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HIV policy in Jamaica: good form and substance but inadequate application and accountability

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ABSTRACT

The HIV epidemic and response in Jamaica was reviewed in April–November 2019 as part of the preparation of a National Strategic Plan for 2020-25. The National HIV Programme, which includes multi-sectoral partners, has made substantial achievements in reducing the spread of HIV in the population. Mortality due to HIV in Jamaica has decreased from 25 deaths/100,000 population in 2004 to 13 deaths/100,000 population in 2016. Jamaica has committed to the UNAIDS fast track strategy for ending the AIDS epidemic, but HIV incidence rates remain too high, (1,600/100,000 in 2018). This paper reviews key national policies that have guided Jamaica's HIV response. We discuss challenges and gaps in policy application and development that impede Jamaica's efforts to achieve universal access to HIV prevention, treatment and care services.

Keywords: Policy, Enabling environment, Universal access, HIV response, Jamaica

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INTRODUCTION

The preparation of a new Jamaica National HIV Strategic Plan 2020-2025, during 2019, provided an opportunity to review policies and legislation related to the HIV epidemic and response in Jamaica. There is no doubt that legislation and policy play an important role in the containment of epidemics [1,2]. In the Jamaican context, the National HIV policy, the HIV/AIDS workplace policy, and the national policy for HIV management in schools, were enacted to create an enabling environment for HIV response. However, implementation of these policies has been inadequate and other critical policy initiatives are needed. This paper reviews key national policies that have guided Jamaica's HIV response and discusses challenges and gaps in policy application that impede Jamaica's efforts to achieve universal access to HIV prevention, treatment and care services.

Mortality due to HIV in Jamaica has decreased from 25 deaths/100,000 population in 2004 to 13 deaths/100,000 population in 2016 and tens of thousands of new HIV infections have been avoided. Despite this significant progress, much remains to be done to achieve the UNAIDS 90-90-90 targets[3] which aim to provide universal access to HIV testing and treatment to people living with HIV, and to achieve the UN Fast Track Strategy for ending the AIDS epidemic as a public health problem by 2030.

In public health settings, the development of policy incorporates the creation and enactment of public health law, regulations or voluntary practices that induce the creation of systems, lead to organizational change, and motivate the adoption of individual behaviours to improve health outcomes[4]. Constructive public policies such as decriminalizing sex work (in practice in Thailand, India and the Dominican Republic[5,6,7]) and providing incentives to keep girls in school (e.g. Malawi[8]) have positively addressed social determinants that contribute to the HIV epidemic in those countries.

Some key evidence-based HIV policy reforms relevant in many countries include: implementing programmes to prevent mother-to-child transmission (PMTCT)[9]; ensuring that marginalized populations

have access to care and treatment services[10]; revising antiretroviral initiation guidelines to start treatment earlier in the disease progression[11]; and implementing HIV workplace policies based on International Labour Organization (ILO) principles to strengthen the capacity of the employers, workers' organizations and government agencies to develop and manage a comprehensive workplace response to HIV and AIDS[12]. These policy reforms have been shown to improve the scale and effectiveness of national HIV programmes. For example, in Uganda health policy reforms reduced incidence rates from 7.6/1,000 in 1990 to 3.2/1,000 in 1998[13]. Jamaica has had a similar experience following the introduction of the public access antiretro-viral treatment (ART) programme in 2004[14].

Jamaica has both a generalized and a concentrated HIV epidemic; adult HIV prevalence increased from 1.5% in 1996 to 1.8% in 2017, but fell back to 1.5% in 2018, with a significant decline in new infections.[15,16] HIV prevalence among female sex workers has been reduced from 12% in 1990 to 2% in 2017.[17] Mother-to child-transmission of HIV and congenital syphilis, which are linked in the provision of ante-natal care, are on the verge of elimination.

Early in the epidemic (1988) Jamaica established an active multi-sectoral response led by the Ministry of Health. A public access antiretroviral treatment programme, introduced in 2004, has contributed to a 64% decrease in deaths due to HIV related causes, from 25 deaths/100,000 in 2004, to just over nine deaths/ 100,000 in 2015[18].

The Government of Jamaica has committed to the UNAIDS Fast Track Strategy for ending the AIDS epidemic as a public health problem by 2030 and the achievement of the 90-90-90 targets,[3] but much remains to be done to meet these ambitious goals. This includes addressing structural factors that make individuals and groups vulnerable to HIV infection: e.g., criminalization of same-sex relationships[19], sex work[20], underage sex[21] and drug-use[22] all of which accompany and reinforce stigmatization, creating barriers to the provision and/or uptake of HIV prevention services and increasing risky behaviours.

METHODS AND MATERIALS

A team of three researchers from the Public Health department of the University of the West Indies, guided by key leaders in the Ministry of Health and its multi-sectoral partners in the HIV response, developed the 2020-2025 National HIV Strategic Plan. This involved a process of review of official records of the National HIV/STI/TB programme that track the epidemic and the programme responses in Jamaica. This included reviewing the national HIV surveillance database, the antiretroviral treatment information system, the UNAIDS Spectrum report 2019,[23] HIV programmatic data and survey reports. Programme reviews, consultant reports and published papers were also reviewed. Consultations were conducted with government officials, HIV programme staff and representatives of civil society and UN agencies. The current policy frameworks were reviewed and interrogated to guide a multi-sectoral strategic planning process. The authors used a simplified framework for public policy analysis to guide their analysis.[24] This approach specifies analysis based on effectiveness, unintended effects, equity, cost, implementation feasibility and acceptability of each policy[25]. The framework has previously been applied in the review of NCD policy development and implementation in Barbados (2000–2013)[26]

RESULTS

In Jamaica, there is no single overarching HIV-specific law. The main conventions and policies relating to HIV are: the Public Health Act, the 2003 Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS, the 2004 Management of HIV/AIDS in Schools Policy, the 2005 National HIV/AIDS Policy (revised in 2017), HIV/AIDS for Incarcerated Populations in Jamaica and the 2011 National HIV/AIDS Workplace Policy (Table 1). Discrimination is addressed and equality under the law irrespective of sex, race, ethnicity or political affiliation is guaranteed by the Jamaican Constitution. In this paper, we present national policies that influence the delivery of HIV prevention and treatment in Jamaica and discuss how they relate to human rights, drive stigma and discrimination, and provide legal or policy safeguards against HIV-related discrimination, and present barriers to holistic care.

The Public Health Act (1985)

HIV was classified as a Class 1 notifiable disease under the Public Health Act (1985)[27]. The act was passed for the purpose of promoting public health and for preventing the spread of communicable and epidemic diseases. The classification authorizes medical professionals to implement measures to prevent HIV transmission and to provide treatment. Since its application to, the act has been effective in serving the needs of HIV programme implementation in Jamaica[28].

Plan of Action for Orphans and Other Children Made Vulnerable (OVC) by HIV/AIDS (2003)

The needs of orphans and children affected by HIV was addressed in the 2003 Plan of Action for Orphans and Other Children Made Vulnerable (OVC) by HIV/AIDS[29]. It sought to enhance OVC's access to social amenities and reduce the stigma and discrimination experienced by those living with HIV. This policy needs urgent revision and updating, in keeping with international best practices. Its current iteration is supplemented by the revised National HIV Policy, which states that access to education including resources for attending school e.g. fees, uniforms and supplies, should be provided to all OVC. There is immediate need to implement minimum standards of care for OVC in state care[30] and to increase the child rearing competence and resources of those who care for OVC, including family.[31]

Table 1 National HIV related policies

Policy/Law	Description
The Public Health Act [27] (Public Health Act of 1985 Secs. 2(1), 14(1), http://www.gnpplus.net/criminalisation/sites/default/files/Jamaica%20Public%20Health%20Act.pdf)	Categorizes HIV as a notifiable disease and authorizes medical professionals to apply measures to prevent and provide treatment.
The Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS, 2003 [29] (UNICEF Jamaica http://www.unicef.org/jamaica/NPA_for_OVC_.pdf)	Proposes social, educational, organizational and administrative approaches for assisting children affected by HIV/AIDS.
The Management of HIV/AIDS in Schools Policy, 2004 [32] (Ministry of Education Youth and Culture http://www.jis.gov.jm/special_sections/aids/HIVNationalPolicyBook.pdf)	Outlines anti-discrimination guidelines, purports support for students affected by HIV and AIDS and promotes the information and education of all stakeholders.
The National HIV/AIDS Policy, 2005 revised in 2017 [34] (Ministry of Health Jamaica, 2005)	Establishes broad-based approaches to HIV/AIDS and its effect on the entire population. Focuses on HIV prevention and treatment and upholds the rights of persons living with HIV.
The Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica, 2009 [38] (Ministry of Health Jamaica , 2009)	Proposes guidelines for HIV prevention testing and treatment among persons detained and in correctional institutions as well as their partners.
The National HIV/AIDS Workplace Policy, 2011 [40] (Ministry of Labour and Social Security www.ilo.org › public › documents › legaldocument › wcms_132639)	Addresses the rights of workers infected and/or affected by HIV and reduction of stigma and discrimination at the workplace through education and training.
The Occupational Health and Safety Bill, 2017[41] (Jamaica Parliament) https://japarliament.gov.jm/attachments/article/339/The%20Occupational%20Safety%20and%20Health%20Act,%202017%20(2).pdf)	Provides a framework to secure the safety and health of workers and bans discrimination based on infection or disease.

National Policy for HIV Management in Schools (2004)

Prior to the implementation of the Ministry of Education's National Policy for HIV Management in Schools (2004)[32] there were no clear, documented guidelines for educational institutions in Jamaica regarding the treatment of students and teachers living with or affected by HIV. This policy sought to promote non-discriminatory attitudes towards PLHIV (people living with HIV) by providing guidelines for educational institutions on the treatment of such students and school personnel.[12] It guarantees the right of students with HIV to attend educational institutions and forbids compulsory disclosure of HIV status of students and staff to the institution. The policy prohibits mandatory HIV testing of students or educators as a requirement for admission or employment and prohibits denial of appointment or promotion of staff based on HIV status. It specifically stipulates the delivery of age-appropriate education on HIV within the curriculum for all students, and integration of HIV-related information in the Health and Family Life Education (HFLE) programme for pre-primary, primary and secondary school students. The policy also purports to provide counselling and to address self-stigma among students affected by the disease. The policy does not address the issue of discrimination on grounds of sexual orientation or identity, however. Efforts to broaden the HFLE curriculum to address sexual diversity led to public uproar and withdrawal of a manual and curriculum component developed to assist teachers to address the issue[33].

National HIV Policy

Coordination of a national and sectorial HIV and AIDS response required strategic implementation and was guided by Jamaica's first National HIV Policy[34], unanimously adopted by Parliament in 2005. This policy addresses distinct facets of HIV, including prevention and treatment, and the need for a wide-ranging approach to HIV and its effect on society. In addition to seeking to ensure the promotion of human rights and protection from discrimination, the policy objectives are based on the principles of equity and non-exclusion, including the participation of people living with HIV (PLHIV) and vulnerable groups in certain activities. It contains general requisites on access to information on HIV, public education, reducing stigma and discrimination, capacity building and research. The National HIV Policy also affirms the rights of vulnerable populations to goods and services that help prevention (e.g. HIV testing, condoms, lubricants), information and skills, treatment (for opportunistic infections and anti-retroviral therapy), infant formula, voluntary and provider-initiated counselling and testing (VCT) as well as support from family, friends and society. The rights of PLHIV were further asserted through the Jamaica Ministry of Health's (MOH) endorsement of the WHO 2016 consolidated ARV guidelines – a 'treat all' PLHIV policy[35] – that raised the bar to treat all people living with HIV. The national HIV policy was revised in 2017 based on data that emerged from the 2012 Modes of Transmission (MoT) study[36] and evaluations. The incorporation of findings from these studies and guidelines resulted in a lengthy revised policy which, is considered to be less comprehensible to stakeholders. The 2005 and 2017 versions of the policy affirm the rights of all people to HIV prevention and universal treatment and care. This was not explicitly guaranteed in the Jamaica constitution.

HIV/AIDS Strategic Framework for Incarcerated Populations in Jamaica (2009)

High rates of HIV have been recorded in Jamaican penal institutions over two decades (2003-2019)[37,38]. The 2009 HIV/AIDS Strategic Framework for incarcerated populations[39] in Jamaica calls for increased HIV prevention and treatment services for persons who are incarcerated. It stipulates enhanced provision of voluntary counselling and testing (VCT) and risk reduction and prevention interventions for inmates. The framework directs expanded HIV testing for adults and juveniles on entry to correctional institutions or intake centres. It also encourages establishing the practice of training peer educators to deliver stigma and discrimination sessions for all inmates. The second objective of the framework advocates for legal, policy and procedural change to facilitate critical, HIV prevention, treatment, care and support for juvenile and adult

inmates. This second objective sought to address the limitations of prevention interventions, as condom distribution is not currently allowed in Jamaican correctional institutions. Protocols outlined in the Clinical Management of HIV/AIDS stipulates approaches for the prevention of occupational exposure to HIV applicable to prison staff. Though the offence of buggery is not always enforced in the general population, the law is rigorously applied in correctional institutions. All penal institutions in Jamaica are single sex and since sodomy and buggery are legally prohibited in Jamaica, sex in prison is an offence and is denied by the authorities. This provides a barrier to implementation of prevention interventions, particularly condom distribution and prevention interventions that target same-sex activity. Routine HIV testing is conducted among new inmates, however HIV testing is not offered to juveniles and adult inmates on release from prison.

The National HIV/AIDS Workplace Policy

As the HIV epidemic in Jamaica progressed, many implications for the workforce emerged given the disease is most prevalent in the most productive age group. The National HIV/AIDS Workplace Policy[40] was approved by Parliament in 2010. It authorized anti-discrimination requirements on employers. Aspects of the policy were subsequently revised to align with the International Labour Organization (ILO) principles and recommendations from the Attorney General of Jamaica. These revisions were approved by the Cabinet in 2013. It sought to protect the rights of workers living with HIV and/or affected by the epidemic through strengthening the limited legal framework in place to protect PLHIV.

The National HIV/AIDS Workplace Policy sought to facilitate a multisectoral response to HIV prevention by supporting the development and execution of work plans for dissemination and training in the use of culturally appropriate, gender-specific information on HIV. Another of its objectives was to address HIV-related stigma and discrimination through workplace HIV education, involving PLHIV from design to implementation. There has been uneven implementation of the policy in the public and private sector and no evaluation of its implementation.

The Occupational Health and Safety Bill (2017)

There are numerous anecdotal reports and incidents documented in the Jamaica Anti-discrimination System for HIV (JADS) that indicate the need to address stigma and discrimination in the workplace. The Occupational Health and Safety bill (2017)[41] purports measures to monitor, reduce and provide redress for discrimination on the basis of health status. The bill is still in the process of being passed by the Jamaican parliament but seeks to address safety and health in the Jamaican workplace and to provide a framework that offsets the potentially competing interests of employers and workers.

DISCUSSION

Despite the enacted policies, stigma and discrimination associated with HIV remains an important barrier to accessing HIV services.

People Living with HIV (PLHIV)

PLHIV are fearful of revealing their HIV status, though the majority of them report satisfactory service when accessing health services.[42] Measures must be taken to further reduce stigma and discrimination and affirm the human rights of PLHIV. It is important not to criminalize HIV transmission, as this will discourage people from taking an HIV test and will drive the epidemic underground[43,44] resulting in further spread of HIV.

The Jamaican constitution does not guarantee a right to health and the charter of fundamental rights and freedom (2011) excludes a prohibition of discrimination based on disability, gender identity, sexual orientation, health or HIV status.[45] These gaps are acknowledged in the National HIV Policy (revised 2017) which indicates that discrimination related to health condition, HIV status, gender identity, sexual orientation, or disability in the delivery of HIV prevention, treatment and care should be eliminated. Jamaica's National Development Plan's 'Vision 2030' also recognizes HIV as a threat to national development and includes it in the Health Sector Plan.[46] Furthermore, the Jamaican government endorses the Sustainable Development Goals (SDGs)[47] and the 90-90-90 ambitious treatment target set by UNAIDS towards ending the AIDS

pandemic.[3] Given this contradictory and exacting legal and policy context, the susceptibility of some groups, e.g. men who have sex with men (MSM) and transgender persons, to HIV infection is increased. This environment also decreases their ability to cope with the consequences of HIV, including consistently accessing healthcare. Female sex workers (FSWs) are also vulnerable, as there is little if any enforcement of laws that criminalize their operations.

Female sex workers

The burgeoning of the Jamaican sex trade[48,49] gives testimony to the acceptance of the services of female sex workers as part of the entertainment industry, even as they remain stigmatized. Extensive and coordinated HIV prevention and treatment services for FSWs, guided by the national HIV policy and National Strategic Plans, are delivered by the Ministry of Health and its NGO partners. Stigma and discrimination remain a barrier, as does the demand for HIV test results from owners of establishments where FSWs solicit.

These barriers could be better addressed under the National Workplace Policy[40] and the Occupational and Safety Act[41] if sex work was decriminalized and recognized as a legitimate occupation. Considerable human and financial resources have been utilized in targeting interventions for female sex workers in Jamaica. While these have resulted in substantial achievements including consistent declines in HIV prevalence, sex workers in certain settings and the clients of sex workers have not been reached as successfully. HIV prevalence among female sex workers was estimated to be 12% in 1990, 9% in 1997, and 2005, 4.9% in 2008, 5.4% in 2011 and 3.2% in 2014 and 2% in 2017, indicating that rates are dropping, despite this.[17,53,54,55] While reported condom use is very high among female sex workers with their clients, a condom is not always used with a regular client and is frequently not used with the sex worker's main partner.[56] The high prevalence of other STIs among sex workers is consistent with the failure to use a condom at all times. Interventions for sex workers have also been less than effective in addressing drug dependency and interpersonal violence. Important structural barriers remain, including outdated legislation and a lack of regulatory policies. Section 68 of the Offences Against the Person Act of 1864[50] (see table 2) makes living on the earnings of prostitution and solicitation or sex work a criminal act in Jamaica. While soliciting and loitering are criminalized in Jamaica under the Towns and Communities Act section 3r (1843 amended 1995)[58] the authorities generally turn a blind eye unless there are specific complaints. In addition, the National HIV programme (NHP) has discouraged heavy sanctioning of sex workers by the police in order to facilitate outreach health workers' access to them, with prevention messages and services. Evidence suggests that enforcement efforts (e.g. police crackdowns, raids) and punitive sanctions can dissuade sex workers from accessing HIV prevention services, limit their ability to negotiate condom use, and prevent the roll-out and assessment of HIV interventions.[59] Decriminalization of sex work and implementation of appropriate regulatory frameworks such as those applied in Amsterdam and Thailand[60] confirm that sex workers are able to operate in safe working conditions and access health care as needed if the occupation is decriminalized.

Men Who Have Sex With Men (MSM)

Homophobia is a barrier to HIV services for gay men and other men who have sex with men, whether for transaction or pleasure. The Anti-Buggery Law (Offences Against the Person Act of 1864 sections 76 and 77) makes consensual sex between adult men illegal[50] and is also an ongoing reminder to MSM that they are rejected by society and criminalized. The rejection often induces shame, conflict, low self-esteem and risk-taking. MSM of lower socio-economic status are particularly vulnerable and boys may be chased from their homes and subject to sexual abuse, transactional sex or forced into commercial sex. MSM who are of low literacy or who experience adverse life events such as violence, jail or homelessness are at significantly higher risk of HIV infection.[51] Many MSM are forced to disguise their sexuality and live a life in fear, at times practicing deception, such as having a relationship with a woman or marrying to pretend to be straight. The Charter of Fundamental Rights and Freedoms was approved by the Jamaica parliament in 2011 but

attempts by advocates to incorporate broad non-discriminatory language, however, to protect against discrimination founded on sexual orientation, proved fruitless and was intentionally omitted from the charter.

Gender inequalities

Gender inequity and some cultural factors contribute to risky sexual behaviour. The gap between new HIV cases among males and females decreased between 2004-2014.[63] Of those cases newly reported in 2018, 47% were females and 53% were males. One third (32%) of newly diagnosed HIV infections were among women who had no obvious risk and therefore became infected because of the risk-taking behaviour of their male sexual partner.[18] Thirteen percent (13%) of new HIV infections were among women of high risk (multiple sex partners, STIs) and 2% among female sex workers. Factors driving the epidemic are identified as gender norms, gender inequity and sexual violence.[64] Heterosexual men with a high-risk profile (multiple sex partners, having a sexually transmitted infection (STI) or being a client of a sex worker) accounted for 43% of all newly diagnosed HIV infections in 2018. The prevailing culture assures men significant control over women and widely held beliefs and customs support male privilege while inhibiting female autonomy.[65] At the national level Jamaica has no gender policy that addresses the needs of both men and women. The National Development Plan makes a national commitment to redressing long-term systemic discrimination against women. The revised (2017) National HIV Policy also includes a policy statement on gender equality and equity that states, "All HIV programmes, policies and action plans should take into consideration issues of gender in terms of access for all population groups".

Transgender people

Transgender people frequently experience social and legal exclusion, economic susceptibility, and heightened risk of facing violence. Poor self-worth and absence of power contribute to the inability or unlikelihood of transgender women being empowered to negotiate condom use. The high levels of stigma and discrimination against transgender persons contributes to their HIV vulnerability, resulting in a 30-50 times higher prevalence of HIV than is recorded in the general population.[52] More needs to be done to promote acceptance of transgender persons and to counteract the abuse and violence they frequently experience.

Other vulnerable populations

Other key populations are affected by stigma and discrimination and their risk increased by the lack of an enabling environment.

Prison inmates

HIV prevalence among prison inmates was 3.3% in 2003, 2.5% in 2013 and 2017, and 6.9% in 2019.[37,38] When released from correctional institutions, HIV-positive inmates become a key risk factor for the spread of HIV to the general population.[61] The provision of HIV prevention, treatment and support services are critical within the correctional services to reduce risk of transmission during incarceration. This is tied to the challenges of addressing the issue of HIV infection amongst MSM, addressed above.

Homeless drug users

HIV prevalence among homeless persons increased from 8.8% in 2009 to 13.8% in 2015 (males 11.6%, females 26.7%)[62]. Many homeless persons are drug users and participate in transactional sex. The 2017 revised National HIV Policy asserts that persons who use drugs should not be denied access to healthcare and related services. It includes rights-based, harm reduction approaches to the provision of healthcare including providing treatment to persons living with HIV who are drug users. The policy also stipulates disaggregation of HIV prevalence by sex, gender, MSM and drug users.

Minors' access to sexual and reproductive health

Regarding access to sexual reproductive health (SRH) education, information and services by minors, there is major uncertainty and conflicting guidelines between the Law Reform (Age of Majority) Act,[66] Offences Against the Person Act[35], Sexual Offences Act,[28] the Child Care and Protection Act,[67] and the Access to Contraceptives Policy for Minors. The Reproductive Health Policy Guidelines (2004) for persons under 16 years[68] clearly states that the

government is committed to ensuring that no child is deprived of his or her right of access to healthcare and that the best interest of the child shall be the primary consideration of those responsible for his/her guidance. These guidelines gave healthcare providers flexibility to treat a minor even when that minor could not be persuaded to involve a parent or guardian. The provider was empowered to provide reproductive health services based on his/her judgment of the situation in the best interest of the child. However, the Child Care and Protection Act of 2005 has reduced access to reproductive health services and criminalized sex among adolescents of a similar age where one of them is under 16 years of age. Under the Law Reform Age of Majority Act (1979), at age 16 one can consent to 'any surgical, medical or dental treatment' (p6 section 8), inclusive of investigative and secondary procedures. The consent of the parent or guardian of a child aged 16 or older is not required for such treatment/procedure. In addition what comprises medical treatment is not ascribed a legal definition, and this lack of clarity results in some healthcare providers not willing to deliver services as a safeguard against being prosecuted for aiding and abetting the crime of sex with a minor which is illegal under the Sexual Offences Act.

This situation has resulted in limited access to condoms and contraceptives for young persons. A 2017 national survey confirmed that 42% of boys and 12% of girls aged 15–24 years reported initiating sex before 15 years of age. Most of this sexual activity is with their peers and therefore should not be criminalized as statutory rape. However, a significant proportion of adolescent girls and some boys have relationships with persons who are considerably older than them.[69] These relationships usually have a transactional aspect that may include financial support of the adolescent or parent of the adolescent by older men. Relationships between older men and adolescent girls put adolescent girls at risk of sexual abuse, pregnancy, HIV and other STIs. Teenage pregnancy and multiple partnerships remain common, while access to condoms and contraceptives remains limited for young persons.

Table 2 Legislation that affects national HIV related policies

Law	Description
Offences against the Person Act (1864 amended in 2014) [50] (Ministry of Justice Offences against the person Act *moj.gov.jm › laws › offences-against-person-act)*	Lists offences against the person including homicide, assault, rape (applies to women only), protection of women and girls, suppression of brothels, child stealing, bigamy, abortions, infanticide, unnatural offences (specifies anal sex).
Towns and Communities Act section 3r (1843 amended 1995) [58] (Ministry of Justice Towns and communities Act http:// moj.gov.jm › laws › towns-and-communities-act)	Makes provision for the maintenance of good order in towns and communities.
Dangerous Drug Act (1948 amended 2013)[72] (Ministry of Justice The Dangerous Drug Act https://moj.gov.jm/laws/dangerous-drugs-act)	Regulates the importation, exportation, manufacture, sale and use of opium and other dangerous drugs

Policy as a barrier

Policies play an important role in controlling the HIV epidemic. In relation to the Jamaica HIV response, policies address HIV-related vulnerabilities that are fueled by inequalities and prejudices entrenched within the legal, social, economic and cultural structures of society. The critical policy initiatives described earlier are essential to reducing the barriers to HIV services, but their implementation has been uneven and of limited effect. This is largely due to lack of political will fueled by conservative and aggressively articulated Christian viewpoints that regard the legal and policy changes required to attain a more equitable society as threating to traditional Christian principles.[70, 71] On the other hand, there are several laws and policies in Jamaica that create

barriers to proven interventions that can effectively prevent HIV among adolescents and provide appropriate treatment and care. Laws that criminalize sex work, private, consensual sex acts between same-sex adults, and drug use include:

1) Offences against the Person Act (1864 amended in 2014)
2) Sexual Offences Act (2009)
3) Towns and Communities Act section 3r (1843 amended 1995)
4) Dangerous Drug Act (1948 amended 2013) [72]

Laws, policies and guidelines to protect the rights of PLHIV, children and key population groups, including protection against any form of stigma and/or discrimination should be revised in keeping with international best practices.[73] Government must amend laws, policies and practices that increase stigma and discrimination on the grounds of sex, sexual orientation and gender identity. Specifically, government should facilitate the review and amendment of the Charter of Fundamental Rights and Freedoms to include protection against discrimination based on health, including mental illness, gender identity and sexual orientation. Urgency is required on the part of parliamentarians to have the Occupational Safety and Health (OSH) Act[41] passed. The OSH Act has been delayed for a protracted period and when enacted, will provide protection from discrimination based on health. There is urgent need to decriminalize private, consensual same-sex behaviour and revoke laws that discriminate against choice in relation to sexual orientation and gender identity.

Young persons must be given age-appropriate sex education and taught safe sex skills at school. Sexually active young persons including minors (those aged under 16 years of age) must have access to counselling as well as condoms and contraceptives to protect themselves from HIV, STIs and unwanted pregnancy. This can be achieved by reinstituting the reproductive health policy approved by the Cabinet in 2004 whereby minors get access to reproductive health services without requiring the permission of their parents. In addition, a 'close in age' clause can be introduced in the Offenses Against the Person Act so that persons of a similar age having sex (e.g. with a person within 4 – 5 years of their own age), where one party is a minor is not automatically considered to be statutory rape. The Joint Committee of the House recommended this amendment in their report. Medical practitioners, nurses and other relevant professionals (counsellors, social workers, teachers) must regain the right to judge in which circumstances they need to report that a minor is being sexually or otherwise abused. The discretionary right of healthcare providers is not a novel concept and has been implemented in the United Kingdom (UK). The UK Sexual Offences Act (2003)[74] like its Jamaican version makes it possible to provide counselling and contraceptives to a minor without this being regarded as aiding and abetting a sexual abuse offence. Unlike the Jamaican law, Sections 14(2) and 73 of the UK Statute provides the following exceptions and protection for healthcare providers:

"A person is not guilty of aiding, abetting or counselling the commission against a child of an offence to which this section applies if he acts for the purpose of—

1) Protecting the child from sexually transmitted infection,
2) Protecting the physical safety of the child,
3) Preventing the child from becoming pregnant, or
4) Promoting the child's emotional well-being by the giving of advice, and not for the purpose of obtaining sexual gratification or for the purpose of causing or encouraging the activity constituting the offence or the child's participation in it."

The Joint Committee of the House of Representatives of the Jamaican parliament recommend that this could be done by indemnifying the respective professionals.

The quest for a reasoned and holistic approach to sexual reproductive health (SRH) for minors is faced with a major hurdle imposed by the assortment of legislations, guidelines and involved authorities relating to adolescents and young adults. Within the abundance of laws and policies, the 'best interest of

the child' benchmark remains discretionary and subject to interpretation by legislators and those who provide SRH services. This issue of a coherent comprehensive approach warrants much more interrogation than can be covered in this paper but needs to be systematically assessed.

Measures must be taken to reduce stigma and discrimination and affirm the human rights of PLHIV, MSM and other marginalized groups. The Occupational Safety & Health Act (Jamaica Parliament, 2017), which proposes the prohibition of discrimination based on health status, needs to be passed without further delay. The Act ensures observance of specified practices that help to create favourable working environments that will protect employees' welfare, while augmenting productivity. When passed, the act will make the National HIV/AIDS Workplace Policy legally enforceable. Private and public agencies and organizations will be required to accept and apply polices addressing HIV-linked discrimination in the workplace. A National HIV-Related Discrimination Reporting and Redress System was implemented in 2009 but a review in 2013[75] revealed that many people were ignorant of the system. The reporting and redress system suffers from insufficient human resources and inadequate technical capacity. It is not attached to a specific institution. This is a work in progress and has been re-branded the Jamaica Anti-Discrimination System for HIV (JADS). It is supported by the office of the public defender but will only succeed if the constituents engage and persevere in seeking redress.

Recognition for sex work as a legal occupation is a long-term goal. The National HIV Programme has documented the link between criminalization, marginalization, and discrimination of sex workers and their increased risk of HIV infection. However, this has not led to legal reform. Accounts of compulsory HIV testing for employment (e.g. in massage parlours) and police officers demanding sex in exchange for release are shared by sex workers. Under the Towns and Communities Act they can be fined or face imprisonment. Those social services that can be accessed by sex workers offer a limited range of services that often fail to meet their needs. A major driver of vulnerability to HIV infection among sex workers is poverty. There is limited access to social protection or alternate income earning schemes for sex workers and their families. Trans women who sell sex are particularly vulnerable as the existing HIV policies do not address their needs. There are practically no interventions that target the clients of sex workers and partners of those clients. The involvement of sex workers in HIV prevention planning is narrowly confined to recruitment of sex workers as peer educators and there is no capacity building to encourage sex workers to contribute at that level. In the meantime, positioning sex work as a valid occupation, as in the best practices in Amsterdam and Songachi[76,77] where HIV and STI prevention is a logical part of health and safety considerations, can be achieved in the short to medium term. Generally HIV and STI interventions among female sex workers in low-resource settings show less effect with behavioural interventions alone compared to those with a combination of policy change and sex work-led interventions, along with the provisions of healthcare worker-led STI and reproductive health services.[55]

The rights of prisoners to effective prevention and treatment services must be guaranteed through the development and implementation of suitable policies by the Ministry of National Security, through the Correctional Services Department.[78] Programmes in correctional institutions should include discrete and easy access to condoms[79] for prisoners (they should not need to ask for the condoms or be seen taking them) and provide information and education on discrimination for prisoners and prison workers.

The Management of HIV/AIDS in Schools Policy assures students and staff non-discrimination based on HIV-status. However, the policy cannot legally be enforced and does not provide redress mechanisms. It has not been reviewed since its adoption in 2004 and no independent procedures or structures for monitoring or for evaluation of its implementation exist. The extent to which there has been a consistency of approach or quality of delivery is not clear. There are no published reports of the impact of HIV prevention and stigma reduction curricula in

schools, nor measures of HIV-related stigma and discrimination and effects such as failure to finish school. Further, the policy makes no reference to the school-related needs of orphans and vulnerable children affected by HIV. Revision is needed to focus on HIV-related discrimination in the school and community, incidents of violence, the needs of orphans and vulnerable children affected by HIV/AIDS, and HIV related issues of gender.

The framework for addressing HIV prevention among drug users in Jamaica does not embrace harm reduction nor is it prioritized in the national HIV response. The National HIV/AIDS Policy does not mention harm reduction for persons who use drugs, nor does it address the stigma and discrimination or the dearth of training in a rights- based approach for professionals who work with drug users, or psychological, social and mental health interventions for this population. The services that do exist fail to acknowledge intersections between key populations of MSM, the homeless, sex workers, inmates, and drug use even though there is documented evidence of major overlap. As in the case of other key populations, drug users are not included in the planning and implementation of HIV programmes.

CONCLUSION

Studies in the USA and Zimbabwe show that successfully addressing structural/policy barriers empowers individuals and key populations and facilitates access to HIV prevention services.[80,81.82] Yet such interventions are difficult to implement because they attempt to deal with deep-rooted social and gender norms, cultural factors, religious values and pervasive stigma and discrimination. For example, despite sustained advocacy efforts directed towards the faith-based and education sectors, very little progress has been made on resolving the challenges that infringe on the sexual and reproductive rights of young people. Options for providing extensive protection against stigma and discrimination in Jamaica include a comprehensive HIV law, a universal anti-discrimination law, a human rights commission, or legislation that protects against HIV-related discrimination. We believe that the Occupational Safety and Health Act (if and when enacted) will provide legal protection against HIV discrimination in the workplace. There is need to challenge the outdated laws in Jamaica and test their conflict with the constitution. This has been done in Guyana, where the 19th-century Guyanese law that bars cross-dressing was challenged and made void in the country's final appeal court, the Caribbean Court of Justice. Similarly, the successful challenge in 2016 to the law in Belize that made "carnal intercourse against the order of nature" (including anal sex) a crime punishable by up to 10 years imprisonment resulted in the decriminalization of sex between men.

Unfortunately, it is difficult to directly link changes in HIV incidence to the policy change. Bold policy action is reliant on government's determination to achieve reforms that may threaten popularity and political viability. As we have demonstrated in this paper, many suitable HIV policies exist Jamaica but many are aspirational. Consistent and meaningful application of these policies has not been achieved and changes in behaviour towards PLHIV and other vulnerable groups have not shifted sufficiently. This is the result of a failure of the political and institutional leadership to hold persons accountable when they do not adhere to the principles and actions outlined in the policies. Structural changes have not been forthcoming largely because the political directorate is reluctant to confront majority positions molded by conservative Christian beliefs[70].

In addition, despite the increased importance of health and human rights at the international policy level, and even though health and rights support and reinforce one another, many health professionals maintain suspicions of and do not support human rights. This indicates that law or policy are not enough. Social and political will, with adequate local and international funding and aggressive advocacy from interest groups for implementation and enforcement, must accompany a rights-respecting population if real change is to take hold. Policy developed through stakeholder consultation can define a vision for the future which in turn helps to establish targets and points of reference for medium- and long-term implementation of critical health and human rights frameworks.

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