5 2013].

⁴⁰ <http://arc-international.net/global-advocacy/sogi-statements/oas-resolution-2012> [accessed on September 5 2013].

⁴¹ <http://www.caricom.org/jsp/projects/hiv-aidsstrategicframework.pdf> [accessed on September 5 2013].

⁴² Public Health Act of 1985 Secs. 2(1), 14(1), <http://www.gnppplus.net/criminalisation/sites/default/files/Jamaica%20Public%20Health%20Act.pdf> [accessed on September 18 2013].

- Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS (2003). This plan sets forth several strategies for assisting children impacted by HIV/AIDS, via social programs, public education, and coordination at the governmental level.⁴³
- Management of HIV/AIDS in Schools Policy (2004). This Policy sets forth non-discrimination standards, envisions support for students affected by the disease, and calls for education on the disease.⁴⁴
- National HIV/AIDS Policy (2005). This Policy is aimed at addressing several different aspects of the disease, including prevention and treatment, as well as establishing a comprehensive governmental approach to both HIV/AIDS and its larger effect on society.
- Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica (2009). This Framework envisions increasing efforts to prevent, test, and treat the disease among incarcerated populations and their partners.
- National HIV/AIDS Workplace Policy (2011). This Policy, if enacted by currently pending legislation, would impose anti-discrimination obligations on employers.
- National HIV/AIDS Strategic Plan (2012-2017), which like the 2005 Policy envisions a multi-sector approach to preventing, treating, and addressing the larger societal impact of the disease.

In 2006, a comprehensive HIV legal review in Jamaica was conducted with broad recommendations (Fig. 4).⁴⁵ The current legal assessment builds upon this previous review.

Fig. 4 Recommendations from 2006 HIV Legal Review in Jamaica

Laws & Policies	Gaps	Recommended amendments	Status
1. Public Health Act	- repugnancy and duplicity, especially when there is a need for interpretation by the Courts or other tribunals - no specific HIV and AIDS Regulation - no distinction is made between categories of communicable & notifiable diseases.	- Repeal Quarantine Act, The Venereal Diseases Act and the Leprosy Act - Enact a HIV and AIDS specific Regulation - Amend the Public Health Act to address the issue of definitions to distinguish categories of communicable diseases and notifiable diseases, using vector as the basis for the distinction.	- Tabled - No action - Submission to the Cabinet in 2010.
2. Child Care and Pr Act	- lack of protection on the disclosure of medical info of children to the court, in sex offence cases.	- Amend Child Care and Protection Act to ensure the child and the sexual offender right to privacy and confidentiality	- No action
3. Employment Termination and Redundancy (Payment) Act	- lack of protection to prohibit discrimination in the workplace	- Amend to prohibit discrimination in the workplace and prevent the screening of persons for purposes of employment.	- The Occupational Safety and Health Act tabled

⁴³ http://www.unicef.org/jamaica/NPA_for_OVC_.pdf [accessed on September 18 2013].

⁴⁴ http://www.jis.gov.jm/special_sections/aids/HIVNationalPolicyBook.pdf [accessed on September 18 2013].

⁴⁵ McNeil and McFarlane. 2006. HIV-related legal Review in Jamaica.

4. National Insurance Act and the Mortgage Insurance Act	- lack of legal protection to prohibit discrimination in access to insurance and mortgage	- Amend to prohibit discrimination in life insurance.	- No action
5. Offences Against the Person Act	- criminalizes same sex sexual acts; - rape is narrowly defined	- Repeal the Buggery offence to ensure the principle of non-discrimination based on sexual orientation and the right of privacy - Redefine rape to i) exclude gender distinction; ii) include both vaginal and anal penetration as the basis for rape; iii) include the insertion of objects or other bodies parts and not just the penis as the basis for rape.	- No action
6. Constitution	- lack of expressed provisions to protect equality rights, leaving doubt as to the rights which are protected.	- Amend the Constitution to allow for certain rights to be guaranteed by expressed provisions.	- Charter of Fundamental Rights and Freedoms
7. General anti- discrimination legislation	- lack of a general anti-discrimination legislation	- Enact a general anti-discrimination legislation of general application including areas such as race, gender, ethnicity, sexual orientation, health status, disability, physical attributes and language; with clear remedies and procedures.	- No action
8. Education Act	- no express policy to ensure equality of treatment for all persons who are infected with HIV in respect of both private and public providers of education services at all levels	- Enact a National Education Policy Act to ensure equality of treatment for all persons who are infected with HIV in respect of both private and public providers of education services at all levels; and to ensure confidentiality.	- No action
9. Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act 1946	- no protection to ensure that prospective immigrants who are tested and found to be HIV positive will not be prohibited from entering and remaining in the country mainly on the basis of their health status.	- Amend to ensure that prospective immigrants who are tested and found to be HIV positive will not be prohibited from entering and remaining in the country mainly on the basis of their health status; should also include amendments relating to confidentiality of medical information, and the categories of persons entitled to information and provide sanctions for breaches.	- No action
10. Amendment to the Corrections Act	- no protection to ensure prisoners' right to access prevention information, testing, care, and treatment for HIV/AIDS.	- Amend the Corrections Act to ensure prisoners' right to access prevention information, testing, care, and treatment for HIV/AIDS.	- No action
11. National HIV/ AIDS Control Authority	- lack of a national authority to coordinate HIV and AIDS actions especially in integrating development planning.	- Put in place a National HIV and AIDS Control Authority to integrate HIV and AIDS into development planning and for better coordination and control of the National HIV/AIDS policies, and to avoid duplicity in personnel and the use of resources and to allow for a wider involvement of all the stakeholders.	- Since early 2013, the National HIV/ STI Programme has been integrated with the National Family

			Planning Board under the new Sexual and Reproductive Health Authority for Jamaica.
12. Regulations under the Public Health Act as it relates to sex workers	- no specific regulation to ensure sex workers' access to HIV and AIDS preventive measures, care and treatment	- Enact a regulation under the Public Health Act to provide access to HIV and AIDS preventive measures, care and treatment for sex workers; - Ensure HIV and AIDS education of sex workers and clients	- No action
13. Others - Pension Act - National Family Planning Act - Legal Aid Act - Standards Act (read in conjunction of the Consumer Protection Act)	- applies only to the public sector - no protection on confidentiality of medical info - not clear role in HIV and AIDS education - inadequate funding of the Council - Insufficient mechanisms in place to ensure that people living with HIV and AIDS are aware of the requirements that prescribed equipment, protective devices, medical products, testing kits must be standardized and comply with International standards.	- Amend to include the private sector and to ensure confidentiality of medical info - Clarify role in HIV and AIDS education - Increase funding to enable it to provide legal aid assistance in the civil matters. - Add specific mechanisms to ensure product protection pertaining to HIV and AIDS; and protection of confidentiality regarding medical information.	- No action - No action - No action - No action

The most significant legal development since the 2006 legal review was the passage of the Charter of Fundamental Rights and Freedoms in 2011. The Jamaican Constitution addresses discrimination generally, guaranteeing equal treatment under the law regardless of race, political opinion, place of origin, colour, creed or sex. The Constitution also grants all citizens the right to life; the right to personal liberty; security of person; freedom of movement; freedom from inhuman treatment or punishment; enjoyment of property; freedom of conscience and expression; freedom of peaceful association and assembly; respect for private and family life; freedom from discrimination on the grounds of race and the right to vote.⁴⁶

The Constitution provides for any person who feels that her rights are being violated or likely to be contravened to apply to the Supreme Court (or on appeal to the Court of Appeal) for the enforcement of rights and for redress.⁴⁷ The Jamaican Constitution does not have a provision on the right to health. Section 13(i) of the Charter of Fundamental Rights and Freedoms prohibits discrimination on the grounds of i) being male or female; ii) race, place of origin, social class, colour, religion or political opinions. It does not prohibit discrimination on the grounds of health status, HIV status, gender identity, sexual orientation, or disability.

In addition, a number of bills, amendments, and policy drafts are in the Jamaican Parliament or in discussion within

⁴⁶Chapter 3, Jamaican Constitution (1962).

⁴⁷Jamaica National Report for the Universal Periodic Review 2010.

line ministries:

- Public Health (Notifiable Diseases) Order. If enacted this will remove provisions that are prejudicial to PLHIV relating to access to education, certain public facilities and employment within the food and tourism industries, e.g. in applying for a Food Handler's Permit;
- Occupational Safety and Health Act. If passed, this law will give legislative effect to the National HIV/AIDS Workplace Policy. Among other things, it will require private and public sector entities to adopt and implement policies within the workplace to address HIV-related discrimination;
- A Manual on Life Threatening Illnesses (under the Ministry of Labor and Social Security). This will prohibit HIV discrimination, treating HIV like other chronic illnesses.
- Jamaica will present its draft migration policy to the UN High Level Dialogue on International Migration and Development in October 2013. A five-year action plan will be developed and funding has already been secured to implement the policy and action plan.

However, many legal gaps identified in the 2006 review remain. Without a comprehensive HIV and AIDS law, general anti-discrimination law, or a human rights commission, legal or policy protections against HIV-related discrimination fall under the jurisdiction of individual sectoral ministries. The 2011 Report of the Working Group on the Universal Periodic Review of Jamaica noted that several countries urged Jamaica to consider the establishment of a national human rights institution (South Africa, Panama, Mauritius, and Haiti).⁴⁸ If and when enacted, the Occupational Safety and Health Act will provide the only legally enforceable protection against HIV discrimination at the workplace.

While the Management of HIV/AIDS in Schools Policy does include a guarantee of non-discrimination based on HIV-status, the policy is not enforceable in a court of law. And, it has not yet been reviewed since its adoption in 2004. In 2009, a National HIV-Related Discrimination Reporting and Redress System was put in place, but a 2013 review shows that most people living with and affected by HIV and AIDS are unaware of the system. The system also lacks an institutional home, has limited human resources, and limited and technical capacity.⁴⁹ Thus, as of 2013, Jamaica does not have in place any legally enforceable protections against HIV-related discrimination in schools, the media, or in any other aspects of civil, political, social, economic, or cultural life.

In particular, a number of laws and policies in Jamaica contain provisions that present obstacles to effective, evidence-informed HIV prevention, treatment, care, and support. For example, private, consensual same-sex sex acts, as well as sex work, and drug use are criminalized in the following laws:

- Offences against the Person Act;
- Sexual Offences Act;
- Towns and Communities Act; and
- Dangerous Drug Act.

Under the Law Reform Age of Majority Act, a child at age 16 can consent to 'any surgical, medical or dental treatment', including diagnostic and ancillary procedures. The consent of the parent or guardian of a child aged 16 or older is not required for such treatment/procedure. What constitutes "medical treatment" is not legally defined and is a grey zone that some healthcare professionals are reluctant to enter due to fear of prosecution for "aiding and abetting" a criminal act—sex with minor—prohibited in the Sexual Offences Act.

⁴⁸ UN Human Rights Council. 2011. Report of the Working Group on the Universal Periodic Review of Jamaica (A/HRC/16/14), http://ap.ohchr.org/documents/alldocs.aspx?doc_id=18040 [accessed on September 18 2013].

⁴⁹ Gray, Vivian A. 2013. "Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica." Kingston, Jamaica: Futures Group, Health Policy Project.

There is no specific law or policy addressing stigmatization of HIV and AIDS. However, the Jamaican government has taken a number of measures to reduce stigma and discrimination related to key populations affected by HIV. On April 29, 2011 the then Prime Minister, Honourable Bruce Golding and the then leader of the Opposition, the Most Honourable Portia Simpson Miller signed a Declaration of Commitment to eliminate stigma and discrimination and gender inequality affecting the HIV response in Jamaica. The current Prime Minister, the Most Honourable Portia Simpson Miller also made an electoral promise in having a conscience vote on the “buggery” offence within the Offences against the Person Act during her current mandate. In the current economic and political climate, however, it is unclear if or when the conscience vote will be scheduled, and what the outcome would be.

Financial Resources. The cost of the national HIV response increased from J\$ 1,680 million (US\$ 19.3 million) to J\$1,727 million (US\$ 20.4 million) between 2009/2010 and 2010/2011. The largest component of HIV and AIDS spending is on prevention, at 36.2% (J\$ 625 million in 2010/11). A large share of prevention spending was geared towards “communication for social and behavioral change” targeting the general or young population. The program also included measures targeting sex workers and their clients, men who have sex with men, and drug users. A total of approximately J\$ 10 million (US\$ 120,000) was spent on these issues in 2010/11. Treatment and care absorbed 27.7% of the total budget (at J\$ 469 million or US\$ 5.5 million in 2010/11), the majority of which is accounted for by the cost of antiretroviral therapy (19% of total spending in 2010/11). Project management occupied 19.6% of spending, whereas impact mitigation represented 17.1% of the total budget.⁵⁰

The 2012 financial sustainability study of Jamaica’s HIV Program shows that preventing one HIV infection at a cost of less than J\$ 501,000 (US\$ 5,800) remains a good financial investment and reduces the financial costs of the national response to HIV/AIDS. However, current international funding programs with the Global Fund and PEPFAR will end within the next few years. Classified as an Upper-Middle Income country, Jamaica can only access the limited Targeted Funding Pool under the new funding model of the Global Fund, which requires Jamaica to increase its domestic share of funding from the current 29% to 60% as counterpart financing.

In the 2010 Universal Periodic Review of Jamaica, the UN Human Rights Committee noted this concern and Jamaica’s “calling for recognition of a special category of countries known as highly indebted middle-income countries.”⁵¹ The sustainability study clearly indicates that the costs incurred by new infections from MSM and sex workers are very high and effective prevention in the short-term will result in lower spending on treatment in the long-term. New and innovative funding sources will have to be identified to scale up prevention, and, in particular, target these most at-risk populations.⁵²

Health Systems Strengthening. Although the government has introduced different measures to increase access to healthcare in Jamaica (e.g. the abolition of user fees), the health system suffers from numerous challenges that bear a direct impact on the effectiveness of the national HIV response. The IMF Agreement enforcing public sector wage freeze and spending caps largely constrains the capacity of the national health system. Insufficient policy frameworks and inadequate planning, monitoring and evaluation, and enforcement of health legislation are structural weaknesses.

The public sector has a low absorptive capacity for health development programs due to underfunding, staff shortages, and a lack of skilled personnel, especially in monitoring and evaluation. Significant out-migration of health care personnel continues to represent a major health system bottleneck in terms of delivery of treatment, care, and support. A weak and fragmented health information system with no national health information policy, unreliable data and limited reporting by the private sector has an impact on many issues including privacy and confidentiality of medical information.⁵³

⁵⁰ Mziray, Elizabeth; Haacker, Markus; Shiyao Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank. <http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program> [accessed on September 5 2013].

⁵¹ UN Human Rights Council. 2011. Report of the Working Group on the Universal Periodic Review (A/HRC/16/14), http://ap.ohchr.org/documents/alldocs.aspx?doc_id=18040

⁵² Ibid.

⁵³ WHO. 2010. *Jamaica Country Cooperation Strategy*.

Multisectoral Cooperation Involving Civil Society and Private Sector

The national HIV response of Jamaica is guided mainly through:

- **A Single, Unified Action Framework:** the National HIV/AIDS Policy (2005) and the National HIV/AIDS Strategic Plan (2012-2017);
- **One Coordinating Authority:** the National HIV/STI Programme integrated with the National Family Planning Board to become the Sexual and Reproductive Health Authority of Jamaica since 2013; and
- **A Monitoring and Evaluation System:** the M&E Plan and unit within the Ministry of Health.

Both the National HIV/AIDS Policy and the National HIV/AIDS Strategic Plan (2012-2017) specifically highlight multisectoral involvement and the greater involvement of people living with HIV and AIDS (GIPA) as two of the guiding principles:

- **Multisectoral Approach and Partnerships:** The active involvement of all sectors of society is necessary to ensure an effective response, including effective partnerships, consultations, and coordination with all stakeholders in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS.
- **Participation:** The meaningful involvement of people living with and affected by HIV and AIDS and most vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV and AIDS is vital to optimize stated outcomes.

Further, the National HIV/AIDS Strategic Plan (2012-2017) emphasizes capacity building and communications for multistakeholder involvement as two of its ten priorities:

- **Continued capacity building** for stakeholders on monitoring and evaluation through widespread training and use of technical assistance.
- **Strengthen partnerships and communication** mechanisms with key stakeholders in the national response.

While the national response has been led by the Ministry of Health and its four regional health authorities since the establishment of the NHP in 1986, it has expanded since 2002 to include the Ministry of Labor and Social Security; the Ministry of Industry and Tourism; the Ministry of Education, Youth, and Culture; the Ministry of Local Government Community Development and Sport; and the Ministry of National Security.

The Jamaica Business Council on HIV/AIDS was created in 2006 to mobilize private sector response and resources. With the assistance of the NHP and USAID, the National Foundation on HIV was launched in July 2011 with the objective of mobilizing funds to sustain Jamaica's national HIV response and to finance HIV/STI related initiatives including for the economic empowerment of PLHIV.

The engagement and support for the involvement of PLHIV and key populations in the national AIDS response fall under Enabling Environment and Human Rights, one of the six focus area within the National HIV/AIDS Strategic Plan. An enabling environment is one in which:

All Jamaicans including persons living with HIV, can be facilitated by policies, programmes and supportive legislation to reduce their risk of infection or re-infection and to access needed treatment and care. Barriers that limit the creation of and support for these efforts include stigma and discrimination, failure to protect privacy and confidentiality across service sectors and

workplaces, widespread gender role and sexuality stereotypes, inadequate and inappropriate education, persistent poverty and some religious beliefs.⁵⁴

The mandate of the Enabling Environment and Human Rights focus area involves the engagement of people living with and affected by HIV/AIDS, policy makers, and faith-based organizations in particular, to review relevant legislation and policies and to advocate for legislative change in order to reduce stigma and discrimination against people living with and affected by HIV and AIDS and key affected populations. The current HIV-related legal assessment falls under this mandate with the objective of advancing and realizing the rights of people living with and affected by HIV and AIDS in Jamaica.

⁵⁴ National HIV/STI Strategic Plan of Jamaica, 2012-2017.

Jamaica HIV and AIDS Legal Assessment 2013 Analysis

I. Access to Essential Services

Factor 1: Public Education, Research, and Information Exchange

Every person enjoys an equal right to seek, receive, and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV/AIDS. The State implements and supports HIV-related awareness-raising, stigma-reduction, training, and information exchange programs, and ensures that HIV research adheres to the highest ethical standards.

Conclusion

Access to HIV information, awareness-raising, stigma-reduction, training, and research is a clearly stated component of relevant policies. However, the absence of legally enforceable protections to ensure access by key populations means that access to HIV information, education, and training is often sporadic, at the discretion of individual providers or institutional practice. Underfunding, social norms, religious influence, criminalization, lack of monitoring and evaluation of policy implementation, and the non-binding nature of existing policies also impede an effective delivery of HIV information and education to both key populations and the general population. All these obstacles make it difficult for Jamaica to achieve effective results from its investment in HIV information and education.

International Laws / Recommendations / Guidelines

- ICCPR, Art 19: Right to Information.
- International Guidelines on HIV/AIDS and Human Rights, Guideline 6: Access to Prevention, Treatment, Care, and Support.
- 2001 UNGASS Declaration of Commitment on HIV/AIDS, para. 52 and 2006 Political Declaration on HIV/AIDS, para. 22: to ensure that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour.
- 2009 Partnership with faith-based organizations: UNAIDS strategic framework. The objectives include: to encourage global and national religious leaders to take supportive public action in the AIDS response; create strong partnerships between UNAIDS and established FBOs working on HIV; promote strengthened links, including

coordination and oversight, with FBOs at the country level in order to ensure that there is an appropriate interface as part of a comprehensive national AIDS response; strengthen the capacity of FBOs to work on HIV issues and the capacity of UNAIDS staff to work with FBOs; target FBOs not yet working on HIV to include HIV-related activities in their work; mobilize local faith communities to become involved in the local AIDS response; and identify and document examples of FBO good practice.⁵⁵

• **2012 UNESCO Strategy on HIV/AIDS:** comprehensive strategy on HIV and sexuality education; gender equality and human rights.

National Laws, Policies and Actions

In Jamaica, a number of policy documents contain provisions on access to HIV information, awareness-raising, stigma-reduction, training, and research.

1. The 2005 National HIV/AIDS Policy

Objective 3.2.5 strives to affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS through an environment that 1) reduces HIV/AIDS related stigma and discrimination and 2) improves access to condoms, prevention information, prevention skills, ARV and other treatment for opportunistic infections, infant formula, VCT and family and community support.

2. The 2012-2017 National HIV/AIDS Strategic Plan

“Prevention” is one of the Plan’s six priority areas, and the area contains strategies to increase the use of social media to engage key populations, increase access to condoms and lubricant, increase partnerships with social agencies to decrease social vulnerability (including stigma and discrimination, and gender-based violence), scale up outreach HIV and syphilis testing, and scale up civil society response. These strategies will be guided by operational research including evaluation of prevention interventions.

3. The 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS

This Plan contains two relevant Objectives:

Objective II. Disseminate information on, and facilitate access to, existing social services.

Many citizens are not aware of existing programmes that offer support to the public. Further, many of our citizens do not know what their entitlements are, or how to access these programmes and services. Many services are also not user-friendly for Orphans and Vulnerable Children (OVC) and their caregivers. The Plan calls for action to increase public awareness of services and service user skills.

Objective IV: Reduce stigma and discrimination against PLWHA and those associated with them.

The Plan proposes a broad and comprehensive public sensitization campaign, along with focused community interventions aimed at dispelling myths and reducing stigma and discrimination. The Plan also calls for the active involvement of PLWHA in these interventions at all levels. A broad range of interventions is envisaged as central to the effectiveness of this component.⁵⁶

4. The 2004 Management of HIV/AIDS in Schools Policy

This Policy contains a Statement on Education and HIV/AIDS:

- A continuing Health and Family Life (HFLE) and HIV/AIDS education programme must be implemented at all schools and institutions for all students and school personnel. Age-appropriate education on HIV/AIDS must form part of the curriculum for all students, and should be integrated in the HFLE programme for pre-primary, primary and secondary school students. A holistic programme for Health and Family Life Education and HIV/AIDS education should encourage disclosure. This should include the following:

⁵⁵ http://data.unaids.org/Pub/report/2010/jc1786_fbo_en.pdf [accessed on October 15 2013].

⁵⁶ 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS, http://www.unicef.org/jamaica/NPA_for_OVC_.pdf [accessed on September 18 2013].

- i. Providing information on HIV/AIDS and developing the life skills necessary for the prevention of HIV transmission;
- ii. Emphasizing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases, avoiding traumatic contact with blood, and the application of universal precautions with respect to first aid;
- iii. Providing information on the role of drugs, sexual abuse and violence, and sexually transmitted infections (STIs) in the transmission of HIV, and empowering students to deal with these issues;
- iv. Encouraging students to make use of health care, counseling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted infections) offered by community service organizations and other disciplines; ensure the provision of systematic and consistent information and educational material on HIV/AIDS to students and school personnel throughout the system;
- v. Teaching students how to behave towards persons with HIV/AIDS, raising awareness of prejudice and stereotypes relating to HIV/AIDS;
- vi. Cultivating an enabling environment and a culture of non-discrimination towards persons with HIV/AIDS; and
- vii. Inculcating from an early age, basic first aid principles including how to deal with bleeding with the necessary safety precautions.

- Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable. Participatory methods of learning including games, role play and drama are more effective. Children should be encouraged to ask questions and to expect reasonable, comprehensible and appropriate answers.⁵⁷

5. The 2012 National HIV/AIDS Workplace Policy

This Policy contains two relevant Objectives:

Objective 2: To contribute to the reduction of HIV transmission through effective workplace policies and programmes through the i) sensitization and dissemination of the National Workplace Policy on HIV/AIDS; and ii) development and execution of work plans for the dissemination and training in the use of culturally appropriate, gender-specific HIV/AIDS information;

Objective 3: To contribute to the reduction of HIV-related stigma and discrimination through the involvement of persons living with HIV/AIDS in education and training programmes from design to implementation.

6. The 2009 Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica

This Framework would call for increased HIV preventative and treatment measures for incarcerated persons.

Strategic Objective 1: Improved delivery of a VCT and behaviour change communication based prevention interventions targeting inmates.

- 1. Scale up HIV testing for inmates at all major intake institutions and Juvenile centres;
- 2. Establish cadre of trained Peer Educators to facilitate Stigma and Discrimination sessions among all inmates at intake as well as follow-up;

Strategic Objective 2: Increased advocacy for legislative, policy and systems changes to support access to essential, treatment, care and support and HIV prevention for juvenile and adult inmates.

⁵⁷ The 2004 Management of HIV/AIDS in Schools Policy, http://www.jis.gov.jm/special_sections/aids/HIVNationalPolicyBook.pdf [accessed on September 18 2013].

Strategic Objective 3: Increased interactions with Sex Partner/Visitor to the centers to supports access to HIV prevention information and link into treatments where needed.

HIV-related information and training is provided by the NHP mainly through various outreach programs targeted to each key population including MSM, drug users, sex workers, prisoners, and youth. Media campaigns have been organized including the “Pinch, Leave an inch, and Roll” targeting condom-use sensitization among youth; “Putting a face to HIV” through the introduction of two people living with HIV/AIDS; women initiating condom use; HIV testing; communication with children about sexual issues; and reduction of multiple partnerships. Often, these programs are delivered by community-based organizations (CBOs) such as AIDS Support for Life, the Jamaica Forum for Lesbians, All-Sexuals and Gays (J-Flag), Sex Workers Association of Jamaica, Jamaica Youth Network, and Caribbean Vulnerable Communities. The Ministry of Labor and Social Security provides access to HIV-related information and training at the workplace through the Voluntary Compliance Program of the National HIV/AIDS Workplace Policy. HIV information and sexuality education in schools are mainly provided through the Health and Family Life Education curriculum.

Gaps

Stakeholders interviewed for this project mentioned a number of hurdles in ensuring equal and sustained access to HIV information and training in Jamaica including underfunding, social norms, religious influence, punitive laws, lack of monitoring and evaluation of policy implementation, the voluntary nature of existing policies, and the lack of mandatory continuous education of healthcare and other professionals. According to the 2012-2017 National HIV/AIDS Strategic Plan, “despite the scale up of interventions to reach key populations, it is estimated that only 30% of these populations are being reached.” **Underfunding** is compounded by persistent **social norms** surrounding homosexuality, sex work, drug use, prisoners, and sexual behavior of minors. While the existing program may reach a certain segment of MSM (with lower social-economic status), professional MSMs with higher socio-economic status who are in a heterosexual marriage relationship may be in denial of their risks and do not seek HIV information and education. Similarly, while tremendous progress has been made in sex worker outreach, clients of sex workers, partners of clients of sex workers, as well as sex workers who work in massage parlours or through the Internet or telephone are not being reached. Homeless MSM, youth, and drug users are also hard-to-reach populations.

Religious influences represent a major *de facto* barrier to consistent HIV information, education, and training for the general populations. In 2013, the Ministry of Education removed a few pages pertaining to sex and sexuality education within the Health and Family Life Education (HFLE) curriculum, after they were deemed controversial. Many interviewees pointed to the influence of some faith-based groups in the outcome. The incident shows not only the socio-political, cultural, and religious sensitivity surrounding sex and sexuality education, but also potential conflict between different stakeholders in ensuring access to HIV information that is age and culture appropriate, and based on scientific evidence and human rights.

Under the new governance structure, the Sexual and Reproductive Health Authority of Jamaica has statutory authority over the provision of information, education, and training on sexual and reproductive health while the Ministry of Education retains its traditional jurisdiction over sex, sexuality education, and HIV education in the formal education sector. The relationship between the Sexual and Reproductive Health Authority of Jamaica and all line Ministries and other entities in the multi-sectoral response needs to be clarified.

Punitive laws and the absence of key-population specific legal/policy protections to ensure access by key populations mean that access to HIV information, education, and training is sporadic, at the discretion individual providers or institutional practice. There are a number of laws and policies regulating minors’ access to sexual and reproductive health information and services (see Factor 15). The Law Reform (Age of Majority) Act sets the age of consent for a child at sixteen in Jamaica, when she can consent to ‘any surgical, medical or dental treatment’, including diagnostic and ancillary procedures, without the consent of the parent or guardian. Sexual acts with a person under that age of consent are deemed to be statutory rape prohibited in the Offences Against the Person Act and Sexual Offences Act. Yet, it is commonly believed that minors under the age of consent are having sex and need to be protected through age-appropriate information and education.

The 2012 HIV/AIDS Knowledge Attitudes and Behavior Survey shows that 49% males and 12.5% of females reported initiating sex before 15. Minors under sixteen may not access HIV information, education, and services without the fear of prosecution. Healthcare workers may also be reluctant to provide sexual and reproductive health information and services to minors below 16 for fear of being prosecuted for aiding and abetting a criminal act. There is also no legal or formal policy provision for the access of HIV information of prisoners. Further, criminalization of same-sex sexual acts and drug use make awareness campaigns difficult as these could be seen by some segments within the Jamaican society as “aiding and/or abetting” criminal acts.

The lack of monitoring and evaluation, and the non-binding nature of existing policies mean that we do not know whether and how the principles and initiatives outlined in various policies are implemented. The review of the 2004 Management of HIV/AIDS in Schools Policy remains incomplete. Its voluntary nature also means that there is no legal sanction in case of breaches. Similarly, the 2012 National HIV/AIDS Workplace Policy works primarily through a Voluntary Compliance Program. As of 2013, roughly 5% (116) of institutions have signed the commitment. The shortage of staff within the Ministry of Labor and Social Security makes it difficult to scale up the program.

Stigma and discrimination remain persistent especially in the food industry and people living with HIV have been dismissed from their employment because they are perceived to be infectious. The Ministry of Labor and Social Security is currently developing a voluntary certification program through which food establishments will make a public proclamation on their recognition of HIV/AIDS at their workplace. The National HIV/AIDS Workplace Policy does not have a redress mechanism. The Occupational Safety and Health Act, when enacted, would allow individuals to bring forth their complaints in front of the Industrial Disputes Tribunal.

The absence of a specific HIV-related anti-stigma policy with enforceable sanctions make anti-stigmatization one of the greatest challenges in the national HIV response in Jamaica.⁵⁸ A number of sensitization campaigns have been implemented, but they have not been sustained.

There are **no programs for transgender persons and migrants** to access HIV information, education, and training. There is neither HIV surveillance data nor research about these populations in Jamaica.

Finally, there is **no sustained HIV and human rights training** for medical professionals and others including judges, correctional officers, police, social workers, teachers, and journalists.

Recommendations

1.1 Enact key-population specific policies to ensure equal and sustained access to HIV information, education, and training.

1.2 Make a policy exemption to ensure that minors under the age of consent can access SRH information and that healthcare professionals can provide age-appropriate information without fear of prosecution.

1.3 Fund to scale up HIV and anti-discrimination public education.

1.4 In a memorandum of understanding, clarify the relationship between the Sexual and Reproductive Health Authority of Jamaica and the Ministry of Education in the provision of sexual and reproductive health and HIV information.

1.5 Fund capacity building for the engagement of civil society groups in policy-making.

⁵⁸ In August 2011, an advertisement sponsored by the Jamaica Forum for Lesbians, All-Sexuals and Gays on “Unconditional Love” which encourage Jamaicans to love their family members regardless of sexual orientation was refused by two national television stations - Television Jamaica and CVM Television - and the government-owned Public Broadcasting Corporation of Jamaica after some public protest against the ad. A case related to this is currently before the Jamaican Supreme Court.

1.6 Engage FBOs in providing access to HIV information.

1.7 Enact an anti-stigma policy in the context of HIV/AIDS or incorporate a provision on anti-stigmatization in the general anti-discrimination law. Such a law should be accompanied by a robust implementation and enforcement structure.

1.8 Sustain HIV and anti-discrimination training among healthcare workers and other professionals.

1.9 Obtain disaggregated data and research on invisible populations including migrants, transgender persons, MSMs with higher socio-economic status, and sex workers who work in massage parlors or through telephone or the Internet.

1.10 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use.

Factor 2: HIV Prevention

Every person has equitable and sustainable access to a wide range of effective, human rights-based, and evidence-informed measures aimed at preventing HIV transmission.

Conclusion

Prevention occupies the largest component of Jamaica's national HIV and AIDS budget, at 36.2%. It is also one of the six priority programme areas within the National HIV/AIDS Strategic Plan. But despite significant gains, especially in PMTCT and among sex workers, numerous challenges remain, especially among key populations. These include funding gaps; the absence of key-population specific protections on access to prevention services; the criminalization of same-sex sexual acts, sex work, and drug use; little sustained engagement of PLHIV and CBOs in the policy-making process and program design; and a lack of psychosocial support. Structural barriers to prevention also exist, such as poverty, stigma, and discrimination. Within the health care system, barriers include inadequate implementation of provider initiated HIV testing at important points of access; lack of cooperation by regional health authority; absence of sexual and reproductive health policy to ensure minors' access to HIV prevention services; and the lack of legal or policy provisions on harm reduction strategies for drug users and prisoners.

International Laws / Recommendations / Guidelines

- **ICESCR**, General Comment 14 on Art 6, stating that states are obliged to take measures to control epidemics, including establishing prevention and education programs to address HIV.
- **ICCPR**, UN Human Rights Committee, General Comment No. 6: The Right to Life (April 30, 1982), stating the states are obliged to take measures aimed at reducing the spread of epidemics.
- **International Guidelines on HIV/AIDS and Human Rights**, Guideline 6: Access to Prevention, Treatment, Care, and Support.
- **Millennium Declaration**: Ensuring children's access to school is an important aspect of HIV prevention.
- **MDG 6**: Have halted by 2015 and begun to reverse the spread of HIV/AIDS and achieve, by 2010, universal access to treatment for HIV/AIDS including prevention services for all those who need it.
- **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 47-54: Prevention must be the mainstay of our

response with national time-bound targets

- **2001 ILO Code of Practice on HIV/AIDS & the World of Work, Principle 9:** Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment. The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.
- **2003 CRC General Comment 3 on HIV and the Rights of the Child:** Provision on prevention, education, child-sensitive services, HIV testing and counseling, and PMTCT; right-based approaches including non-discrimination and participation.
- **2006 Political Declaration on HIV/AIDS**, para. 22: to ensure that a wide range of prevention programmes; and para 24: states committing to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services.
- **2011 Political Declaration on HIV/AIDS**, paras. 58-64.
- **2012 UNESCO Strategy on HIV/AIDS:** prevention approaches be based on human rights, gender-transformative programming, evidence, cultural appropriateness, and participation of young people.

National Laws, Policies and Actions

Prevention is one of the six priority programme areas within the **National HIV/AIDS Strategic Plan**. It occupies the **largest component of HIV and AIDS spending** at 36.2%, or J\$ 625 million out of a total budget of J\$1,727 million (roughly US\$ 20.4 million).⁵⁹ The objective is to understand and tackle underlying factors that determine risky behaviour in key populations through a **combination prevention approach** including behavior change communication (BCC), outreach, testing, counseling, research, training, treatment as well as measures to promote social justice and human rights. The key populations include MSM, persons with multiple sexual partners persons with a history of STIs, sex workers, adolescent boys and girls, youth, inmates, and homeless drug users. An effective prevention strategy is dependent on robust public education, research, and information exchange (see Factor 1).

The **BCC strategy** provides a framework for prevention interventions based on 9 principles:

- 1. Focus on the most vulnerable populations:** These are persons who are at an increased risk of HIV due to their social circumstances, their unsafe sexual behaviours, and who have the ability to affect the dynamics of the epidemic. These persons include MSM, SW, In-school youths, Out-of-school youths, Inmates, Homeless drug users, and individuals residing in low income high-prevalence communities as well as STI clinic attendees. Within all these populations there are sub-groups that can be regarded as being at highest risk owing to their low income and limited access to social services. These socially marginalized persons are likely to engage in risky sexual behaviours in order to survive.
- 2. Positive health, dignity and prevention:** As the life expectancy of PLHIV increases with the availability of ART there is a need to ensure that the quality of life for these individuals is optimized while avoiding HIV transmission to their sexual partners.
- 3. Addressing social vulnerability:** Structured, sustainable policies, strategies and programmes are needed to reduce social vulnerability.

⁵⁹ Mziray, Elizabeth; Haacker, Markus; Shiyan Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank. <http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program> [accessed on September 5 2013].

4. Gender: Gender inequality and socially ascribed gender roles and behaviours contribute to increased vulnerability and risk to HIV for both females and males in Jamaica. Gender inequality and stereotypes affect the ability of males and females to access HIV, health and social services.

5. Evidence based: Prevention programs must be designed and implemented on the basis of evidence and best practice. The findings and lessons of the PLACE surveys and other research conducted in Jamaica informed the scaling up of interventions.

6. Key sectors partnerships: Partnerships that have been forged with the Ministries of Education, National Security, Labour and Tourism and other governmental agencies as well as a wide range of organizations and stakeholders including various private sector and NGOs must be maintained and strengthened.

7. Civil Society involvement: A wide range of civil society organizations and stakeholders have been involved in the prevention response despite challenges of limited technical capacity and resources and sustainability of programmes. Some NGOs have provided access to persons most at risk who are hard to reach. Involvement of civil society must continue to expand and be strengthened.

8. BCC skills building: The prevention strategies have evolved from provision of information on HIV to an increased emphasis on engaging the most at risk populations in risk reduction conversations. This shift reinforces the need for building BCC skills of HIV prevention practitioners within the national programme, civil society and its other partners. This involves the standardization of approaches and improved monitoring for quality of interventions as well as initiatives to develop a minimum package of services for key populations.

9. Reaching general population: All Jamaicans must know how to reduce their risk of HIV infection. This has been approached through the use of mass media, educational materials, special events and cultural activities. These interventions will continue in order to shift, reinforce or create new social and cultural norms that reduce HIV vulnerability and risk.⁶⁰

Some of the interventions during the previous strategic plan period of 2007-2012 included delivery of prevention interventions including testing and peer educator training for MSM and sex workers; risk reduction education, HIV outreach testing, condom skills and access, income generating activities and skills, and education grants for adolescents and youths by Regional Health Authorities, Child Development Agency and NGOs including Hope Worldwide, Children First and Jamaica Red Cross in out of school settings; increased condom outlets for the most at risk populations in community shops, bars, clubs, and itinerant vendors; the implementation of the HFLE curriculum in 87% of schools and the development of a baseline survey; introduction of HIV rapid tests and the acquisition of two mobile testing buses; as well as six new media campaigns targeting youth condom-use sensitization, introducing PLHIV, women initiating condom use, HIV testing, communicating with children about sexual issues, and reduction of multiple partnerships. Other sectoral responses included institutionalized routine HIV screening and risk reduction activities for migrant labourers by the Ministry of Labour and Social Security and outreach HIV testing for most at risk workers who are most likely to be involved in sex tourism by the Ministry of Tourism.⁶¹

The focus of the 2012-2017 Strategic Plan is on increased use of **social media** to engage key populations; increased access to condoms and lubricant; partnerships with social agencies to decrease social vulnerability (including stigma and discrimination, and gender-based violence); scaling up of outreach HIV and syphilis testing; and scaling up of civil society response. These strategies will be guided by operational research including evaluation of these and other prevention interventions.

PMTCT is ensured through HIV screening for pregnant women who present for care (over 95% of public sector antenatal clinics) and the provision of ARVs for all HIV infected pregnant women and HIV exposed infants.

⁶⁰ Ibid.

⁶¹ Ibid.

Among people living with HIV, a **Positive Health, Dignity and Prevention Policy** was drafted in 2012 that include three core elements:

- Sexual and reproductive health including practicing safer sex, avoiding other STIs, reducing the chance of unwanted pregnancies or planning for safe conception and healthy pregnancy;
- Delay of HIV progression by increasing access to effective HIV management (ART is potentially the best prevention strategy currently available), as well as support to explore healthy nutrition, adequate exercise, and reducing harmful behaviours; and
- Promoting shared responsibility to reduce the risk of HIV transmission: to increase the esteem and confidence of PLHIV to protect their own sexual health and avoid passing on the infection.⁶²

Further, the **Guidelines for the Clinical Management of HIV/AIDS** spell out strategies for the prevention of occupational exposure to HIV that includes risk assessment and risk reduction activities such as using universal precautions; wearing heavy-duty gloves when disposing of “sharps;” assessing protective and other equipment for risk and safety; adopting safe techniques and procedures, such as disposing of needles without recapping, or recapping using the single-handed method; using sterile nasal catheters and other resuscitation equipment; using a separate delivery pack for each delivery; not using episiotomy scissors to cut the umbilical cord; making appropriate disinfectants and cleaning materials available; and sterilizing equipment properly. A training manual on post-exposure prophylaxis is in use and antiretroviral drugs are available and accessible in all regions for the prevention of HIV transmission to accidentally exposed health care workers.

Gaps

Funding gap remains one of the major bottlenecks in scaling up prevention efforts. It is estimated that only 30% of the key populations are currently being reached.

The absence of key-population specific legal protections to ensure their access to comprehensive HIV prevention services makes it difficult to legally enforce the provision of appropriate targeted interventions.

Criminalization of private, consensual same-sex sexual acts, sex work, and drug use continues to create significant prevention access barriers due to fear of prosecution and self-stigma.

PLHIV and civil society groups feel that the current **prevention strategy is driven by the Ministry of Health with a biomedical model** with little sustained engagement of PLHIV and CBOs in policy-making process and program designs. Despite groups such as the Civil Society Forum of Jamaica, **civil society engagement** to scale up prevention efforts continues to be hampered by limited technical, financial, and human capacity. Further, the **lack of psychosocial support as well as structural barriers** including poverty, low literacy, and poor health seeking behaviour of men translate into small uptake of testing and other prevention services.

Current prevention strategies fail to reach the **most-at-risk segments within key populations** including homeless MSM and drug users, middle-income MSM who do not perceive HIV risks, unattached youth, and adolescents.

HIV prevention through early STI treatment remains insufficiently developed.

Stigma and discrimination within the health care system, inadequate implementation of provider initiated HIV testing at important points of access, and the lack of cooperation by regional health authority in implementing certain prevention services mean sub-optimal reach of key populations.

Certain discussions on **sex and sexuality education** have been pulled out of the HFLE curriculum. The Ministry of Education lacks capacity to adequately enforce mandatory implementation of the programme at the school level. There is **no sexual and reproductive health policy** to ensure targeted, age-appropriate interventions for minors and

⁶² 2013 Guidelines for the Clinical Management of HIV/AIDS.

youth. Teenage pregnancy is a serious social issue and teen mothers are particularly vulnerable to HIV infections. The rights for teenage mothers to continue education are not guaranteed in any policy provisions.⁶³

There is **no law or policy ensuring and supporting the provision of comprehensive harm reduction strategies for drug users and prisoners** including “policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.”⁶⁴

While **treatment as prevention** is now widely recognized as a cost-effective way to fight the epidemic, the WHO cautions that “in the absence of sufficient resources, fair procedures are needed to adjudicate between the range of available HIV interventions. Principles of ethics, equity and human rights are important components of the rationale and framework for interventions, and can be used to aid the decision-making process when deciding upon the allocation of scarce resources.”⁶⁵ Interviewees mentioned a number of concerns in adopting and scaling up treatment as prevention in Jamaica: low testing and treatment uptake and ARV adherence; lack of domestic and international funding, in particular when current funding sources expire; and significant legal and political obstacles to accessing treatment.

Recommendations

2.1 Scale up prevention through additional funding as well as assess spending choices across prevention activities. Preventing one HIV infection at a cost of less than J\$ 501,000 (US\$ 5,800) remains a good financial investment and reduces the financial costs of the national response to HIV/AIDS. The financial sustainability study of Jamaica’s HIV Program clearly indicates that the costs incurred by new infections from MSM and sex workers are very high and that effective prevention in the short-term will result in lower spending on treatment in the long-term. Efforts need to focus on reaching these most at-risk populations.⁶⁶

2.2 Enact key-population specific legal/policy protections to ensure their access to comprehensive HIV prevention services.

2.3 Roll out treatment as prevention in accordance with the principle of progressive realization, taking into consideration funding availability and other human rights concerns.

2.4 Enact a sexual and reproductive health policy and make a policy exemption to ensure access to prevention services by minors and the provision of such services by healthcare professionals. Teenage mothers should be ensured to continue education through specific policy provisions (currently in progress).

2.5 Ensure harm reduction is an integral part of the national HIV response and enact policies to provide comprehensive targeted harm reduction strategies for drug users and prisoners.

2.6 Create and expand key-population-friendly sites and facilities to provide testing and other prevention services.

2.7 Move away from a biomedical to a community-based care model that integrates psychosocial support and other services addressing structural barriers such as poverty, low literacy, and poor health seeking behaviour.

⁶³ There is a ministerial statement on teenage mothers and their access to education.

⁶⁴ <http://www.ihra.net/what-is-harm-reduction> [accessed on September 6, 2013].

⁶⁵ WHO. 2013. Strategic Use of Antiretrovirals for Treatment and Prevention of HIV Infection: 2nd Expert Panel Meeting.

⁶⁶ Mziray, Elizabeth; Haacker, Markus; Shiyan Chao. 2012. *Assessing the Financial Sustainability of Jamaica's HIV Program*. Washington DC : World Bank. <http://documents.worldbank.org/curated/en/2012/12/17120450/assessing-financial-sustainability-jamaicas-hiv-program> [accessed on September 6 2013].

- 2.8 Activate review of existing policies such as the Management of HIV/AIDS in schools including the HFLE curriculum.
- 2.9 Focus on early STI treatment as part of prevention.
- 2.10 Address stigma and discrimination within the health care system through continuous training.
- 2.11 Fund capacity building for the engagement of civil society groups in policy-making and program delivery.
- 2.12 Engage FBOs in prevention policy development and scaling up prevention services.
- 2.13 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use.⁶⁷

Factor 3: Testing, Counseling, and Referral

Every person has unrestricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counseling and referral to essential services. Arbitrary, mandatory, or compulsory HIV testing is prohibited.

Conclusion

The right to privacy, confidentiality, informed consent, and voluntary testing and disclosure in an environment free of stigma and discrimination is stipulated in both the National HIV/AIDS Policy and the Positive Health, Dignity and Prevention Strategy. Voluntary counseling, testing, and referral services are offered in 23 HIV treatment sites as well as peripheral clinics. Additionally, some CBOs offer VCT services on site and through their outreach programs. However, nearly half of all people living with HIV are unaware of their status. There is a lack of capacity in implementing routine testing throughout the health system. Criminalization of same-sex sexual acts, sex work, and drug use further impedes effective access to testing and counseling. Some concerns have been raised by interviewees about the lack of informed consent in mandatory or routine HIV testing among certain populations. Counseling services remain grossly inadequate due to a lack of resources to recruit, train, and retain counselors. In particular, HIV counseling and testing services should be expanded for individuals who likely do not self-identify as being at risk of HIV infection. There is no law protecting data confidentiality. The lack of a centralized electronic medical system, low sensitization of healthcare workers around issues of privacy and confidentiality, and the lack of redress for breaches of confidentiality further discourage testing uptake.

⁶⁷ Pending considerations of decriminalization, immunity should be given to those providing and receiving prevention services, as proposed in the Indian HIV/AIDS bill,

<http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf>

Chapter VII, para 21. Illustrations. A, supplies condoms to B, a sex worker or to C, a client of B. Neither A, nor B, nor C can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the strategy. (b) M, an intervention project on HIV/AIDS and sexual health information, education and counselling for men who have sex with men provides safer sex information, material and condoms to N, a man who has sex with other men. Neither M nor N can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention. (c) X, an intervention providing registered needle exchange programme services to injecting drug users, supplies a clean needle to Y, an injecting drug user who exchanges the same for a used needle. Neither X nor Y can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention. (d) R, an intervention programme for children living on the streets and K, a counselor in a school, provide sexual health and safer sex information, education and counselling, material and small-sized condoms to S, a child living on the street and L, a student in school, respectively. Neither R, S, K nor L can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

International Laws / Recommendations / Guidelines

- **ICCPR**, Art. 7: No one shall be subjected without his free consent to medical or scientific experimentation; Art 9: Right to liberty and security of person.
- **ICESCR**, Art. 12: Right to Health.
- **International Guidelines on HIV/AIDS And Human Rights**, Guideline 5: Privacy and Confidentiality
- **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 52: Expanded access to voluntary and confidential counseling and testing
- **2001 ILO Code of Practice on HIV/AIDS & the World of Work**, 5.2 *Employers and their Organizations*:
(1) Support for confidential voluntary HIV counseling and testing. Employers, workers and their representatives should encourage support for, and access to, confidential voluntary counseling and testing that is provided by qualified health services; *8.1 Prohibition in recruitment and employment*: HIV/AIDS screening should not be required of job applicants or persons in employment. There is no justification for asking job applicants or workers to disclose HIV-related personal information. *8.2 Prohibition for insurance purposes*: HIV testing should not be used as a condition of eligibility for insurance purposes; epidemiological surveillance in accordance with the ethical principles of scientific research; voluntary testing; and tests and treatment after occupational exposure.
- **2004 UNAIDS & WHO, Policy Statement on HIV Testing**
- **2006 Political Declaration on HIV/AIDS**, para. 25: to ensure access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.
- **2011 Political Declaration on HIV/AIDS**, paras 65-76.

National Laws, Policies and Actions

The **National HIV/AIDS Policy** lays out clear objectives pertaining to unrestricted access to voluntary, confidential or anonymous HIV testing:

3.2.2. To strengthen mechanisms for the treatment, care and support of persons living with and affected by HIV/AIDS through a policy and legal framework and enabling environment that:

- assists in normalizing HIV/AIDS allowing uninhibited access to VCT, treatment, care and support; and
- provides appropriate guidelines for health workers to administer treatment, care and support without any form of stigma and discrimination.

3.2.3. To mitigate the socio-economic impact of HIV/AIDS on individuals, families, communities and the nation through a policy and legal framework that:

- guides the nation in eliminating HIV screening for job applicants and continuation of employment.

3.2.5. To affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS through an environment that:

- reduces HIV/AIDS related stigma and discrimination.
- improves access to condoms, prevention information and skills, ARV and other treatment for opportunistic infections (OI), infant formula, VCT and family and community support.

For people living with HIV, the right to privacy, confidentiality, informed consent and voluntary disclosure form one of the two guiding principles in the **Positive Health, Dignity and Prevention Strategy**.

The 2013 **Guidelines for the Clinical Management of HIV/AIDS** outlines the HIV testing regime. Routine HIV screening is recommended in four situations: annual HIV screening of all sexually active persons between the ages of 15-49; all patients accessing care at a hospital, public health center or private practitioner annually; all STI clinic attendees; and all antenatal clinic attendees. Rapid testing using either finger stick or oral swab methodology is recommended. All initial positive test results must have confirmatory testing performed.

According to these Guidelines, counseling and psychosocial support must be part of the HIV testing and treatment programme to assist persons to cope with HIV, prevent re-infection and the transmission of HIV to others, and to enable persons living with HIV to improve the quality of their life and the outcome of the disease. Pre-test Counseling is no longer an absolute requirement. The concept of provider initiated testing and counseling requires the opportunity for the patient to “opt-out” of testing (the patient must be informed that an HIV test is being performed and given the opportunity to deny the test). All patients should be notified in person of the test result. Post-Test counseling including referral to support services is a component of disclosing results.

The 2004 **Management of HIV/AIDS in Schools Policy** contains provisions on the prohibition of HIV testing as condition for school admission or staff employment (Objective 2) and privacy and confidentiality (Objective 4). The 2012 **National HIV/AIDS Workplace Policy** also stipulates the establishment of an appropriate environment for provision of confidential pre-test and post-test counseling education with access to referral for voluntary counseling and testing (Objective 4).

Voluntary counseling, testing, and referral services are offered in 23 HIV treatment sites as well as peripheral clinics. Some CBOs including Jamaica AIDS Support for Life, Jamaican Network of Seropositives, and Eve for Life offer VCT services on site and through their outreach programs.

Gaps

It is estimated that potentially 15,000 persons who are HIV infected do not know their status out of an estimated 32,000 persons living with HIV. Young people (15-24 years old) are less likely to be tested than those aged 25-49 years. Males are less likely to be tested than females. Key populations including MSM and sex workers are less likely to be tested than members of the general population.⁶⁸ The effectiveness of HIV education and prevention is hampered by restricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counseling and referral to essential services.

The lack of top management prioritization and follow-up in implementing routine/provider-initiated testing throughout the health system including low levels of provider initiated testing in accident and emergency departments, among patients admitted to hospitals, and persons attending STI clinics in both public and private health sectors constitutes one of the main testing bottlenecks in Jamaica.⁶⁹ Only about 10% of hospital admissions are being tested for HIV, and even smaller percentages from family planning and other regular clinics.⁷⁰

Criminalization of private, consensual same-sex sexual acts, sex work, and drug use represents another access barriers to testing and counseling uptake.

There have been concerns about **the lack of informed consent in HIV testing among certain populations** including pregnant women, drug users, prisoners, and applicants to the Overseas Employment Programme.

Counseling services remain grossly inadequate due to lack of human resource and funding.

A 2012 National Strategic Plan Costing study finds that approximately 40% of incident infections will occur among persons who are considered to be engaging in low risk sex. In addition to scaling up testing for key populations,

⁶⁸ National HIV/AIDS Strategic Plan 2012-2017.

⁶⁹ Aran, Daniel. 2012. *National Strategic Plan Costing: National HIV/AIDS Program Jamaica*. Kingston: UNAIDS Jamaica.

⁷⁰ National HIV/AIDS Strategic Plan 2012-2017.

HIV counseling and testing services for individuals who likely do not self-identify as being at risk of HIV infection should be expanded.

Recommendations

3.1 Ensure top management prioritization in implementing routine/provider-initiated testing throughout the health system.

3.2 Create and expand key-population-friendly sites and facilities including the engagement of civil society organizations to provide testing and counseling services.

3.3 Ensure appropriate materials such as low literacy materials are provided for full informed consent of all key populations including pregnant women with the possibility to “opt-out” in routine HIV testing.

3.4 Enact legal or policy provisions to regulate access to voluntary, confidential or anonymous HIV testing by all key populations

3.5 Eliminate mandatory HIV screening requirement in the Overseas Employment Programme, as it is discriminatory.

3.6 Develop a plan to train additional counselors including partnering with institutions already providing such training.

3.7 Expand HIV counseling and testing services for individuals who likely do not self-identify as being at risk of HIV infection.

3.8 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use to remove stigma and discrimination to facilitate testing uptake by key populations.

3.9 Enact a Data Protection Act to ensure legal protections against breaches of privacy and confidentiality in all fiduciary relationships including in HIV contexts.

Factor 4: Treatment, Care, and Other Health Services

PLHIV enjoy the right to the highest attainable standard of physical and mental health, including equitable and sustainable access to comprehensive health care. The State takes concrete steps to progressively realize universal access to HIV-related treatment and care.

Conclusion

Expanding treatment access is a priority area within the national HIV response. National policies, plans, and guidelines set forth treatment-related objectives and protocols. Treatment, care, and support services are offered in 23 HIV treatment sites. Despite these policy and clinical guidelines, however, treatment uptake remains sub-optimal, with only 43% of persons who need them receiving treatment. Low testing uptake is a primary factor of the treatment gap in Jamaica. PLHIV have to spend long waiting time in the underfunded and overcrowded public healthcare sector to access testing and treatment. The current biomedical approach to test and treat offers little psychosocial support and counseling services to address the social vulnerability of HIV. Serious adherence problems lead to high HIV drug resistance. Adherence counselors often lack professional training, and the clinical guidelines are not always implemented. ARVs are free of cost, but support for the treatment of opportunistic infections, STIs, and psychosocial structures is limited. Community and home-based care are not funded by the government.

International Laws / Recommendations / Guidelines

- **ICESCR, Art. 12: Right to Health.**
- **ICESCR, General Comment No. 14 On The Right To Health** para. 43: the right to health includes essential primary care; essential drugs; equitable distribution of all health facilities, goods, and services; and nondiscriminatory access to health facilities, goods, and services, especially for vulnerable or marginalized groups.
- **International Guidelines on HIV/AIDS And Human Rights, Guideline 6:** States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.
- **MDG 6B:** Universal access to treatment for HIV/AIDS.
- **2001 UNGASS Declaration of Commitment on HIV/AIDS, para 55:** to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity.
- **2001 ILO Code of Practice on HIV/AIDS & the World of Work, Principle 4.10:** All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependents in access to and receipt of benefits from statutory social security programmes and occupational schemes.
- **2001 Doha Declaration on the TRIPS Agreement and Public Health, para. 4-5.** “The TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:
 - (a) In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.
 - (b) Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.
 - (c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.
 - (d) The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.
- **2006 Political Declaration on HIV/AIDS, para. 25:** to ensure access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.
- **2010 UNAIDS 2011-2015 Strategy: Getting to Zero, Strategic direction 2: Catalyzing the next generation of treatment, care and Support through i) universal access to antiretroviral therapy for people living with HIV who are**

eligible for treatment; ii) TB deaths among people living with HIV reduced by half; and iii) people living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support.

• **2010 Special Rapporteur on the right to health: Right to health in the context of access to medicines and intellectual property rights (A/HRC/11/12)**

• **2011 WHO/UNAIDS, The Treatment 2.0 Framework for Action: Catalysing the Next Phase of Treatment, Care and Support**, ushering the next phase of HIV treatment scale up through promoting innovation and efficiency gains in five priority areas: 1) optimize drug regimens; provide point of care diagnosis; 3) reduce costs; 4) adapt delivery systems and 5) mobilize communities.

• **2012 Global Commission on HIV and the Law: Risks, Rights and Health**, Recommendation 12: Develop an effective IP regime for pharmaceutical products.

National Laws, Policies and Actions

The **National HIV/AIDS Policy** lays out the vision and objectives pertaining to access to treatment:

3.2.2. To strengthen mechanisms for the treatment, care and support of persons living with and affected by HIV/AIDS through a policy and legal framework and enabling environment that:

- includes increased access to affordable ARV for persons, including children, living with HIV/AIDS (PLWHA) and the provision of optimal infant feeding counseling and options for babies born to HIV positive mothers;
- provides information and support for age-specific adherence and compliance to treatment protocols; and
- provides appropriate guidelines for health workers to administer treatment, care and support without any form of stigma and discrimination.

The 2012-2017 **National HIV/AIDS Strategic Plan** sets treatment as one of the six priority areas. Treatment requires an extensive system that facilitates access to HIV testing and counseling, diagnostic services, specialized clinical care, antiretroviral medications, psychological and social support.

The 2013 **Guidelines for the Clinical Management of HIV/AIDS** outlines the national treatment protocol. All adults and adolescents should commence ART when CD4 count < 350 cells/mm³. ART is offered regardless of CD4 count in four categories: pregnancy, active Tuberculosis, hepatitis B requiring therapy, and HIV associated nephropathy. Before the onset of AIDS, **pre-ART management** include the prevention of HIV transmission through positive prevention messages, education in condom use and negotiation, and management of STIs; the monitoring CD4 counts every 6-12 months; performing all baseline evaluations; the prevention and management of chronic diseases and other illnesses; and the promotion of general health practices. **Patient optimization**—an active process of identifying barriers to ART adherence prior to commencement—should be used to discuss issues including HIV knowledge, fears and perceptions of ART; motivation and self-efficacy; stigma and discrimination; social support systems; transportation and nutritional issues; depression or other mental health disease; substance abuse counseling.⁷¹

Because of high virus replication and mutation rate, adherence to antiretroviral therapy is of critical importance. Studies show that patients who miss no more than 1 drug dose per month (95% adherence) do significantly better than those who miss more than 1 dose per month (>95% adherence). Before initiating therapy, adherence must be made part of the patient's routine care to understand and address issues in the patient's health history including the level of literacy, beliefs and attitudes about HIV, social support, income, housing, food availability, medical insurance, alcohol and drug use, mental illness and any other pressing issues which may be potential barriers to compliance.⁷²

⁷¹ 2013 Guidelines for the Clinical Management of HIV/AIDS.

⁷² Ibid.

Treatment, care, and support services are offered in 23 HIV treatment sites integrated in the primary health care system throughout the country.

Gaps

Despite these guidelines, **treatment uptake remains sub-optimal** at 43%, i.e. 14,000 people in need of ARVs against 8,000 currently receiving ARV. **Low testing coverage** is a primary factor of the treatment gap in Jamaica.⁷³

Criminalization of private, consensual same-sex sexual acts, sex work, and drug use perpetuates stigma and discrimination against key populations, impeding effective access to treatment.

PLHIV have to spend **long waiting time in the underfunded and overcrowded public healthcare sector** to access testing and treatment. Laboratory tests for the clinical monitoring of persons on ARV therapy are frequently not available or the results are slow in being returned to clinicians. Most patients cannot afford to access these tests in the private sector. Public pharmacies are overwhelmed and patients have to wait long hours for prescriptions to be filled often having to return the following day. There are far too few pharmacies stocking ARV drugs and stock outs are common. Basic drugs for related conditions such as STI are frequently not available in the public sector and too expensive for most patients in the private sector.⁷⁴

The current **biomedical approach to test and treat offers little psychosocial support and counseling services** to address the social vulnerability of HIV such as poverty, low literacy, inadequate food intake, evictions, drug use, and mental health issues.

Many of those who are on treatment do not adhere adequately to ARV medication. **High HIV drug resistance** (at 12.6%), identified in a 2013 study of a sample of 103 chronically infected but treatment naïve patients, calls for the need to **introduce HIV drug resistance surveillance** in Jamaica.⁷⁵

Adherence counselors, while offering PLHIV peer support, may lack professional counseling training to address adherence barriers.

The **clinical guidelines for health workers** to administer treatment, care and support are not always implemented.

High STI rates have a significant negative impact on HIV transmission. While the diagnosis and treatment of STIs and opportunistic infections are included in the National HIV/AIDS policy, HIV physicians and key populations reported de facto barriers to access to screening and treatment due to insufficient funding and weak health system. **Psychosocial support structures** are also limited.

Whereas there is acknowledgement of **community and home-based care**, such work is not funded by the government. Such services are usually offered by CSOs and FBOs through their treatment and care programme. The NHP has in the past trained home-based care workers (before the availability of ARV) but was not able to employ them.

Recommendations

4.1 Through the involvement of CBOs, redesign gender-sensitive and key-population friendly treatment, care and support services.

⁷³ National HIV/AIDS Strategic Plan 2012-2017.

⁷⁴ Interview with the founder of Jamaican Network of Seropositives, August 30 2013; National HIV/AIDS Strategic Plan 2012-2017.

⁷⁵ Barrow, G, Hylton-Kong T, Rodriguez N, Yasuhiro Yamamura, and Figueroa JP. 2003. "HIV-1 drug resistance in treatment-naïve, chronically infected patients in Jamaica." *Antiviral Therapy*, June 6 doi: 10.3851/IMP2869.

4.2 Move from a supply-driven biomedical model to a holistic demand-driven rights-based approach to treatment literacy. Fund CBOs to design and deliver treatment literacy training and research, and develop treatment support groups.⁷⁶

4.3 Fund health system strengthening to improve the delivery of HIV/STI treatment, care and support.

4.4 Expand the pre-ARV program before patients drop out within the first twelve months.

4.5 Implement strategies to promote ARV adherence and ensure that adherence counselors have professional training.

4.6 Ensure ARV supply in all pharmacies and prevent stock out.

4.7 Introduce HIV drug resistance surveillance and monitoring.

4.8 Scale up support for treatment of opportunistic infections and STIs, and psychosocial structures.

4.9 Offer continuous training to health workers to ensure the implementation of clinical guidelines in an environment free of stigma and discrimination.

4.10 Provide referrals for mental health services and nutrition counseling as part of treatment.

4.11 Fund community and home-based care programs.

4.12 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use to remove stigma and discrimination and encourage treatment uptake by key populations.

Factor 5: Social Protection and Material Assistance

PLHIV enjoy the right to an adequate standard of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness, or disability.

Conclusion

Both the National HIV/AIDS Policy and the National HIV/AIDS Workplace Policy set out an objective to mitigate the socio-economic impact of HIV and AIDS on individuals and families through a number of measures. But, employment termination based on HIV-status remains one of the most common and disabling experiences for PLHIV in Jamaica. Until the Occupation Safety and Health Act is enacted, no law prohibits employment or pension discrimination, or termination based on HIV-status. There are also no laws or policies to ensure the right of PLHIV to an adequate standard of living and social protection in the event of unemployment, sickness, or disability.

Interviewees complained that the system of social protection is not HIV-sensitive. For instance, there is no specific financial protection for PLHIV. Further, there is no prohibition of the denial of housing, forced evictions, and other forms of threats and violence related to HIV status. Community stigma and discrimination also remain a serious

challenge to the full enjoyment of PLHIV in social life and protection. Finally, mandatory HIV testing and the denial of health insurance and a higher premium requirement for PLHIV coverage are common and legal.

⁷⁶ See, for example, http://www.itpcglobal.org/treatment_literacy [accessed on September 28 2013].

International Laws / Recommendations / Guidelines

- Universal Declaration on Human Rights, Art. 25, which states that “Everyone has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her] control.”
- ICESCR, Arts. 9, 11: Right to an Adequate Standard of Living.
- MDG : Universal access to treatment for HIV/AIDS.
- **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 68 and 69 on Alleviating social & economic impact:
Develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; and develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS.
- **2001 ILO Code of Practice on HIV/AIDS & the World of Work**, Principle 8: Continuation and Employment and Prohibition of HIV testing as a condition of eligibility for insurance purposes; Principle 9.6 on social security coverage; and Principle 9.8 on Employee and family assistance programmes.

National Laws, Policies and Actions

The **National HIV/AIDS Policy** sets out a number of measures under:

- Objective 3.2.3 To mitigate the socio-economic impact of HIV/AIDS on individuals, families, communities and the nation through a policy and legal framework that:
- encourages sector, labour force and workplace needs and impact assessments;
 - caters for the needs of HIV-infected and affected employees and establishes reasonable accommodation until such persons are diagnosed medically unfit to perform;
 - promotes home-based care through families, community-based and FBOs;
 - promotes the inclusion of HIV/AIDS in social security benefits and schemes;
 - guides the nation in eliminating HIV screening for job applicants and continuation of employment;
 - encourages the business sector to deal with HIV/AIDS costs and its impact on productivity taking into account prevention and support issues.

Further, the 2012 **National HIV/AIDS Workplace Policy** lays out Objective 4: To strengthen the capacities of workplaces to provide care and support for persons living with and affected by HIV/AIDS including social support schemes and benefits to include provision for HIV/AIDS.

The National HIV/STI Program has implemented a number of income-generating projects for PLHIV. The **National Foundation for HIV**, created in 2011, has the objective of mobilizing private sector funds to finance income-generating projects for PLHIV.

Gaps

The **absence of laws to ensure the right of PLHIV to an adequate standard of living and social protection** in the event of unemployment, sickness, or disability means that the provisions in the National HIV/AIDS Policy or the National HIV/AIDS Workplace Policy are not legally enforceable. Interviewees complained of a system of social protection that is not HIV-sensitive. For instance, there is no specific financial protection, including social transfers, catered for PLHIV.

Until the Occupation Safety and Health Act is enacted, there is also **no law that prohibits discrimination based on HIV-status including employment termination**. According to the Founder of the Jamaican Network of Seropositives, employment dismissal is one of the biggest barriers that PLHIV face in Jamaica. The problem is further compounded by the lack of awareness of their employment and other social and economic rights by PLHIV. Employment dismissal due to HIV-related discrimination necessitates social protection measures for PLHIV (see Factor 10).

There is also **no law or policy prohibiting the denial of housing, forced evictions, and other forms of threats and violence related to HIV status**. In particular, community stigma and discrimination remain a serious challenge to the full enjoyment of PLHIV in social life and protection.

There is **no law or policy prohibiting non-discrimination in life insurance coverage and in pension** based on HIV status

The **private sector** has been slow to step up to deal with HIV and AIDS costs and its impact, and provide support for PLHIV.

Recommendations

5.1 Ensure non-discrimination of PLHIV and key populations in employment, housing, insurance, pension, and other areas of socio-economic life through a comprehensive HIV/AIDS law⁷⁷ and/or a general anti-discrimination law and/or amendment of relevant law and regulations.⁷⁸ HIV infection and clinical AIDS should be treated no less favourably than any other serious illness or condition. Such reforms in law should be accompanied by a robust implementation and enforcement structure.

5.2 Put in place HIV-sensitive social protection measures such as cash transfers for PLHIV.

5.3 Ensure that employee and family assistance programmes are established for PLHIV who need them through the Voluntary Compliance Program of the National HIV/AIDS Workplace Policy or a Occupation Safety and Health Act.⁷⁹

⁷⁷ India has one of the most comprehensive draft HIV/AIDS Bill,
<http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf>

Several countries have enacted HIV/AIDS laws:

- Philippines passed the 1997 Act Promulgating Policies and Prescribing Measures for the Prevention and Control of HIV/AIDS in the Philippines and Regulations Implementing the 1997 Act, which has been considered by UNAIDS as being best practices regarding the treatment of PLWHA,

http://www.who.int/hiv/topics/vct/sw_toolkit/summary_booklet_best_practices.pdf.

- Cambodia adopted the 2002 Law on the Prevention and Control of HIV/AIDS.

- Burkina Faso passed the 2008 Law Governing HIV/AIDS and Protection of the Rights of Persons Living with HIV/AIDS.

- Brazil adopted the 1996 Law on the Free Distribution of Medicine to HIV Carriers and AIDS Patients.

- Tanzania enacted the HIV AIDS Prevention and Control Act of 2008.

- Sierra Leone passed the 2007 Prevention and Control of HIV and AIDS Act.

See also South African Development Community, 2008 Model Law on HIV in South Africa; East African Community, 2010 HIV and AIDS Prevention and Management Bill; UNAIDS: Guidance Note on Addressing HIV-related Law at a National Level; and the World Bank: Legal Aspects of HIV/AIDS, A Guide for Policy and Law Reform.

⁷⁸ See CARICOM model anti-discrimination legislation; Namibia, Labour Act of 2007 (prohibits employment discrimination against PLWHA) and HIV/AIDS Charter of Rights; Botswana, National Industrial Relations Code of Good Practice (prohibits employment discrimination against PLWHA); Bahamas, Employment Act of 2001 (prohibits employment discrimination against PLWHA); and Los Angeles, California, U.S.A., HIV/AIDS Anti-Discrimination Handbook.

⁷⁹ For more details, see 2001 ILO Code of Practice on HIV/AIDS and the World of Work. The family assistance programme may include compassionate leave; invitations to participate in information and education programmes;

5.4 Sustain income-generating projects for PLHIV and key populations in the National HIV/STI Program.

5.5 Engage the private sector to finance income-generating projects for PLHIV and key populations, notably through the National Foundation for HIV.⁸⁰

5.6 Provide training for PLHIV and key populations on basic social, economic, and cultural rights.

Factor 6: Protection of Privacy and Confidentiality

PLHIV enjoy effective protection from arbitrary or unlawful interference with their privacy. Their medical and personal information is subject to strict rules of data protection and confidentiality.

Conclusion

Confidentiality is incorporated as one of the key guiding principles in the National HIV/AIDS Policy in accordance with the ILO Principles on HIV/AIDS and the World of Work. National policy also stipulates that employers and workers should be informed about these principles, and the right to privacy and other human rights should be protected. However, interviewees reported incidents where their right to privacy and confidentiality was infringed. There is no law protecting data confidentiality in general or in the context of HIV and AIDS. The lack of a centralized electronic medical system and low sensitization of healthcare workers mean that privacy and confidentiality of the medical records of PLHIV are not always enforced. There is also no redress mechanism for breaches of confidentiality.

International Laws / Recommendations / Guidelines

• **ICCPR**, Art. 17: Right to Privacy

• **International Guidelines on HIV/AIDS And Human Rights**, Guideline 5: Anti-discrimination and protective laws: para 22. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

• **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 52: Expanded access to voluntary and confidential counseling and testing

• **2001 ILO Code of Practice on HIV/AIDS & the World of Work**, *Principle on Confidentiality*: There is no

referrals to support groups, including self-help groups; assistance to families of workers to obtain alternative employment for the worker; specific measures, such as support for formal education, vocational training and apprenticeships, to meet the needs of children and young persons who have lost one or both parents to AIDS;; coordination with all relevant stakeholders and community-based organizations including the schools attended by the workers' children; direct or indirect financial assistance; managing financial issues relating to sickness and the needs of dependents; legal information, advice and assistance; and assistance in relation to understanding the legal processes of illness and death such as managing financial issues relating to sickness, preparation of wills and succession plans (p. 18).

⁸⁰ For public-private partnerships in HIV, see HIV-related Public-Private Partnerships and Health Systems Strengthening (UNAIDS 2009), http://data.unaids.org/pub/Report/2009/jc1721_publicprivatepartnerships_en.pdf [accessed on October 15 2013].

See also Can, Elif. 2012, ABA-ILRC-UNDP, Botswana Public Private Partnerships.

justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data. 5.2 *Employers and their Organizations* (g) Confidentiality. HIV/AIDS-related information of workers should be kept strictly confidential and kept only on medical files, whereby access to information complies with the Occupational Health Services Recommendation, 1985 (No. 171), and national laws and practices.

Access to such information should be strictly limited to medical personnel and such information may only be disclosed if legally required or with the consent of the person concerned. 5.3 *Workers and their Organizations* (j) Confidentiality. Workers have the right to access their own personal and medical files. Workers' organizations should not have access to personnel data relating to a worker's HIV status. In all cases, when carrying out trade union responsibilities and functions, the rules of confidentiality and the requirement for the concerned person's consent set out in the Occupational Health Services Recommendation, 1985 (No. 171), should apply.

- **2006 Political Declaration on HIV/AIDS**, para. 25: to ensure access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.
- **2007 UNAIDS Interim Guidelines on Protecting the Confidentiality and Security of HIV Information.**

National Laws, Policies and Actions

Various medical professional bodies have a Code of Conduct that has a confidentiality requirement. For example, the Pharmaceutical Society of Jamaica states that "A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to patients and their families. Such information must not be disclosed to anyone without the consent of the patient or appropriate guardian unless the interest of the public or the patient requires such disclosure."⁸¹

Confidentiality in the context of HIV and AIDS is incorporated as one of the key guiding principles in the **National HIV/AIDS Policy** in accordance with the ILO Principles on HIV/AIDS and the World of Work.

Further, the 2012 **National HIV/AIDS Workplace Policy** stipulates that employers and workers should be 1) informed about the ten guiding principles for HIV and AIDS and the world of work including confidentiality; and 2) the social and economic well being of workers infected and/or affected by HIV and AIDS are guaranteed by ensuring the protection of their right to privacy and other human rights.

Gaps

Despite these policy provisions, interviewees reported incidents where their right to privacy and confidentiality was infringed. Codes of ethics of various professional organizations are voluntary, and there is **no law protecting data confidentiality** in general or in the context of HIV/AIDS. The **lack of a centralized electronic medical system** and **low sensitization of healthcare workers** mean that privacy and confidentiality of the medical records of PLHIV are not always enforced. There is also **no redress mechanism** for breaches of confidentiality.

Recommendations

6.1 Enact confidentiality and privacy laws that would prohibit unauthorized use and publication of HIV-related

⁸¹ <http://pharmasocietyja.com/about-pharmaceutical-society-ja/code-of-ethics/> [accessed on September 17 2013].

information on individuals through the inclusion of HIV in a general privacy legislation or the inclusion of these issues in a comprehensive HIV and AIDS law.⁸² Ensure that HIV-related information is included within the definitions of personal/medical data subject to privacy protections. Ensure that individuals have access to their own personal and medical records and the ability to request amendments to ensure that information is accurate, relevant, complete, and up-to-date. The laws should also contain mechanisms and remedies to redress breaches of confidentiality as well as exceptions where confidentiality may have to be breached.

6.2 Ensure the enforcement of existing codes of conduct of professional bodies to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct. Ensure also that health care workers undergo minimum ethics and/or human rights training including confidentiality guidelines.

⁸² For a sample provision on non-discrimination in insurance, see Section 4 (ii) (j) of the draft HIV/AIDS Bill in India, <http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf> [accessed on September 8 2013].

II. Equality of PLHIV in Public and Private Life

Factor 7: Political, Social, and Cultural Life

PLHIV enjoy full equality and inclusion in political, social, and cultural life. The State ensures the right of PLHIV, HIV/AIDS advocates, and service workers to peaceful assembly and association.

Conclusion

Equality, human rights, and the full participation of PLHIV are clearly endorsed as key principles in the National HIV/AIDS Policy and National HIV/AIDS Strategic Plan. But, the criminalization of same-sex sexual acts, sex work, and drug use make it difficult for CBOs to impart information about HIV/AIDS. There is no law or policy to ensure that PLHIV, HIV and AIDS advocates, and service workers enjoy the rights to freedom of opinion and expression. There are also no legal sanctions against HIV- or key-population-related hate speech. While there have been some initiatives to increase PLHIV involvement, notably through a GIPA Program within the Human Rights and Enabling Environment unit of the National HIV/STI Program, the effort has been small in scale and not sustained. Much more needs to be done to continue the capacity building of PLHIV to participate meaningfully in the design and implementation of HIV-related laws, policies, and programs, and to assert their full social, cultural, and political rights.

International Laws / Recommendations / Guidelines

- **ICCPR**, Art. 15: Right to Participate in Social and Cultural Life; 19: Right to Hold Opinions and Freedom of Expression; Art. 21 and 22: Right to Peaceful Assembly & Association.
- **1994 GIPA Principle**: To support a greater involvement of people living with HIV at all levels and to stimulate the creation of supportive political, legal and social environments.
- **International Guidelines on HIV/AIDS And Human Rights**, Guideline 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.
- **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 58: Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and the respect for the rights of people living with HIV and AIDS drives an effective response. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.
- **2006 Political Declaration on HIV/AIDS**, para. 29. Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and the respect for the rights of people living with HIV and AIDS drives an effective response.

National Laws, Policies and Actions

The **National HIV/AIDS Policy** is built upon the principles of:

3.3.4 Participation

The meaningful involvement of people living with and affected by HIV/AIDS and most vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS is vital to optimize stated outcomes.

3.3.5 Equity

This principle means that all responses to HIV/AIDS should ensure that no person shall be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location, level of literacy, capacity to understand the nature of HIV/AIDS and how it is prevented and treated or vulnerability to exposure. This includes orphans, wards of the state, men who have sex with men, commercial sex workers, street and working children, persons living with disabilities and prisoners.

3.3.6 Promotion and Protection of Human Rights

An important aspect of the response to the epidemic requires that the rights to equality before the law and freedom from discrimination are respected, protected and fulfilled. Discriminatory practices (including unequal gender relations) create and sustain conditions leading to vulnerability to HIV infection and to inadequate treatment, care and support as well as access to prevention services.

Participation of PLHIV, equity, and gender equality are also among the principles underlying the 2012-2017 **National HIV/AIDS Strategic Plan**.

Gaps

Criminalization of private, consensual same-sex sexual acts, sex work, and drug use make it difficult for CBOs to impart information about HIV and AIDS for education and advocacy, as such kinds of activities might be seen as socially inappropriate, politically provocative, or “encouraging” criminal acts. While the rights to freedom of opinion and expression are guaranteed in the Charter, they are not assured for PLHIV, HIV and AIDS advocates, and service workers to impart sexual health information and education.⁸³

Despite codes of ethics for media professionals (e.g. Jamaica Press Association updated its Code of Ethics in 2010 which included a non-discrimination clause),⁸⁴ there are also **no legal sanctions against HIV- or key-population-related hate speech** that hampers the full social, cultural or political participation of PLHIV and key populations. On May 20, 2008, the then Jamaican Prime Minister Bruce Golding said in a BBC interview that no gays would form part of his cabinet. On May 27, 2013, the Jamaica Coalition for a Healthy Society, chaired by ran an editorial in the Gleaner, portraying HIV as a gay disease.⁸⁵ These incidents perpetuate stigma against key populations.

The two major HIV-related policies—National Workplace Policy on HIV/AIDS and the Management of HIV/AIDS in Schools Policy—regulate HIV-related discrimination and prevention only in economic and school life. There is **no policy that ensures equality and inclusion in all aspects of political, social, and cultural life of PLHIV**.

While there have been some initiatives to increase **PLHIV involvement**, notably through a GIPA Program within

⁸³ See Supra footnote 57.

⁸⁴ <http://pressassociationjamaica.org/wp-content/uploads/2010/07/Code-for-Media-Practitioners.pdf> [accessed on September 18 2013].

⁸⁵ <http://jamaica-gleaner.com/gleaner/20130527/lead/lead1.html> [accessed on September 7 2013].

the Human Rights and Enabling Environment unit of the NHP to build their capacity in their participation in the HIV response, this effort has been small in scale and not sustained. Much more needs to be done to continue the capacity building of PLHIV to participate meaningfully in the design and implementation of HIV-related laws, policies, and programs.

Recommendations

7.1 Ensure the rights to freedom of opinion and expression of PLHIV and key populations are guaranteed through legal or policy provisions in order for them to carry out their advocacy work.

7.2 Develop a code of ethics for media professionals and mandate that the discussion of HIV and AIDS in the media is uncensored, objective, sensitive, and factually accurate.⁸⁶

7.3 Prohibit HIV-related discrimination including hate speech and vilification surrounding HIV, sexual orientation, and gender identity in an HIV and AIDS law or a general anti-discrimination law.

7.4 Develop a policy to ensure equality and inclusion in all aspects of political, social, and cultural life of PLHIV and key populations.

Factor 8: Family, Sexual, and Reproductive Life

PLHIV enjoy full equality in family life and the right to the highest attainable standard of sexual and reproductive health. The State facilitates prevention of vertical transmission.

Conclusion

Gender equality as well as access to reproductive and sexual health education and services are clearly stipulated as key guiding principles in national policies. The new governance structure of the Sexual and Reproductive Health Authority of Jamaica should facilitate the integration of HIV and AIDS interventions into sexual and reproductive health care services. There is no law or policy to ensure that PLHIV enjoy full equality in family life. There are numerous reports of health care providers discouraging the founding of families by PLHIVs as well as promoting sterilization and the involuntary sterilization of PLHIV. Several interviewees raised the concern of the lack of full informed consent in routine HIV testing of pregnant women as well as instances of forced abortions on HIV-positive women.

Abortion is illegal and maternity mortality rates are high. Couples' access to voluntary pre-marital HIV testing and counseling is subject to the discretion of service providers. There are no laws prohibiting asserting HIV status as the sole ground for divorce; mandatory HIV testing in child custody proceedings; or arbitrary exclusion of HIV-positive prospective foster parents. Further, there is no policy or law promoting access to sexual and reproductive health education and services by PLHIV. Regarding minors, the 2007 Access to Contraceptives Policy for Minors provides guidelines for healthcare professionals to provide SRH information and services. However, concerning minors' access to SRH education, information, and services, there is a great deal of confusion and conflicting directions between applicable laws. And, age-appropriate reproductive and sexual health education is not always ensured.

⁸⁶ The Press Council of India under the mandate of Section 13(2)(b) of the Press Council Act, 1978 has built up a set of guidelines to facilitate the functioning of the Media. The guidelines on coverage of HIV/AIDS related matter was drawn up in the year 1993, http://www.nbanewdelhi.com/pdf/final/NBA_Guidelines_HIV-AIDS-2.pdf [accessed on September 7 2013].

International Laws / Recommendations / Guidelines

- **ICCPR**, Art. 9: right to liberty and security of person; Art. 17: freedom from arbitrary or unlawful interference with his privacy, family; Art. 23(2) protects the right to marry and found a family.

- **1994 International Conference on Population and Development (ICPD) Programme of Action**, paras. 7.2 - 7.48 on reproductive rights and reproductive health; family planning; sexually transmitted diseases and prevention of HIV; human sexuality and gender relations; and adolescents. **Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

- **1995 Beijing Platform for Action**, para. 94 (cf ICPD para 7.2): Para. 96: The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

- **International Guidelines on HIV/AIDS And Human Rights**, Guideline 5: Anti-discrimination and protective laws, para 22 (f): Anti-discrimination and protective laws should be enacted to reduce human rights violations against women in the context of HIV, so as to reduce vulnerability of women to infection by HIV and to the impact of HIV and AIDS. More particularly, laws should be reviewed and reformed to ensure equality of women regarding property and marital relations and access to employment and economic opportunity, so that discriminatory limitations are removed on rights to own and inherit property, enter into contracts and marriage, obtain credit and finance, initiate separation or divorce, equitably share assets upon divorce or separation, and retain custody of children.

Laws should also be enacted to ensure women's reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape. The age of consent to sex and marriage should be consistent for males and females and the right of women and girls to refuse marriage and sexual relations should be protected by law. The HIV status of a parent or child should not be treated any differently from any other analogous medical condition in making decisions regarding custody, fostering or adoption.

- **MDG Target 5.B**: Achieve universal access to reproductive health.

- **2001 UNGASS Declaration of Commitment on HIV/AIDS**, para 60: By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

- **2006 Political Declaration on HIV/AIDS**, para. 30 on sexual and reproductive health.

National Laws, Policies and Actions

Gender equality is as one of the key guiding principles in the **National HIV/AIDS Policy**. Specifically, one of the strategies under Objective 4: Enabling Policy regulatory and legislative environment is to “incorporate **age appropriate reproductive and sexual health education** into the early childhood, primary and secondary school curricula for all students and school personnel and ensure that similar reproductive and sexual education is made accessible to youth out of school to protect them from HIV and other STIs.”

The **2011 National Policy for Gender Equality** also strives to “ensure that the country remains on target for achieving the MDG goals with respect to reducing maternal mortality rates and improving reproductive health indicators. Once there is a final and agreed upon national position on abortions, ensure that women have access to safe and affordable procedures.”⁸⁷

PMTCT is ensured through HIV screening for pregnant women who present for care (with a coverage of over 95% of public sector antenatal clinics) and the provision of ARVs for all HIV infected pregnant women and HIV exposed infants free of cost.

The 2004 **Management of HIV/AIDS in Schools Policy** stipulates that a continuing **Health and Family Life Education curriculum and HIV/AIDS education program** must be implemented at all schools and institutions for all students and school personnel:

- ii. Emphasizing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse, the use of condoms, faithfulness to one’s partner, obtaining prompt medical treatment for sexually transmitted diseases, avoiding traumatic contact with blood, and the application of universal precautions with respect to first aid; and
- iv. Encouraging students to make use of health care, counseling and support services (**including services related to reproductive health care** and the prevention and treatment of sexually transmitted infections) offered by community service organizations and other disciplines; ensure the provision of systematic and consistent information and educational material on HIV/AIDS to students and school personnel throughout the system.

The Ministry of Education has been implementing the HFLE curriculum to in school youths aged 10-15 years.

The 2007 **Access to Contraceptives Policy for Minors** provides guidelines on access to sexual and reproductive health information and contraceptives for minors. Training was carried out in tandem with the policy launch to sensitize health care providers, guidance counselors, and persons who deal with minors.

Above all, the new governance structure of the **Sexual and Reproductive Health Authority of Jamaica**, merging the National HIV/STI Program and the National Family Planning Board should facilitate the integration of HIV/AIDS interventions into sexual and reproductive health care services.

Gaps

There is **no law or policy to ensure that PLHIV enjoy full equality in family life**. There are numerous reports of health care providers discouraging the founding of families by PLHIVs as well as promoting/carrying out **sterilization of PLHIV** including after birth tubal ligations. Couples’ **access to voluntary pre-marital HIV testing and counseling** is subject to the discretion of service providers. There is also no law that prohibits asserting **HIV status as the sole ground for divorce, mandatory HIV testing in child custody proceedings, and arbitrary exclusion of HIV-positive prospective foster parents**.

There have been reported incidents where HIV status was used as the only ground for divorce and for denial of child custody. While the general rules of fostering and adoption apply to PLHIV and are subject to the discretion of the

⁸⁷ <http://www.jis.gov.jm/pdf/NPGE-JA-FINALwCover21311.pdf> [accessed on September 9 2013].

courts, experience has shown that some judges are cautious about approving adoption where there is suspicion of sero-status and extensive investigations are often required. The situation is exacerbated when the child under consideration is HIV-positive. Prospective foster parents are asked to do a medical examination and to disclose any illnesses. A long-held fear is that a HIV-positive prospective foster parent might be seen as less capable of parenting.

There is **no single sexual and reproductive policy or HIV and AIDS law ensuring the access to sexual and reproductive health education and services by PLHIV** including their ability to decide freely and responsibly, free of coercion, discrimination, and violence, on matters related to one's sexuality such as the right to be free from sexual violence, forced abortion, and sterilization. Several interviewees raised the concern of the lack of full informed consent in routine HIV testing of pregnant women as well as instances of **forced abortions on HIV-positive women and involuntary sterilization of HIV-positive men and women.**

Abortion is illegal in Jamaica under Sections 72 and 73 of the Offences Against the Person Act of 1864. Under the Act, any person who, intending to procure a miscarriage, regardless of whether the woman is with child, unlawfully administers to her any poison or noxious thing or unlawfully uses any instrument or other means to the same end is subject to life imprisonment, with or without hard labour. A pregnant woman who acts in the same way with respect to her own pregnancy is subject to the same penalty. Grounds on which abortion is permitted include: to save the life of the woman; to preserve physical health; and to preserve mental health. But rape or incest, foetal impairment, and economic or social reasons are not recognized as grounds for abortion.

In order to perform an abortion on the grounds of mental health, foetal impairment, rape or incest, the approval of two specialists must be obtained. Further, the spouse's consent is required.⁸⁸ Physicians are generally reluctant to perform an abortion, as they fear prosecution, and the number of illegal abortions has been increasing. In June 2013, the Minister of Youth Lisa Hanna called for a review of the anti-abortion law, a measure supported by the Director of Health Promotion in the Ministry of Health, Dr. Kevin Harvey. The **maternal mortality ratio** in Jamaica remains high and has increased from 89 per 100,000 live births in 2008 to 110 in 2010).⁸⁹

There are longstanding debates about abortion in Jamaica. In 1975, in a Ministry Paper entitled "Abortion: Statement of Policy," the then Minister of Health, the Honorable Kenneth McNeil wrote, "the present Laws relating to abortion are contained partly in our Common Law and partly in the Statute Law The Offences Against the Person Act. The Statute Law position is that it is a criminal offence to procure an unlawful abortion. Indeed sections 65 and 66 of the Offences Against the Person Act lay down a maximum penalty of life imprisonment for the offence. The Statute also provides a maximum penalty of three years 'imprisonment for anyone who assists in procuring an unlawful abortion. Despite these severe penalties, the Statute is absolutely silent on the circumstances in which an abortion would be lawful."

The fact that the Statute is silent in this regard is the main reason why our qualified medical practitioners develop inhibitions in this area of work."⁹⁰ In the public Opinion Survey of 2006, when asked whether "women should be legally allowed to access abortions in Jamaica, 53% said "NO." In contrast when asked whether "a pregnant woman should have the legal right to terminate a pregnancy," (TOP) only 38% said "NO," 54% said "under special conditions" and 4.3% said under all conditions". A total of over 58% of respondents gave a positive response to legalization of TOP.

The 2007 **Final Report by the Ministry of Health Abortion Policy Review Advisory Group** made 14 recommendations:

- Repeal the relevant sections of the Offences Against the Persons Act, and substitute it with a Civil Law, titled "Termination of Pregnancy Act" stating the conditions under which medical termination of pregnancy will be lawful.

⁸⁸ www.un.org/esa/population/publications/abortion/doc/jamaica.doc [accessed on September 9 2013].

⁸⁹ <http://www.indexmundi.com/g/g.aspx?c=jm&v=2223> [accessed on September 9 2013].

⁹⁰ 2007. Jamaica Ministry of Health, Abortion Policy Review Advisory Group Final Report.

- Develop, maintain and staff specified centres in each health region for the provision of therapeutic abortions. Such centres should be registered by the Ministry, and monitored according to the Ministry's standards.
- Doctors private offices may be assessed, registered and monitored for the provision of abortion services for women who are less than 12 weeks pregnant.
- Pregnancies up to 12 weeks gestation (calculated from the first day of the last menstrual period) can be performed in registered facilities by an authorized medical practitioner in consultation with the woman. The methods recommended are pharmaceuticals, and menstrual vacuum aspiration.
- Pregnancies over 12 weeks gestation are to be performed by, or under the supervision of an Obstetrician/Gynaecologist in the formal setting of a hospital, equipped to effectively manage, utilizing the best current medical practice, any complication that may arise.
- Termination of pregnancies over 22 weeks gestation is not recommended, except under exceptional circumstances agreed by the woman and two authorized medical practitioners and performed in an appropriate setting authorized by the Ministry.
- It is highly recommended that persons involved in the provision of these services receive specific training from a recognized institution
- Pre and post abortion counseling, including available options to termination and the use of effective contraception is highly recommended.
- Special provisions are recommended for the mentally disabled.
- Special provisions are recommended for minors, i.e. persons under age 18 years.
- The right to conscientious objection is recognized.
- In all matters pertaining to this Policy, confidentiality is paramount.
- The establishment of a monitoring and advisory Board is recommended to oversee implementation of the policy.
- Finally, penalties for unlawful actions under this Act have been suggested.⁹¹

Services for early STI screening and treatment remain insufficiently developed (see also Factor 2 and 4).

Concerning the access to **SRH education, information, and services by minors**, there is a great deal of confusion and conflicting directions between the Law Reform (Age of Majority) Act, Offences Against the Person Act, Sexual Offences Act, the Child Care and Protection Act, and the Access to Contraceptives Policy for Minors.⁹² Under the Law Reform Age of Majority Act, a child at age 16 can consent to 'any surgical, medical or dental treatment', including diagnostic and ancillary procedures. The consent of the parent or guardian of a child aged 16 or older is not required for such treatment/procedure.

What constitutes "medical treatment" is not legally defined. The **Offences Against the Person Act and Sexual Offences Act** creates a criminal offence for a person to engage in sexual acts with a girl under that age of sixteen. The **Sexual Offences Act** creates a criminal offence for a person to engage in sexual acts with a girl or a boy under the age of sixteen, even though data shows that many boys and girls have sexual debut below the age of 16. The **Child Care and Protection Act** raises concerns of minors' privacy and confidentiality in matters of sexual health. It

⁹¹ Ibid.

⁹² See Chambers, Tania. 2012. *The Law and Policy Framework for ASRH in Jamaica: A rights-based approach to assessing ASRH issues in Jamaican law and policy*. Kingston: UNFPA Jamaica.

states, where an individual is charged with or convicted of an offence that has a sexual nature in respect of a child, or is an offence involving conduct likely to result in the transmission of a communicable disease to a child, the court may make an order for that individual to submit to medical examination and testing.

An order may also be made for the medical examination of a child if the child is deemed in need of care and protection and there is reason to believe the child has been abused. The **Access to Contraceptives Policy for Minors** of 2007 outlines the procedure for the provision of contraceptive advice, counseling, and treatment to persons under 16 years of age by a healthcare provider. Health professionals first provide counseling, try to persuade the minor to involve a parent or guardian and then promote abstinence. If there is evidence of HIV/STIs, pregnancy, carnal abuse or sexual violence, confidentiality cannot be honored (see Factor 15).⁹³

Age-appropriate reproductive and sexual health education through the Health and Family Life Education curriculum is not always ensured. There is inadequate monitoring and evaluation on the delivery of the HFLE curriculum. The 2013 decision by the Ministry of Education shows the political, religious, and social influence on SRH policy-making (see also Factor 1). Three reasons have been commonly cited to oppose parts of the HFLE curriculum, that it is age inappropriate; pushed by a “gay agenda;” and imposed by foreign powers.

Recommendations⁹⁴

8.1 Develop an education campaign and enact a comprehensive policy on sexual and reproductive health and rights with provisions for PLHIV including, among other things, access to post-exposure prophylaxis, and freedom from sexual violence, forced abortion, sterilization.

8.2 Align different SRH provisions in existing legislations and policies.

8.3 Develop a multi-sectoral policy or a memorandum of understanding pertaining to SRH education (including HFLE), information, and services, clarifying the distinct roles and responsibilities of each sector.

8.4 Implement the recommendations outlined in the 2007 Final Report by the Ministry of Health Abortion Policy Review Advisory Group.

8.5 Strengthen and integrate STI screening and treatment services with HIV interventions.

8.6 Through funding CBOs, put in place a system of psychosocial support for SRH services for men, women, MSM, transgender persons, sex workers, drug users, youth, adolescents, and minors.

Factor 9: Education and Training

PLHIV enjoy the right to equal educational opportunity. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and increase their representation in educational institutions.

Conclusion

The National HIV/AIDS Strategic Plan emphasizes education as one of the sectoral responses in HIV, highlighting the linkage between the lack of educational attainment and HIV vulnerability. The Management of HIV/AIDS in Schools Policy was catalytic in focusing attention on the need for a continuum of care for young people.

⁹³ “The Law and Sexual Reproductive Health,” The Beacon, February 2012, http://www.jnfpb.org/guidance/Sexuality_And_The_Law_Feb%2028,%202012.pdf [accessed on September 9 2013].

⁹⁴ Note that many of these recommendations are drawn from Chambers 2012.

It also broadened the response to HIV to health promotion in schools in general, as well as spearheading other sectors' responses to address HIV vulnerability among minors and youth. However, the non-binding policy does not provide legal protection to ensure children living with HIV and AIDS enjoy equal treatment and privacy protections in all educational institutions.

The policy is not legally enforceable, or subject to monitoring and evaluation. The policy also does not address issues of HIV-related stigma, violence, and discrimination in the community. Further, the policy is silent on gender-related issues relevant to HIV and AIDS education. The existing policy only applies to early childhood, primary, and secondary education. There is currently no policy guidance on HIV and AIDS in higher education in Jamaica. Although research on youth, education, and HIV and AIDS been commissioned from a number of sources, interviewees complain that most of this research is unknown and inaccessible to them.

International Laws/Recommendations/Guidelines

- **ICESCR**, Art. 13 protects the right to an education, accessible to all, without discrimination, especially in regards to the most vulnerable groups.
- **UNESCO Convention against Discrimination in Education** arts. 1, 3 also advises states to protect the right to education, free from discrimination.
- **CRC**, Art. 28 protects the right to education.
- **UNESCO Convention against Discrimination in Education**, Arts. 1 and 3 on non-discrimination in education.
- **2006 Education for All (EFA) and HIV and AIDS**: Linking education sector planning with commitments to achieving universal access; reducing stigma and discrimination; addressing the impact of HIV and AIDS on the education sector; adopting anti-discriminatory workplace policies; developing and strengthening life skills education to promote awareness of HIV and AIDS; ensuring that orphans and vulnerable children have access to, and complete, quality basic education; ensuring access to care and support and treatment for teachers and staff; and fostering comprehensive education responses through cross-sectoral partnerships.⁹⁵

National Laws, Policies and Actions

The **National HIV/AIDS Strategic Plan** emphasizes education as one of sectoral responses in HIV, highlighting the linkage between the lack of educational attainment and HIV vulnerability. The 2008 Reproductive and Health Survey confirmed that educational status was a predictor of high risk behavior. Low literacy and poor education contribute to increased HIV vulnerability. The 2011 PLHIV Stigma Index Survey reported that 26% of PLHIV had attained only primary level education, while 61% had attained secondary level and 12% university level education.⁹⁶

The 2004 **Management of HIV/AIDS in Schools Policy** prohibits HIV-related discrimination including mandatory HIV testing in educational institutions:

1. Non-Discrimination and Equality

1.1 No student or staff member with HIV/AIDS may be discriminated against directly or indirectly. Speculation or gossip concerning any person suspected of having HIV/AIDS must be discouraged.

⁹⁵ <http://download.ei-ie.org/docs/IRISDocuments/EI%20Campaigns/EFAIDS%20Programme/2006-00213-01-E.pdf> [accessed on September 9 2013].

⁹⁶ National HIV/AIDS Strategic Plan 2012-2017.

1.4 To prevent discrimination, all students and school personnel should be educated about fundamental human rights as contained in the Constitution of Jamaica and the UN Convention on the Rights of the Child to which Jamaica is a signatory.

2. HIV/AIDS Testing, Admission and Appointment

2.1 No student may be denied admission to or continued attendance at an institution on account of his or her HIV/AIDS status or perceived HIV/AIDS status.

2.2 No staff member may be denied the right to be appointed in a post, or to be promoted on account of his or her HIV/AIDS status or perceived HIV/AIDS status. Nor shall HIV/AIDS status be a reason for dismissal, or for refusing to renew any staff member's employment contract.

2.3 There is no medical justification for routine testing of students or educators for proof of HIV infection. The testing of students for HIV/AIDS as a prerequisite for admission to, or continued attendance at an educational institution, is prohibited. The testing of staff members for HIV/AIDS as a prerequisite for appointment or continued service is also unnecessary and prohibited.

3. Attendance at Institutions by Students with HIV/AIDS

3.1 Students with HIV have the right as any other to attend educational institutions. The needs of students with HIV/AIDS with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

4. Disclosure and Confidentiality

4.1 No student (or parent on behalf of a student), or educator, is compelled to disclose his or her HIV/AIDS status to the institution or employer.

Gaps

The Management of HIV/AIDS in Schools Policy, adopted one year before the National HIV/AIDS Policy, was catalytic in bringing the attention to the need for a continuum of care for young people and broadened the response beyond HIV through health promotion in schools in general, as well as spearheading other sectoral response to address HIV vulnerability among minors and youth. However, **the voluntary policy does not provide legal protection** to ensure children living with HIV and AIDS enjoy equal treatment and privacy protections in all educational institutions.

The policy also **does not provide redress** mechanisms. Despite the decade-long policy, stigmatization still exists. The policy has never been reviewed; there is **no formal monitoring and evaluation** on policy implementation including the consistency of approach, quality of delivery and representation, extent and effectiveness of HIV prevention and stigma reduction in schools, and number of incidents of HIV-related discrimination including dropping out due to stigma and other reasons.

The policy **does not address issues of HIV-related stigma, violence, and discrimination in the community**. HIV-positive students may choose to leave a school in her community or attend a private institution in a different district due to stigma. The Management of HIV/AIDS in Schools Policy can encourage school-community partnerships. Further, the policy is **silent on the needs of orphans and vulnerable children** affected by HIV and AIDS and **gender equality in education and gender-related issues relevant to HIV and AIDS**.⁹⁷

There is currently **no policy guidance on HIV and AIDS in higher education** in Jamaica. The existing policy only applies to early childhood, primary, and secondary education. Given that there is no single authority governing the

⁹⁷ Clark, David. 2005. *The Response of the Education Sector In Jamaica to HIV and AIDS*. Kingston: UNESCO.

tertiary education sector in Jamaica (the Council of Tertiary education exists it does not police individual college policies), existing model policies have to be adapted, implemented, and monitored by institutions on an individual basis.

Mona campus of the University of the West Indies (UWI) as well as the University of Technology, Jamaica have developed a comprehensive policy on HIV and AIDS, but it is unclear whether and how they have been monitored and evaluated. The UWI HIV/AIDS Response Programme (UWI-HARP) was developed through USAID funding to build capacity for HIV/AIDS response and should be considered as best practice. However, its benefits have largely been limited to health-related capacities in teaching and research, and the sustainability of the program is in question.⁹⁸

Although **research on youth, education, and HIV and AIDS** been commissioned from a number of sources including the National HIV/STI Program, development partners including UNESCO, UNFPA, UNICEF, the European Union, NGOs (e.g. Save the Children UK and Human Rights Watch), and by UWI, interviewees complain that most of this research is unknown and inaccessible to them. Currently, the Caribbean Centre for Child Development holds a database, hosted by the Sir Arthur Lewis Institute of Social and Economic Studies at the University of the West Indies, on research related to HIV stigma and discrimination; gender and gender norms related to HIV, and gender based violence and HIV. Further, the US-funded Health Policy Project is working on an online research database located within UWI-HARP.

Recommendations

9.1 Ensure non-discrimination of children living with HIV/AIDS in education with a redress mechanism through a comprehensive HIV/AIDS law and/or a general anti-discrimination law and/or amendment in the Education Act.

9.2 Activate the review of the Management of HIV/AIDS in Schools Policy. Include a discussion on the issue of HIV-related stigma, violence, and discrimination in the community, the needs of orphans and vulnerable children affected by HIV/AIDS, and gender-related issues relevant to HIV and AIDS.

9.3 Provide HIV and anti-discrimination training among school personnel.

9.4 Ensure coordination, communication, and accessibility of youth and HIV and AIDS research through an online database.

Factor 10: Employment, Work, and Economic Life

PLHIV enjoy equal rights to: work in public and private sectors, including just, favorable, safe, and healthy conditions of work; property and inheritance; and credit. Where appropriate, special measures are employed to provide PLHIV with income-generating opportunities and reasonable accommodations in the workplace.

Conclusion

The adoption of the National HIV/AIDS Workplace Policy in 2012 was a very significant development in encouraging non-discrimination regarding PLHIV in the workplace, as well as increasing prevention and training programs in accordance 10 ILO principles. However, only roughly about 5% of institutions have committed to the Voluntary Compliance Program to develop HIV workplace policy. Staff shortage makes it difficult to scale up implementation of the National HIV/AIDS Workplace Policy. If and when enacted, the Occupation Safety and Health Act and associated regulations will give legal protections against employment discrimination based on HIV-

⁹⁸ Ibid.

status. Further, the Ministry of Labor and Social Security is preparing a Manual on Life Threatening Illnesses which will treat HIV like other chronic illnesses, prohibiting employment discrimination.

It will also give rise to certification programs, designed to encourage restaurants to declare their workplaces as HIV-discrimination free. The National Foundation for HIV has the mandate to mobilize private sector funds to finance income-generating projects for PLHIV. While the National HIV/STI Program has implemented a number of income-generating projects for PLHIV, the efforts have not been sustained. Stigmatization and HIV-related discrimination, particularly in the food industry, remain a key challenge for PLHIV. Discrimination is further compounded by the lack of awareness of their employment and other social and economic rights by PLHIV. Interviewees talked of a social protection system that is not HIV-sensitive.

International Laws / Recommendations / Guidelines

- **ICESCR**, Art. 6: Right to work.
- **International Guidelines on HIV/AIDS And Human Rights, Guideline 10:** States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.
- **The 2001 ILO Code of Practice on HIV/AIDS and the World of Work**, which provides guidance on implementing work place policies on HIV.
- **2010 ILO Recommendation 200 on HIV/AIDS and the World of Work**, Principles:
 - (a) the response to HIV and AIDS should be recognized as contributing to the realization of human rights and fundamental freedoms and gender equality for all, including workers, their families and their dependents;
 - (b) HIV and AIDS should be recognized and treated as a **workplace issue**, which should be included among the essential elements of the national, regional and international response to the pandemic with full participation of organizations of employers and workers;
 - (c) there should be **no discrimination against or stigmatization of workers**, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection;
 - (d) **prevention** of all means of HIV transmission should be a fundamental priority;
 - (e) workers, their families and their dependents should have **access to and benefit from prevention, treatment, care and support** in relation to HIV and AIDS, and the workplace should play a role in facilitating access to these services;
 - (f) **workers' participation and engagement** in the design, implementation and evaluation of national and workplace programmes should be recognized and reinforced;
 - (g) workers should benefit from programmes to prevent specific risks of **occupational transmission** of HIV and related transmissible diseases, such as tuberculosis;
 - (h) workers, their families and their dependents should enjoy protection of their **privacy, including confidentiality** related to HIV and AIDS, in particular with regard to their own HIV status;

- (i) no workers should be required to undertake an HIV test or disclose their HIV status;
- (j) measures to address HIV and AIDS in the world of work should be part of national development policies and programmes, including those related to labour, education, social protection and health; and
- (k) the protection of workers in occupations that are particularly exposed to the risk of HIV transmission.

National Laws, Policies and Actions

The 2012 **National HIV/AIDS Workplace Policy** was developed in consultation with employers, employees, and their representatives in accordance with the 10 ILO principles:

1. To strengthen the legal framework for HIV/AIDS as a workplace issue.
2. To contribute to the reduction of HIV transmission through effective implementation.
3. To contribute to the reduction of HIV/AIDS related stigma and discrimination through continuous education, training and involvement of persons living with HIV and AIDS.
4. To strengthen the capacities of organizations to provide care and support for persons living with or affected by HIV/AIDS.
5. To manage and mitigate the impact of HIV/AIDS in the workplace through workplace based research and prevention and support programmes.

In 2010, a submission was made to the Cabinet to **amend Public Health (Notifiable Diseases) Order**, to remove provisions that are prejudicial to PLHIV as it relates to employment, particularly within the food and tourism industries e.g. in applying for a Food Handler's Permit.

If and when enacted, the **Occupation Safety and Health Act** and associated regulations will give legal protection and sanction against discrimination based on HIV-status including employment termination.

Further, the Ministry of Labor and Social Security is preparing a **Manual on Life Threatening Illnesses** that will treat HIV like other chronic illnesses and prohibit HIV discrimination, as well as a **certification program** to encourage restaurants and eateries to declare their workplace HIV-discrimination free.

The **National Foundation for HIV**, created in 2011, has the mandate of mobilizing private sector funds to finance income-generating projects for PLHIV.

Gaps

The 2013 Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica reported several incidents of employment termination of PLHIV between 2007-2010. According to the Founder of the Jamaican Network of Seropositives, **employment dismissal is one of the biggest barriers that PLHIV face in Jamaica**. Until the Occupation Safety and Health Act and related regulations are enacted, there is no legal protection against all forms of HIV-related discrimination at the workplace. Only roughly about 5% of institutions have committed to the Voluntary Compliance Program to develop HIV workplace policy. Staff shortage makes it difficult to scale up implementation of the National HIV/AIDS Workplace Policy. Stigmatization and HIV-related discrimination are particularly severe within the food industry (see Factor 1).

The National HIV/AIDS Workplace Policy does not have a **redress** mechanism. For such a policy to be effective and meaningful, it should find articulation in law, supported by a robust redress mechanism. When enacted, the

Occupational Safety and Health Act will allow individuals to bring forth their complaints in front of the Industrial Disputes Tribunal. The problem of redress is further compounded by the **lack of awareness of their employment and other social and economic rights by PLHIV.**

Mandatory HIV testing is enforced for applicants to the **Overseas Employment Programme** (Jamaicans leaving abroad to participate in various training and employment programs, notably in the US and Canada) (see Factor 3).

While the National HIV/STI Program has implemented a number of income-generating projects for PLHIV, the efforts have not been sustained. Interviewees talked of a **social protection system that is not HIV-sensitive.**

There is **no law or policy prohibiting non-discrimination in life insurance coverage and in pension** based on HIV status (see Factor 5).

The **private sector** has been slow to step up to deal with HIV and AIDS costs and its impact, and provide support for PLHIV.

Recommendations (see Factor 5)

10.1 Ensure non-discrimination of PLHIV in employment, insurance, and pension in a comprehensive HIV and AIDS law and/or a general anti-discrimination law. HIV infection and clinical AIDS should be treated no less favourably than any other serious illness or condition.

10.2 Eliminate mandatory HIV screening requirement in the Overseas Employment Programme, as it is discriminatory.

10.3 Put in place HIV-sensitive social protection measures such as cash transfers for PLHIV.

10.4 Ensure that employee and family assistance programmes are established for PLHIV who need them through the Voluntary Compliance Program of the National HIV/AIDS Workplace Policy or an Occupation Safety and Health Act.⁹⁹

10.5 Sustain income-generating projects for PLHIV in the National HIV/STI Program.

10.6 Engage the private sector to finance income-generating projects for PLHIV, notably through the National Foundation for HIV.

10.7 Provide training for PLHIV on basic social, economic, and cultural rights.

Factor 11: Private and Public Housing

PLHIV enjoy equal access to adequate private and public housing, including residential facilities. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and protect their

⁹⁹ For more details, see 2001 ILO Code of Practice on HIV/AIDS and the World of Work. The family assistance programme may include compassionate leave; invitations to participate in information and education programmes; referrals to support groups, including self-help groups; assistance to families of workers to obtain alternative employment for the worker; specific measures, such as support for formal education, vocational training and apprenticeships, to meet the needs of children and young persons who have lost one or both parents to AIDS;; coordination with all relevant stakeholders and community-based organizations including the schools attended by the workers' children; direct or indirect financial assistance; managing financial issues relating to sickness and the needs of dependents; legal information, advice and assistance; and assistance in relation to understanding the legal processes of illness and death such as managing financial issues relating to sickness, preparation of wills and succession plans (p. 18).

rights in the place of residence. Segregation, exclusion, and coercive or punitive measures based on HIV status are prohibited.

Conclusion

There is no law or policy prohibiting the denial of housing based on HIV status; nor does any law or policy address the connection between persons affected by the disease and inadequate housing. The 2013 Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica reported several incidents of housing denial for PLHIV between 2007-2010. Community stigma and discrimination, resulting in home evictions, remain a serious challenge.

International Laws / Recommendations / Guidelines

- **ICCPR**, Art. 17: Freedom from arbitrary or unlawful interference with his privacy, family, home.
- **ICESCR**, Art. 11: Right to housing.
- **1996 Habitat Agenda** (UN Conference on Human Settlements): urges States not only to eliminate discrimination in housing, but also to provide equitable and sustainable access to adequate shelter and basic services, taking into account specific needs of vulnerable populations. Special accommodations for the underserved (including PLHIV) may include: targeted and transparent subsidies.
- **Charter of the Organization of American States** art. 24, which obligates states to attempt to supply all persons with adequate housing.

National Laws, Policies and Actions

In Jamaica, there is no law or policy that prohibits the denial of housing based on HIV status. The 2013 Review of the National HIV-Related Discrimination Reporting and Redress System in Jamaica reported several incidents of housing denial for PLHIV between 2007-2010.

Gaps

PLHIV's equal access to adequate private and public housing, including residential facilities is not guaranteed by law or legal provisions. Neither the National HIV/AIDS Policy nor Strategic Plan specifically addresses the links between poor health, HIV, and the lack of adequate housing. Community stigma and discrimination, resulting in home evictions, remain a serious challenge to the full enjoyment of PLHIV in social life and protection (see Factor 5). No special measures have been put in place to provide reasonable accommodations for PLHIV and protect their rights in the place of residence. Currently, some CBOs run temporary shelters for PLHIV evicted from their homes.

Recommendations

11.1 Ensure non-discrimination of PLHIV in housing through a comprehensive HIV and AIDS law and/or a general anti-discrimination law and/or amendment of relevant law and regulations with clear redress mechanisms.

11.2 Integrate provisions on housing protections in the National HIV/AIDS Policy and Strategic Plan.

11.3 Put in place HIV-sensitive reasonable accommodations for PLHIV and protect their rights in the place of residence including housing subsidies.

11.4 Fund CBOs to expand shelter services and provide training for PLHIV on basic social, economic, and cultural rights.

Factor 12: Entry, Stay, and Residence

The State does not impose restrictions on the entry, stay, and residence of PLHIV based on HIV status. PLHIV are not returned to countries where they face persecution, torture, or other forms of cruel, inhuman, or degrading treatment. Migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services.

Conclusion

There have been no reported cases of denial of entry, stay, residence, or naturalization in Jamaica based on HIV status. The existing law does not prohibit travel restrictions based on HIV status or mandatory HIV testing of migrants. Mandatory HIV testing is enforced for applicants to the Overseas Employment Programme (Jamaicans leaving abroad to participate in various training and employment programs, notably in the US and Canada). The HIV-related needs of migrants and mobile populations are not integrated in the national HIV response and existing health care programs. Little data is available on diverse mobile populations in Jamaica. There are no culturally and linguistically appropriate HIV intervention programs targeting mobile populations, especially high risk groups including sex workers, sex tourists, and MSM. At the same time, migrants may not be aware of their right to information and right to health due to legal status, stigma, and socio-economic and cultural alienation.

International Laws / Recommendations / Guidelines

- **International Guidelines on HIV/AIDS And Human Rights: Right To Liberty Of Movement:** There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever. Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns. Where States prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency.
- **2000 UNESCO/UNAIDS, Migrant Populations and HIV/AIDS: the Development and Implementation of Programmes:** Best practice on development of programs targeting migrant populations.
- **2008 UNAIDS Report of the International Task Team on HIV-Related Travel Restrictions, Findings and Recommendations 6:** Strongly encourage all countries to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status.
- **2010 ILO Recommendation 200 on HIV/AIDS and the World of Work, para 25:** HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, jobseekers and job applicants.

National Laws, Policies and Actions

The Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act of 1946 does not contain provisions

pertaining to travel restrictions based on HIV status or mandatory HIV testing of migrants. There have been no reported cases of denial of entry, stay, residence, or naturalization in Jamaica based on HIV status.

Mandatory HIV testing is enforced for applicants to the **Overseas Employment Programme** (Jamaicans leaving abroad to participate in various training and employment programs, notably in the US and Canada).

Jamaica will present its **draft migration policy** to the UN High Level Dialogue on International Migration and Development in October 2013. A five-year action plan will be developed and funding has already been secured to implement the policy and action plan.

Gaps

The estimated immigrant population in Jamaica is 1.1% (roughly 30,000 people).¹⁰⁰ There is **no legal protection against HIV-related travel restrictions and discrimination of migrants and mobile populations**. Even though there have been no reported cases of denial of entry, stay, residence, or naturalization in Jamaica based on HIV status, such cases may arise in the future as the Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act of 1946 does not prohibit mandatory HIV testing of migrants or travel restrictions based on HIV status.

The HIV-related needs of migrants and mobile populations are **not integrated** in the national HIV response and existing health care programs. **Little data is available on diverse mobile populations in Jamaica**, which include immigrants (refugees and asylum-seekers; labour immigrants; foreign students; inland tourists; irregular immigrants) and emigrants (refugees and asylum-seekers abroad; labour emigrants; students abroad; outbound tourists; and irregular emigrants).¹⁰¹ There has been **little research** on their demographics and mobility patterns; HIV and AIDS prevalence; modes of transmission; sexual and other risk behaviors; health knowledge, belief, and practices; health seeking behavior and status; motives for migration and period of migration; legal status; and specific health and other related needs.

There are no culturally and linguistically appropriate HIV intervention programs targeting various mobile populations especially at risk groups including sex workers, sex tourists, and MSM. At the same time, migrants may not be aware of their right to information and right to health due to legal status, stigma, and socio-economic and cultural alienation.

Mandatory HIV testing in the **Overseas Employment Programme** is discriminatory and should be removed as a condition for employment.

Recommendations

12.1 Amend the Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act of 1946 to ensure that prospective immigrants who are tested and found to be HIV positive will not be prohibited from entering and remaining in the country based on their HIV status; and to ensure confidentiality of their medical information.

12.2 Remove mandatory HIV testing in the Overseas Employment Programme.

12.3 Integrate HIV policy and programmes for immigrant populations as part of migrant population policy within a national development policy.

12.4 Establish a migrant focal point and steering committee within the national HIV response.

¹⁰⁰ <http://www.iom.int/cms/en/sites/iom/home/where-we-work/americas/central-and-north-america-and-th/jamaica.html> [accessed on September 17 2013].

¹⁰¹ IOM. 2010. Migration Country Profile: Jamaica, http://publications.iom.int/bookstore/free/IOM-MigrationinJamaica2010_FINAL_311012.pdf [accessed on September 10 2013].

12.5 Collect data on migrant HIV prevalence rates and other related indicators.

12.6 Recruit and train cultural mediators to conduct HIV awareness campaigns within diverse mobile populations.

12.7 Provide and integrate SRH information, education, and services with HIV interventions for migrants.

12.8 Train health and welfare personnel, police officers, customs and immigration officials, and public officials at the Planning Institute of Jamaica that devise migration-related policy, Ministry of Foreign Affairs, and Passport Immigration and citizenship Agency on migrant HIV vulnerabilities and needs.

Factor 13: Non-Criminalization of HIV Exposure and Transmission

HIV exposure and non-intentional transmission are not criminalized. Deliberate and intentional transmission of HIV is prosecuted under general rather than HIV-specific criminal law.

Conclusion

Jamaica does not have a HIV-specific criminal law, and there has been no prosecution or conviction related to HIV transmission. HIV transmission can be prosecuted under Section 22 of the Offences against the Person Act 1864. A person living with HIV can be isolated under Section 14 (1) of the Public Health Act of 1985. In 2010, a successful submission was made to the Cabinet to have HIV and AIDS removed from the Public Health (Class 1

Notifiable Diseases) Order. Some government officials have advocated for an HIV-specific law to criminalize intentional transmission. Politicians, religious leaders, as well as the public do not seem to be well informed about international standards concerning criminalization of HIV transmission.

International Laws / Recommendations / Guidelines

- **International Guidelines on HIV/AIDS And Human Rights, Guideline 4:** States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups. Criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality, and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.
- **2006 Political Declaration on HIV/AIDS**, para. 25: promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.
- **2008 UNAIDS, Criminalization of HIV Transmission, Policy Brief 1:** UNAIDS urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.
- **2010 UNAIDS 2011-2015 Strategy: Getting to Zero.** 1. *Zero new infections by 2015:* All new HIV infections prevented among people who use drugs. 3. *Zero discrimination by 2015:* Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half.
- **2010 Special Rapporteur on the Right to Health: Right to Health and Criminalization of Same-Sex Conduct & Sexual Orientation, Sex-Work & HIV Transmission (A/HRC/14/20): para 76 (c) Recommendation:** To

immediately repeal laws criminalizing the unintentional transmission of or exposure to HIV, and to reconsider the use of specific laws criminalizing intentional transmission of HIV, as domestic laws of the majority of States already contain provisions which allow for prosecution of these exceptional cases.

• **2012 Global Commission on HIV and the Law: Risks, Rights and Health.** Recommendations:

2.1. Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been advanced to support the enactment of such laws should be withdrawn and amended to conform to these recommendations.

2.2. Law enforcement authorities must not prosecute people in cases of HIV non-disclosure or exposure where no intentional or malicious HIV transmission has been proven to take place. Invoking criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.

2.3. Countries must amend or repeal any law that explicitly or effectively criminalises vertical transmission of HIV. While the process of review and repeal is under way, governments must place moratoria on enforcement of any such laws.

2.4. Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but such prosecutions should be pursued with care and require a high standard of evidence and proof.

2.5. The convictions of those who have been successfully prosecuted for HIV exposure, non-disclosure and transmission must be reviewed. Such convictions must be set aside or the accused immediately released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records.¹⁰²

National Laws, Policies and Actions

Jamaica does not have a HIV-specific criminal law and there has been no prosecution and conviction related to HIV transmission. However, HIV/AIDS is classified as a notifiable disease under Section 2(1) of the Public Health Act of 1985. As such, a person living with HIV can be isolated under Section 14 (1) of this Act: The Minister may make regulations generally for carrying out the provision and purposes of this Act, and in particular, subject to section 7, but without prejudice to the generality of the foregoing, may make regulations in relation to (a) notifiable and communicable disease, the treatment and prevention thereof and the isolation of patients suffering therefrom. In 2010, a submission was made to the Cabinet to have HIV and AIDS removed from the Public Health (Class 1 Notifiable Diseases) Order to use vector as the basis for the distinction to differentiate between different categories of communicable diseases and notifiable diseases.

HIV transmission could be prosecuted under Section 22 of the Offences against the Person Act 1864: Whoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any person, either with or without any weapon or instrument, shall be guilty of a misdemeanor, and, being convicted thereof, shall be liable to be imprisoned for a term not exceeding three years, with or without hard labour.

In 2010, the Labour Minister threatened to push for legislation to impose criminal sanctions on persons who

¹⁰² <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf> [accessed on September 17 2013].

¹⁰³ <http://www.gnpplus.net/criminalisation/country/jamaica> [accessed on September 10 2013].

¹⁰⁴ <http://jamaica-gleaner.com/gleaner/20100211/news/news4.html> [accessed on September 10 2013].

Gaps

Some people including legal officers from different line ministries advocate for a HIV-specific law to criminalize HIV transmission.¹⁰⁵ Politicians, religious leaders, as well as the public do not seem to be well informed about the international guidelines concerning criminalization of HIV transmission. International human rights advocates agree that enacting HIV-specific criminal law is not an effective way to fight against the epidemic. Criminalizing HIV transmission is justified only when individuals purposely or maliciously transmit HIV with the intent to harm others. In these rare cases, existing criminal laws can and should be used, rather than passing HIV-specific laws. Such laws promote fear and stigma, and further oppress women who may be prone to violence in disclosure.¹⁰⁶

Recommendations

13.1 Develop sensitization training for political leaders, legal officers within line ministries, FBOs, and the public to understand that criminalization of HIV transmission perpetuates stigma of PLHIV, discourages testing, and is recognized as an ineffective way to fight against the epidemic by international human rights advocates.

¹⁰⁵ Second stakeholder workshop, Kingston, August 20 2013.

¹⁰⁶ <http://www.opensocietyfoundations.org/publications/ten-reasons-oppose-criminalization-hiv-exposure-or-transmission> [accessed on September 10 2013].

III. Key Populations

Factor 14: Women

The State takes all appropriate measures to reduce specific HIV vulnerabilities of women, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

Conclusion

Although gender equality is clearly enshrined as a principle in Vision 2030, the National HIV/STI Strategy, and the National Policy for Gender Equality, there is no national strategy pertaining specifically to women and HIV. The most prevalent factors that increase HIV vulnerability among women are not addressed in the National HIV/AIDS Policy. Little gender-segregated HIV prevalence data is available and women are not recognized as a key population in the context of HIV/AIDS. There is no effective policy or legal framework to ensure women's access to comprehensive sex, health, and HIV education, and prevention, care, and support services including their full sexual and reproductive health and rights. Abortion is illegal in Jamaica, and some interviewees raised concerns regarding the lack of full informed consent in routine HIV testing of pregnant women as well as instances of forced abortions on HIV-positive women and involuntary sterilization of HIV-positive women.

Teenage pregnancy is a serious issue in Jamaica, and there is no law that prohibits discrimination against pregnant teenage mothers in access to schooling. The predominant health framework for women focuses on maternal and child health, and STI. There is very little messaging and programming that addresses a broader range of concerns. Women are particularly vulnerable to engaging in transactional sex in the current economic downturn and there are few financial or other social protection programs generally, let alone for women living with HIV/AIDS. There is no effective policy or legal framework that addresses the sexual diversity of women, including the needs of lesbians and transgender women in their access to health services. Policy-making and program design in the HIV sector are dominated by men. Women remain underrepresented in HIV governance structures. There is inadequate gender-sensitive HIV training for judicial and law enforcement officers as well as social workers and health care providers.

International Laws / Recommendations / Guidelines

- CEDAW, Arts. 1-5: Right to non-discrimination; Art 10: Right to equality in education; Art 16: Right to equality in family life; Arts 5, 6, 12, 16, 32: Right to be free from violence and harmful traditional practices; Arts 11, 13, 16: women's economic rights; Art 12: Right to health.

- **International Guidelines on HIV/AIDS And Human Rights, Guideline 8:** States, in collaboration with and through the community, should promote a supportive and **enabling environment for women**, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

(a) States should support the establishment and sustainability of **community associations** comprising members of different vulnerable groups for peer education, empowerment, positive behavioural change and social support.

(b) States should support the development of adequate, accessible and effective HIV-related **prevention** and care education, information and services by and for vulnerable communities and should actively involve such communities in the design and implementation of these programmes.

(c) States should support the establishment of national and **local forums** to examine the impact of the HIV epidemic on women. They should be multisectoral to include Government, professional, religious and community representation and **leadership** and examine issues such as: (i) The role of women at home and in public life; (ii) The **sexual and reproductive rights of women and men**, including women's ability to negotiate safer sex and make reproductive choices; (iii) Strategies for increasing **educational and economic opportunities** for women; (iv) Sensitizing service deliverers and improving health care and social support **services for women**; and (v) The impact of **religious and cultural traditions on women**.

(d) States should implement the Cairo Programme of Action of the International Conference on Population and Development and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women. Primary health services, programmes and information campaigns in particular should include a gender perspective. **Violence against women**, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated. Positive measures, including formal and informal education programmes, increased work opportunities and support services, should be established.

(e) States should support **women's organizations** to incorporate HIV and human rights issues into their programming.

(f) States should ensure that all women and girls of child-bearing age have access to accurate and **comprehensive information and counseling** on the **prevention of HIV transmission** and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose.

- **MDG 1-6:** Eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria, and other diseases.

- **2006 Political Declaration on HIV/AIDS:** para. 27: to ensuring that pregnant women have access to antenatal care, information, counseling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counseling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care; para 31: ourselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV and AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

- **2010 UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-2014, 3 Recommendations:** 1) jointly generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls (knowing your epidemic and response); 2) reinforce the translation of political commitments into scaled-up action and resources for policies and programmes that address the rights and needs of women and girls in the context of HIV; and 3) champion leadership for an enabling environment that promotes and protects women's and girls' human rights and their empowerment in the context of HIV, through increased advocacy and capacity and adequate resources.¹⁰⁷

- **UNAIDS 2011-2015 Strategy: Getting to Zero.** 3. Zero Discrimination: HIV-specific needs of women and girls are addressed in at least half of all national HIV responses.

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http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf [accessed on September 10 2013].

National Laws, Policies and Actions

In **Vision 2030**, the strategic intent to reduce all inequalities that contribute to HIV vulnerabilities of women is outlined under Priority National Outcome of Effective Governance under National Goal # 2: The Jamaican Society Is Secure, Cohesive and Just in the second Medium Term Socio-Economic Policy Framework 2012-2015:

Finally, it should also be noted that **inequalities and disparities between women and men are still evident in our education system, the labour market, health delivery, crime and violence, employment opportunities** and other aspects of our society. As under the previous MTF, a gendered approach to development planning and implementation will be employed. The specific strategy for gender equity is included under the Priority National Outcome for Effective Governance. Additionally, each policy and programme will be evaluated for its differential impact on men and women, and the gender lens will be used to evaluate societal issues to support the development of appropriate policies and programmes.

The **National HIV/AIDS Policy** endorses **gender equality** as one of the key guiding principles: “The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.” Specifically, Objectives 1 and 4 speak to **gender-sensitive approaches to prevention and legislative measures to eliminate sexual violence**:

Objective 1: Prevention of new HIV infections

The policy and legislative framework will also enable the promotion of prevention programmes developed for and with adolescents and young people to delay sexual initiation, to abstain from sexual activity and to increase condom use among those who opt to remain sexually active. It will encourage the promotion of abstinence and secondary virginity as a viable option while recommending consistent condom use for the sexually active. Gender sensitive approaches must be adopted to maximize the effects of these messages within the context of prevailing social and cultural norms. This is especially important since female adolescents in the age group 15 to 19 are particularly vulnerable because of reported transactional and coercive relationships with older men. Strategies include:

- **increasing condom use and strengthening condom negotiation skills among women** and other vulnerable populations.
- strengthening **PMTCT** including the promotion of universal VCT for pregnant women, access to ARV treatment, counseling and optimal infant feeding options.

Objective 4: Enabling policy regulatory and legislative environment

Amending legislation to minimize human rights violations:

- ensure that **women and girls are protected against violence**, including sexual violence, rape and other forms of coerced sex.

Further, the **2011 National Policy for Gender Equality (NPGE)** sets targets and strategies in six areas (Appendix 5):

I) Legislation and Human Rights

1. To eliminate all forms of discrimination against women
2. To enhance women’s awareness of their legal rights through legal literacy programmes
3. To increase access to legal aid for economically vulnerable women in matters of discrimination
4. To enact legislation to ensure social entitlements and right to work for PLHIV
5. To promote a human rights approach to issues of sexuality
6. To reduce the maternal mortality rate by eliminating the need for unsafe abortions

II) Labor and Economic Empowerment

7. To pursue the enactment of sexual harassment legislation
8. To harmonize age of consent (for boys and girls) in all legislation, instruments and policies relating to

children and youth

9. To ensure that definition of discrimination on the basis of sex as stipulated in the CEDAW is incorporated in amendments to the Constitution as set out in the Charter of Rights
10. To promote a human rights approach to issues of sexuality
11. To eliminate gender disparity in wages and labour laws
12. To improve conditions of work for women and men in low paying sectors in keeping with the ILO Decent Work Agenda
13. To develop and enforce sexual harassment workplace policies in the private and public sectors
14. To address structural barriers that create and reinforce sex segregation of the labour market
15. To increase employment opportunities for women in the formal sector increased
16. To institute measures to ensure social protection of persons, mainly women, engaged in social reproduction and the unpaid 'care' economy
17. To remove vulnerabilities associated with the commercial sex industry

III) Empowerment of Vulnerable Women

18. To establish a lobby group and ensure provision of support services to women in micro, small and medium sized enterprises
19. To develop and implement strategies to alleviate poverty and other vulnerabilities among rural women
20. To design and implement a comprehensive plan to eliminate sexual and other forms of violence against women, punish offenders and provide services for victims and children, in keeping with the principles of the Belem do Para Convention and CEDAW
21. To provide women's crisis shelters for victims of sexual and domestic violence
22. To introduce measures to address trafficking in women and children implemented and enforced
23. To integrate a gender perspective in analyses of crime and violence perpetrated by males
24. To integrate a gender perspective in mandatory anger management and conflict resolution sessions designed for male perpetrators of violence

IV) Education and Culture

25. To transform prevailing gender ideologies that under-gird a sexual division of labour and reproduces a male/female hierarchy in educational institutions and ultimately the wider society
26. To re-socialize adolescent males and females away from entrenched stereotypical views on expressions and performance of masculinity and femininity towards an understanding of the importance of shared roles
27. To promote equality in male/female participation in higher levels of education system increased
28. To create an environment in educational institutions that fosters mutual respect and in which there is no tolerance for sexual harassment and abuse

V) Governance and Decision-Making

29. To ensure women are equipped with requisite skills to assume positions of leadership
30. To institute special measures to increase women's level of representation in decision-making to 30% in local and central government and all of State owned enterprises

VI) Gender Mainstreaming

31. To make the collection of data disaggregated by sex and location mandatory by all public and private agencies in the social, economic and political sectors on a regular and timely basis
32. To set up systems to facilitate ready retrieval of these data as required by researchers, planners and policy-makers
33. To equip all persons involved in planning and policy formulation with the tools for conducting gender analyses and the skills to use the information produced to develop, monitor and evaluate projects, programmes and policies.
34. To produce a comprehensive manual of gender indicators related to all major sectors which can be used to inform design of plans, projects and programmes and for monitoring their impact
35. To appoint Gender Focal Points in all line ministries, critical statutory organizations and executive agencies and to establish an inter-sectoral Committee to oversee implementation of the NPGE and to

mainstream gender in plans, programmes and policies of their respective organizations.¹⁰⁸

There have been some significant legal and policy changes concerning gender equality in Jamaica. The **Charter of Fundamental Rights and Freedoms** of 2011 prohibits discrimination on the basis of being a male or female. Amendments were made to the **Domestic Violence Act**, which now provides redress and protection to women affected by domestic violence. The National Strategic Plan to Eliminate Gender-Based Violence will be submitted to the Cabinet.¹⁰⁹ The **Property Rights of Spouses Act**, 2004 introduced new statutory rules to provide for the equitable division of assets between spouses upon marriage or common-law relationship breakdown. The **Maintenance Act** of 2005 replaces the old Act and makes comprehensive provisions for maintenance within the family. It confers equal rights and obligations on spouses with respect to the support of each other and their children. The **Sexual Offences Bill of 2009**, which covered amendments to the Incest Punishment Act and the Offences against the Person Act, established the offence of marital rape, made new provisions for the prosecution of rape and other sexual offences.¹¹⁰

A **Gender Focal Point** was established within the National HIV/AIDS Program. The Ministry of Health is currently developing a training manual on Gender and HIV. The National Policy for Gender Equality noted, however, that **legislative reform by itself will not achieve gender equality** especially where gendered roles (and interpretation of law) tend to be rooted in and built on custom, tradition, religion, and deeply held ideology and beliefs about what constitutes “proper” social ordering.

In 2011, the then Prime Minister, Honourable Bruce Golding and the then leader of the Opposition, the Most Honourable Portia Simpson Miller signed a **Declaration of Commitment to eliminate stigma and discrimination and gender inequality** affecting the HIV response in Jamaica. It commits the representatives of the people of Jamaica “...to the creation and promotion of a supportive and enabling social, policy and legal environment that respects and protects the rights of all Jamaican women, girls, men and boys and guarantees universal access to prevention, treatment, care and support in relation to HIV and AIDS.” The high-level political declaration on HIV and AIDS was the first of its kind not only in Jamaica, but also in the region.

Gaps

There is **no national strategy on gender and HIV**. The most prevalent factors that create **HIV vulnerability among women**—including poverty; single parent household; limited employability especially among youth; general powerlessness related to economic vulnerability and cultural norms; gender-based violence; and inability to negotiate and initiate safer sex practices—although included in the 2011 National Policy for Gender Equality, are **not integrated in the National HIV/AIDS Policy**.

Women represent a growing proportion of new cases with heterosexual sex as a driver of HIV infection. There are significant gaps in condom use among women based on sex and age. **Little gender-segregated HIV prevalence data** is available and women are **not recognized as a key population** in the context of HIV and AIDS. There is **no effective policy or legal framework to ensure women’s access to comprehensive sex, health, and HIV education, and prevention, care, and support services**.

Although the Ministry of Health has implemented gender-sensitive public education campaigns on HIV and continue to address gender power imbalance in social relations (e.g. through advertising that shows women purchasing condoms), there is still **no law or policy that addresses and ensures the full sexual and reproductive health and rights of women**. Violence against women remains a serious issue in Jamaica.

Abortion is illegal in Jamaica under Sections 72 and 73 of the Offences Against the Person Act of 1864 (see Factor 8). Some interviewees also raised the concern of the **lack of full informed consent in routine HIV testing**

¹⁰⁸ <http://www.jis.gov.jm/pdf/NPGE-JA-FINALwCover21311.pdf> [accessed on September 11 2013].

¹⁰⁹ <http://opm.gov.jm/national-strategic-plan-to-eliminate-gender-based-violence-to-be-submitted-to-cabinet/> [accessed on October 15 2013].

¹¹⁰ Ibid.

of pregnant women as well as instances of **forced abortions on HIV-positive women and involuntary sterilization of HIV-positive men and women (see Factor 8)**. **Services for early STI screening and treatment** are insufficiently developed due to insufficient resources and integration with HIV services.

The **predominant health framework for women** focuses on maternal and child health, and STI. There is very little messaging and programming that addresses a broad range of issues such as gender socialization and disparities in economic and political participation from public health perspectives. Although Vision 2030 recognizes the importance of a gendered approach to development planning and implementation, a **rights-based approach to sexuality, gender mainstreaming, and empowerment** is still missing in the national development plan as well as National HIV/AIDS Programme.

Access to comprehensive HIV information, sex and sexuality education, and prevention services and supplies in and out of schools remains a serious challenge due to legal barriers and exerts a greater impact on girls due to gender socialization. Teenage pregnancy is a serious issue in Jamaica, and there is **no law that prohibits discrimination against pregnant teenage mothers in access to schooling**. There is a great deal of confusion and conflicting directions between the Sexual Offences Act, the Child Care and Protection Act, and the Access to Contraceptives Policy for Minors. Age-appropriate reproductive and sexual health education through the Health and Family Life Education curriculum is not always ensured (see Factor 8).

There is **no effective policy or legal framework that addresses the sexual diversity of women** including the needs of lesbians and transgender women in their access to health services.

Policy-making and program design in HIV are dominated by men. **Women remain underrepresented in HIV governance structures**.

Gender-sensitive HIV training for judicial and law enforcement officers as well as social workers and health care providers have not been sustained.

Women are particularly vulnerable to **transactional sex** in the current economic downturn and there are few financial or other social protection programs especially for women living with HIV and AIDS.

These various concerns are highlighted in the **2011 Draft Report of the Working Group on the Universal Periodic Review of Jamaica** where different countries urge Jamaica to:

98.7. Address appropriately the challenges identified by treaty bodies' reports, particularly those relating to gender equality, the rights of the child and the elimination of violence against women, and consider requesting technical assistance from OHCHR in order to duly implement treaty bodies' recommendations (Costa Rica);

98.8. Continue to address gender inequality (Bangladesh);

98.9. Continue strengthening the institutions and preventive policies relating to gender issues and discrimination against women (Chile);

98.10. Implement further policies to ensure gender equality throughout society and strengthen the promotion of the rights of women (South Africa);

98.11. Continue the measures to increase women's participation in public and political life (Azerbaijan);

98.12. Further intensify the already laudable steps being taken to improve the conditions of juvenile detention (Mauritius);

98.13. Continue implementing further plans and programmes to reduce levels of violence against women and girls (Colombia);

98.14. Continue its efforts to eliminate violence against women (Azerbaijan);

98.15. Consider additional awareness-raising campaigns concerning domestic violence cases (Republic of Moldova);

98.16. Ensure prompt and effective investigation of gender-based violence and that alleged perpetrators are prosecuted (Norway);

98.27. Continue implementing actions aimed at reducing maternal mortality from indirect causes (Colombia);

98.37. Adopt targeted policies and programmes to offer protections for the most vulnerable in society, including women, children and persons with disabilities, and to eliminate discrimination against them (Canada).¹¹¹

Recommendations

14.1 Integrate a rights-based approach to sexuality, gender mainstreaming, and empowerment in the national development plan and National HIV/AIDS Strategic Plan.

14.2 Develop a national strategy on gender and HIV to address sexual diversity among women and men and all factors that increase HIV vulnerability among women and men, and to ensure their access to comprehensive sex, health, and HIV education, and prevention, care, and support services.

14.3 Disaggregate HIV prevalence data by gender and consider women as a key population for HIV interventions.

14.4 Enact a comprehensive policy on sexual and reproductive health and rights including provisions for PLHIV on freedom from sexual violence, forced abortion, and sterilization among other things.

14.5 Ensure minors' especially girls' access to comprehensive HIV information, sex and sexuality education, and prevention services and supplies in and out of schools by aligning different SRH provisions in existing legislations and policies.

14.6 Develop a multi-sectoral policy or a memorandum of understanding pertaining to SRH education (including HFLE), information, and services, clarifying the distinct roles and responsibilities of each sector.

14.7 Implement the recommendations outlined in the 2007 Final Report by the Ministry of Health Abortion Policy Review Advisory Group.

14.8 Strengthen and integrate STI screening and treatment services with HIV interventions.

14.9 Take special measures to ensure women's representation on HIV governance structures.

14.10 Provide gender-sensitive HIV training for health care providers, social workers, teachers, and judicial and law enforcement officers.

14.11 Develop legal literacy programmes for women.

14.12 Develop special initiatives aiming at the economic empowerment of women especially those living with HIV and AIDS.

¹¹¹ UN Human Rights Committee. 2011. Draft Report of the Human Rights Council on its Sixteenth Session (A/HRC/16/L.41), <http://www2.ohchr.org/english/bodies/hrcouncil/docs/16session/DraftReport16thSessionHRC.pdf> [accessed on September 18 2013].

Factor 15: Children and Youth

The State takes all appropriate measures to reduce specific HIV vulnerabilities of children and youth, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

Conclusion

Although protection and care for children and youth are outlined as a priority area in various national policies, there is no law that prohibits HIV-related discrimination against children and youth including those living with HIV and AIDS. The 2004 Management of HIV/AIDS in Schools Policy prohibits HIV-related discrimination in school settings, but it is not legally enforceable. A major challenge to a coherent and comprehensive approach is the multiplicity of laws, policies, and sectoral jurisdictions pertaining to children and youth. In the profusion of laws and policies, the “best interest of the child” standard is left at the discretion and subjective interpretation of policymakers and service providers.

There are some forthcoming changes to government policies regarding HIV and children. And, the new governance structure of the Sexual and Reproductive Health Authority offers an opportunity for a more coordinated approach to SRH, though it is unclear to what extent any eventual national sexual and reproductive policy will address children and youth. Interviewees had a prevailing sentiment of an abstinence approach rather than an empowerment one in youth-targeted HIV prevention policy and program delivery. There has been little evaluation on the effectiveness of this approach to address youth vulnerability to HIV. Existing policies and programs also fail to take into consideration of sexual diversity among youth including youth MSM and transgender youth. Homophobic bullying in schools is a serious concern.

Psychosocial support for different youth sub-populations is absent. While age-sensitive HIV training for social workers, health care providers, and judicial and law enforcement officers is being provided, there is little monitoring and evaluation on the quality of delivery and there is no redress mechanism in case of breaches of privacy and confidentiality. Interviewees spoke of a hostile healthcare environment, especially for teen mothers, young people living with HIV; MSM; and youth with disabilities. SRH remains largely a taboo subject; many healthcare providers are still in denial that youth and children are having sex and require information and services. Although there are some efforts in mainstreaming young people in policy development, no policy ensures that children’s perspectives are incorporated in the development of health care programs targeted to meet their needs. Finally, there is still a lack of qualitative, ethnographic data on children’s sexual behavior of children and youth and other drivers of HIV vulnerability.

International Laws / Recommendations / Guidelines

- **CRC:** the right to non-discrimination (art. 2), the right of the child to have his/her interest as a primary consideration (art. 3), the right to life, survival and development (art. 6) and the right to have his/her views respected (art. 12); the right to access information and material aimed at the promotion of their social, spiritual and moral well-being and physical and mental health (art. 17); the right to preventive health care, sex education and family planning education and services (art. 24 (f)); the right to an appropriate standard of living (art. 27); the right to privacy (art. 16); the right not to be separated from parents (art. 9); the right to be protected from violence (art. 19); the right to special protection and assistance by the State (art. 20); the rights of children with disabilities (art. 23); the right to health (art. 24); the right to social security, including social insurance (art. 26); the right to education and leisure (arts. 28 and 31); the right to be protected from economic and sexual exploitation and abuse, and from illicit use of narcotic drugs (arts. 32, 33, 34 and 36); the right to be protected from abduction, sale and trafficking as well as torture or other cruel, inhuman or degrading treatment or punishment (arts. 35 and 37); and the right to physical and psychological recovery and social reintegration (art. 39).

• **International Guidelines on HIV/AIDS And Human Rights, Guideline 8:** States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

• **2003 CRC General Comment No. 3 on Children and HIV/AIDS**, para. 8: Of particular concern is **gender-based discrimination** combined with taboos or negative or judgmental attitudes to sexual activity of girls, often limiting their access to preventive measures and other services. Of concern also is discrimination based on **sexual orientation**. In the design of HIV/AIDS-related strategies, and in keeping with their obligations under the Convention, States parties must give careful consideration to prescribed gender norms within their societies with a view to eliminating gender-based discrimination as these norms impact on the vulnerability of both girls and boys to HIV/AIDS. States parties should, in particular, recognize that discrimination in the context of HIV/AIDS often impacts girls more severely than boys.¹¹²

• **2004 UNICEF Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS**, which lay out five key strategies: 1. Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV and AIDS; 2. Mobilizing and strengthening community-based responses; 3. Ensuring access to essential services for orphaned and vulnerable children; 4. Ensuring that governments protect the most vulnerable children; and 5. Raising awareness to create a supportive environment for children affected by HIV and AIDS.¹¹³

• 2006 Division for the Advancement of Women and UNICEF Expert Group Meeting, the **Elimination of all Forms of Discrimination and Violence against the Girl Child on the Rights of the Child:**

- Freedom from discrimination based on gender, age, race, color, language, religion, ethnicity, or any other status, or on the status of the child's parents.

- A standard of living adequate for a child's intellectual, physical, moral, and spiritual development.

- A healthy and safe environment.

- The highest possible standard of health and to equal access to health care.

- Equal access to food and nutrition.

- Life and to freedom from prenatal sex selection.

- Freedom from cultural practices, customs and traditions harmful to the child, including female genital mutilation.

- To education - to free and compulsory elementary education, to equal access to readily available forms of secondary and higher education, and to freedom from all types of discrimination at all levels of education.

- To information about health, sexuality and reproduction.

- Protection from all physical or mental abuse.

- Protection from economic and sexual exploitation, prostitution, and trafficking.

- Freedom from forced or early marriage.

- Equal rights to inheritance.

- Freely express an opinion, and to have this opinion duly taken into account when taking decisions affecting the child's life.¹¹⁴

• **2010 UNAIDS 2011-2015 Strategy: Getting to Zero. 1. Zero new infections by 2015:** Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work.

¹¹²

[http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/309e8c3807aa8cb7c1256d2d0038caaa/\\$FILE/G0340816.pdf](http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/309e8c3807aa8cb7c1256d2d0038caaa/$FILE/G0340816.pdf) [accessed on September 11 2013].

¹¹³ http://www.unicef.org/aids/files/Framework_English.pdf [accessed on September 28 2013].

¹¹⁴ <http://www.un.org/womenwatch/daw/egm/elim-disc-viol-girlchild/ExpertPapers/EP.15%20Khatab.pdf> [accessed on September 11 2013].

National Laws, Policies and Actions

The second Medium Term Socio-Economic Policy Framework (2012-2015) under **Vision 2030** includes the **Protection and Care for Children and Youth** as a priority area under National Goal # 2: The Jamaican Society Is Secure, Cohesive and Just.

The **National HIV/AIDS Policy** addresses youth-related issues. Specifically, Objectives 1 and 4 speak to strengthening protection for children against violence and access to reproductive and health education:

Objective 1: Prevention of new HIV infections

- disseminating HIV/AIDS information within a life skills context at all levels of formal and non-formal education.
- strengthening the role of parents and guardians in shaping positive attitudes and behaviours in children and young people with regards to sexuality and gender roles.
- promoting Voluntary Counseling and Testing (VCT) for HIV, with appropriate pre- and post-test counseling, ensuring improved access to vulnerable groups including adolescents and youth.

Objective 4: Enabling policy regulatory and legislative environment

- Strengthen and enforce existing legislation to protect children and young people against any type of abuse and exploitation with particular reference to the new Child Care and Protection Act (2004).
- Incorporate age appropriate reproductive and sexual health education into the early childhood, primary and secondary school curricula for all students and school personnel and ensure that similar reproductive and sexual education is made accessible to youth out of school to protect them from HIV and other STIs.

The 1994 **National Youth Policy** (updated in 2003) focuses on 6 areas of youth development including living environments; education and training; employment and entrepreneurship; health; participation and empowerment; and care and protection. Specifically, the health issues of **four priority youth groups** are emphasized: 1) Youth at risk of early pregnancy, substance, misuse, HIV and other STIs; 2) younger and underserved rural youth; 3) youth in institutional care; and 4) adults influential in young people's lives and responsible for the implementation of youth focused health activities. Three strategies include: to create through advocacy networks, a supportive policy environment that fosters positive health outcomes; to improve knowledge, influence attitudes and selected priority health practices and behaviours; and to improve access to and quality of health services.¹¹⁵ A review of the National Youth Policy is currently tabled in the Parliament. Among various aspects, youth involvement in youth policy development and youth access to sexual and reproductive health are two issues being addressed in the review.

In 2012, UNFPA funded a detailed **assessment on the law and policy framework for adolescent sexual and reproductive health in Jamaica**, outlining ten recommendations on policy reforms, child rights breaches, protection from sexual violence, and psychosocial support etc.¹¹⁶ A multisectoral taskforce has since been established to take the recommendations forward.

The NHP, through the support of CBOs, has implemented and supported child- and youth-oriented HIV programs through public awareness campaigns and interventions in health fairs and other events in the community. Examples of television and radio advertisements include Pinch, Leave an Inch, and Roll; Real Men don't Ride without Condoms; and Live Up as part of a Caribbean-wide regional HIV sensitization campaign through well-known sports heroes.

Gaps

The most prevalent factors that increase HIV vulnerability among children and youth are lack of educational and

¹¹⁵ http://planipolis.iiep.unesco.org/upload/Youth/Jamaica/Jamaica_2003YouthPolicy.pdf [accessed on September 12 2013].

¹¹⁶ Chambers, Tania. 2012. *The Law And Policy Framework For Adolescent Sexual And Reproductive Health In Jamaica: A Rights-Based Approach To Assessing ASRH Issues In Jamaican Law And Policy*. Kingston: UNFPA.

employment opportunities; poverty; precarious living conditions; violence including gender-based violence; teenage pregnancy; lack of access to sex education, accurate information about HIV, and HIV prevention measures including condoms; intergenerational sex; serostatus and/or having lost one or both parents to AIDS; and youth with disabilities.

There is **no law that prohibits HIV-related discrimination against children and youth**. The 2004 Management of HIV/AIDS in Schools Policy prohibits HIV-related discrimination only in school settings and is voluntary. Vision 2030 focuses on children and youth solely from the perspectives of security and crime reduction such as diversionary sentencing options for children and youth.

A major challenge to a coherent and comprehensive approach is the **multiplicity of laws, policies, and sectoral jurisdictions pertaining to children, youth, sexual reproductive health, and HIV**. The 2003 **Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS** aims to facilitate access of orphans and children affected by HIV and AIDS to existing social services as well as reduce stigma and discrimination against those living with HIV and AIDS. The 2004 **Management of HIV/AIDS in Schools Policy** is supposed to guarantee access of children and youth to age-appropriate reproductive and sexual health education through the HFLE curriculum.

The actual delivery of the HFLE curriculum is at the discretion of individual teachers and there is no formal monitoring and evaluation. The 2013 incident of HFLE censorship illustrates the political, religious, and cultural influence on policy-making and implementation surrounding sexuality education. Under the **Law Reform Age of Majority Act**, a child at age 16 can consent to ‘any surgical, medical or dental treatment’, including diagnostic and ancillary procedures. The consent of the parent or guardian of a child aged 16 or older is not required for such treatment/procedure. What constitutes “medical treatment” is not legally defined. The **Offences Against the Person Act** creates a criminal offence for a person to engage in sexual acts with a girl under that age of sixteen.

The **Sexual Offences Act** creates a criminal offence for a person to engage in sexual acts with a girl or a boy under the age of sixteen, even though data shows that many boys and girls have sexual debut below the age of 16. The **Access to Contraceptives Policy for Minors** of 2007 outlines the procedure for the provision of contraceptive advice, counseling, and treatment to persons under 16 years of age by a healthcare provider, but service delivery is at the discretion of health professionals who may be reluctant for fear of aiding and abetting in criminal acts. The **Child Care and Protection Act** raises concerns of minors’ privacy and confidentiality in matters of sexual health. It states, where an individual is charged with or convicted of an offence that has a sexual nature in respect of a child, or is an offence involving conduct likely to result in the transmission of a communicable disease to a child, the court may make an order for that individual to submit to medical examination and testing. An order may also be made for the medical examination of a child if the child is deemed in need of care and protection and there is reason to believe the child has been abused (see Factor 1 and 8). In this profusion of laws and policies, the **“best interest of the child” as a primary consideration** is left at the discretion and subjective interpretation of policymakers and service providers.

The review of the 2004 Management of HIV/AIDS in Schools Policy remains incomplete. The 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS has never been reviewed.

While the new governance structure of the **Sexual and Reproductive Health Authority** (merging the NHP and the National Family Planning Board) offers an opportunity for a more coordinated approach to SRH, it is unclear to what extent any eventual national sexual and reproductive policy will address children and youth needs and concerns.

In terms of youth-targeted HIV prevention policy and program delivery, interviewees complained of a **heavy abstinence approach** (e.g. the Abstinence Makes Sense campaign) rather than an **empowerment** approach. There has been little evaluation on the **effectiveness of the behavior change and communication approach** to address youth vulnerability to HIV. The 2012 HIV Knowledge, Attitudes, and Behavior Survey of Jamaica shows that youth between 15 and 24 are less likely to recall the three appropriate methods to prevent HIV transmission (one faithful partner; condom use all the time; and abstinence) compared to the 25-49 age group. Existing policies and programs fail to take into consideration of **sexual diversity among youth** including youth MSM and transgender youth. Homophobic bullying in schools is a serious concern and perpetuates stigma against young MSM. Psychosocial

support for different youth sub-populations is absent.

Although there have been some efforts in mainstreaming young people in policy development, no policy ensures that children's perspectives are incorporated in the development of health care programs targeted to meet their needs. There is also the need to **train and empower children and youth** to understand their rights and responsibilities.

While **age-sensitive HIV training** for social workers, health care providers, and judicial and law enforcement officers is being provided, there is little monitoring and evaluation on the quality of delivery and there is **no redress mechanism** in case of breaches of privacy and confidentiality. Interviewees spoke of a **hostile healthcare environment**, especially for teen mothers, young people living with HIV; MSM; and youth with disabilities. SRH remains largely a taboo subject; many healthcare providers are still in denial that youth and children are having sex and require information and services.

Finally, there is still a **lack of qualitative, ethnographic data** on orphans and children affected by HIV and AIDS, sexual behavior of children and youth, and other drivers of HIV vulnerability.

Recommendations

15.1 Ensure non-discrimination against children and youth based on HIV status in a comprehensive HIV and AIDS law and/or a general anti-discrimination law with redress mechanisms.

15.2 Align existing laws and policies to address HIV vulnerability and needs of children and youth including access to HIV information, sex and sexuality education, sexual and reproductive health, sexual diversity, prevention services and treatment, stigma reduction, and redress for discrimination.

15.3 Activate and complete the reviews of the 2004 Management of HIV/AIDS in Schools Policy and the 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS.

15.4 Ensure that a national SRH policy encompasses children and youth perspectives and needs.

15.5 In addition to BCC and abstinence approaches, add an empowerment approach in HIV and youth policy and program design.

15.6 Through CBOs, train children and youth to participate in policy development.

15.7 Ensure monitoring and evaluation of age-sensitive HIV training for social workers, health care providers, and judicial and law enforcement officers.

15.8 Make existing research accessible to youth and develop further qualitative, ethnographic research on orphans and children affected by HIV and AIDS, sexual behavior of children and youth, and other drivers of HIV vulnerability.

Factor 16: People who Use Drugs

The State takes all appropriate measures to reduce specific HIV vulnerabilities of people who use drugs, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

Conclusion

Data suggests that injecting drug users do not constitute a significant population in terms of HIV prevalence.

However, a 2005 survey of crack/cocaine users showed 5% HIV prevalence in this population and 27% homeless men and women reported crack/cocaine use. Interviewees raised concerns about the ability of the NHP to provide reliable data concerning this key population due to underfunding and absence of national data. The 2012-2013 National HIV/AIDS Strategic Plan identifies drug users as a key population in the priority area of prevention. Section 8(B) of the Dangerous Drugs Act makes the possession of cocaine of any amount a criminal offence in Jamaica.

The Drug Court Act provides a diversion program through which non-violent offenders being prosecuted for the possession of small amounts of drugs for personal use have the option to be admitted to a rehabilitation program instead of a prison. The government delivers HIV prevention and treatment services targeting drug users, and CBOs also provide peer counseling for drug users. However, there is no law or policy that prohibits mandatory HIV testing and HIV-related discrimination of people who use drugs or ensures the provision of harm reduction services to drug users in Jamaica. The National Security Policy approaches drug use from a crime control perspective. The NHP does not allocate a specific budget for HIV programs focusing on people who use drugs. Services are delivered out of the National Council on Drug Abuse.

The framework for services for drug users in Jamaica remains predominantly abstinence-based and high-threshold interventions. Harm reduction is not yet an integral part of the national HIV response; neither the National HIV/AIDS Policy nor the Strategy mentions harm reduction. There seems to be little understanding of harm reduction by multisectoral stakeholders. Interviewees mentioned the continuous stigma and discrimination against people who use drugs and the lack of human rights training and education for various professionals who work with drug users.

There is also a lack of psychosocial support and mental health services for this population. Existing services do not address the intersectionality of MSM, homelessness, sex work, inmates, and drug use despite data showing a significant overlap of these key populations. People who use drugs are largely absent in the design and implementation of HIV programs.

International Laws / Recommendations / Guidelines

- **International Guidelines on HIV/AIDS And Human Rights, Guideline 4:** (d) Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider: the authorization or legalization and promotion of needle and syringe exchange programmes; the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes.

- **2010 UNAIDS 2011-2015 Strategy: Getting to Zero.** 1. *Zero new infections by 2015:* All new HIV infections prevented among people who use drugs. 3. *Zero discrimination by 2015:* Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half.

- **2010 Special Rapporteur on the Right to Health: Right to health and International Drug Control (A/65/255), Recommendations:**

Para. 76. Member states should:

- Ensure that all **harm-reduction measures** (as itemized by UNAIDS) and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations;

- **Decriminalize** or de-penalize possession and use of drugs.

- Repeal or substantially reform laws and policies inhibiting the **delivery of essential health services** to drug users, and review law enforcement initiatives around drug control to ensure compliance with human

rights obligations.

- Amend laws, regulations and policies to increase **access to controlled essential medicines**. Para. 77. The United Nations drug control bodies should:

- Formulate guidelines that provide direction to relevant actors on taking a **human rights-based approach to drug control**, and devise and promulgate rights-based indicators concerning drug control and the right to health.

- **2012 WHO, UNODC, and UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users**: comprehensive package of HIV interventions for people who use drugs, (1) Needle exchange programs; (2) Opioid substitution therapy and other drug dependence treatment; (3) HIV testing and counseling; (4) ART; (5) prevention and treatment of STIs; (6) condom programs for people who use drugs and their sexual partners; (7) targeted information, education and communication for people who use drugs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of TB.¹¹⁷

- **2012 Global Commission on Drug Policy, The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic**. Ten recommendations including:

1. Acknowledge and address the causal links between the war on drugs and the spread of HIV/AIDS, drug market violence and other health (e.g., hepatitis C) and social harms.

2. Respond to the fact that HIV risk behavior resulting from repressive drug control policies and underfunding of evidence-based approaches is the main issue driving the HIV epidemic in many regions of the world.

3. Push national governments to halt the practice of arresting and imprisoning people who use drugs but do no harm to others.

4. Replace ineffective measures focused on the criminalization and punishment of people who use drugs with evidence-based and rights-affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.

5. Countries that under-utilize proven public health measures should immediately scale up evidence-based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution and other safer injecting programs. Failure to take these steps is criminal.¹¹⁸

National Laws, Policies and Actions

Surveillance data suggests that injecting drug users do not constitute a significant population in terms of HIV prevalence. However, a 2005 survey of crack/cocaine users showed 5% HIV prevalence in this population and 27% homeless men and women reported crack/cocaine use.¹¹⁹

Section 8(B) of the **Dangerous Drugs Act** makes the possession of cocaine a criminal offence in Jamaica. The **Drug Court Act** provides a **diversion program** through which non-violent offenders being prosecuted for the possession of small amounts of drugs for personal use have the option to be admitted to a rehabilitation program instead of a prison.

¹¹⁷ http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf [accessed on September 12 2013].

¹¹⁸ http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf [accessed on September 12 2013].

¹¹⁹ National HIV/AIDS Strategic Plan, 2012-2017.

The 2012-2013 **National HIV/AIDS Strategic Plan** identifies drug users as a key population in the priority area of prevention. HIV prevention and treatment services targeting drug users are delivered primarily by the **National Council on Drug Abuse (NCDA)** through a Global Fund-funded program called the **‘Tek it to Dem’ initiative**. The mandate of this initiative is to provide a long term sustained and coordinated prevention approach to assist in the fight against HIV/AIDS among the extremely vulnerable population of the drug users and homeless in Kingston, St Andrew and St. Catherine.

The outreach team focuses on various substance misusing street populations including: street based sex workers, MSM, chaotic drug users, poly drug users, and dual diagnosis clients. A *dega dega mobile van* provides prevention information, testing, condoms, food, and referral services to homeless and drug users in Kingston and in Montego Bay. In addition to engaging with substance users, the team also makes contact with local businesses and members of the public to ensure that they are aware of the services that are available by NCDA. This also provides further insight into the local community, helps to identify any problem hotspots and new clients in need of substance misuse support.

The outreach work involves working closely with treatment and rehabilitation facilities doing joint outreach to target problematic drug and alcohol users and reduce the impact on the local community. The team also attends monthly meeting with the National Committee for the Homeless for housing provision focusing on linking clients into suitable local housing options to address support needs. The Strategic intervention and outreach approaches of this initiative comprise of seven dimensions:

1. Provision of healthcare (physical, mental, nutritional and security), psychosocial support;
2. Provision of referral services: medical, mental, detoxification, rehabilitation programmes and drug treatment services; psychosocial, social and welfare support services/drop in centers; homeless shelters; MSM friendly services;
3. Health Systems Strengthening/Anti-stigma and discrimination interventions: (a) identify MSM friendly public and private health care facilities for referrals as a mechanism to fast track treatment and diagnostic services and mitigate persons being lost to follow-up; (b) ongoing and systematic re-orientation of outreach officers and stakeholders regarding stigma and discrimination, confidentiality, needs and issues of the MSM population etc; (c) establish a peer-based outreach approach to promote behavior change and provide a supportive environment for the promotion of ARV adherence and safer sexual behaviours among MSM; (d) identify resources for psychosocial support (explore opportunities for reuniting with families; (e) establish guidelines and protocol for outreach activities to ensure adherence with local and international public health and human rights standards;
4. Specialist support from trained practitioners for people with the 'dual diagnosis' of mental health and substance use problems, through our key partners on the project such as the Department of Community Health and Psychiatry;
5. Treatment and care and scale up of HIV testing: Fill prescription for clients where possible; distribution of care packages and meals; conduct harm reduction group and one-on-one sessions with clients; conduct free HIV and substance tests; provide voluntary counseling and testing services; provide one-to-one structured support and case management of clients; conduct mapping to determine hot spots –in order to provide and expand services on the spot, and to gain greater/better insight into the practices and social norms of drug users and the homeless population; provide mobile outreach service via a van to take services to the streets and community of homeless population;
6. Social Inclusions: Housing advice and referral; provide advice and information about housing, social welfare benefits, healthcare and childcare; facilitate family, social and employment reintegration; facilitate family reunification; provide support with education, training and employment; and

7. Increase Civil Society/Community Level Intervention: (a) provide Capacity building and institutional strengthening technical assistance support to key partners and stakeholders working with the homeless population (which includes drug users, sex workers, MSM, mentally ill) in areas of harm reduction, behavior change communication, motivational interviewing, harm minimization, and substance abuse.

CBOs such as the Caribbean Vulnerable Communities also provide **peer counseling** for drug users.

Gaps

There is **no law or policy that prohibits mandatory HIV testing and HIV-related discrimination of people who use drugs or ensures the provision of harm reduction services** to drug users in Jamaica. The **National Security Policy** approaches drug use from a crime control perspective. Research such as the 2012 study by the Global Commission on Drug Policy entitled *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic* has shown the causal links between the war on drugs and the spread of HIV/AIDS, drug market violence and other health (e.g., hepatitis C) and social harms.

The National HIV/AIDS Policy does not address **specific HIV vulnerabilities of people who use drugs**.

Interviewees raised concern about the ability of the NHP to provide reliable data concerning this key population due to **underfunding and absence of national data** (excising HIV surveillance data among drug users comes from outreach programs run by the National Council on Drug Abuse). Jamaica **does not submit data on HIV transmission among people who use drugs** in UNGASS reporting since Target 2 only addresses HIV transmission among people who inject drugs.¹²⁰ When HIV prevalence data is reported, **drug users and homeless** are lumped into one category due to limits in the data collection method (the National Council on Drug Abuse runs programs for both populations). The problem of data collection has been further exacerbated since the end of a Global Fund-funded project in 2013 when rapid tests are no longer available. Instead, less reliable oral substance test kits (urine tests) are used which are not always feasible on the street.

The NHP does not allocate a **specific budget for HIV programs focusing on people who use drugs**. Services are delivered out of the National Council on Drug Abuse.

According to the WHO, UNODC, and UNAIDS, a comprehensive harm reduction approach includes: (1) Needle exchange programs; (2) Opioid substitution therapy and other drug dependence treatment; (3) HIV testing and counseling; (4) ART; (5) prevention and treatment of STIs; (6) condom programs for people who use drugs and their sexual partners; (7) targeted information, education and communication for people who use drugs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of TB. **Harm reduction is not yet an integral part of the Jamaican national HIV response.**

Neither the National HIV/AIDS Policy nor the Strategy mentions harm reduction. There seems to be **little understanding of harm reduction** by multisectoral stakeholders. Although the concept of harm reduction is embraced by some practitioners within the National Council on Drug Abuse, the framework for services for drug users in Jamaica remains predominantly **abstinence-based and high-threshold interventions which** require the user to accept a certain level of control of their drug use and which also demand that the patient accept counseling.

There is a lack of a rights-based approach and consideration of some of the latest scientific evidence concerning crack/cocaine users and HIV transmission.¹²¹ Mental health issues or criminal record may prevent some drug

¹²⁰ See UNGASS Jamaica Country Report 2012.

¹²¹ Some recent studies highlight the need for evidence-based prevention and harm reduction initiatives that directly target crack cocaine smokers, with particular attention given to female dual users of injection drugs. In Canada, human rights advocates have called for a medically supervised safer smoking facility to smoke pre-obtained non-injection drugs. See, for instance, Shannon K, Rusch M, Morgan R, Oleson M, Kerr T, Tyndall MW. 2008. "HIV and HCV prevalence and gender-specific risk profiles of crack cocaine smokers and dual users of injection drugs." In *Substance Use Misuse*. Volume 43(3-4):521-34, <http://www.ncbi.nlm.nih.gov/pubmed/18365948> and

offenders from accessing the diversion program. Police officers may not be familiar with the Drug Court and diversion program. Condoms are not available in the two rehabilitation centers on the island. The pilot harm reduction project funded by the Global Fund (the mobile van) is only limited to Kingston and Montego Bay.

Interviewees mentioned the **continuous stigma and discrimination against people who use drugs** and the **lack of human rights training and education** for various professionals. There is also a **lack of psychosocial support and mental health services** for this population. Existing services do not address the **intersectionality of MSM, homelessness, sex work, inmates, and drug use despite** data showing a significant overlap of these key populations. Existing HIV prevention approaches target various key populations as if they are distinct. In reality, young homeless MSM sex workers who use drugs face multiple factors of vulnerabilities and require specific targeted services.

People who use drugs are largely **absent in the design and implementation of HIV programs**.

Recommendations

16.1 Ensure that the linkage between criminalization, marginalization, and discrimination of people who use drugs and their vulnerability to HIV is addressed in the National HIV/AIDS Policy and Strategic Plan.

16.2 Ensure that harm reduction is an integral part of the national HIV response and that all relevant harm-reduction measures (as itemized by UNAIDS) and substitution therapy and drug-dependence treatment services are available to people who use drugs.

16.3 Ensure HIV-related non-discrimination against drug users in a comprehensive HIV and AIDS law and/or a general anti-discrimination law.

16.4 Develop policy guidelines that provide direction to relevant actors on taking a human rights-based approach to drug control, and devise rights-based indicators concerning drug control and the right to health.

16.5 Develop and disaggregate HIV prevalence data among drug users and the homeless population; and by gender, MSM, and sex work among drug users.

16.6 Provide treatment literacy as well as capacity building training for drug users to demand their rights, take personal responsibility, and participate effectively in HIV policy-making.

16.7 Decriminalize or de-penalize possession of small amounts drugs for personal use.¹²²

16.8 Repeal or substantially reform laws and policies inhibiting the delivery of essential health services to drug users, and review law enforcement initiatives around drug control to ensure compliance with human rights obligations.

16.9 Amend laws, regulations and policies to increase access to controlled essential medicines and consider the

Shannon, Kate, Tomiye Ishida, Robert Morgan, Arthur Bear, Megan Oleson, Thomas Kerr, and Mark W Tyndall. 2006. "Potential community and public health impacts of medically supervised safer smoking facilities for crack cocaine users." In Harm Reduction Journal. Volume 3: 1, <http://www.harmreductionjournal.com/content/3/1/1> [accessed on September 12 2013].

¹²² In the 2012 Drug Decriminalisation Policies in Practice: A Global Summary, Steve Rolles and Niamh Eastwood recommends that, "when adopting a decriminalisation policy, a number of factors have to be considered to ensure the framework is meaningful in its goal of not criminalising those caught in possession of drugs for their own personal use... where threshold amounts are adopted to determine whether someone is in possession for personal use the level needs to reflect market realities and be flexible enough to ensure that the principle of decriminalisation of personal possession is properly achieved (p.162)," http://www.ihra.net/files/2012/09/04/Chapter_3.4_drug-decriminalisation_.pdf

decriminalization marijuana per the recommendations of the 2001 Report of the National Commission on Ganja.¹²³

Factor 17: Adults Engaged in Commercial Sex

The State takes all appropriate measures to reduce specific HIV vulnerabilities of adults engaged in commercial sex, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

Conclusion

Sex work in Jamaica is criminalized. The 2012 Modes of HIV Transmission in Jamaica Study shows HIV prevalence at 4.1% and HIV incidence at 1% among sex workers. However, the HIV incidence rate among clients of sex workers is at 6% while the infection rate for partners of clients of sex workers is 3%. There is no law or policy that prohibits HIV-related discrimination and ensures sex workers receive equitable and sustainable access to comprehensive HIV-related services. While the National HIV/AIDS Policy identifies sex workers as a vulnerable population, stigma and discrimination, and low literacy levels among sex workers remain the biggest barriers to accessing HIV prevention, treatment, and care services for sex workers.

The recognition of the link between criminalization, marginalization, and discrimination of sex workers and their vulnerability to HIV within the NHP has not translated into legal or policy reforms. Sex workers reported incidents of mandatory HIV testing in order to gain employment (e.g. in massage parlors) as well as police asking for sex in return for releasing them. There is no alternative to incarceration of sex workers in Jamaica. Most social services available to sex workers cover only some of their needs without offering a wide range of services. Poverty remains one of the biggest drivers of HIV vulnerability among sex workers. Income-generation projects and other kinds of social protection support measures for sex workers and their families are very limited. Existing HIV prevention programs do not address the needs of sex worker sub-populations.

They also fail to reach clients of sex workers and partners of clients of sex workers. More sensitizing training and education on health-oriented and human rights-based approach to sex work need to be conducted for all professionals who deal directly with the sex workers. Legal literacy programs should be designed specifically for sex workers to encourage them to access legal aid. Despite the training and recruitment of sex workers as peer educators, there is both little involvement of sex workers in HIV decision-making process and a lack of capacity building to encourage sex workers to participate effectively in such processes.

International Laws / Recommendations / Guidelines

• **International Guidelines on HIV/AIDS And Human Rights, Guideline 4:** (b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services; (c) With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating Occupational Safety and Health conditions to protect sex workers and their clients, including support for safe sex during sex work.

Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients. Criminal law should ensure that children and adult sex workers who have been trafficked or otherwise coerced into sex work are protected from participation in the sex industry and are not prosecuted for such participation but rather are removed from sex work and provided with medical and psychosocial support services, including those related to HIV.

¹²³ <http://www.cannabis-med.org/science/Jamaica.htm> [accessed on September 12 2013].

• **2010 UNAIDS 2011-2015 Strategy: Getting to Zero.** 1. *Zero new infections by 2015:* All new HIV infections prevented among people who use drugs. 3. *Zero discrimination by 2015:* Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half.

• **2010 Special Rapporteur on the Right to Health: Right to Health and Criminalization of Same-Sex Conduct & Sexual Orientation, Sex-Work & HIV Transmission (A/HRC/14/20), para 76 Recommendation:** (c) To repeal all laws criminalizing sex work and practices around it, and to establish appropriate regulatory frameworks within which sex workers can enjoy the safe working conditions to which they are entitled. He recommends that States implement programmes and educational initiatives to allow sex workers access to appropriate, quality health services; (d) To introduce monitoring and accountability mechanisms so as to ensure their obligations to safeguard the enjoyment of the right to health through legislative, judicial and administrative mechanisms, including policies and practices to protect against violations; (e) To provide human rights education for health professionals, and to create an environment conducive to collective action and participation.

National Laws, Policies and Actions

Jamaica has an estimated population of sex workers of 15000.¹²⁴ The demographic is varied with both male and female sex workers including women who sell to men, men who sell to men mostly, and, to lesser extent, men who sell to women. Most sex workers are Jamaican and are primarily concentrated in tourist industries in Ochos Rios and Montego Bay. It is a highly mobile population with different levels of visibility among various sub-populations ranging from female sex workers on the streets being the most visible to largely invisible sex workers in massage parlors or MSM sex workers.

The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence at 4.1% and HIV incidence (new infections) at 1% among sex workers. However, the HIV incidence rate among clients of sex workers is at 6% while partners of clients of sex workers is at 3%. The UNAIDS data surveillance model shows no decline in the projected number of new HIV infections associated with sex work in Jamaica in the foreseeable future.¹²⁵

Sex work (living on the earnings of prostitution and solicitation) is criminalized in Jamaica under Section 68 of the **Offences against the Person Act**; Section 23 of the **Sexual Offences Act**, and Section 3(r) of the **Towns and Communities Act**.

The **National HIV/AIDS Policy** identifies sex workers as a vulnerable population and aims to intensify prevention interventions among sex workers. It emphasizes the responsibility of sex workers in protecting themselves as well as that of their clients and their sexual partners from the risk of HIV and other sexually transmitted infections; access to peer education training, condoms, condom-use and condom negotiation skills, VCT and proper diagnosis and treatment of STIs; and more user-friendly clinics to improve the non-threatening access of sex workers to prevention information, skills and services.

The NHP designs specific prevention activities targeting sex workers through outreach interventions (with distribution of condoms and lubricants, actual condom demonstration, risk-reduction conversations, and testing) and training and empowerment workshops. These are mostly delivered by CBOs such as Jamaica AIDS Support for Life and the National Sex Workers Association of Jamaica. The National Sex Workers Association of Jamaica also offers remedial programs to sex workers as well as police training sensitization workshops.

Gaps

Stigma and discrimination remain the biggest barriers to HIV prevention, treatment, and care for sex workers in

¹²⁴ National HIV/AIDS Strategic Plan, 2012-2017.

¹²⁵ Ibid.

Jamaica. There is **no law or policy that prohibits HIV-related discrimination and ensures sex workers with equitable and sustainable access to comprehensive HIV-related services.**

Criminalization of sex work makes it difficult to reach this mobile and vulnerable population especially the most invisible sex workers such as MSM sex workers and those who work through the Internet or telephone. The recognition of the **link between criminalization, marginalization, and discrimination of sex workers and their vulnerability to HIV** within the NHP has not translated into legal or policy reforms.

Sex workers reported incidents of **mandatory HIV testing** in order to gain employment (e.g. in massage parlors) as well as **police asking for sex** in return for releasing them. There is no alternative to incarceration of sex workers in Jamaica.

Sex workers continue to face serious **barriers to accessing HIV information and services:** low literacy level, little knowledge about rights and services, stigma including internalized stigma due to criminalization, and fear of the justice system in general. HIV testing uptake among sex workers remains low (at 60%). Most access to services is linked to outreach which covers only some of the needs of sex workers without offering a wide range of services such as counseling and STI treatment. Healthcare service delivery is at the discretion of individual providers and there is no redress mechanism in case of breach of privacy and confidentiality or other rights.

Poverty remains one of the biggest drivers of HIV vulnerability among sex workers. **Income-generation projects and other kinds of social protection support measures for sex workers and their families** are very limited.

Existing prevention programs do not address the **needs of sex worker sub-populations** such as sex workers who use crack/cocaine who are reported to be eight times more likely to be HIV-positive¹²⁶, MSM sex workers, and young sex workers. Prevention programs also fail to reach clients of sex workers and the partners of their clients, who together represent 9% of all new HIV infections in Jamaica; and partners of sex workers who may engage in multiple partnerships.

Human rights education including HIV and anti-discrimination education for all professionals who deal directly with the sex work communities has not been sustained.

There is a lack of **ethnographic research and data** on the social contexts and drivers of HIV vulnerability among sex workers such as economic conditions, criminalization, and exploitation by police. Understanding sex workers' attitudes and perceptions towards HIV infection risks, condom negotiation with clients, and opinions about decriminalization of sex work will enhance a more effective and targeted HIV response for sex workers.

Despite the training and recruitment of sex workers as peer educators, there is both **little involvement of sex workers in HIV decision-making processes** and a lack of capacity building for sex workers to participate effectively in such processes.

Legal literacy programs should be designed specifically for sex workers to encourage them to access legal aid as they face human rights abuses such as police harassment, violence from clients, and discrimination.

Recommendations

17.1 Ensure that the linkage between criminalization, marginalization, and discrimination of sex workers is addressed in the National HIV/AIDS Policy and Strategic Plan and translates into legal and policy reforms.

17.2 Ensure HIV-related non-discrimination against sex workers including the prohibition of mandatory HIV testing through a comprehensive HIV/AIDS law and/or a general anti-discrimination law.

17.3 Develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to

¹²⁶ Duncan et al 2005, cited in the National HIV/AIDS Strategic Plan, 2012-2017.

sex work and ensure programmes and educational initiatives to ensure sex workers have access to appropriate, quality health services.

17.4 Scale up HIV prevention services for sex workers including moving to a sex-worker friendly model that addresses their comprehensive needs including access to counseling and STI treatment.

17.5 Expand the existing prevention strategy to reach invisible sex work and related sub-populations including clients of sex workers and partners of clients of sex workers; partners of sex workers who engage in multiple partnerships; sex workers who use crack/cocaine; MSM sex workers; and young and migrant sex workers.

17.6 Repeal all laws criminalizing sex work and practices around it, and to establish appropriate regulatory frameworks within which sex workers can enjoy the safe working conditions to which they are entitled.

17.7 Provide treatment literacy, legal literacy, and capacity building training for sex workers to demand their socio-economic rights, take personal responsibility, and participate effectively in HIV policy-making.

17.8 Develop income-generation projects and other kinds of social protection support measures for sex workers and their families including alternatives to sex work.

17.9 Scale up sensitizing training and education on health-oriented and human rights-based approach to sex work for all professionals who deal directly with the sex work communities.

17.10 Fund ethnographic research on the social contexts and drivers of HIV vulnerability among sex workers.

Factor 18: Men who Have Sex with Men, and Transgender People

The State takes all appropriate measures to reduce specific HIV vulnerabilities of men who have sex with men, and transgender people, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

Conclusion

The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence at 32.8% and HIV incidence at 30% among MSM. The government has recognized that high rates of HIV infection among MSM and bisexuality among MSM fuels heterosexual HIV transmission. Female partners of MSM account for 7% of new HIV infections. MSM are criminalized in Jamaica. Despite the recognition by the National HIV/AIDS Policy that homophobia in Jamaica is a powerful cultural influence which forces MSM underground, stigma and discrimination represent significant barriers to HIV prevention, treatment, and care for MSM in Jamaica.

No law or policy prohibits HIV-related discrimination or ensures MSM receive equitable and sustainable access to comprehensive HIV-related services. Criminalization of private, consensual same-sex sexual acts perpetuates homophobia and makes prevention messaging difficult. In particular, the current strategy fails to reach the most-at-risk sub-populations, such as MSM with high socio-economic status, young MSM, rural MSM, MSM sex workers, homeless MSM, and drug-using MSM. Some religious groups continue to portray HIV as a gay disease, hampering prevention efforts targeting other key populations including a bridging population of women who are partners of MSM. There is little research or data on the transgender population.

Stigma and discrimination against MSM by healthcare workers remain a serious challenge. While some efforts have been made at sensitivity training and human rights education for relevant professionals, these have been hampered by high staff turnover in the health sector due to out-migration.

International Laws / Recommendations / Guidelines

- **ICCPR**, Article 17, which the Human Rights Committee has interpreted as protecting the right to private consensual sexual conduct between adults. The Committee has on several occasions criticized state parties for criminalizing aspects of homosexuality. Human Rights Committee, Concluding Observations: Romania, CCPR/C/79/Add.111 (1999), para. 16; Human Rights Committee, Concluding Observations: United States of America, CCPR/C/79/Add.50 (1999), para. 287.
- **International Guidelines on HIV/AIDS and Human Rights**, Guideline 4: (b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.
- **2006 Yoghakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity.**¹²⁷
- **2010 UNAIDS 2011-2015 Strategy: Getting to Zero.** 1. *Zero new infections by 2015*: Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work. 3. *Zero discrimination by 2015*: Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half.
- **2010 Special Rapporteur on the Right to Health: Right to Health and Criminalization of Same-Sex Conduct & Sexual Orientation, Sex-Work & HIV Transmission (A/HRC/14/20)**, para 76 Recommendations (a) To take immediate steps to decriminalize consensual same-sex conduct and to repeal discriminatory laws relating to sexual orientation and gender identity, as well as to implement appropriate awareness-raising interventions on the rights of affected individuals; (d) To introduce monitoring and accountability mechanisms so as to ensure their obligations to safeguard the enjoyment of the right to health through legislative, judicial and administrative mechanisms, including policies and practices to protect against violations; (e) To provide human rights education for health professionals, and to create an environment conducive to collective action and participation.
- **2011 UN Human Rights Council, Discriminatory Laws and Practices and Acts Of Violence against Individuals Based on Their Sexual Orientation and Gender Identity**, with seven recommendations including “Repeal laws used to criminalize individuals on grounds of homosexuality for engaging in consensual same-sex sexual conduct.”¹²⁸
- **2012 WHO, UNODC, and UNAIDS Technical Guide For Countries To Set Targets For Universal Access To HIV Prevention, Treatment And Care For Injecting Drug Users**: comprehensive package of HIV interventions for people who use drugs, (1) Needle exchange programs; (2) Opioid substitution therapy and other drug dependence treatment; (3) HIV testing and counseling; (4) ART; (5) prevention and treatment of STIs; (6) condom programs for people who use drugs and their sexual partners; (7) targeted information, education and communication for people who use drugs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of TB.¹²⁹

National Laws, Policies and Actions

The estimated population of men who have sex with men in Jamaica is 33,000.¹³⁰ The 2012 Modes of HIV Transmission in Jamaica study shows:

- HIV prevalence at 32.8% and HIV incidence (new infections) at 30% among MSM; and

¹²⁷ http://www.yogyakartaprinciples.org/principles_en.pdf [accessed on September 28 2013].

¹²⁸ http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41_English.pdf [accessed on September 28 2013].

¹²⁹ http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf [accessed on September 12 2013].

¹³⁰ National HIV/AIDS Strategic Plan, 2012-2017.

- 86% of men surveyed reported having only female sex partners while 14% reported having male sex partners. However, the sexual practice of 40% of men with AIDS is unknown and may reflect under reporting by MSM or weakness in data surveillance.

In an earlier 2007 survey, 56.7% of MSM had at least one female partner in the past 12 months and almost two thirds (64.3%) self-identified as bi-sexual; 27.4% MSM had multiple male partners within the last 4 weeks; only 57.7% had ever done an HIV test and 32.9% had done so in the past 12 months; 67% reported using a condom at last sex with their main male partner while 62% reported doing so at last sex with a female partner.¹³¹

Both sets of data point to **high rates of HIV infection among MSM and bisexuality among MSM fueling heterosexual HIV transmission** as important factors driving the HIV epidemic in Jamaica. HIV incidence among MSM has remained mostly constant over the past fifteen years. The UNAIDS projection model does not indicate any meaningful decline in new HIV infections among MSM over the next few years.¹³² Qualitative research suggests that sexual identities and relation patterns among MSM are diverse with little data on subgroups including MSM with high socioeconomic status, adolescent MSM, homeless MSM, transgender MSM, and “down low” MSM, i.e. those who engage in MSM activities without disclosing).¹³³

“Buggery” and “any act of gross indecency with another male person” are criminalized in Jamaica under Sections 76, 77 and 79 of the **Offences against the Person Act**. Although the “buggery” offence does not make a distinction on whether the act is between a man and another man or woman, it is mostly applied to same-sex sexual acts.

During the 2010 **Universal Periodic Review of Jamaica** by the UN Human Rights Committee, the issue of continuous violence, stigma, and discrimination faced by the LGBT community was discussed at length. Jamaica stressed that “the issue of male homosexuality was one of great sensitivity in Jamaican society, in which cultural norms, values, religious and moral standards underlay a rejection of male homosexual behaviour by a large majority of Jamaicans; and that the Government was committed to ensuring that all citizens were protected from violence.”¹³⁴

The US “appreciated Jamaica’s commitment to starting a **public information campaign to combat discrimination based on sexual orientation** and strongly supported recommendations made to repeal the sections of the Offences against the Person Act, which criminalized same-sex intercourse. It urged Jamaica to reconsider recommendations to investigate incidents or acts of violence with suspected motivations on the grounds of sexual orientation, and to take measures to ensure that lesbian, gay transgender and bisexual persons (LGBT) may fully participate in society without fear of attack or discrimination.”¹³⁵ Further, the Draft Report of the Human Rights Committee noted that COC Netherlands and the Jamaica Forum for Lesbians, All-sexuals and Gays (J-Flag) were encouraged by Jamaica’s adoption of recommendations to **train law enforcement officials and undertake public campaigns to combat discrimination on the grounds of sexual orientation**.

Citing the recent incident in February in Montego Bay, they stated that LGBT people continued to be the victims of human rights violations by non-state actors and state actors, such as police. The hope was expressed that Jamaica would demonstrate leadership in the fight against intolerance for LGBT Jamaicans. They encouraged the Government to take bold steps towards the decriminalization of consensual same-sex activities. They asked that within the current review of the Charter of Fundamental Rights and Freedoms a more inclusive clause on non-discrimination be considered for adoption.”¹³⁶

¹³¹ Ibid.

¹³² Ibid.

¹³³ Royes, 2003; Anderson, 2010; and UWI HARP, unpublished, cited in National HIV/AIDS Strategic Plan, 2012-2017.

¹³⁴ UN Human Rights Council. 2011. Report of the Working Group on the Universal Periodic Review of Jamaica (A/HRC/16/14), para. 32, http://ap.ohchr.org/documents/alldocs.aspx?doc_id=18040 [accessed on September 18 2013].

¹³⁵ UN Human Rights Committee. 2011. Draft Report of the Human Rights Council on its Sixteenth Session (A/HRC/16/L.41), para. 654, <http://www2.ohchr.org/english/bodies/hrcouncil/docs/16session/DraftReport16thSessionHRC.pdf> [accessed on September 18 2013].

¹³⁶ Ibid.

The **Report of the Working Group on the Universal Periodic Review of Jamaica** concluded:

100. The following recommendations will be examined by Jamaica...

100.21. Reinforce legal protections against discrimination to include sexual orientation and gender identity as prohibited grounds for discrimination (Canada);

100.22. Initiate or join public campaigns so as to encourage tolerance towards homosexual, bisexual and transsexual persons (Belgium);

100.23. Start a public information campaign to combat discrimination based on sexual orientation (Netherlands).

101. The following recommendations do not enjoy the support of Jamaica:

101.18. Repeal all provisions that criminalize same-sex activities between consenting adults (Netherlands);

101.19. Repeal sections 76, 77 and 79 of the Offences against the Person Act, which criminalize same-sex male intercourse (United States);

101.20. Decriminalize consensual sexual relations between adults of the same sex, and abolish all legal provisions discriminating against homosexual, bisexual or transsexual persons (Belgium);

101.21. Decriminalize sexual activity between consenting adults of the same sex, and address hate crimes on the grounds of sexual orientation and gender identity, as a matter of urgency (Slovenia);

101.22. Decriminalize consensual same-sex relations between males, investigate all incidents and acts of violence suspected of being motivated on the grounds of sexual identity, and take all necessary measures to ensure the full enjoyment of human rights by lesbian, gay, bisexual and transgender persons, as stipulated by the principle of non-discrimination established under international human rights law and articulated in the Yogyakarta principles (Sweden);

101.23. Include in the Charter of Rights Bill, currently before Parliament [this has since been passed], a specific prohibition of discrimination on the grounds of sexual orientation and repeal all legal provisions criminalizing consensual relations between adults of the same sex; and combat this type of discrimination through awareness-raising campaigns and education programmes in school (Spain);

101.24. Repeal all legal provisions constituting discrimination against lesbian, gay, bisexual and transgender persons (France);

101.25. Remove legislation which discriminates against individuals on the basis of their sexual orientation or gender identity (Australia);

102. The following recommendation does not enjoy the support of Jamaica, as Jamaica considers it is based on false or erroneous premises:

102.1. Ensure the protection of defenders of the rights of lesbian, gay, bisexual and transgender persons; and take measures to ensure that lesbian, gay, bisexual and transgender persons can fully and freely exercise their rights without fear of attack or reprisal (United States).¹³⁷

The 2012 Report on the Situation of Human Rights in Jamaica by the **Inter-American Commission On Human Rights** states that “discrimination based on sexual orientation, gender identity, and gender expression is widespread

¹³⁷ UN Human Rights Council. 2011. Report of the Working Group on the Universal Periodic Review (A/HRC/16/14), http://ap.ohchr.org/documents/alldocs.aspx?doc_id=18040 [accessed on September 18 2013].

throughout Jamaica, and that discrimination against those in the lesbian, gay, bisexual, trans, and intersex (LGBTI) communities is entrenched in Jamaican State institutions. Those who are not heterosexual or cisgender face political and legal stigmatization, police violence, an inability to access the justice system, as well as intimidation, violence, and pressure in their homes and communities.”¹³⁸

The **National HIV/AIDS Policy** identifies MSM as a vulnerable population. It recognizes that **homophobia** in Jamaica is a powerful cultural influence which forces MSM underground and that MSM should have the right of access to prevention knowledge, skills and services and to treatment care and support within a non-threatening environment.

The NHP designs specific prevention activities targeting MSM through outreach interventions (with distribution of condoms and lubricants, actual condom demonstration, risk-reduction conversations, and testing). These are mostly delivered by CBOs such as Jamaica AIDS Support for Life and the J-Flag. Recent efforts try to reach out to the most vulnerable MSM sub-groups such as homeless MSM.

In 2011, the then Prime Minister, Honourable Bruce Golding, and the then leader of the Opposition, the Most Honourable Portia Simpson Miller, signed a **Declaration of Commitment to eliminate stigma and discrimination and gender inequality** affecting the HIV response in Jamaica. It commits the representatives of the people of Jamaica “...to the creation and promotion of a supportive and enabling social, policy and legal environment that respects and protects the rights of all Jamaican women, girls, men and boys and guarantees universal access to prevention, treatment, care and support in relation to HIV and AIDS.” The Most Honourable Portia Simpson Miller also made an electoral promise in having a conscience vote on the “buggery” offence within the Offences against the Person Act.

Gaps

Homophobia, self-stigma, double-stigma of being MSM and HIV-positive, and discrimination represent significant barriers to HIV prevention, treatment, and care for MSM in Jamaica. **No law or policy prohibits HIV-related discrimination and ensures MSM receive equitable and sustainable access to comprehensive HIV-related services.** Stigma and discrimination impede access to services by MSM, fueling the HIV epidemic in Jamaica.

Criminalization of private, consensual same-sex sexual acts means that the NHP as well as CBOs have to “tread lightly” in prevention messaging. It is difficult for CBOs to speak of risks in terms of anal intercourse that constitutes a criminal act. While there has been some recognition of discrimination against MSM in top leadership (e.g. 2011 bi-partisan high-level declaration), there is less political buy-in or movement in terms of decriminalization of private, consensual same-sex sexual acts.

Recent **international funding focused on most-at-risk populations** has helped to scale up prevention efforts among MSM. The current strategy, however, fails to reach certain sub-populations such as MSM with high socio-economic status, young MSM, rural MSM, MSM sex workers, homeless MSM, and drug using MSM.

Some religious groups continue to **portray HIV as a gay disease**, hampering prevention efforts targeting other key populations including a bridging population of women who are partners of MSM.

There is little research or data on the **transgender population** that is currently subsumed under the MSM key population.

Stigma and discrimination against MSM by healthcare workers as well as privacy and confidentiality issues remain a serious challenge. Sensitization training and human rights education for healthcare workers and other professionals in contact with MSM populations have been hampered by high staff turnover in the health sector due to out-migration.

¹³⁸ <http://www.oas.org/en/iachr/docs/pdf/Jamaica2012eng.pdf> [accessed on October 15 2013].

Recommendations

18.1 Ensure that the linkage between criminalization, marginalization, and discrimination of MSM translates into legal and policy reforms.

18.2 Ensure HIV-related non-discrimination against MSM through a comprehensive HIV and AIDS law and/or a general anti-discrimination law.

18.3 Develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to MSM and create programmes and educational initiatives to ensure MSM receive access to appropriate, quality health services and which guarantee their privacy and confidentiality.

18.4 Scale up and expand the existing prevention strategy to reach invisible and most-at-risk MSM sub-populations such as MSM with high socio-economic status, young MSM, rural MSM, MSM sex workers, homeless MSM, and drug using MSM.

18.5 Take immediate steps to decriminalize private, consensual same-sex conduct and to repeal discriminatory laws relating to sexual orientation and gender identity.

18.6 Gather surveillance data on the transgender population and develop specific prevention measures to address their needs.

18.7 Provide treatment literacy, legal literacy, and capacity building training for MSM to demand their rights, take personal responsibility, and participate effectively in HIV policy-making.

18.8 Sustain sensitization training and human rights education including on privacy and confidentiality issues for healthcare workers and other professionals in contact with MSM populations.

18.9 Fund ethnographic research on the social contexts and drivers of HIV vulnerability among MSM.

Factor 19: People under State Custody

The State takes all appropriate measures to reduce specific HIV vulnerabilities of people under state custody, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services. Terminally ill PLHIV are considered for early release and given proper treatment outside of prisons.

Conclusion

The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence among inmates is 2.5%. Data is not available on the percentage of inmates who acquired HIV in prison. Since same-sex sexual acts are criminalized, condom distribution in prisons is not feasible.¹³⁹ The Corrections Act outlines security requirements in respect of prisoners. However, the National HIV/AIDS Policy identifies inmates as a vulnerable population and the 2009 Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica provides guidance on inmates' access to HIV prevention and treatment services.

While the Corrections Act does address prisoners' access to medical treatment, a prisoner's right to demand general medical care is not always ensured. There is no law or policy that prohibits HIV-related discrimination against inmates. Further, while existing laws prohibits torture, inhumane treatment, rape, and sexual abuse against inmates, they are not always enforced in prison settings. On-site services include the provision of HIV information, testing

¹³⁹ Ibid.

for entering inmates as well as their visiting partners, and training of peer educators. Some Church groups offer support services for inmates. The Guidelines for the Clinical Management of HIV/AIDS spell out strategies for the prevention of occupational exposure to HIV including for prison staff. While the “buggery” offence may not always be enforced in the general population, it is strictly applied in prison settings, which makes prevention work quasi-impossible. Service delivery is left at the discretion of prison officials and there is no mechanism for a prisoner to seek recourse if he/she does not receive treatment. While there is routine HIV testing among new inmates, this practice raises concerns about voluntary and confidential HIV testing. Voluntary HIV testing is not available to juveniles and HIV testing is not offered to exiting prisoners.

Despite the recognition that inmates are a key population, there is a lack of multisectoral political buy-in and consensus on what needs to be done regarding prevention and treatment. HIV programs for inmates within the NHP have been underfunded and are not integrated into the prison policy and system. Harm reduction supplies and services are practically non-existent. There is no STI management except in symptomatic cases, due to insufficient resources, even though doctors are trained to provide such services. Rapid tests for other STI except HIV and syphilis are not available. Basic commodities are not provided to inmates, and as a consequence sex is often used as exchange for basic necessities. Access to prevention and treatment by women inmates is a particular challenge. Statistics on sexual violence in Jamaican prisons are not available due to criminalization and denial of sexual acts in prison.

International Laws / Recommendations / Guidelines

- **International Covenant on Civil and Political Rights**, Article 10(1), which provides that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.” The ICCPR Human Rights Committee has concluded specifically in regards to Jamaica, that this imposes an obligation to provide adequate health care to persons in state custody. *Morrison v. Jamaica*, Communication No. 663/1995 (25 November 1998), para. 8.8, CCPR/C/64/D/663/1995.

- **1993 WHO Guidelines on HIV Infection and AIDS in Prisons**, General principles (right to health); voluntary and anonymous HIV testing; preventive measures (i) education and information, (ii) sexual transmission, (iii) transmission by injection, (iv) use of other substances that may increase the likelihood of HIV transmission; management of HIV-infected prisoners (non-segregation); confidentiality in relation to HIV/AIDS; care and support of HIV-infected prisoners; Tuberculosis in relation to HIV infection; specific needs of women prisoners; prisoners in juvenile detention centres; foreign prisoners; semi-liberty and release; early release; and contacts with the community and monitoring.¹⁴⁰

- **International Guidelines on HIV/AIDS And Human Rights, Guideline 4: Criminal Laws and Correctional Systems (e)** Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to **protect prisoners from rape, sexual violence and coercion**. Prison authorities should also provide prisoners (and prison staff, as appropriate), with **access to HIV-related prevention information, education, voluntary testing and counseling, means of prevention (condoms, bleach and clean injection equipment), treatment and care** and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should **prohibit mandatory testing, segregation** and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.

- **2007 WHO, UNODC, and UNAIDS Effectiveness of Interventions to Manage HIV in Prisons: Provision of Condoms and Other Measures to Decrease Sexual Transmission**, Recommendations on condom provision and measures to decrease sexual transmission:

¹⁴⁰ https://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub01/jc277-who-guidelines-prisons_en.pdf [accessed on September 12 2013].

1. Prison authorities in jurisdictions where condoms are currently not provided should introduce condom distribution programmes and expand implementation to scale as soon as possible.
2. Condoms should be made easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others.
3. Together with condoms, water-based lubricant should also be provided since it reduces the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission.
4. Educational and informational activities for prisoners and for staff should precede the introduction of condom distribution programmes, which should be carefully prepared.
5. Female prisoners should have access to condoms as well as dental dams.
6. Prison systems should develop and implement multi-prong strategies for enhancing the detection, prevention, and reduction of all forms of sexual violence in prisons and for the prosecution of offenders.
7. Formal evaluations of the various components of the policies and programmes to address rape and other forms of sexual violence in prison should be undertaken.
8. Victims of sexual assault in prison should have access to post-exposure prophylaxis.¹⁴¹

National Laws, Policies and Actions

The estimated population of inmates in Jamaica is 4,600 in 2011. The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence among inmates at 2.5% (HIV incidence data is not available). However, surveillance of new male and female inmates in 2010 recorded higher levels of HIV prevalence (5.4% among male inmates and 2.3% among female inmates).¹⁴² One 2007 study finds that inmates are seventeen times more likely to get HIV compared to the general population.

Sections 76, 77 and 79 of the **Offences against the Person Act**, criminalizing same-sex sexual acts, rules out condom distribution in prisons.¹⁴³

The **Corrections Act** outlines security requirements in respect of prisoners.

The **National HIV/AIDS Policy** identifies inmates as a vulnerable population and emphasizes that they should not be denied the right to access prevention knowledge, skills and services and voluntary counseling and testing. Further, access to HIV/AIDS/STI prevention information, treatment, care and support should take into account protection from rape, sexual violence and coercion. Juveniles should be segregated from adult inmates to protect them from abuse. Inmates should not be subjected to HIV testing without their informed consent, isolation, or any form of quarantine on the basis of real or perceived HIV and AIDS status.

The 2009 **Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica** provides guidance on inmates' access to HIV prevention and treatment services (see Factor 1). On-site services include the provision of HIV information, opt-out testing for entering inmates as well as their visiting partners, and training of peer educators. Some Church groups offer support services for inmates.

The **Guidelines for the Clinical Management of HIV/AIDS** spell out strategies for the prevention of occupational exposure to HIV that includes risk assessment and risk reduction activities. A training manual on post-exposure prophylaxis is in use and antiretroviral drugs are available and accessible in all regions for the prevention of HIV transmission to accidentally exposed health care workers (see Factor 2).

¹⁴¹ http://www.who.int/hiv/idu/Prisons_condoms.pdf [accessed on September 12 2013].

¹⁴² National HIV/AIDS Strategic Plan, 2012-2017.

¹⁴³ Ibid.

Gaps

Criminalization of same-sex sexual acts rules out condom distribution in prisons. While the “buggery” offence is not always enforced in the general population, it is strictly applied in prison settings, which makes prevention work quasi-impossible. Situational same sex sexual acts due to gender segregation in prison, sexual violence, and drug use expose inmates to higher risks of HIV infection.

While the Corrections Act does address prisoners’ access to medical treatment, available on a need basis, **a prisoner’s right to demand general medical care is not always ensured**. Service delivery is left at the discretion of prison officials and there is no mechanism for a prisoner to seek compensation for failure to treat him/her.¹⁴⁴ Inmates complained that their ARV supplies were irregular and their basic medical and nutritional needs were neglected.¹⁴⁵

There is no law or policy that prohibits HIV-related discrimination against inmates. Routine HIV testing among new inmates raises concerns about voluntary and confidential HIV testing.

While existing laws prohibits torture, inhumane treatment, rape, and sexual abuse against inmates, they are not always enforced in prison settings. Apart from a special section for MSM, inmates have **no right to protective custody** when his health or physical well-being is threatened.

The 2009 **Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica** is not officially adopted.

Despite the recognition of inmates as a key population, there is a **lack of multisectoral political buy-in and consensus** on what needs to be done for inmates. HIV programs for inmates within the NHP have been **underfunded** (roughly JD\$1.5 million in 2013, from USAID) and are **not integrated into prison policy or the prison system**.

Harm reduction supplies and services—such as condoms, water-based lubricants, dental dams; materials to enable safer smoking and inhalation of drugs, such as pipes, screens, push sticks, alcohol wipes, and lip balm; and drug dependence treatment services—are practically non-existent. Some condoms are “unofficially” distributed, but their supply is inconsistent and much smaller than the demand.

There is **no STI management** except in symptomatic cases due to insufficient resources even though doctors are trained to provide such services. Rapid tests for other STI except HIV and syphilis are not available.

Basic care packages including toothpaste, toothbrush, and soap etc. are not provided, and as a consequence sex is often used as exchange for basic necessities.

Access to prevention and treatment by women inmates is a particular challenge. The existing strategy does not address issues of sexual violence in prison. **Statistics on sexual violence** (including rape) in Jamaican prisons are not available due to criminalization and denial that sexual acts occur in prison. Access to post-exposure prophylaxis by victims of sexual assault in prison is not always ensured.

Voluntary HIV testing is not available to juveniles and HIV testing is not offered to exiting prisoners. Data is not available on the percentage of inmates who acquired HIV in prison.

¹⁴⁴ McNeil and McFarlane. 2006. HIV-related legal Review in Jamaica.

¹⁴⁵ http://www.jamaicaobserver.com/news/HIV-positive-inmates-say-they-are-neglected-in-prison_9090443 [accessed on September 17 2013].

*Recommendations*¹⁴⁶

19.1 Ensure HIV-related non-discrimination against inmates including the prohibition of mandatory HIV testing through a comprehensive HIV and AIDS law and/or a general anti-discrimination law.¹⁴⁷

19.2 Engage multisectoral actors to develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to prisoners and ensure programmes and educational initiatives to allow inmates' access to appropriate, quality health services.

19.3 Fund and scale up HIV testing, prevention, and treatment services for inmates.

19.4 Educational and informational activities for prisoners and for staff should precede the introduction of condom distribution programmes, which should be carefully prepared.

19.5 Introduce condom distribution programmes and expand implementation to scale as soon as possible.

19.6 Condoms should be made easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others.

19.7 Make available other harm reduction supplies such as water-based lubricant, dental dams, and safer smoking materials that would help reduce the risk of HIV transmission.

19.8 Conduct formal evaluations of the various components of the policies and programmes to address rape and other forms of sexual violence in prison, and gather statistics.

19.9 Prison systems should develop and implement multi-prong strategies for enhancing the detection, prevention, and reduction of all forms of sexual violence in prisons and for the prosecution of offenders.

19.10 Victims of sexual assault in prison should have access to post-exposure prophylaxis.

19.11 Ensure inmates' access to basic care packages including toothpaste, toothbrush, and soap, as well as STI services.

19.12 Ensure female prisoners have access to gender-sensitive HIV and STI prevention and treatment services.

19.13 Sustain sensitization training and human rights education for correctional officers.

19.14 Policy guidelines should address services directed to incarcerated populations upon release to provide linkages to testing, prevention, and continuation of treatment.

¹⁴⁶ Ralf Jürgens, Manfred Nowak, and Marcus Day. 2011. "HIV and Incarceration: Prisons and Detention," *Journal of the International AIDS Society*, 14:26, <http://www.biomedcentral.com/1758-2652/14/26>

¹⁴⁷ See Pearshouse R, Csete J. 2006. "Model Law to Address HIV/AIDS in Prison." *International Journal of Prisoner Health*, 2(3): 193-205.

IV. Access to Justice

Factor 20: Legal Protection

Every person enjoys the right to an adequate and effective protection against violations of human rights based on HIV status, vulnerability, advocacy, or service work.

Conclusion

The Legal Aid Act enables persons who satisfy a means test to receive legal representation in most criminal cases, and as permitted by government resources in civil cases. In practice, underfunding of the Legal Aid Council means that legal aid for civil cases is inadequate. The majority of HIV-related discrimination cases, however, are civil cases. As such, PLHIV have little *de facto* access to legal aid for HIV-related discrimination complaints. A National HIV-Related Discrimination Reporting and Redress System (NHDRRS) has been operational since 2009.

A 2013 review of reported cases compiled by the Jamaica Network of Seropositives shows the most prevalent forms of discrimination faced by PLHIV included breach of medical confidentiality; harassment/verbal abuse; denial of health care; employment disputes (hiring and firing decisions based on HIV status); denial of access to education; denial of access to adequate housing; discrimination and being forced out by family and community members; and threats to person or property. The NHDRRS is merely a reporting and documentation tool, and was set up using existing structures and complaint mechanisms within various line ministries.

None of the statutes for various professional regulatory bodies (e.g., the Office of the Public Defender, the Medical Council of Jamaica, the Nursing Council of Jamaica, the Pharmacy Council of Jamaica and the Police Authority) makes specific reference to any form of discrimination including HIV-related ones as a basis for disciplinary action. Further, most PLHIV are unaware of the NHDRRS. The lack of formal arrangement between the NHDRRS and various professional regulatory bodies makes it difficult to utilize the services of these organizations to address instances of HIV-related discrimination.

International and Regional Laws / Recommendations / Guidelines

- **American Convention on Human Rights**, Art. 8(d): “the right of the accused to defend himself personally or to be assisted by legal counsel of his own choosing, and to communicate freely and privately with his counsel.”
- **ICCPR**, Art. 14(3)(D): Everyone has the right to “to be tried in his presence, and to defend himself in person or through legal assistance of his own choosing; to be informed, if he does not have legal assistance, of this right; and to have legal assistance assigned to him in any case where the interests of justice so require, and without payment by him in any such case if he does not have sufficient means to pay for it.”
- **International Covenant on Economic, Social, and Cultural Rights’** implementing Committee has addressed legal aid in a General Comment 7. This document calls for a series of legal protections for persons threatened with forced evictions. These include “where possible” the provision of legal aid. The Covenant itself does not address legal aid.
- **CEDAW**, Art. 2 (c): To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
- **CRC**, Art. 4: States Parties shall undertake all appropriate legislative, administrative and other measures for the

implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

- **1990 UN Basic Principles on the Role of Lawyers**, calls for governments to “ensure the provision of sufficient funding and other resources for legal services to the poor and, as necessary, to other disadvantaged persons. Professional associations of lawyers shall cooperate in the organization and provision of services, facilities and other resources.”

- **1991 UN Human Rights Commission Resolution 1992/54, Paris Principles** on the establishment of a national human rights institution.

- **International Guidelines on HIV/AIDS And Human Rights**, Guideline 7: Legal Support Services: States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of Ministries of Justice, ombudspersons, health complaint units and human rights commissions.

- **2012 UN Guidelines and Principles on Access to Legal Aid in Criminal Justice Systems**, Guidelines 1-18 on right to legal aid, right to be informed, funding, gender sensitivity, best interests of the child, role of paralegals etc.

- **2012 WHO, UNODC, and UNAIDS Technical Guide For Countries To Set Targets For Universal Access To HIV Prevention, Treatment And Care For Injecting Drug Users**: comprehensive package of HIV interventions for people who use drugs, (1) Needle exchange programs; (2) Opioid substitution therapy and other drug dependence treatment; (3) HIV testing and counseling; (4) ART; (5) prevention and treatment of STIs; (6) condom programs for people who use drugs and their sexual partners; (7) targeted information, education and communication for people who use drugs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of TB.¹⁴⁸

National Laws, Policies and Actions

As mentioned above in “Jamaica Background,” the Jamaican Constitution addresses discrimination generally, guaranteeing equal treatment under the law regardless of race, political opinion, place of origin, colour, creed or sex. The Constitution also grants all citizens the right to life; the right to personal liberty; security of person; freedom of movement; freedom from inhuman treatment or punishment; enjoyment of property; freedom of conscience and expression; freedom of peaceful association and assembly; respect for private and family life; freedom from discrimination on the grounds of race and the right to vote. Section 13(i) of the **Charter of Fundamental Rights and Freedoms** prohibits discrimination on the grounds of i) being male or female; ii) race, place of origin, social class, colour, religion or political opinions. It does not prohibit discrimination on the grounds of health status, HIV status, gender identity, sexual orientation, or disability.

The **Legal Aid Act** enables all those who are unable to afford to receive legal representation. There is no specific provision/exemption for PLHIV who have to fulfill the same economic criteria for eligibility as everyone else.

A **National HIV-Related Discrimination Reporting and Redress System** (NHDRRS) has been operational since 2009. It was designed to “deal systematically with incidents of HIV-related discrimination by collecting, investigating and being a focal point for redress for complaints of discrimination related to the real or perceived HIV status of an individual.” The System was intended to be integrated with existing reporting mechanisms and government agencies.¹⁴⁹ The overall responsibility for implementation of the system lies with the NHP, within the

¹⁴⁸ http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf [accessed on September 12 2013].

¹⁴⁹ Draft Cabinet Submission National HIV-Related Discrimination Reporting and Redress System, Ministry of Health and Environment, paragraph 1.2, cited in Vivian Gray, 2003, “Review of the National HIV-Related

Ministry of Health, though three other parts of the government address complaint collection and interviews with complainants: the Jamaica Network of Seropositives (Advocacy Officer); the Ministry of Labour and Social Security (Director, Occupational Health and Safety); and the Ministry of Education (HIV Coordinator).

A 2013 review of reported cases compiled by the Jamaica Network of Seropositives shows the most prevalent forms of discrimination faced by PLHIV included breach of medical confidentiality; harassment/verbal abuse; denial of health care; employment disputes (hiring and firing decisions based on HIV status); denial of access to education; denial of access to adequate housing; discrimination and being forced out by family and community members; and threats to person or property.¹⁵⁰ The lack of access to legal aid did not seem to be an area reported by PLHIV as identified in the review.

Gaps

The lack of legal recognition of human rights in Jamaica remains a major hurdle in ensuring adequate and effective protection of the human rights of PLHIV and key populations.

Underfunding of the Legal Aid Council means that legal aid for civil cases remains limited. The majority of HIV-related discrimination cases summarized in the 2013 review are civil cases. As such, PLHIV have little *de facto* access to legal aid for HIV-related discrimination complaints.

The NHDRRS is essentially a reporting and documentation tool and **relies on existing structures and complaint mechanisms within various line ministries**. The 2013 comprehensive review of this system shows a number of structural weaknesses resulting from this arrangement, as well as underfunding. Most PLHIV are unaware of the NHDRRS's existence. Other regulatory bodies (e.g., the Office of the Public Defender, the Medical Council of Jamaica, the Nursing Council of Jamaica, the Pharmacy Council of Jamaica and the Police Authority) have broad enough legal mandate to potentially address HIV-related discrimination cases. But none of these bodies' authorizing statutes make specific reference to discrimination, including HIV-related discrimination, as a basis for disciplinary action. The lack of formal arrangement between the NHDRRS and the regulatory bodies makes it difficult to utilize the services of these organizations to resolve cases of HIV-related discrimination.¹⁵¹

In May 2013, the CSO J-Flag brought a suit in the Supreme Court to declare unconstitutional the criminality of same-sex sex. The suit was opposed by the Attorney General, who was joined by a several religious groups and other CSOs. *Javed Saunja Jaghai v. the Attorney General of Jamaica* is currently before the Supreme Court of Jamaica.¹⁵² Legal aid for cases such as this one can help spark societal debates and accelerate HIV-related legal reforms.

Recommendations

20.1 Ensure legal recognition of human rights and secure proper funding for the Legal Aid Council to enable it to provide legal aid assistance in civil matters.¹⁵³

20.2 Integrate the NHDRRS into the organizational structure of the Jamaica Network of Seropositives (JN+) and strengthen the financial and human resource capacity of JN+.

Discrimination Reporting and Redress System in Jamaica.” Kingston, Jamaica: Futures Group, Health Policy Project.

¹⁵⁰ Ibid.

¹⁵¹ Ibid.

¹⁵² <http://76crimes.com/2013/06/26/jamaica-legal-challenge-to-anti-gay-law-under-way> [accessed on September 17 2013].

¹⁵³ This was one of the recommendations in the 2006 legal review by McNeil and McFarlane.

Factor 21: Legal Awareness, Assistance, and Representation

The State implements and supports educational programs aimed at raising legal literacy among PLHIV. PLHIV have equal access to adequate and affordable legal assistance and representation.

Conclusion

There is no law or policy ensuring or promoting legal literacy training among PLHIV. The government does not fund CSOs to provide legal advice for PLHIV. No private sector lawyers provide *pro bono* services to people living with HIV in areas such as anti-discrimination and disability, health-care rights (informed consent and confidentiality), property (wills, inheritance) and employment law. Programmes to educate, raise awareness, and build self-esteem among people living with HIV concerning their rights are not an integral part of the national HIV response in Jamaica. There is no evidence that HIV-related issues are included in public and private law school curricula.

International Laws / Recommendations / Guidelines

• **International Guidelines on HIV/AIDS and Human Rights**, Guideline 7: Legal Support Services: 55. States should consider the following features in establishing such services:

(a) State support for **legal aid systems specializing in HIV casework**, possibly involving community legal aid centres and/or legal service services based in AIDS service organizations;

(b) State support or inducements (e.g. tax reduction) to private sector law firms to provide **free *pro bono* services to people living with HIV** in areas such as anti-discrimination and disability, health-care rights (informed consent and confidentiality), property (wills, inheritance) and employment law;

(c) State support for **programmes to educate, raise awareness and build self-esteem** among people living with HIV concerning their rights and/or to empower them to draft and disseminate their own charters/declarations of legal and human rights; State support for production and dissemination of HIV legal rights brochures, resource personnel directories, handbooks, practice manuals, student texts, model **curricula for law courses and continuing legal education** and newsletters to encourage information exchange and networking should also be provided. Such publications could report on case law, legislative reforms, national enforcement and monitoring systems for human rights abuses.

• **United Nations Principles and Guidelines on Access to Legal Aid in Criminal Justice** calls for persons to be educated on their right to access the legal system.

• **The UN Basic Principles on the Role of Lawyers** states that “Governments and professional associations of lawyers shall promote programmes to inform the public about their rights and duties under the law and the important role of lawyers in protecting their fundamental freedoms. Special attention should be given to assisting the poor and other disadvantaged persons so as to enable them to assert their rights and where necessary call upon the assistance of lawyers.”¹⁵⁴

National Laws, Policies and Actions

There is no policy to ensure or promote legal literacy training among PLHIV.

¹⁵⁴ <http://www.unrol.org/files/UNBasicPrinciplesontheRoleofLawyers.pdf> [accessed on October 15 2013].

Gaps

The government does not fund CSOs to provide legal advice for PLHIV. No private sector law firms target *pro bono* services to people living with HIV specifically in areas such as discrimination, disability law, employment law, health care rights (e.g. addressing informed consent and confidentiality), or property (including subjects such as wills and inheritance).

The government's HIV response does not include programmes specifically devoted to educating, raising legal awareness, and developing a cohesive legal strategy to approach HIV-related discrimination among people living with or affected by HIV. Additionally, there is no evidence that HIV-related issues are included in public and private law school curricula.

Little/no funding is available for CBOs to develop sensitization materials on the NHDRRS and conduct legal literacy training for PLHIV to make them aware of their rights and the reporting system.

Recommendations

21.1 Enable and encourage CSOs to provide legal advice targeted specifically to the needs of PLHIV.

21.2 Develop private sector law firm *pro bono* programs for HIV-related legal assistance.

21.3 Fund a sensitization brochure on the NHDRRS and conduct legal literacy training for PLHIV to make them aware of their rights and the reporting system.

22.4 Integrate HIV-related legal issues into law school curricula.

Factor 22: Access to a Forum, Fair Trial, and Enforcement of Remedies

PLHIV, HIV/AIDS advocates and service workers are guaranteed equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.

Conclusion

Most HIV-specific regulations are voluntary, without redress mechanisms and unenforceable in court. Legislation affecting the legal rights of PLHIV is currently pending, however. The Occupational Safety and Health Act is tabled in the Parliament. If and when passed, this Act will provide legal protections for PLHIV and sanctions against workplace discrimination. Redress mechanisms within the NHDRRS may address a range of HIV-related types of discrimination, but no legal action has as of yet arisen from the System.

There is also no comprehensive HIV and AIDS law, general anti-discrimination law, or a human rights commission in Jamaica. Discrimination based on health status including HIV status is not prohibited by the Charter of Fundamental Rights and Freedoms. While the Management of HIV/AIDS in Schools Policy does include provisions regarding non-discrimination, the Policy is not legally enforceable. The National HIV/AIDS Workplace Policy similarly addresses discrimination, but will not be legally enforceable until (or unless) the Occupational Safety and Health Act is enacted.

International Laws / Recommendations / Guidelines

- **ICCPR**, Art. 2 (3) (a) obliges states “to ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity; (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy; (c) To ensure that the competent authorities shall enforce such remedies when granted.”

- **1991 UN Human Rights Commission Resolution 1992/54, Paris Principles** on the establishment of a national human rights institution.

- **International Guidelines on HIV/AIDS And Human Rights**, Guideline 7: Legal Support Services dictates that “States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of Ministries of Justice, ombudspersons, health complaint units and human rights commissions.”

National Laws, Policies and Actions

Most HIV-related regulations, including the Management of HIV/AIDS in Schools Policy and the National HIV/AIDS Workplace Policy, are advisory and thus not legally enforceable.

The Occupational Safety and Health Act is currently tabled in the Parliament. If and when it is passed, it will provide legal protections and sanctions regarding workplace discrimination against people living with HIV.

Redress mechanisms within the NHDRSS are meant to include a complaint and reporting mechanism, as well as result in legal action.

Gaps

There is no HIV-specific law that is enforceable within the Jamaican court system. Nor are existing policies directed specifically at discrimination legally enforceable. Further, there is a need for alternative forums to address HIV-related discrimination, such as a human rights commission. Codes of conduct for lawyers and judges do not specifically address HIV-related discrimination within the professions.

Recommendations

22.1 Ensure HIV-related discrimination is prohibited via legally enforceable legislation.

22.2 Develop alternative dispute resolution mechanisms to provide meaningful remedy for PLHIV complainants.

22.3 Add provisions on HIV-related discrimination in professional codes of conduct for lawyers and judges.

Appendix 1 Literature Review

I) International Documents

International and Regional Human Rights Treaties

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Appendix 2A Second Stakeholder Workshop Participant List

Registration Data Gathering Workshop
 HIV and the Law Project
 August 20, 2013

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⁵ ASHLEY WILSON	Coordinator	NFPB/NHP	881-8421	ashley.wilson@nfpb.gov.jm	Ashley
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⁷ MITSY BEAUMONT-DALEY	Senior Legal Officer (Acting)	MINISTRY OF NATIONAL SECURITY	280-0209	mitsy.beaumont@mins.gov.jm	MBe
⁸ Janelle Bass	Prog. Officer	UNESCO	630-5300	j.bass@unesco.org	Janelle
⁹ Nicola Skyles	Dr. R. T. S.	NHP	564-9284	skylesn@nhp.gov.jm	Nicola
¹⁰ Petra-Cary Joyce	HIV Program Director	MLSS	3128702	petra-cary.joyce@gmail.com	Petra
¹¹ STEPHY L. LEWIS	Executive Director	TOULASMT PRODUCTIONS LTD	574-0971	stephyll.lewis@toulasmt.com	Stephy
¹² Sharlene Jarrett	NE Jor Director	NHP/NFPB	564-9267	jarrett@nhp.gov.jm	Sharlene
¹³ KAREN E. Ombwa	Dir. Eval. Ev.	NHP/NFPB	522-4007	kalck@nfpb.gov.jm	Karen
¹⁴ RACHEL MORRISON	HIV Prog. Officer	UNDP	863-7164	rachel.morrison@undp.org	Rachel

Registration Data Gathering Workshop
 HIV and the Law Project
 August 20, 2013

Name	Title	Organization	Contact#	Email	Signature
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¹⁷ Khadrea Forbes	Sho Actg.	MLSS	967-3429	kforbes@mlss.gov.jm	Khadrea
¹⁸ Lord Dantley	Human Rights & Gender	UNHCR	817-6616	dantley@unhcr.org	Lord
¹⁹ Joi Chamberlain	Actg. Health	MOH	317-8179	chamberlain@mo.gov.jm	Joi
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²¹ Genice Wright	WTO	MOH/NHP	569-4901	wrightg@mo.gov.jm	Genice
²² Kandra Simons	GAPE	JAGC	904-4189	klarsimons@gmail.com	Kandra
²³ Allen Davis	Dr. NPM	MUS	6196-019	allen.davis@mms.gov.jm	Allen
²⁴ Ian McInnes	E.D.	CUC	631-7299	ianmcinnes@gmail.com	Ian
²⁵ Sergio Suleb	ED (Acting)	NFPB	564-9219	esuleb@nfpb.gov.jm	Sergio
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²⁷ Sheryl Dennis	Legal Officer	MOH			Sheryl
²⁸					

Appendix 2B Second Stakeholder Workshop Report

Report Second Stakeholder Workshop HIV and the Law Project,
August 20, 2013
Knutsford Court Hotel
8:30am-11:30am

The purpose of the second stakeholder workshop was as a Data Gathering exercise to assist with the legal review currently being conducted. Jennifer Chan was introduced as the consultant hired to conduct the current legal review which forms output 1 of the HIV and the law project entitled “**Building Capacity for Reform of HIV Related Law and Policy in Jamaica**” being undertaken by UNDP in partnership with the Enabling Environment component of the National HIV Programme. As part of her introduction, it was necessary for Ms. Chan to be allowed to give a clear outline of the methodology to be used in gathering and analysing data for the review. Ms. Chan would also explain her format and reporting structure, incorporating the ABA /ROLI legal assessment tool http://www.americanbar.org/content/dam/aba/directories/roli/misc/aba_rol_i_hiv_aids_legal_assessment_tool_11_12_authcheckdam.pdf.

It was also key for Ms. Chan to obtain from various stakeholders a clear indication of the policies and laws they felt it was important to examine as priorities within the context of the legal review and to obtain a general sense of what gaps stakeholders felt existed in the local legislation. This would be critical for her comparison of the international treaty commitments, the perception of what gaps exist and the realities based on the obligations within the treaties.

The workshop began with Karlene Temple Anderson, Director of the Enabling portfolio giving an update on the actions taken since the last legislative review was conducted in 2006. At the first stakeholder workshop it was clear that there was some misconception as to what changes had taken place in the legal environment since 2006. There were also misconceptions as to what obtained as practice on the ground and what concrete laws and policies guided these practices. The update was to bring the stakeholders to the same understanding of what changes had come out of the 2006 legal review based on the consultants’ recommendations.

It was also brought to the attention of the stakeholders that even though the Charter of Rights developed in 2011 was a major step forward in placing citizens’ rights as a primary consideration in governance , within the charter there was a savings law clause - Clause 13 (12) which saves the buggery law from judicial review “Nothing contained in or done under the authority of any law in force immediately before the commencement of the Charter of Fundamental Rights and Freedoms (Constitutional Amendment) Act, 2011, relating to:

- (a) sexual offences; (this relates to OAPA)
- (b) obscene publications; or

(c) offences regarding the life of the unborn, shall be held to be inconsistent with or III contravention of the provisions of this Chapter” This once again drove home the importance of parliamentarians as gatekeepers in the legal reform process and the role of morality in influencing the shape of legislation in Jamaica.

Below is the table of recommendations made by the consultant and the actions taken since then as presented to the stakeholders with recommended adjustments included.

	Priority Recommendations from the 2006 Legislative Framework Review as stated in the report	Actions taken – up to August 2013
A	<p>Immediate amendments to the Public Health Act By amending the Public Health Act, the issues of definitions can be addressed, and distinctions included that differentiates between categories of communicable disease and notifiable diseases, using vector as the basis for the distinction</p> <p>This provides the best opportunity for other legislations such as the Quarantine Act, The Venereal Disease Act and the Leprosy Act, to be repealed and their provisions subsumed under one main Act</p>	<ul style="list-style-type: none"> The cabinet approved the amendment to the Public Health Order to ensure that HIV and AIDS are communicable diseases for the <i>sole purpose of reporting to the Ministry of Health and surveillance</i> of the disease in order to design appropriate public health interventions to address the impact of the disease.
B	<p>Correlation of the proposal amended Public Health Act with the provisions of the Child Care & Protection Act, as it relates to medical examination of children, and the issues of disclosure of medical information to the courts in sex offence cases.</p>	<ul style="list-style-type: none"> .Multi-stakeholder group formed to begin discussions around developing an Adolescent Sexual Reproductive health policy A review is currently being conducted of the Child Care and Protection Act
C	<p>Amend the Employment Termination and Redundancy (Payment) Act, to prohibit discrimination in the workplace and prevent the screening of persons for purpose of employment.</p>	<ul style="list-style-type: none"> Both Houses of Parliament approved the National Workplace Policy on HIV and AIDS as a White Paper which includes the ILO Code of Practice on HIV/AIDS & the World of Work. The Jamaica HIV and AIDS Regulations are being developed. It will be appended to the pending approval of the newly revised Occupational, Safety and Health Act The regulations along with the Workplace Policy will provide clear guidelines on how to treat with HIV-related issues and breaches in the workplace.
D	<p>Enact and where possible amend such laws as the National Insurance Act, and the Mortgage Insurance Act in order to regulate the service industry; in particular the insurance industry.</p>	
E	<p>Amend the Offences Against the Person Act, to repeal the provision as it relates to the offences of buggery, to bring the Act in line with the principle of non-discrimination, based on sexual orientation and ensure the right to privacy is guaranteed.</p>	

	<p>i. There is no need to create any new criminal offence for wilful transmission in respect of HIV/AIDS as it has been decided in other jurisdiction with similar provisions as our Offences Against the Persons Act (as it relates to offences such as assault occasioning grievous bodily harm and other aggravated assaults) that there are adequate provisions.</p>	
F	<p>Proposed amendments to the Constitution of Jamaica to allow for certain rights to be expressly guaranteed, to remove any doubt as to the rights which are protected.</p>	
G	<p>Introduction of a general anti-discrimination legislation, which provides equality in treatment for all individuals and provides adequate mechanism for breaches of individual human rights, will need to support any constitutional provision including the changes being proposed under the Charter of Rights.</p>	<ul style="list-style-type: none"> • In 2011 Hon Orette Bruce Golding, the then Prime Minister of Jamaica, and the then Leader of the Opposition, Mrs Portia Simpson Miller signed a Declaration of Commitment to Eliminate Stigma and Discrimination and Gender Based violence affecting the Jamaica HIV response. • The National HIV-related Discrimination Reporting and Redress System (NHDRRS) was established. The aim of the system is to provide a means of protecting the rights of persons with HIV. It is designed to collect, investigate and through referrals seek to get redress for complaints of HIV-related discrimination. • A review of the National HIV-related Discrimination Reporting and Redress System (NHDRRS) is being conducted. • Two (2) anti-stigma media campaigns were launched. They featured four (4) persons with HIV – namely Ainsley Reid, Anneisha Taylor, Rosie Stone and Jason Richards.
H	<p>The implementation of a National Education Policy Act, as one of the primary tools in closing the divide between publicly funded and privately funded institutions as there is no express policy to ensure equality of treatment for all persons who are infected with the HIV virus in respect of both private and public providers of education services at all levels.</p>	<ul style="list-style-type: none"> • Jamaica signed Ministerial Declaration “Preventing through Education” seeking to enhance HIV prevention through education at the 1st first meeting of the Ministers of Health and Ministers of Education to stop HIV in Latin America and the Caribbean, 1st of August 2008 Mexico City.
I	<p>The Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act 1946, should be amended to ensure the prospective immigrants who are tested and found to be HIV positive will not be prohibited from entering and remaining in the country mainly on the basis of their health status.</p>	
J	<p>Amendments to the Corrections Act to give prisoners the right to request diagnostic testing for HIV/AIDS and other diseases and to be provided with educational material on prevention, treatment and care; and where appropriate to be provided with protective devices.</p>	<ul style="list-style-type: none"> • Commissioner of corrections has allowed National HIV programme to conduct diagnostic testing and initiate prevention and treatment support programmes.
K	<p>The conversation needs to begin to address in a comprehensive way the development issues. There may</p>	<ul style="list-style-type: none"> • The integration of the National HIV/STI programme and National Family Planning Board into the Sexual and

	<p>arise the need for a body (National HIV/AIDS Control Authority) to be put in place to allow for better coordination and control of the National HIV/AIDS policies, and to avoid duplicity in personnel and the use of the resources.</p>	<p>Reproductive Health Authority.</p>
<p>L</p>	<p>There needs to be introduction of regulations under the Public Health Act, as it relates to Commercial Sex Workers, in order to provide access to prevention measures, care and treatment where necessary, as well as education aimed at placing moral responsibility on clients and the organizers of sex workers. This would provide a mechanism for monitoring activities within the industry from a health perspective, as well as provide epidemiological data.</p>	<ul style="list-style-type: none"> • National HIV STI/Programme has programme and JASL have had special targeted interventions with sex workers. Prevalence rate among sex workers has decreased. Clients of sex workers identified as key target group for future initiatives.

The consultant Ms. Chan then conducted a series of exercises with stakeholders. The following observations were made by Ms. Chan. In brackets are the numbers of participants advocating for various actions

List of Recommended Legal, Policy, and Other Reforms

I) Legal Reforms

A. Repeal punitive laws

- Repeal buggery law (5)
- Decriminalize Sex Work (SW) (4); Regularize and regulate SW/legislation to protect (2)
- Amend Sexual Offenses Act for i) greater protections for children and ii) decriminalization of SW
- No testing of farm workers and others in Overseas Employment Programmes
- Amend Insurance Act
- Repeal any law/policy that fosters discrimination

[persons who knowingly and wilfully infect others with HIV can be held criminally liable]

* note that there is strong consensus among human rights lawyers and advocates that such a law is ineffective in fighting against the epidemic.

See: <http://www.opensocietyfoundations.org/publications/ten-reasons-oppose-criminalization-hiv-exposure-or-transmission>

B. Enact enabling laws

- Enact anti-discrimination legislation (14 including 2 “without repealing the buggery law” and 1 “without legalizing SW”)
- Revise the Charter of Rights to include sexual orientation discrimination (2) and other key populations (1)
- Set age of consent to be in line with age of majority (2)
- Pass the Occupation and Safety Health Act (and have the HIV Regulations appended to OHS Act)
- Enact a sexual expression act
- Enact a Data Protection Act
- Amend a Legal Aid Act
- Amend Child Care and Protection Act so that minors can access confidential SRH services without parental consent if it is in their best interests (2)
- Finalize life threatening illness policy
- Enact confidentiality legislation
- Enact an affirmative action law (treating key populations favourably)
- sign CEDAW Optional Protocol (allowing CEDAW to receive individual or group complaints)
- subsume those policies under the laws that are now redundant
- Align local legislative framework with pertinent international human rights issues
- Explore legislative reforms from a gender perspective

II) Policy Changes

- Universal access to HIV testing, treatment and prevention services regardless of age, Sexual Orientation etc.
- Allocation of funds to Department of Corrections similar to JDF Office of Services Commission (includes HIV issues into the Staff Orders)
- All Educational institutions mandate comprehensive sexuality education that is life-skills based, and that education is really comprehensive and relevant to young people's needs and concerns and it's properly taught
- Introduction of harm reduction for drug users
- Policy to provide access to HIV testing and other related services for prisoners
- Administrative procedures for hearing a matter before the Industrial Dispute Tribunal
- more congruence between policies and laws

III) Other Changes

- greater enforcement of the laws and sanctions where there are deviations
- greater involvement of PLHIV in policy and program decision-making
- scale up treatment
- equal access to services
- adequate structure to support treatment and core programs
- scale up prevention activities
- strengthen/empower NGOs
- medical doctors have to undertake a one-week orientation at the MOH where they are sensitized on human rights, accepting attitudes. Their re-certification for licenses should also include having done/attended a refresher course.
- ministries return to the era when they also conducted in-housing training. By doing so they can tie appointments/promotions to the individual presenting a certificate of participation at sessions targeting how they treat each other/customer services (internal and external) and accepting attitudes to diversity groups.
- young people and adolescents who need SRH services can access them, without fear or judgement, in friendly centers, by trained professionals. They can do so without parental consent if their health is at risk.
- adequate funding to support legal reform process (consultations; community-based dialogue) (2)
- unlimited resources
- greater support for homeless populations
- campaigns to mobilize community leaders, gate-keepers, and key influences.
- champion the concerns of groups

List of Prioritized Reforms, Actions, and Lead Actors based on Group dialogue

Group 1: "soft approaches"

- Affirmative action
- Employment assistance to key populations
- Social security net for PLHIV who can't work

- Pass OHS Act (to emphasize that we do have an anti-HIV discrimination provision)
- Prevent discrimination at workplace based on HIV-status (doctor reports to workplace as life-threatening illness instead of reporting as HIV)
- A HIV regulation is in draft and maybe passed before the OSH Act
- Administrative procedures of the Industrial Dispute Tribunal to provide for redress in case of breach of OSHA and HIV Regulation

Group 2: 4 priorities

- anti-discrimination law
- adolescents (legal barriers to SRH)
- laws to protect confidentiality of health info generally (not to isolate HIV)
- buggery law

Actionable items

- Access for young people (a lot in place; revision of Childcare Protection Act, what we need is to ensure evidence is there in terms of barriers for young people, aligning the policy of access to minors to the Child Care Protection Act; discussion of age of consent and age of majority)... based on evidence, aligning policy and laws. We already have policies, but need to align laws).
- Enforcement of laws

Lead actors: Ministry of Youth and Ministry of Health

Group 3: 6 priorities

- anti-discrimination law
- data protection of PLHIV
- enforcement of laws that we already have; we need to have sanction e.g. wilful transmission of HIV
- needs laws and policies on gender and equality
- currently no legislation to clarify the duty of healthcare providers to warn partners (balance between professional obligation of confidentiality and the duty to warn)

*Jennifer Chan note: this can be dealt with in a comprehensive HIV/AIDS law. See, for instance, the Indian HIV/AIDS Bill, <http://www.lawyerscollective.org/hiv-and-law/draft-law.html>

Group 4

- Antidiscrimination law without repealing buggery law (buggery law is not used in court system as an anti-homosexuality law but to prosecute cases of buggery against practice Common usage by attorneys in Jamaican court system. eg given by lawyers of 15 cases of buggery; it's buggery on minors; reflects issues of definitions of rape under the sexual offences act and referral to offenses against the persons act
- Different views on regulating SW

Jennifer Chan question:

Who are missing in today's stakeholder workshop?

- academics who can provide technical expertise in drafting legislation
- parliamentarians
- ministers
- law enforcement and judiciary, practicing attorneys
- faith based leaders (block advocacy as part of the process so as to expedite)

In concluding one of the participants asked that the process once again be contextualized as to how the legal review will take the group towards concrete actions around legal reform. This was clarified by the HIV Programme Officer of UNDP Rachel Morrison. Ms. Morrison explained that the legal assessment and plan of action would guide the group action in advocating for legal reform from within the various Ministries where legal changes were expected to take place. Ms. Morrison also emphasised the importance of having as part of the stakeholder group representation from various legal offices based in the different ministries to give guidance on drafting legislative documents and the processes within the various ministries. It was also noted that once priorities were decided by the stakeholders strategies would have to be employed to engage the responsible ministries and parliamentarians. It was also indicated that funding agencies like UNDP and UNAIDS would have to provide financial support to continue the legal reform process. The stakeholders were reminded of the following date obligations of the consultant.

- Legal assessment completed September 16, 2013
- Draft Plan of Action for Legal Reform September 30, 2013
- Final Plan of Action for Legal Reform October 14, 2013.

The meeting was then adjourned at 11:32 am.

Appendix 3. Interviewee list (36)

I) Politicians

Minister of Justice
Minister of Health
Minister of Labor and Social Security
Jamaica Labor Party, General Secretary of Generation 2000

II) Government

National Family Planning Board, Executive Director
Ministry of Health, National HIV/STI Program, Acting Head
Ministry of Health, National HIV/STI Program, Director of Prevention
Ministry of Health, National HIV/STI Program, Director of Treatment
Ministry of Health, National HIV/STI Program, Behaviour Change Communications Officer
Ministry of Health, National HIV/STI Program, Behaviour Change Coordinator
Ministry of Health, Director of Health Promotion and Protection
Ministry of Labor and Social Security, Director of Occupational Health

III) Civil Society Organizations

1. Positive Network

Jamaican Network of Seropositives, Founder

2. Men who have Sex with Men and Transgender

Jamaica Forum for Lesbians, All-Sexuals and Gays, Executive Director

3. Drug Use

National Council on Drug Abuse, Executive Director
Patricia House, Executive Director
Caribbean Drug Abuse Research Institute, Executive Director

4. Sex Work

Sex Workers Association of Jamaica, Executive Director
Jamaica AIDS Support for Life, Outreach Manager

5. Youth

Jamaica Youth Network, Programme Officer and International Youth Speak Out Council Member

6. Gender

Quality of Citizenship Jamaica, Convenor and co-Convenor

7. Others

Caribbean Vulnerable Communities, Executive Director and Policy Director
UNAIDS/United Theological College of the West Indies project, Faith-Based Organization Steering Committee,
Former Chair
Jamaica Business Council on HIV/AIDS, Executive Director
Jamaicans for Justice, Executive Director
Jamaican Civil Society Coalition, Co-Executive Director
Caribbean HIV/AIDS Legal Network, Lawyer
World Learning Bahamas and Caribbean, HIV/AIDS Grant Solicitation and Management Program, Project Director
Panos Caribbean, Programme Director

IV) Research Organization and Medical Professionals

Center for HIV/AIDS Research, Education, and Services, U. Hospital of the West Indies, Director
Public Health Physician

V) International Organizations/Agencies

UNAIDS, Country Representative
UNDP Jamaica, Assistant Resident Representative
UNESCO, National Programme Officer for HIV & AIDS
International Organization for Migration, Jamaica Head of Office
Health Policy Project, Jamaica Country Program Manager

Appendix 4. Summary of HIV- related Legal Compliance Gaps and Recommendations in Jamaica

Factors of HIV Vulnerability	Jamaica Laws, Policies and Actions	Gaps	Recommended Legal Reforms and Accompanying Actions
<p>Factor 1 Public Education, Research, and Information Exchange <i>Every person enjoys an equal right to seek, receive, and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV/AIDS. The State implements and supports HIV-related awareness-raising, stigma-reduction, training, and information exchange programs, and ensures that HIV research adheres to the highest ethical standards.</i></p>	<ol style="list-style-type: none"> 1. The 2005 National HIV/AIDS Policy 2. The 2012-2017 National HIV/AIDS Strategic Plan 3. The 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS 4. The 2004 Management of HIV/AIDS in Schools Policy: Statement on Education and HIV/AIDS 5. The 2012 National HIV/AIDS Workplace Policy 6. The 2009 Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica 	<p>norms surrounding homosexuality, sex work, drug use, prisoners, and sexual behaviour of minors.</p> <ol style="list-style-type: none"> 2. Religious influences as barrier to consistent HIV information, education, and training for the general populations. 3. The relationship between the Sexual and Reproductive Health Authority of Jamaica and the Ministry of Education needs to be clarified. 4. Punitive laws and absence of key-population specific legal/policy protections to ensure access by key populations. 5. Lack of monitoring and evaluation of non-binding policies. 6. Absence of a specific HIV-related anti-stigma policy and the lack of legal sanctions. 7. No HIV surveillance data, research, or programs for transgender persons and migrants. 8. No sustained HIV and human rights training for medical professionals and others. 	<ol style="list-style-type: none"> 1.1 Enact key-population specific policies to ensure equal and sustained access to HIV information, education, and training. 1.2 Make a policy exemption to ensure that minors under the age of consent can access SRH information and that healthcare professionals can provide age-appropriate information without fear of prosecution. 1.3 Fund to scale up HIV and anti-discrimination public education. 1.4 Clarify the relationship between the Sexual and Reproductive Health Authority of Jamaica and the Ministry of Education in the provision of sexual and reproductive health and HIV information. 1.5 Fund capacity building for the engagement of civil society groups in policy-making. 1.6 Engage FBOs in providing access to HIV information. 1.7 Enact an anti-stigma policy in the context of HIV/AIDS or incorporate a provision on anti-stigmatization in the general anti-discrimination law. 1.8 Sustain HIV and anti-discrimination training among healthcare workers and other professionals. 1.9 Research on invisible populations including migrants, transgender persons, professional MSMs, and sex workers who work in massage parlours or through telephone or the Internet. 1.10 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use.
<p>Factor 2: HIV Prevention <i>Every person has equitable and sustainable access to a wide range of effective, human rights-based, and evidence-informed measures aimed at preventing HIV transmission.</i></p>	<ol style="list-style-type: none"> 1. National HIV/AIDS Strategic Plan: prevention as one of the six priority areas. 2. Prevention occupies the largest component of HIV/AIDS spending at 36.2%. 3. Combination prevention approach including BCC strategy. 	<ol style="list-style-type: none"> 1. Funding gap: only 30% of the key populations are currently being reached. 2. Absence of key-population specific legal/policy protections to ensure access. 3. Criminalization of same-sex sexual acts, sex work, drug use, and sex with minors under the age of consent. 	<ol style="list-style-type: none"> 2.1 Scale up prevention through additional funding as well as assess spending choices across prevention activities. Preventing one HIV infection at a cost of less than J\$ 501,000 (US\$ 5,800) remains a good financial investment and reduces the financial costs of the national response to HIV/AIDS. The financial sustainability study of Jamaica's HIV Program clearly indicates that the costs incurred by new infections from MSM and sex workers are very high and that effective prevention in the short-term will result in lower spending on treatment in the long-term. Efforts need to focus

	<p>4. PMTCT programme with the current expansion to eMTCT certification.</p> <p>5. Positive Health, Dignity and Prevention Policy.</p> <p>6. Guidelines for the Clinical Management of HIV/AIDS spell out strategies for the prevention of occupational exposure to HIV and management approaches to key populations.</p>	<p>4. Current prevention strategy driven by the MoH with a biomedical model and little sustained engagement of PLHIV and CBOs.</p> <p>5. Civil society engagement to scale up prevention efforts hampered by limited technical, financial, and human capacity.</p> <p>6. Lack of psychosocial support.</p> <p>7. Structural barriers including poverty, low literacy, and poor health seeking behaviour of men.</p> <p>8. Current prevention strategies fail to reach the most-at-risk segments within key populations including homeless MSM and drug users, middle-income MSM, unattached youth, and adolescents.</p> <p>9. HIV prevention through early STI treatment insufficiently developed.</p> <p>10. Stigma and discrimination within the health care system, inadequate implementation of provider initiated HIV testing, and the lack of cooperation by regional health authority.</p> <p>11. The MoE lacks capacity to adequately enforce mandatory implementation of the programme at the school level. There is no sexual and reproductive health policy to ensure targeted, age-appropriate interventions for minors and youth.</p> <p>12. No law or policy ensuring and regulating the provision of comprehensive harm reduction strategies for drug users and prisoners.</p>	<p>on reaching these most at-risk populations.</p> <p>2.2 Enact key-population specific legal/policy protections to ensure their access to comprehensive HIV prevention services.</p> <p>2.3 Roll out treatment as prevention in accordance with the principle of progressive realization, taking into consideration funding availability and other human rights concerns.</p> <p>2.4 Enact a sexual and reproductive health policy and make a policy exemption to ensure access to prevention services by minors and the provision of such services by healthcare professionals. Teenage mothers should be ensured to continue education through specific policy provisions.</p> <p>2.5 Ensure harm reduction is an integral part of the national HIV response and enact policies to provide comprehensive targeted harm reduction strategies for drug users and prisoners.</p> <p>2.6 Create and expand key-population-friendly sites and facilities to provide testing and other prevention services.</p> <p>2.7 Move away from a biomedical to a community-based care model that integrates psychosocial support and other services addressing structural barriers such as poverty, low literacy, and poor health seeking behaviour.</p> <p>2.8 Activate review of existing policies such as the Management of HIV/AIDS in schools including the HFLE curriculum.</p> <p>2.9 Focus on early STI treatment as part of prevention.</p> <p>2.10 Address stigma and discrimination within the health care system through continuous training.</p> <p>2.11 Fund capacity building for the engagement of civil society groups in policy-making and program delivery.</p> <p>2.12 Engage FBOs in prevention policy development and scaling up prevention services.</p> <p>2.13 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use.</p>
<p>Factor 3: Testing, Counselling, and Referral <i>Every person has</i></p>	<p>1. The National HIV/AIDS Policy: objectives pertaining to unrestricted access to voluntary, confidential or anonymous HIV testing.</p>	<p>1. Half of HIV infected persons do not know their status. Young people, men, and key populations including MSM and sex workers are less likely to</p>	<p>3.1 Ensure top management prioritization in implementing routine/provider-initiated testing throughout the health system.</p>

<p><i>unrestricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counselling and referral to essential services. Arbitrary, mandatory, or compulsory HIV testing is prohibited.</i></p>	<p>2. Positive Health, Dignity and Prevention Strategy.</p> <p>3. The 2013 Guidelines for the Clinical Management of HIV/AIDS outlines the HIV testing regime.</p> <p>4. The 2004 Management of HIV/AIDS in Schools Policy contains provisions on the prohibition of HIV testing as condition for school admission or staff employment, and privacy and confidentiality.</p> <p>5. The 2012 National HIV/AIDS Workplace Policy stipulates the establishment of an appropriate environment for provision of confidential pre-test and post-test counselling education with access to referral for VCT.</p> <p>6. Voluntary counselling, testing, and referral services are offered in 23 HIV treatment sites as well as peripheral clinics. Some CBOs can offer VCT services on site and through their outreach programs.</p>	<p>be tested than the general population.</p> <p>2. Lack of top management prioritization in implementing routine testing throughout the health system.</p> <p>3. Criminalization of private, consensual same-sex sexual acts, sex work, drug use, and sex with minors under the age of consent.</p> <p>4. Lack of informed consent in HIV testing among certain populations including pregnant women, drug users, prisoners, and applicants to the Overseas Employment Programme.</p> <p>5. Counselling services remain grossly inadequate due to lack of human resource and funding.</p> <p>6. A 2012 Modes of Transmission study finds that approximately 40% of incident infections will occur among persons who are considered to be engaging in low risk sex. In addition to scaling up testing for key populations, HIV counselling and testing services for individuals who likely do not self-identify as being at risk of HIV infection should be expanded.</p>	<p>3.2 Create and expand key-population-friendly sites and facilities including the engagement of civil society organizations to provide testing and counselling services.</p> <p>3.3 Ensure appropriate materials such as low literacy materials are provided for full informed consent of all key populations including pregnant women with the possibility to “opt-out” in routine HIV testing.</p> <p>3.4 Enact legal or policy provisions to regulate access to voluntary, confidential or anonymous HIV testing by drug users and prisoners.</p> <p>3.5 Eliminate mandatory HIV screening requirement in the Overseas Employment Programme, as it is discriminatory.</p> <p>3.6 Develop a plan to train additional counsellors.</p> <p>3.7 Expand HIV counselling and testing services for individuals who likely do not self-identify as being at risk of HIV infection.</p> <p>3.8 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use to remove stigma and discrimination to facilitate testing uptake by key populations.</p> <p>3.9 Enact a Data Protection Act to ensure legal protections against breaches of privacy and confidentiality in fiduciary relationships including in HIV contexts.</p>
<p>Factor 4: Treatment, Care, and Other Health Services <i>PLHIV enjoy the right to the highest attainable standard of physical and mental health, including equitable and sustainable access to comprehensive health care. The State takes concrete steps to progressively realize universal access to HIV-related treatment and care.</i></p>	<p>1. The National HIV/AIDS Policy: pertaining to access to treatment.</p> <p>2. The 2012-2017 National HIV/AIDS Strategic Plan sets treatment as one of the six priority areas.</p> <p>3. The 2013 Guidelines for the Clinical Management of HIV/AIDS outlines the national treatment protocol.</p> <p>4. Treatment, care, and support services are offered in 23 HIV treatment sites integrated in the primary health care system throughout the country.</p>	<p>1. Treatment uptake remains sub-optimal at 43%.</p> <p>2. Criminalization of private, consensual same-sex sexual acts, sex work, drug use, and sex with minors under the age of consent.</p> <p>3. PLHIV have to spend long waiting time in the underfunded and overcrowded public healthcare sector to access testing and treatment.</p> <p>4. The current biomedical approach to test and treat offers little psychosocial support and counselling services to address the social vulnerability of HIV such as poverty, low literacy, inadequate food intake, evictions, drug use & mental health issues.</p> <p>5. Low adherence (46%) and high HIV drug</p>	<p>4.1 Through the involvement of CBOs, redesign gender-sensitive and key-population friendly treatment, care and support services.</p> <p>4.2 Move from a supply-driven biomedical model to a holistic demand-driven rights-based approach to treatment literacy. Fund CBOs to design and deliver treatment literacy training and research, and develop treatment support groups.</p> <p>4.3 Fund health system strengthening to improve the delivery of HIV/STI treatment, care and support.</p> <p>4.4 Expand the pre-ARV program before patients drop out within the first twelve months.</p> <p>4.5 Implement strategies to promote ARV adherence and ensure that adherence counselors have professional training.</p>

		<p>resistance (at 12.6%).</p> <p>6. Adherence counselors, while offering PLHIV peer support, may lack professional counselling training to address adherence barriers.</p> <p>7. The clinical guidelines for health workers to administer treatment, care and support are not always implemented.</p> <p>8. High STI rates have a significant negative impact on HIV transmission. ARVs are free of cost, but support for treatment of opportunistic infections and STIs, and psychosocial structures are limited.</p> <p>9. Community and home-based care is not funded by the government.</p>	<p>4.6 Ensure ARV supply in all pharmacies and prevent stock out.</p> <p>4.7 Introduce HIV drug resistance surveillance and monitoring.</p> <p>4.8 Scale up support for treatment of opportunistic infections and STIs, and psychosocial structures.</p> <p>4.9 Offer continuous training to health workers to ensure the implementation of clinical guidelines in an environment free of stigma and discrimination.</p> <p>4.10 Increase programmatic emphasis for mental health services and nutrition counselling as part of treatment.</p> <p>4.11 Fund community and home-based care programs.</p> <p>4.12 Decriminalize private, consensual same-sex sexual acts, sex work, and possession of small amounts of drugs for personal use to remove stigma and discrimination and encourage treatment uptake by key populations.</p>
<p>Factor 5: Social Protection & Material Assistance PLHIV enjoy the right to an adequate standard of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness, or disability.</p>	<p>1. The National HIV/AIDS Policy sets out a number of measures to mitigate the socio-economic impact of HIV/AIDS.</p> <p>2. The 2012 National HIV/AIDS Workplace Policy lays out Objective 4: To strengthen the capacities of workplaces to provide care and support for persons living with and affected by HIV/AIDS including social support schemes and benefits to include provision for HIV/AIDS.</p> <p>3. The National HIV/STI Program has implemented a number of income-generating projects for PLHIV.</p> <p>4. The National Foundation for HIV, created in 2011, has the objective of mobilizing private sector funds to finance income-generating projects for PLHIV.</p>	<p>1. Absence of laws to ensure the right of PLHIV to an adequate standard of living and social protection in the event of unemployment, sickness, or disability.</p> <p>2. Provisions in the National HIV/AIDS Policy or the National HIV/AIDS Workplace Policy are not legally enforceable.</p> <p>3. A social protection system that is not HIV-sensitive.</p> <p>4. Until the Occupational Safety and Health Act is enacted, there is also no law that prohibits discrimination based on HIV-status including employment termination.</p> <p>5. No law or policy prohibiting the denial of housing, forced evictions, and other forms of threats and violence related to HIV status.</p> <p>6. No law or policy prohibiting non-discrimination in life insurance coverage and in pension based on HIV status.</p>	<p>5.1 Ensure non-discrimination of PLHIV and key populations in employment, housing, insurance, pension, and other areas of socio-economic life through a comprehensive HIV/AIDS law and/or a general anti-discrimination law and/or amendment of relevant law and regulations. HIV infection and clinical AIDS should be treated no less favourably than any other serious illness or condition. Such reforms in law should be accompanied by a robust implementation and enforcement structure.</p> <p>5.2 Put in place HIV-sensitive social protection measures such as cash transfers for PLHIV.</p> <p>5.3 Ensure that employee and family assistance programmes are established for PLHIV who need them through the Voluntary Compliance Program of the National HIV/AIDS Workplace Policy or a Occupation Safety and Health Act.</p> <p>5.4 Sustain income-generating projects for PLHIV and key populations in the National HIV/STI Program.</p> <p>5.5 Engage the private sector to finance income-generating projects for PLHIV and key populations, notably through the National Foundation for HIV.</p> <p>5.6 Provide training for PLHIV and key populations on basic</p>

		7. The private sector has been slow to step up to deal with HIV/AIDS costs and its impact, and provide support for PLHIV.	social, economic, and cultural rights.
<p>Factor 6: Protection of Privacy and Confidentiality <i>PLHIV enjoy effective protection from arbitrary or unlawful interference with their privacy. Their medical and personal information is subject to strict rules of data protection and confidentiality.</i></p>	<p>1. Confidentiality in the context of HIV/AIDS is incorporated as one of the key guiding principles in the National HIV/AIDS Policy in accordance with the ILO Principles on HIV/AIDS & the World of Work.</p> <p>2. The 2012 National HIV/AIDS Workplace Policy stipulates that employers and workers should be 1) informed about the ten guiding principles for HIV/AIDS and the world of work including confidentiality; and 2) the social and economic well-being of workers infected and/or affected by HIV/AIDS are guaranteed by ensuring the protection of their right to privacy and other human rights.</p>	<p>1. No law protecting data confidentiality in general or in the context of HIV/AIDS.</p> <p>2. The lack of a centralized electronic medical system and low sensitization of healthcare workers mean that privacy and confidentiality of the medical records of PLHIV are not always enforced.</p> <p>3. There is also no redress mechanism for breaches of confidentiality.</p>	<p>6.1 Enact confidentiality and privacy laws that would prohibit unauthorized use and publication of HIV-related information on individuals through the inclusion of HIV in a general privacy legislation or the inclusion of these issues in a comprehensive HIV/AIDS law. Ensure that HIV-related information is included within the definitions of personal/medical data subject to privacy protections. Ensure that individuals have access to their own personal and medical records and the ability to request amendments to ensure that information is accurate, relevant, complete, and up-to-date. The laws should also contain mechanisms and remedies to redress breaches of confidentiality as well as exceptions where confidentiality may have to be breached.</p> <p>6.2 Ensure the enforcement of existing codes of conduct of professional bodies to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct. Ensure also that health care workers undergo minimum ethics and/or human rights training including confidentiality guidelines.</p>
<p>Factor 7: Political, Social, and Cultural Life <i>PLHIV enjoy full equality and inclusion in political, social, and cultural life. The State ensures the right of PLHIV, HIV/AIDS advocates, and service workers to peaceful assembly and association.</i></p>	<p>1. The National HIV/AIDS Policy is built upon the principles of participation and the meaningful involvement of people living with and affected by HIV/AIDS and most vulnerable groups in the design, implementation, monitoring and evaluation of the national response to HIV/AIDS is vital to optimise stated outcomes; and equity.</p> <p>2. Participation of PLHIV, equity, gender equality are also among the principles underlying the 2012-2017 National HIV/AIDS Strategic Plan.</p>	<p>1. Criminalization of private, consensual same-sex sexual acts, sex work, and drug use.</p> <p>2. No law or policy to ensure that PLHIV, HIV/AIDS advocates, and service workers enjoy the rights to freedom of opinion and expression.</p> <p>3. No legal sanctions against hate speech or misrepresentations/vilification of HIV and PLHIV.</p> <p>4. No policy that ensures equality and inclusion in political, social, and cultural life of PLHIV.</p> <p>5. PLHIV involvement has been small in scale and not sustained.</p>	<p>7.1 Ensure the rights to freedom of opinion and expression of PLHIV and key populations through legal or policy provisions in order for them to carry out their advocacy work.</p> <p>7.2 Develop a code of ethics for media professionals and mandate that the discussion of HIV/AIDS in the media is uncensored, objective, sensitive, and factually accurate.</p> <p>7.3 Prohibit HIV-related discrimination including hate speech and vilification surrounding HIV, sexual orientation, and gender identity in an HIV/AIDS law or a general anti-discrimination law.</p> <p>7.4 Develop a policy to ensure equality and inclusion in all aspects of political, social, and cultural life of PLHIV and key populations.</p>
<p>Factor 8: Family, Sexual, and Reproductive Life <i>PLHIV enjoy full equality in family life and the right to the highest attainable standard of sexual and</i></p>	<p>1. Gender equality is one of the key guiding principles in the National HIV/AIDS Policy.</p> <p>2. The 2011 National Policy for Gender Equality also strives to ensure that the country remains on target for achieving the MDG goals</p>	<p>1. No law or policy to ensure that PLHIV enjoy full equality in family life; numerous reports of health care providers discouraging the founding of families by PLHIVs as well as promoting/carrying out sterilization of PLHIV.</p>	<p>8.1 Develop an education campaign and enact a comprehensive policy on sexual and reproductive health and rights with provisions for PLHIV including, among other things, access to post-exposure prophylaxis, and freedom from sexual violence, forced abortion, sterilization.</p>

<p><i>reproductive health. The State facilitates prevention of vertical transmission.</i></p>	<p>with respect to reducing maternal mortality rates and improving reproductive health indicators.</p> <p>3. PMTCT is ensured through HIV screening and the provision of ARVs for all HIV infected pregnant women and HIV exposed infants free of cost.</p> <p>4. The 2004 Management of HIV/AIDS in Schools Policy : The Ministry of Education has been implementing the HFLE curriculum to in school youths aged 10-15 years.</p> <p>5. The 2007 Access to Contraceptives Policy for Minors provides guidelines on access to sexual and reproductive health information and contraceptives for minors.</p> <p>6. The new governance structure of the Sexual and Reproductive Health Authority of Jamaica, merging the National HIV/STI Program and the National Family Planning Board should facilitate the integration of HIV/AIDS interventions into sexual and reproductive health care services.</p>	<p>2. Couples' access to voluntary pre-marital HIV testing and counselling is subject to the discretion of service providers.</p> <p>3. No law that prohibits asserting HIV status as the sole ground for divorce, mandatory HIV testing in child custody proceedings, and arbitrary exclusion of HIV-positive prospective foster parents.</p> <p>4. No single sexual and reproductive policy or HIV/AIDS law ensuring the access to sexual and reproductive health education and services by PLHIV.</p> <p>5. Abortion is illegal in Jamaica.</p> <p>6. Services for early STI screening and treatment remain insufficiently developed.</p> <p>7. Concerning the access to SRH education, information, and services by minors, there is a great deal of confusion and conflicting directions between the Sexual Offences Act (2009), the Child Care and Protection Act (2004), and the Access to Contraceptives Policy for Minors (2007).</p> <p>8. Age-appropriate reproductive and sexual health education through the Health and Family Life Education curriculum is not always ensured.</p>	<p>8.2 Align different SRH provisions in existing legislations and policies.</p> <p>8.3 Develop a multi-sectoral policy or a memorandum of understanding pertaining to SRH education (including HFLE), information, and services, clarifying the distinct roles and responsibilities of each sector.</p> <p>8.4 Implement the recommendations outlined in the 2007 Final Report by the Ministry of Health Abortion Policy Review Advisory Group.</p> <p>8.5 Strengthen and integrate STI screening and treatment services with HIV interventions.</p> <p>8.6 Through funding CBOs, put in place a system of psychosocial support for SRH services for men, women, MSM, transgender persons, sex workers, drug users, youth, adolescents, and minors.</p>
<p>Factor 9: Education and Training <i>PLHIV enjoy the right to equal educational opportunity. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and increase their representation in educational institutions.</i></p>	<p>1. The National HIV/AIDS Strategic Plan emphasizes education as one of sectoral responses in HIV.</p> <p>2. The 2004 Management of HIV/AIDS in Schools Policy prohibit HIV-related discrimination including mandatory HIV testing in educational institutions.</p>	<p>1. The Management of HIV/AIDS in Schools Policy is non-binding and does not provide legal protection to ensure children living with HIV/AIDS enjoy equal treatment and privacy protections in all educational institutions.</p> <p>2. The policy also does not provide redress mechanisms.</p> <p>3. The policy has never been reviewed</p> <p>4. The policy does not address issues of HIV-related stigma, violence, and discrimination in the community.</p> <p>5. The existing policy only applies to early</p>	<p>9.1 Ensure non-discrimination of children living with HIV/AIDS in education with a redress mechanism through a comprehensive HIV/AIDS law and/or a general anti-discrimination law and/or amendment in the Education Act.</p> <p>9.2 Activate the review of the Management of HIV/AIDS in Schools Policy. Include a discussion on the issue of HIV-related stigma, violence, and discrimination in the community, the needs of orphans and vulnerable children affected by HIV/AIDS, and gender-related issues relevant to HIV and AIDS.</p> <p>9.3 Provide HIV and anti-discrimination training among school personnel.</p> <p>9.4 Ensure coordination, communication, and accessibility of youth and HIV/AIDS research through an online database.</p>

		<p>childhood, primary, and secondary education. There is currently no policy guidance on HIV/AIDS in higher education in Jamaica.</p> <p>6. Most of the youth, education, and HIV research is unknown and inaccessible to stakeholders.</p>	
<p>Factor 10: Employment, Work, and Economic Life <i>PLHIV enjoy equal rights to: work in public and private sectors, including just, favorable, safe, and healthy conditions of work; property and inheritance; and credit. Where appropriate, special measures are employed to provide PLHIV with income-generating opportunities and reasonable accommodations in the workplace.</i></p>	<p>1. The 2012 National HIV/AIDS Workplace Policy was developed in consultation with employers, employees, and their representatives in accordance with the 10 ILO principles.</p> <p>2. In 2010, a submission was made to the Cabinet to amend Public Health (Notifiable Diseases) Order, to remove provisions that are prejudicial to PLHIV as it relates to employment, particularly within the food and tourism industries e.g. in applying for a Food Handler's Permit.</p> <p>3. If and when enacted, the Occupation Safety and Health Act and associated regulations will give legal protection and sanction against discrimination based on HIV-status including employment termination.</p> <p>4. The Ministry of Labor and Social Security is preparing a Manual on Life Threatening Illnesses which will treat HIV like other chronic illnesses and prohibit HIV discrimination, and a certification program to encourage restaurants and eateries to declare their workplace HIV-discrimination free.</p> <p>5. The National Foundation for HIV, created in 2011, has the mandate of mobilizing private sector funds to finance income-generating projects for PLHIV.</p>	<p>1. Employment dismissal is one of the biggest barriers that PLHIV face in Jamaica.</p> <p>2. Until the Occupation Safety and Health Act and related regulations are enacted, there is no legal protection against all forms of HIV-related discrimination at the workplace.</p> <p>3. The National HIV/AIDS Workplace Policy does not have a redress mechanism. When enacted, the Occupational Safety and Health Act will allow individuals to bring forth their complaints in front of the Industrial Disputes Tribunal. The problem of redress is further compounded by the lack of awareness of their employment and other social and economic rights by PLHIV.</p> <p>4. Mandatory HIV testing is enforced for applicants to the Overseas Employment Programme (Jamaicans leaving abroad to participate in various training and employment programs, notably in the US and Canada) (see Factor 3).</p> <p>5. Income-generating projects for PLHIV have not been sustained.</p> <p>6. No law or policy prohibiting non-discrimination in life insurance coverage and in pension based on HIV status.</p> <p>7. Private sector slow to step up to deal with HIV/AIDS costs and its impact.</p>	<p>10.1 Ensure non-discrimination of PLHIV in employment, insurance, and pension in a comprehensive HIV/AIDS law and/or a general anti-discrimination law. HIV infection and clinical AIDS should be treated no less favourably than any other serious illness or condition.</p> <p>10.2 Eliminate mandatory HIV screening requirement in the Overseas Employment Programme, as it is discriminatory.</p> <p>10.3 Put in place HIV-sensitive social protection measures such as cash transfers for PLHIV.</p> <p>10.4 Ensure that employee and family assistance programmes are established for PLHIV who need them through the Voluntary Compliance Program of the National HIV/AIDS Workplace Policy or an Occupation Safety and Health Act.</p> <p>10.5 Sustain income-generating projects for PLHIV in the National HIV/STI Program.</p> <p>10.6 Engage the private sector to finance income-generating projects for PLHIV, notably through the National Foundation for HIV.</p> <p>10.7 Provide training for PLHIV on basic social, economic, and cultural rights.</p>
<p>Factor 11: Public and Private Housing <i>PLHIV enjoy equal access to adequate private and public housing, including</i></p>	<p>1. In Jamaica, there is no law or policy that prohibits the denial of housing based on HIV status.</p>	<p>1. PLHIV's equal access to adequate private and public housing, including residential facilities is not guaranteed by law or legal provisions.</p> <p>2. Neither the National HIV/AIDS Policy nor</p>	<p>11.1 Ensure non-discrimination of PLHIV in housing through a comprehensive HIV/AIDS law and/or a general anti-discrimination law and/or amendment of relevant law and regulations with clear redress mechanisms.</p>

<p><i>residential facilities. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and protect their rights in the place of residence. Segregation, exclusion, and coercive or punitive measures based on HIV status are prohibited.</i></p>		<p>Strategic Plan specifically addresses the links between poor health, HIV, and the lack of adequate housing.</p> <p>3. Community stigma and discrimination, resulting in home evictions, remain a serious challenge to the full enjoyment of PLHIV in social life and protection.</p> <p>4. No special measures have been put in place to provide reasonable accommodations for PLHIV and protect their rights in the place of residence.</p>	<p>11.2 Integrate provisions on housing protections in the National HIV/AIDS Policy and Strategic Plan.</p> <p>11.3 Put in place HIV-sensitive reasonable accommodations for PLHIV and protect their rights in the place of residence including housing subsidies.</p> <p>11.4 Fund CBOs to expand shelter services and provide training for PLHIV on basic social, economic, and cultural rights.</p>
<p>Factor 12: Entry, Stay, and Residence The State does not impose restrictions on the entry, stay, and residence of PLHIV based on HIV status. PLHIV are not returned to countries where they face persecution, torture, or other forms of cruel, inhuman, or degrading treatment. Migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services.</p>	<p>1. The Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act do not contain provisions pertaining to travel restrictions based on HIV status or mandatory HIV testing of migrants. There have been no reported cases of denial of entry, stay, residence, or naturalization in Jamaica based on HIV status.</p> <p>2. Mandatory HIV testing is enforced for applicants to the Overseas Employment Programme (Jamaicans leaving abroad to participate in various training and employment programs, notably in the US and Canada).</p>	<p>1. No legal protection against HIV-related travel restrictions and discrimination of migrants and mobile populations.</p> <p>2. The HIV-related needs of migrants and mobile populations are not integrated in the national HIV response and existing health care programs.</p> <p>3. Little data is available on diverse mobile populations in Jamaica.</p> <p>4. There are no culturally and linguistically appropriate HIV intervention programs targeting various mobile populations especially at risk groups including sex workers, sex tourists, and MSM.</p> <p>5. Migrants may not be aware of their right to information and right to health due to legal status, stigma, and socio-economic and cultural alienation.</p> <p>6. Mandatory HIV testing in the Overseas Employment Programme is discriminatory and should be removed as a condition for employment.</p>	<p>12.1 Amend the Immigration Restriction (Commonwealth Citizen) Act and the Aliens Act of 1946 to ensure that prospective immigrants who are tested and found to be HIV positive will not be prohibited from entering and remaining in the country based on their HIV status; and to ensure confidentiality of their medical information.</p> <p>12.2 Remove mandatory HIV testing in the Overseas Employment Programme.</p> <p>12.3 Integrate HIV policy and programmes for immigrant populations as part of migrant population policy within a national development policy.</p> <p>12.4 Establish a migrant focal point and steering committee within the national HIV response.</p> <p>12.5 Collect data on migrant HIV prevalence rates and other related indicators.</p> <p>12.6 Recruit and train cultural mediators to conduct HIV awareness campaigns within diverse mobile populations.</p> <p>12.7 Provide and integrate SRH information, education, and services with HIV interventions for migrants.</p> <p>12.8 Train health and welfare personnel, police officers, customs and immigration officials, and public officials at the Planning Institute of Jamaica that devise migration-related policy, Ministry of Foreign Affairs, and Passport Immigration and citizenship Agency on migrant HIV vulnerabilities and needs.</p>

<p>Factor 13: Non-Criminalization of HIV Exposure and Transmission <i>HIV exposure and non-intentional transmission are not criminalized. Deliberate and intentional transmission of HIV is prosecuted under general rather than HIV-specific criminal law.</i></p>	<ol style="list-style-type: none"> 1. Jamaica does not have a HIV-specific criminal law and there has been no prosecution and conviction related to HIV transmission. 2. In 2010, a submission was made to the Cabinet to have HIV/AIDS removed from the Public Health (Class 1 Notifiable Diseases) Order to use vector as the basis for the distinction to differentiate between different categories of communicable diseases and notifiable diseases. 3. HIV transmission could be prosecuted under Section 22 of the Offences against the Person Act 1864. 4. In 2010, the Labour Minister threatened to push for legislation to impose criminal sanctions on persons who knowingly spread HIV/AIDS. 	<ol style="list-style-type: none"> 1. Some people including legal officers from different line ministries advocate for a HIV-specific law to criminalize HIV transmission. 2. Politicians, religious leaders, as well as the public do not seem to be well informed about the international guidelines concerning criminalization of HIV transmission. International human rights advocates agree that enacting HIV-specific criminal law is not an effective way to fight against the epidemic. Criminalizing HIV transmission is justified only when individuals purposely or maliciously transmit HIV with the intent to harm others. In these rare cases, existing criminal laws can and should be used, rather than passing HIV-specific laws. Such laws promote fear and stigma, and further oppresses women who may be prone to violence in disclosure. 	<p>13.1 Develop sensitization training for political leaders, legal officers within line ministries, FBOs, and the public to understand that criminalization of HIV transmission perpetuates stigma of PLHIV, discourages testing, and is recognized as an ineffective way to fight against the epidemic by international human rights advocates.</p>
<p>Factor 14: Women <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of women, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.</i></p>	<ol style="list-style-type: none"> 1. In Vision 2030, the strategic intent to reduce all inequalities that contribute to HIV vulnerabilities of women is outlined. 2. The National HIV/AIDS Policy endorses gender equality as one of the key guiding principles. 3. The 2011 National Policy for Gender Equality sets targets and strategies in six areas. 4. Some significant legal and policy changes concerning gender equality in Jamaica. 5. A Gender Focal Point was established within the National HIV/AIDS Program. 6. The Ministry of Health is currently developing a training manual on Gender and HIV. 7. The National Policy for Gender Equality noted, however, that legislative reform by itself will not achieve gender equality especially where gender roles (and interpretation of law) tend to be rooted in and built on custom, 	<ol style="list-style-type: none"> 1. No national strategy on women and HIV. The most prevalent factors that create HIV vulnerability among women are not integrated in the National HIV/AIDS Policy. 2. Little gender-segregated HIV prevalence data. 3. No policy to ensure women's access to comprehensive sex, health, and HIV education, and prevention, care, and support services. 4. No law or policy that addresses and ensures the full sexual and reproductive health and rights of women. 5. Abortion is illegal in Jamaica. 6. Lack of full informed consent in routine HIV testing of pregnant women as well as instances of forced abortions on HIV-positive women and involuntary sterilization of HIV-positive men and women. 7. Services for early STI screening and treatment are insufficiently developed. 	<p>14.1 Integrate a rights-based approach to sexuality, gender mainstreaming, and empowerment in the national development plan and National HIV/AIDS Strategic Plan.</p> <p>14.2 Develop a national strategy on gender and HIV to address sexual diversity among women and men and all factors that create HIV vulnerability among women and men, and to ensure their access to comprehensive sex, health, and HIV education, and prevention, care, and support services.</p> <p>14.3 Disaggregate HIV prevalence data by gender and consider women as a key population for HIV interventions.</p> <p>14.4 Enact a comprehensive policy on sexual and reproductive health and rights including provisions for PLHIV on freedom from sexual violence, forced abortion, and sterilization among other things.</p> <p>14.5 Ensure minors especially girls' access to comprehensive HIV information, sex and sexuality education, and prevention services and supplies in and out of schools by aligning different SRH provisions in existing legislations and policies.</p> <p>14.6 Develop a multi-sectoral policy or a memorandum of understanding pertaining to SRH education (including HFLE), information, and services, clarifying the distinct roles and</p>

	<p>tradition, religion, and deeply held ideology and beliefs about what constitutes “proper” social ordering.</p> <p>8. In 2011, the then Prime Minister, Honourable Bruce Golding and the then leader of the Opposition, the Most Honourable Portia Simpson Miller signed a Declaration of Commitment to eliminate stigma and discrimination and gender inequality affecting the HIV response in Jamaica.</p>	<p>8. The predominant health framework for women focuses on maternal and child health, and STI. There is very little messaging and programming that addresses a broad range of issues.</p> <p>9. A rights-based approach to sexuality, gender mainstreaming, and empowerment is still missing in the national development plan as well as National HIV/AIDS program.</p> <p>10. Access to comprehensive HIV information, sex and sexuality education, and prevention services and supplies in and out of schools remains a serious challenge due to legal barriers and exerts a greater impact on girls due to gender socialization.</p> <p>11. No policy that addresses the sexual diversity of women including the needs of transgender women.</p> <p>12. Policy making and program design in HIV are dominated by men. Women remain underrepresented in HIV governance structures.</p> <p>13. Gender-sensitive HIV training for judicial and law enforcement officers as well as social workers and health care providers have not been sustained.</p> <p>14. Women are particularly vulnerable to transactional sex in the current economic downturn and there are few financial or other social protection programs especially for women living with HIV/AIDS.</p>	<p>responsibilities of each sector.</p> <p>14.7 Implement the recommendations outlined in the 2007 Final Report by the Ministry of Health Abortion Policy Review Advisory Group.</p> <p>14.8 Strengthen and integrate STI screening and treatment services with HIV interventions.</p> <p>14.9 Take special measures to ensure women’s representation on HIV governance structures.</p> <p>14.10 Provide gender-sensitive HIV training for health care providers, social workers, teachers, and judicial and law enforcement officers.</p> <p>14.11 Develop legal literacy programmes for women.</p> <p>14.12 Develop special initiatives aiming at the economic empowerment of women especially those living with HIV/AIDS.</p>
<p>Factor 15: Children and Youth <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of children and youth, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.</i></p>	<p>1. The second Medium Term Socio-Economic Policy Framework (2012-2015) under Vision 2030 includes the Protection and Care for Children and Youth as a priority area.</p> <p>2. The National HIV/AIDS Policy addresses youth-related issues.</p> <p>3. The 1994 National Youth Policy (updated in 2003) focuses on 6 areas of youth development.</p> <p>4. In 2012, UNFPA funded a detailed assessment on the law and policy framework</p>	<p>1. There is no law that prohibits HIV-related discrimination against children and youth.</p> <p>2. The 2004 Management of HIV/AIDS in Schools Policy prohibits HIV-related discrimination only in school settings and is non-binding.</p> <p>3. Vision 2030 focuses on children and youth solely from the perspectives of security and crime reduction.</p> <p>4. Multiplicity of laws, policies, and sectoral jurisdictions pertaining to children, youth, sexual reproductive health, and HIV.</p>	<p>15.1 Ensure non-discrimination against children and youth based on HIV status in a comprehensive HIV/AIDS law and/or a general anti-discrimination law with redress mechanisms.</p> <p>15.2 Align existing laws and policies to address HIV vulnerability and needs of children and youth including access to HIV information, sex and sexuality education, sexual and reproductive health, sexual diversity, prevention services and treatment, stigma reduction, and redress for discrimination.</p> <p>15.3 Activate and complete the reviews of the 2004 Management of HIV/AIDS in Schools Policy and the 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS.</p>

	<p>for adolescent sexual and reproductive health in Jamaica, outlining ten recommendations on policy reforms, child rights breaches, protection from sexual violence, and psychosocial support etc. A multisectoral taskforce has since been established to take the recommendations forward.</p> <p>5. The NHP, through the support of CBOs, has implemented and supported child- and youth-oriented HIV programs through public awareness campaigns and interventions in health fairs and other events in the community. Examples of television and radio advertisements include Pinch, Leave an Inch, and Roll; Real Men don't Ride without Condoms; and Live Up as part of a Caribbean-wide regional HIV sensitization campaign through well-known sports heroes.</p>	<p>5. Neither the 2004 Management of HIV/AIDS in Schools Policy nor the 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS has been reviewed.</p> <p>6. It is unclear to what extent any eventual national sexual and reproductive policy will address children and youth needs and concerns.</p> <p>7. A heavy abstinence approach rather than an empowerment approach.</p> <p>8. Existing policies and programs fail to take into consideration of sexual diversity among youth.</p> <p>9. No policy to ensure children's right to be heard in health care.</p> <p>10. Little monitoring and evaluation on the quality of delivery of sensitization training for various professionals and there is no redress mechanism in case of breaches.</p> <p>11. Hostile healthcare environment.</p> <p>12. Lack of qualitative, ethnographic data.</p>	<p>15.4 Ensure that a national SRH policy encompasses children and youth perspectives and needs.</p> <p>15.5 In addition to BCC and abstinence approaches, add an empowerment approach in HIV and youth policy and program design.</p> <p>15.6 Through CBOs, train children and youth to participate in policy development.</p> <p>15.7 Ensure monitoring and evaluation of age-sensitive HIV training for social workers, health care providers, and judicial and law enforcement officers.</p> <p>15.8 Make existing research accessible to youth and develop further qualitative, ethnographic research on orphans and children affected by HIV/AIDS, sexual behavior of children and youth, and other drivers of HIV vulnerability.</p>
<p>Factor 16: People who Use Drugs <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of people who use drugs, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.</i></p>	<p>1. Surveillance data suggests that injecting drug users do not constitute a significant population in terms of HIV prevalence. However, a 2005 survey of crack/cocaine users showed 5% HIV prevalence in this population and 27% homeless men and women reported crack/cocaine use.</p> <p>2. Section 8(B) of the Dangerous Drugs Act of 1948 makes the possession of cocaine a criminal offence in Jamaica.</p> <p>3. The Drug Court Act provides a diversion program through which non-violent offenders being prosecuted for the possession of small amounts of drugs for personal use have the option to be admitted to a rehabilitation program instead of a prison.</p> <p>4. The 2012-2013 National HIV/AIDS</p>	<p>1. No law or policy that prohibits mandatory HIV testing and HIV-related discrimination of people who use drugs or ensures the provision of harm reduction services to drug users.</p> <p>2. The National Security Policy approaches drug use from a crime control perspective.</p> <p>3. The National HIV/AIDS Policy does not address specific HIV vulnerabilities of drug users.</p> <p>4. Concern about the ability of the NHP to provide reliable data on drug users.</p> <p>5. Drug users and homeless are lumped into one category.</p> <p>6. The NHP does not allocate a specific budget for HIV programs focusing on people who use drugs. Services are delivered through the collaboration of</p>	<p>16.1 Ensure that the linkage between criminalization, marginalization, and discrimination of people who use drugs and their vulnerability to HIV is addressed in the National HIV/AIDS Policy and Strategic Plan.</p> <p>16.2 Ensure that harm reduction is an integral part of the national HIV response and that all relevant harm-reduction measures (as itemized by UNAIDS) and substitution therapy and drug-dependence treatment services are available to people who use drugs.</p> <p>16.3 Ensure HIV-related non-discrimination against drug users in a comprehensive HIV/AIDS law and/or a general anti-discrimination law.</p> <p>16.4 Develop policy guidelines that provide direction to relevant actors on taking a human rights-based approach to drug control, and devise rights-based indicators concerning drug control and the right to health.</p>

	<p>Strategic Plan identifies drug users as a key population in the priority area of prevention.</p> <p>5. HIV prevention and treatment services targeting drug users are delivered primarily by the National Council on Drug Abuse through a Global Fund-funded program. A <i>dega dega</i> mobile van provides prevention information, testing, condoms, food, and referral services to homeless and drug users in Kingston and in Montego Bay. CBOs such as the Caribbean Vulnerable Communities also provide peer counselling for drug users.</p>	<p>the Center for HIV/AIDS Research, Education, and Services and the National Council on Drug Abuse.</p> <p>7. Harm reduction is not yet an integral part of the national HIV response.</p> <p>8. Framework for services for drug users in Jamaica remains predominantly abstinence-based and high-threshold interventions.</p> <p>9. Few drug offenders access the diversion program.</p> <p>10. Condoms are not available in the two rehabilitation centers on the island. The pilot harm reduction project funded by the Global Fund is limited to Kingston and Montego Bay.</p> <p>11. Continuous stigma and discrimination against people who use drugs.</p> <p>12. Lack of psychosocial support and mental health services.</p> <p>13. Existing services do not address the intersectionality of MSM, homelessness, sex work, inmates, and drug use.</p> <p>14. People who use drugs are largely absent in the design and implementation of HIV programs.</p>	<p>16.5 Develop and disaggregate HIV prevalence data among drug users and the homeless population; and by gender, MSM, and sex work among drug users.</p> <p>16.6 Provide treatment literacy as well as capacity building training for drug users to demand their socio-economic rights, take personal responsibility, and participate effectively in HIV policy-making.</p> <p>16.7 Decriminalize or de-penalize possession of small amounts of drugs for personal use.</p> <p>16.8 Repeal or substantially reform laws and policies inhibiting the delivery of essential health services to drug users, and review law enforcement initiatives around drug control to ensure compliance with human rights obligations.</p> <p>16.9 Amend laws, regulations and policies to increase access to controlled essential medicines and consider the decriminalization of marijuana per the recommendations of the 2001 Report of the National Commission on Ganja.</p>
<p>Factor 17: Adults Engaged in Commercial Sex <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of adults engaged in commercial sex, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.</i></p>	<p>1. Jamaica has an estimated population of sex workers of 15000. The demographic is varied.</p> <p>2. The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence at 4.1% and HIV incidence (new infections) at 1% among sex workers. However, the HIV incidence rate among clients of sex workers is at 6% while partners of clients of sex workers is at 3%. The UNAIDS data surveillance model shows no decline in the projected number of new HIV infections associated with sex work in Jamaica in the foreseeable future.</p> <p>3. Sex work is criminalized in Jamaica under Section 63 of the Offences against the Person</p>	<p>1. There is no law or policy that prohibits HIV-related discrimination and ensures sex workers with equitable and sustainable access to comprehensive HIV-related services.</p> <p>2. Criminalization of sex work makes it difficult to reach this mobile and vulnerable population especially the most invisible sex workers.</p> <p>3. The recognition of the link between criminalization, marginalization, and discrimination of sex workers and their vulnerability to HIV within the NHP has not translated into legal or policy reforms.</p> <p>4. Sex workers reported incidents of mandatory</p>	<p>17.1 Ensure that the linkage between criminalization, marginalization, and discrimination of sex workers is addressed in the National HIV/AIDS Policy and Strategic Plan and translates into legal and policy reforms.</p> <p>17.2 Ensure HIV-related non-discrimination against sex workers including the prohibition of mandatory HIV testing through a comprehensive HIV/AIDS law and/or a general anti-discrimination law.</p> <p>17.3 Develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to sex work and ensure programmes and educational initiatives to allow sex workers access to appropriate, quality health services.</p> <p>17.4 Scale up prevention services for sex workers including</p>

	<p>Act; Section 23 of the Sexual Offences Act of 2009, and Section 3(r) of the Towns and Communities Act.</p> <p>4. The National HIV/AIDS Policy identifies sex workers as a vulnerable population and aims to intensify prevention interventions among sex workers.</p> <p>5. The NHP designs specific prevention activities targeting sex workers through outreach interventions (with distribution of condoms and lubricants, actual condom demonstration, risk-reduction conversations, and testing) and training and empowerment workshops.</p>	<p>HIV testing in order to gain employment as well as police asking for sex in return for releasing them.</p> <p>5. No alternatives to incarceration of sex workers in Jamaica.</p> <p>6. Barriers to access HIV information and services: low literacy level, little knowledge about rights and services, stigma including internalized stigma due to criminalization, and fear of the justice system in general.</p> <p>7. Poverty remains one of the biggest drivers of HIV vulnerability among sex workers. Income-generation projects and other kinds of social protection support measures for sex workers and their families are very limited.</p> <p>8. Existing prevention programs do not address the needs of sex worker sub-populations.</p> <p>9. Lack of human rights training for all professionals who deal directly with the sex work communities.</p> <p>10. Lack of ethnographic research and data on the social contexts and drivers of HIV vulnerability among sex workers.</p> <p>11. Little involvement of sex workers in HIV decision-making process and lack of capacity building for sex workers to participate effectively in such processes.</p>	<p>moving to a sex-worker friendly model that addresses their comprehensive needs including access to counselling and STI treatment.</p> <p>17.5 Expand the existing prevention strategy to reach invisible sex work and related sub-populations including clients of sex workers and partners of clients of sex workers; partners of sex workers who engage in multiple partnerships; sex workers who use crack/cocaine; MSM sex workers; and young and migrant sex workers.</p> <p>17.6 Repeal all laws criminalizing sex work and practices around it, and to establish appropriate regulatory frameworks within which sex workers can enjoy the safe working conditions to which they are entitled.</p> <p>17.7 Provide treatment literacy, legal literacy, and capacity building training for sex workers to demand their socio-economic rights, take personal responsibility, and participate effectively in HIV policy-making.</p> <p>17.8 Develop income-generation projects and other kinds of social protection support measures for sex workers and their families.</p> <p>17.9 Scale up sensitizing training and education on health-oriented and human rights-based approach to sex work for all professionals who deal directly with the sex work communities.</p> <p>17.10 Fund ethnographic research on the social contexts and drivers of HIV vulnerability among sex workers.</p>
<p>Factor 18: Men who Have Sex with Men, and Transgender People <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of men who have sex with men, and transgender people, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable</i></p>	<p>1. The estimated population of men who have sex with men in Jamaica is 33,000. The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence at 32.8% and HIV incidence (new infections) at 30% among MSM. High rates of HIV infection among MSM and bisexuality among MSM fuelling heterosexual HIV transmission are important factors driving the HIV epidemic in Jamaica.</p> <p>2. Qualitative research suggests that sexual identities and relation patterns among MSM are diverse with little data on subgroups</p>	<p>1. Stigma from the larger population, self-stigma, double-stigma of being MSM and HIV-positive, and discrimination.</p> <p>2. No law or policy prohibits HIV-related discrimination and ensures MSM with equitable and sustainable access to comprehensive HIV-related services.</p> <p>3. Criminalization of private, consensual same-sex sexual acts.</p> <p>4. While there has been some recognition of</p>	<p>18.1 Ensure that the linkage between criminalization, marginalization, and discrimination of MSM translates into legal and policy reforms.</p> <p>18.2 Ensure HIV-related non-discrimination against MSM through a comprehensive HIV/AIDS law and/or a general anti-discrimination law.</p> <p>18.3 Develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to MSM and ensure programmes and educational initiatives to allow MSM to access to appropriate, quality health services.</p>

<p><i>access to comprehensive HIV related services.</i></p>	<p>including MSM with high socioeconomic status, adolescent MSM, homeless MSM, transgender MSM, and “down low” MSM.</p> <p>3. Buggery and “any act of gross indecency with another male person” are criminalized in Jamaica under Sections 76 and 79 of the Offences against the Person Act.</p> <p>4. The National HIV/AIDS Policy identifies MSM as a vulnerable population.</p> <p>5. Declaration of Commitment to eliminate stigma and discrimination and gender inequality affecting the HIV response in Jamaica. The Most Honourable Portia Simpson Miller also made an electoral promise in having a conscience vote on the buggery offence within the Offences against the Person Act.</p> <p>6. The NHP designs specific prevention activities targeting MSM through outreach interventions (with distribution of condoms and lubricants, actual condom demonstration, risk-reduction conversations, and testing).</p>	<p>discrimination against MSM in top leadership (e.g. 2011 bi-partisan high-level declaration), there is less political buy-in or movement in terms of decriminalization of private, consensual same-sex sexual acts.</p> <p>5. The current strategy, however, fails to reach certain sub-populations such as MSM with high socio-economic status, young MSM, rural MSM, MSM sex workers, homeless MSM, and drug using MSM.</p> <p>6. Some religious groups continue to portray HIV as a gay disease, hampering prevention efforts targeting other key populations including a bridging population of women who are partners of MSM.</p> <p>7. Little research or data on the transgender population which is currently subsumed under the MSM key population.</p> <p>8. Stigma and discrimination against MSM by healthcare workers.</p> <p>9. Sensitization training and human rights education for healthcare workers and other professionals in contact with MSM populations have been hampered by high staff turnover in the health sector due to out-migration.</p>	<p>18.4 Scale up and redesign the existing prevention strategy to reach invisible and most-at-risk MSM sub-populations such as MSM with high socio-economic status, young MSM, rural MSM, MSM sex workers, homeless MSM, and drug using MSM.</p> <p>18.5 Take immediate steps to decriminalize private, consensual same-sex conduct and to repeal discriminatory laws relating to sexual orientation and gender identity.</p> <p>18.6 Gather surveillance data on the transgender population and develop specific prevention measures to address their needs.</p> <p>18.7 Provide treatment literacy, legal literacy, and capacity building training for MSM to demand their rights, take personal responsibility, and participate effectively in HIV policy-making.</p> <p>18.8 Sustain sensitization training and human rights education including on privacy and confidentiality issues for healthcare workers and other professionals in contact with MSM populations.</p> <p>18.9 Fund ethnographic research on the social contexts and drivers of HIV vulnerability among MSM.</p>
<p>Factor 19: People under State Custody <i>The State takes all appropriate measures to reduce specific HIV vulnerabilities of people under state custody, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services. Terminally ill PLHIV are considered for early release and given</i></p>	<p>1. The estimated population of inmates in Jamaica is 4,600 in 2011. The 2012 Modes of HIV Transmission in Jamaica study shows HIV prevalence among inmates at 2.5% (HIV incidence data is not available). However, surveillance of new male and female inmates in 2010 recorded higher levels of HIV prevalence (5.4% among male inmates and 2.3% among female inmates). One 2007 study finds that inmates are seventeen times more likely to get HIV compared to the general population.</p> <p>2. Sections 76, 77 and 79 of the Offences against the Person Act, criminalizing same-sex</p>	<p>1. Criminalization of same-sex sexual acts rules out condom distribution in prisons.</p> <p>2. No law or policy ensures a prisoner’s right to demand general medical care.</p> <p>3. No law or policy that prohibits HIV-related discrimination against inmates.</p> <p>4. Routine HIV testing among new inmates raises concerns about voluntary and confidential HIV testing.</p> <p>5. Apart from a special section for MSM, inmates have no right to protective custody when his health or physical well-being is threatened.</p>	<p>19.1 Ensure HIV-related non-discrimination against inmates including the prohibition of mandatory HIV testing through a comprehensive HIV/AIDS law and/or a general anti-discrimination law.</p> <p>19.2 Engage multisectoral actors to develop policy guidelines to provide direction to relevant actors on taking a human rights-based approach to prisoners and ensure programmes and educational initiatives to allow inmates’ access to appropriate, quality health services.</p> <p>19.3 Fund and scale up HIV prevention services for inmates.</p> <p>19.4 Educational and informational activities for prisoners and for staff should precede the introduction of condom distribution programmes, which should be carefully prepared.</p>

<p><i>proper treatment outside of prisons.</i></p>	<p>sexual acts, rules out condom distribution in prisons.</p> <p>3. The Corrections Act outlines security requirements in respect of prisoners.</p> <p>4. The National HIV/AIDS Policy identifies inmates as a vulnerable population.</p> <p>5. The 2009 Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica provides guidance on inmates' access to HIV prevention and treatment services.</p> <p>6. On-site services include the provision of HIV information, testing for entering inmates as well as their visiting partners, and training of peer educators. Some Church groups offer support services for inmates.</p> <p>7. The Guidelines for the Clinical Management of HIV/AIDS spell out strategies for the prevention of occupational exposure to HIV that includes risk assessment and risk reduction activities. A training manual on post-exposure prophylaxis is in use and antiretroviral drugs are available and accessible in all regions for the prevention of HIV transmission to accidentally exposed health care workers.</p>	<p>6. The 2009 Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica is not officially adopted.</p> <p>7. Lack of multisectoral political buy-in and consensus on what needs to be done for inmates.</p> <p>8. HIV programs for inmates within the NHP have been underfunded and are not integrated into prison policy and system.</p> <p>9. Harm reduction supplies and services are practically non-existent.</p> <p>10. No STI management except in symptomatic cases due to insufficient resources.</p> <p>11. Basic care packages including toothpaste, toothbrush, and soap etc. are not provided, and as a consequence, sex is often used as exchange for basic necessities.</p> <p>12. Access to prevention and treatment by women inmates is a particular challenge. The existing strategy does not address issues of sexual violence in prison. Statistics on sexual violence (including rape) in Jamaican prisons are not available. Access to post-exposure prophylaxis by victims of sexual assault in prison is not always ensured.</p> <p>13. Voluntary HIV testing is not available to juveniles and HIV testing is not offered to exiting prisoners. Data is not available on the percentage of inmates who acquired HIV in prison.</p>	<p>19.5 Introduce condom distribution programmes and expand implementation to scale as soon as possible.</p> <p>19.6 Condoms should be made easily and discreetly accessible to prisoners so that they can pick them up at various locations in the prison, without having to ask for them and without being seen by others.</p> <p>19.7 Make available other harm reduction supplies such as water-based lubricant, dental dams, and safer smoking materials that would help reduce the risk of HIV transmission.</p> <p>19.8 Conduct formal evaluations of the various components of the policies and programmes to address rape and other forms of sexual violence in prison, and gather statistics.</p> <p>19.9 Prison systems should develop and implement multi-prong strategies for enhancing the detection, prevention, and reduction of all forms of sexual violence in prisons and for the prosecution of offenders.</p> <p>19.10 Victims of sexual assault in prison should have access to post-exposure prophylaxis.</p> <p>19.11 Ensure inmates' access to basic care packages including toothpaste, toothbrush, and soap, as well as STI services.</p> <p>19.12 Ensure female prisoners have access to gender-sensitive HIV and STI prevention and treatment services.</p> <p>19.13 Sustain sensitization training and human rights education for correctional officers.</p> <p>19.14 Policy guidelines should address services directed to incarcerated populations upon release to provide linkages to testing, prevention, and continuation of treatment.</p>
<p>Factor 20: Legal Protections <i>Every person enjoys the right to an adequate and effective protection against violations of human rights based on HIV status, vulnerability, advocacy, or service work.</i></p>	<p>1. The Legal Aid Act enables all those who are unable to afford to receive legal representation. There is no specific provision/exemption for PLHIV who have to fulfill the same economic eligibility criteria as everyone else.</p> <p>2. A National HIV-Related Discrimination Reporting and Redress System (NHDRRS) has been operational since 2009. A 2013 review of</p>	<p>1. Human rights are not always legally recognized.</p> <p>2. Underfunding of the Legal Aid Council means that legal aid is provided almost exclusively for criminal cases. The majority of HIV-related discrimination cases, as summarized in the 2013 review, however, are civil cases. As such, PLHIV have little de facto access to legal aid for HIV-related discrimination complaints.</p>	<p>20.1 Ensure legal recognition of human rights and secure proper funding for the Legal Aid Council to enable it to provide legal aid assistance in civil matters.</p> <p>20.2 Integrate the NHDRRS into the organizational structure of the Jamaica Network of Seropositives (JN+) and strengthen the financial and human resource capacity of JN+.</p>

	<p>reported cases compiled by the Jamaica Network of Seropositives shows the most prevalent forms of discrimination faced by PLHIV in direct discrimination, unintentional reactive discrimination, harassment, and vilification. Cases include breach of confidentiality; harassment/verbal abuse; denial of healthcare; not hired; forced to leave job; denied education; denied housing; forced out of community; discrimination against relative; and threats to person or property.</p>	<p>3. Most PLHIV are unaware of the NHDRRS.</p> <p>4. The NHDRRS was set up with existing structures and complaint mechanisms within various line ministries. None of the statutes for these regulatory bodies makes specific reference to any form of discrimination including HIV-related ones as a basis for disciplinary action. There is no reported case of disciplinary sanction as a result of a HIV-related discrimination complaint. The lack of formal arrangement between the NHDRRS and various professional regulatory bodies makes it difficult to utilize the services of these organizations to resolve cases of HIV-related discrimination.</p>	
<p>Factor 21: Legal Awareness, Assistance, and Representation <i>The State implements and supports educational programs aimed at raising legal literacy among PLHIV. PLHIV have equal access to adequate and affordable legal assistance and representation.</i></p>	<p>1. There is no policy to ensure or promote legal literacy training among PLHIV.</p>	<p>1. The government does not fund CSOs to provide legal advice for PLHIV.</p> <p>2. No private sector law firms target <i>pro bono</i> services to people living with HIV specifically in areas such as discrimination, disability law, employment law, health care rights (e.g. addressing informed consent and confidentiality), or property (including subjects such as wills and inheritance).</p> <p>3. Programmes to educate, raise awareness, and build self-esteem among people living with HIV concerning their rights are not an integral part of the national HIV response in Jamaica.</p> <p>4. There is no evidence that HIV-related issues are included in public and private law school curricula.</p>	<p>21.1 Enable and encourage CSOs to provide legal advice targeted specifically to the needs of PLHIV.</p> <p>21.2 Develop private sector law firm <i>pro bono</i> programs for HIV-related legal assistance.</p> <p>21.3 Fund a sensitization brochure on the NHDRRS and conduct legal literacy training for PLHIV to make them aware of their rights and the reporting system.</p> <p>22.4 Integrate HIV-related legal issues into law school curricula.</p>
<p>Factor 22: Access to a Forum, Fair Trial, and Enforcement of Remedies <i>PLHIV, HIV/AIDS advocates and service workers are guaranteed equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.</i></p>	<p>1. Most HIV-related regulations including the Management of HIV/AIDS in Schools Policy and the National HIV/AIDS Workplace Policy are non-binding. They are not legally enforceable and do not contain redress mechanisms.</p> <p>2. The Occupational Safety and Health Act is currently tabled in the Parliament. If and when passed, it will provide legal protections and sanctions against discrimination of people living with HIV in the workplace by way of</p>	<p>1. There is no HIV/AIDS law, general anti-discrimination law, or a human rights commission in Jamaica, prohibiting HIV-related discrimination and providing redress. Discrimination based on health status including HIV status is not prohibited by the 2011 Charter of Fundamental Rights and Freedoms.</p> <p>2. While the Management of HIV/AIDS in Schools Policy does include non-discrimination, the policy has no legal sanction. Neither does the National HIV/AIDS Workplace Policy until the</p>	<p>22.1 Ensure HIV-related discrimination is prohibited via legally enforceable legislation.</p> <p>22.2 Develop alternative dispute resolution mechanisms to provide meaningful remedy for PLHIV complainants.</p> <p>22.3 Add provisions on HIV-related discrimination in professional codes of conduct for lawyers and judges.</p>

	<p>regulations to be appended to the Occupational Safety and Health legislation.</p> <p>3. Redress mechanisms within the National HIV-Related Discrimination Reporting and Redress System are supposed to range from sensitization to legal action, but no legal action has yet arisen out of the system.</p>	<p>Occupational Safety and Health Act gives the protections legal teeth through specific regulations.</p>	
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