



## **Jamaica Family Planning Association**

# **Securing Our Future: Lessons in HIV Prevention for Girls and Young Women**

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## National Context of HIV/AIDS and HIV Prevention for girls and young women

*"... Since this year [there has been] an increase in the rate of infection from 1.5 percent to 1.6 percent and the number of persons living with HIV had increased from 25,000 to 30,000... Over 4,500 persons [are] currently on anti-retroviral drugs... Kingston, St. Andrew and St. James were the most challenging parishes and in St. James the prevalence rate was about twice as high as that for the entire country... In terms of distribution of AIDS cases, the majority were in the 20-49 years age group... The adolescent group, the prevalence rate among girls was twice as high as among boys."*<sup>1</sup>

*"... At the end of June 2007, there were 12, 063 persons who were reported with AIDS with males accounting for about 60 percent. Just over 1,186 persons were reported with AIDS between January to December 2006 compared to 1, 344 between January to December 2005. That is an average of three new cases of AIDS diagnosed each day in 2006."*<sup>2</sup>

*"Between 2002 and 2007, the number of newly reported cases [of HIV] for female youth in the 15-24 age group was three times higher than their male counterpart... One in three men who had sex with men were HIV positive and the largest concentration of AIDS cases was in the 20 to 49 age group."*<sup>3</sup>

*"60 percent of Jamaican males reported having multiple partners during the previous year and 16 percent of females. In the 15-24 age group 47 percent reported multiple partners while in the 25-49 age group the figure was 32 percent. 21 percent of persons who had multiple partners were married or in a cohabiting relationship. On average males reported having six partners per year and the females three. 43 percent of the persons reporting multiple partners used a condom."*<sup>4</sup>

*"27 percent of persons in the 15-49 year old population in Jamaica were involved in transactional sex within the past year. 41 percent of those persons used a condom every time. The prevalence of HIV among commercial sex workers was nine percent. The incidence of sexually transmitted infections was 17 percent in the 25-49 years age group."*<sup>5</sup>

*"30 percent of men who had sex with men were HIV infected, 29 percent of them did not use a condom with their last male partner and they also had sex with a female partner without using a condom."*<sup>6</sup>

*"15 percent of the population reported being forced to have sex. In the 15-24 year old age group 13 percent reported being forced to have sex and a condom was not used."*<sup>7</sup>

*In Jamaica, "girls and young women face many factors that make them particularly vulnerable to HIV—sexual activity is often coercive, young people are disproportionately affected by sexually transmitted infections, high adolescent fertility rate with 4 in 10 girls giving birth before 20 years, a third of young men have multiple partners."*<sup>8</sup>

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<sup>1</sup> See Minutes of Meeting of the Joint Select Committee to Consider and Report in the Green Paper on the National Workplace Policy on HIV/AIDS, February 11, 2009, Pg. 2

<sup>2</sup> See National Workplace Policy on HIV and AIDS, April 2008, Pg. 13

<sup>3</sup> See Report of the Joint Select Committee on the Green Paper on National Workplace Policy on HIV/AIDS (Draft), Pg. 4

<sup>4</sup> See Ibid, Pg. 3

<sup>5</sup> See Ibid, Pg. 4

<sup>6</sup> See Ibid, Pg. 4

<sup>7</sup> See Ibid, Pg. 4

<sup>8</sup> See Report Card, Jamaica, 2006

## Introduction

This Report was designed as the core output of the Jamaica Family Planning Association (FamPlan) Member’s Meeting (2009). It was created as an advocacy support tool for influencing and encouraging interest in ‘actions for improving and increasing HIV prevention for girls and young women in Jamaica’.

The Report summarises the key points raised by the Report Card (2006); presents current data on key points raised in the Report Card; outlines the recommendations of youth, from the National Youth Declaration, for addressing the gaps and challenges raised by the Report Card; and evaluates the data to justify the current value and importance of the Report Card.

The Report is titled ‘Securing our Future: Lessons in HIV Prevention for girls and young women,’ because it articulates shares information about a critical social issue—HIV prevention for girls and young women—an absence of quality HIV prevention services for girls and young women translates to an insecure and unsustainable future for all Jamaicans.

Girls and young women are particularly vulnerable to HIV, and thus the need to improve legal, policy, programmatic and funding actions in that direction. Mann and Tarantola (1996) summed up the comparative vulnerability of girls and young women to HIV in the following way,

*“Women are not only being infected with HIV more frequently than men, they are becoming infected at a younger age. The numbers of new infections peak among women between the ages 15 and 25 years, while for men this peak occurs a decade later, between 25 and 35 years old.”<sup>9</sup>*

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<sup>9</sup> See Mann, J and Tarantola, ‘AIDS in the World II’, Oxford University Press, 1996, Pg. 97

# HIV Prevention Legislations

## Overview

The legal provision component examines national laws and regulations that affect actions on HIV prevention for girls and young women. According to the Report Card (2006), there are six legal issues, which make it difficult for girls and young women to benefit from improved and increased actions for HIV prevention. Experts and young people who contributed to HIV prevention discussions raised several concerns about obvious contradictions between national laws and practice. The following testimonies illustrate such contradictions and highlight the vulnerability of young people, because of lack of information and the absence of appropriate laws.

The legal **Age of Consent** for medical procedures is 16 years<sup>10</sup>, but the average age of first intercourse is 14 years<sup>11</sup>.

Some girls and young women don't know **Abortion** is illegal. This is further complicated by the fact that unsafe abortions are managed as part of routine obstetric care in hospitals<sup>12</sup>

*"Young women and girls [often] use unsafe methods to abort and, in so doing, expose themselves to further risks - not only of infection, but also abuse and rape in the course of someone offering them help or asking them to sell sex to get an abortion."* (Interview, Representative, International Agency)<sup>13</sup>

The Law defines statutory rape as any man having sexual relations with a woman under the age of 16 and does not cover **Marital Rape**<sup>14</sup>

*"Married women probably could be seen as less protected, especially because of the popular perception that a husband can't rape his wife."* (Interview, Clinician, STI Treatment Site)<sup>15</sup>

The **Buggery Law** prohibits anal sex, a practice that is reported to be increasingly used by girls and young women to protect their virginity and avoid pregnancy<sup>16</sup>

*"Younger women are turning to anal intercourse as prevention from pregnancy and to protect their virginity. The reluctance to deal with some of these issues is putting young girls at greater risk. People are not really aware of the implications of [the Buggery Law], not just for gay men, but straight couples and young women."* (Interview, Advocate, HIV and AIDS network)<sup>17</sup>

**Sex Work** is illegal<sup>18</sup>

*"... Should anything happen to a young woman in the context of sex work, she has no recourse to law."* (Interview, Representative, International Agency)<sup>19</sup>

There are no **Laws** specific to **HIV/AIDS**, not even to support the many positive national policies being promoted<sup>20</sup>

*"[There is a] lack of information about legislation specifically targeting girls and young women, let alone in the area of prevention... There is no HIV-specific law."* (Interview, Representative, International Agency)<sup>21</sup>

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<sup>10</sup> Report Card (2006): Prevention Component 1, Pg. 2

<sup>11</sup> Report Card (2006): Country Context, Pg 1

<sup>12</sup> See Ibid

<sup>13</sup> See Ibid

<sup>14</sup> See Ibid

<sup>15</sup> See Ibid

<sup>16</sup> See Ibid

<sup>17</sup> Report Card (2006): Prevention Component 1, Pg. 2

<sup>18</sup> See Ibid

<sup>19</sup> See Ibid

<sup>20</sup> See Ibid

<sup>21</sup> See Ibid

## Legal Changes and National Dialogue

The Sexual Offences Act (2009) was amended to include Grievous sexual assault (penetration of vagina or anus and/ or oral sex) of individuals less than 16 years.<sup>22</sup> The **Age of Consent** for sexual activities outlined in subsection 4(1) of the Act is 16 years; therefore a grievous sexual assault occurs when a child under 16 years is involved or otherwise when no consent is given by the participating adult.

An Advisory Committee on Abortion was established in 2005 to “make recommendations for the development of a comprehensive national policy on **Abortion**.”<sup>23</sup> It found that “the laws of the Commonwealth Caribbean are all derived from the 1861 Offences Against the Person Act—the language of the 1861 Act has remained virtually unchanged. That is the case for Jamaica.”<sup>24</sup> The Abortion Policy Review Group recommended that “relevant sections of the Offences Against the Persons Act be repealed and substituted with Civil Law, titled ‘Termination of Pregnancy Act’ stating the conditions under which medical termination pregnancy will be lawful.”<sup>25</sup>

Legislation was enacted in 2009 to address the issue of **Marital Rape**—The Sexual Offences Act (2009) recognises that rape can occur within the context of marriage, “a husband commits the offence of rape against his wife if he has sexual intercourse with his wife in any of the [specified] circumstances”<sup>26</sup>

*“... The penalty to which a person will be liable on conviction in a circuit court for rape, including marital rape, or grievous sexual assault, will be imprisonment for life or a lesser term, considered appropriate by the court.”*  
(Dorothy Lightbourne, Minister of Justice, Jamaica).<sup>27</sup>

National discussions about the legal issues raised in the Report Card, revealed gaps such as, the absence arguments about the impact of such issues on HIV prevention for girls and young women. The following quotes illustrate some of the social and moral barriers to improved legal actions on HIV prevention for girls and young women.

***“The Age of Consent for sexual relationship is 16 in this country and yet we scream about teenage pregnancy. If that is the age of consent, aren't we technically saying that persons can well become families and get married at that time? Aren't we therefore saying that these persons are capable to begin to set up families?”*** (President, National Parent Teachers' Association of Jamaica, Miranda Sutherland)<sup>28</sup>

***“... Safe, medical Abortions are currently readily accessible to women with means to procure the services of private practitioners; the law as it stands, however, serves only to jeopardise the health of women who cannot afford private care.*** The question is, how much of a concern is the issue of unsafe abortion in Jamaica? Data from the Ministry of Health, from public hospitals and the University Hospital of the West Indies, show that about 1,200 woman are seen each year for complications of unsafe abortions. This means that the health of over 1,000 Jamaican women without access to safe care is jeopardised by the current restrictive policy. While few die, many are left with permanent disability, including the inability to have any more children. While these figures are high, they do not capture the true numbers of abortions being performed, as only those with complications surface. With the lack of regulation, no reporting mechanism exists to provide a true

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<sup>22</sup> See The Sexual Offences Act (2009), 4(1)

<sup>23</sup> See Ministry Paper #6/08, Report of the Advisory Committee on Abortion

<sup>24</sup> See Abortion Policy Review Advisory Group Final Report, Ministry of Health, February 2007, Pg 2

<sup>25</sup> See Ibid, Pg. 6

<sup>26</sup> See The Sexual Offences Act, 2009, 5(1), Pg. 5

<sup>27</sup> See The Gleaner, Saturday, May 23, 2009, “Husbands, beware! Debate on marital rape leads to life for spouses”

<sup>28</sup> See JIS, Friday, November 28, 2008, “Increase Age of Consent to 18”

picture of how many women and families are making such a decision. Research suggests that as many as one in three young women have terminated a pregnancy. Is it then fair to say that this is not a matter that affects, or concerns the wider population, when such conditions exist?" (The Jamaica Observer)<sup>29</sup>

***"These legislative framework have, to some extent, led to persons falling under these legislation being unavailable to us. For example, the Buggery Act and Commercial Sex Workers, all of those things are illegal, so how do you legally provide services for persons who are engaged in illegal activities? There must be some kind of room where we can have a kind of a decriminalisation where we can find a common path to work with those persons, even if the activity remains illegal."*** (Dr Kevin Harvey, SMO, Ministry of Health's National HIV/STI Control Programme)<sup>30</sup>

***"We are not going to yield to the pressure, whether that pressure comes from individual organisations, individuals, whether that pressure comes from foreign governments or groups of countries, to liberalise the laws as it relates to Buggery... Every society is shaped and defined by certain moral standards and the laws that evolve in that society are informed by a framework that the society recognises... If we start to yield; if we start to liberalise in the direction that strong organised lobby would insist that we should, then where do you draw the line? We will never start peeping in anybody's bedroom to see what they are doing within their own privacy. We will never start hounding down people because they may have lifestyles that we would prefer did not exist. But what we are not going to do is to give official or legislative endorsement that now holds that up and say this is a perfectly acceptable way to live."*** (Hon. Bruce Golding, Prime Minister, Jamaica)<sup>31</sup>

**"Prime Minister Bruce Golding has rejected the suggestion made by an officer of the Ministry of Health that the Government should tax prostitutes as a legitimate source of revenue, describing the proposal as ludicrous, ill-informed and unauthorized... Through the Ministry of Health, the Government has been conducting a vigorous programme to reduce the spread of sexually transmitted diseases (STDs), especially HIV-AIDS—special attention is given to those who, by virtue of engaging in commercial sex, are at severe risk. This programme will continue."** (Jamaica Information Service)<sup>32</sup>

## Recommendations for Improvement

Young people who participated in the national youth symposium on HIV prevention for girls and young women in June 2008 articulated a number of strategies for addressing the legal challenges that restrict actions for improved HIV prevention services. Interestingly, young people felt that legislative changes were not effective enough, as their existence was no guarantee for improved actions. The recommendations were quite practical, focusing on public education and awareness raising strategies, aimed at empowering young people to make the right choices, plan ahead and solve problems.

- Ensure that **healthcare is delivered non-prejudicially and is universally accessible** by providing public education on the rights of the clients. This should be coupled with a mandatory display of said rights in health care settings. In addition a monitoring/complaint system needs to be in place so that those who are not receiving appropriate care or are being discriminated against have recourse available
- Provide **public education about the legality of abortion, risks associated with illegal abortions, and the use of contraceptives as means of reducing pregnancies leading to abortion**. This is to counteract the many misconceptions that exist about abortion and its legality in Jamaica. Public education to discuss the legality of abortion in Jamaica

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<sup>29</sup> See the Jamaica Observer, Wednesday, September 16, 2009, Jamaica's law on abortion

<sup>30</sup> See The Gleaner, Thursday, June 4 2009, "Prostitution, buggery laws hamper HIV/STI services"

<sup>31</sup> See The Gleaner, Wednesday, March 4, 2009, "Buggery laws firm - PM says life or 15 years for some sex-offence breaches"

<sup>32</sup> See JIS, Tuesday, June 4, 2008, "Prime Minister Repudiates Suggestion to Tax Prostitutes"

- Increase **awareness of the risks associated with alternative sexual practices** (such as anal sex) and the effect of buggery laws on heterosexual couples by educating the public about the risks and challenges
- **Educate persons about the various contexts within which rape can occur**, especially within the context of marriage by including self-esteem and relationship education in schools sexuality curriculum
- **Reduce experiences of HIV/AIDS stigma and discrimination** by integrating HIV/AIDS services with other health care services
- **Make legislation more accessible to the public.** People need to be aware of the laws that exist, especially those working in the area of sexual and reproductive health. Sexual and reproductive health legislation should be placed in one location, like the Charter of Rights and health workers should be educated on the laws that exist

## HIV Prevention Policies

### Overview

The policy prevention component examines national policies, protocols and guidelines that are useful to the improvement of actions taken on HIV prevention for girls and young women in Jamaica. It also identifies gaps, which if addressed would contribute to improved actions. The Report Card (2006) identified two major issues, which were not adequately addressed by the National HIV/AIDS Policy, which if discussed would improve actions taken on HIV prevention for girls and young women—“... *The **distribution of condoms in schools and sex education, remain absent or unclear.***”<sup>33</sup>”

Experts and youth identified four gaps in existing policies for HIV prevention—Confidentiality, contraceptives for minors, opening hours of service sites and quality of sex education:

“We need a policy about **Confidentiality in relation to young people.**” (Interview, Chief Officer, national sexual and reproductive health organisation)<sup>34</sup>

“The **Policy Guidelines for the Provision of Contraceptives to Minors** provides for minors to be given them without the consent of parents in certain circumstances. But they **do not include anything about HIV.**” (Interview, Chief Officer, national sexual and reproductive health organisation)<sup>35</sup>

“**Policies relating to the opening hours of clinics should be changed** to facilitate youth who have to go to school in the days, and who have to work and can’t get the time off. So there is a need for the clinic to open early or very late.” (Interview, Clinician, STI Treatment Site)<sup>36</sup>

“**Sex education is provided at schools but there are weaknesses** with how the topic is approached and taught. Guidance counsellors...are characterized as ‘old school’ and are personally very reluctant to address some of these issues.” (Interview, Advocate, HIV and AIDS network)<sup>37</sup>

### Policy Changes and National Dialogue

A Green Paper was tabled on the **National Workplace Policy on HIV/AIDS** in 2008—to “facilitate the development of a working environment that protects the rights of workers infected and/ or affected by the epidemic...”<sup>38</sup> The ten key principles of the ILO Code of Practice on HIV/AIDS and the World of Work inspired the guiding principles of Jamaica’s

<sup>33</sup> See Report Card (2006): Prevention Component 2, Pg. 3

<sup>34</sup> See Ibid

<sup>35</sup> See Ibid

<sup>36</sup> See Ibid

<sup>37</sup> See Ibid

<sup>38</sup> See National Workplace Policy on HIV and AIDS, April 2008, Pg. 11

National Workplace Policy on HIV/AIDS—HIV/AIDS as a workplace issue, non-discrimination, gender equality, healthy working environment, social dialogue, non-screening for purposes of exclusion from employment and work processes, confidentiality, continuation of employment, prevention and care and support.”<sup>39</sup>

The policies that guide the delivery and management of sex education and HIV/AIDS in schools are being revised to include the issue of HIV prevention and a referral process to work with at-risk youth. Currently, the National Policy for HIV/AIDS Management in Schools (2001) is,

*“... Being revised and should be finalized by early 2010. Revision has so far taken into consideration a principle/clause to guide the development of a Referral Mechanism for at-risk young people 16 years and over. Through this system, young people will be able to access reproductive health services outside of the formal education system; based on referrals made by competent educators (guidance counsellors, nurses)... The National Health and Family Life Education (HFLE) Policy will also speak to HIV prevention services. A first draft of the document has been completed. The Policy is currently being reviewed internally.”* (Health Promotions Education Officer, MOE, Region 3)

Condom distribution in schools is very contentious national issue. The Ministry of Health has been at the forefront of this lobby, but despite their influence, expertise and research in the area of HIV prevention, **Jamaicans are unmoved on the issue of condom distribution in schools. Sex education is now mandatory in secondary level of the education system**, but there are concerns about its quality and the transference of life and risk-reduction skills for HIV prevention. The following quotes highlight the pervading perspectives on condoms in schools,

"The Ministry of Education is not in the business of distributing condoms in schools". (Hon. Andrew Holness, Minister of Education, Jamaica)<sup>40</sup>

"I am an advocate for young people in the schools to learn how to use a condom because if you don't actually practise putting a condom on a dildo you are not going to know how to put it on when it comes to having sex... He added: "We have got to get safe sex education and condom skills in the schools, even while the schools are recognised as no-sex zones. We have to prepare the young people for a sexually active adulthood". (Dr. Peter Figueroa, Chief of Epidemiology and AIDS, Ministry of Health)<sup>41</sup>

*“... Access to contraceptives is not a part of the Ministry’s mandate. Hence the stance remains that condoms will not be distributed in schools, but through the referral mechanisms in place students will know where to access such services.”* (Health Promotions Education Officer, MOE, Region 3)

"All senior students, ages 16 and over in all secondary and high schools, should have condoms available to them in the school system." (Lawman Lynch, President, Kingston and St. Andrew Action Forum)<sup>42</sup>

*"Persons who are in their teen years in school have HIV, we are seeing high rates of teenage pregnancy, we are seeing high rates of STI's like herpes, gonorrhea and syphilis that means teens are having sex, and they are having unprotected sex. We go to schools, we have peer education in schools, we have spent millions of dollars on abstinence campaigns in schools, to have a workshop like this it costs a lot of money. We try to provide pamphlets, name it we have tried it. Now, if all of that isn't working then we realise the next best thing would be to empower these persons that listen if you need to have sex you need to at least do it safely... So we are advocating for the use of condoms in schools. However the powers that be (the legislature), the Ministry of Education, the church, the parents who say 'my daughter is a virgin'.. these are the struggles we face. A health*

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<sup>39</sup> See Ibid, Pg 20-21

<sup>40</sup> See The Sunday Gleaner, December 7, 2008, "Condoms in schools?"

<sup>41</sup> See The Jamaica Gleaner, Thursday, March 16, 2006, "Condom skills should be taught in the classroom"

<sup>42</sup> The Jamaica Gleaner, Monday, January 21, 2008, "Row over schools issuing condoms - Students taped having unsafe sex on campuses"

*worker or nurse or a teacher could be charged with aiding and abetting if he or she were to be seen distributing condoms to a minor because a minor is not supposed to be having sex." (Melanie Walcott, Behaviour Change Communications Officer, St James Health Department).<sup>43</sup>*

## Recommendations for Improvement

Consultations with young people revealed the view point that policy gaps would best be addressed through practical strategies, because **changes in policies do not necessarily translate into actual changes in the experiences of young people**. Therefore, revising the national legal and policy documents for HIV prevention would not directly change young people's actions or those of service providers. **Education about risks, information about youth-friendly service outlets and behavior change communications were seen as preferred strategies for reducing risk.**

## Availability of HIV Prevention Services

### Overview

The availability of services prevention component looks at the number, scale, range and variation of HIV prevention services that exist to meet the needs of girls and young women.

Like the other prevention components, the Report Card (2006) articulates a need for improvement. The quality of information and services for HIV prevention were found to be variable, programmes were seen as largely generic and not addressing the different and specific needs of different categories of girls and young women. The following quotes detail the concerns:

*"... The provision of **services varies greatly** from area to area and is more limited in rural areas. Also, with clinics often overwhelmed by the demand for services, staff cannot always provide young people with comprehensive support. Also, girls and young women are generally unaware of what type of services might help them and where they could get them."<sup>44</sup>*

*"The information that [girls and young women] receive in **schools is often varied in quantity and quality**, largely depending on the interests and commitments of the Guidance Counsellors that provide it, as well as the moral stance of the teachers and Principals."<sup>45</sup>*

*"... Most **programmes tend to be very generic** in nature and few specifically target girls and young women."<sup>46</sup>*

*"**Working with young and middle-aged men** is seen as key to HIV prevention for girls and young women. However, there are few services that specifically target them for this purpose."<sup>47</sup>*

Experts and young people who contributed to the research were also convinced of the need to improve HIV prevention services. The suggestions included: empowering young people with risk-reduction and life skills, diversifying approaches to HIV prevention by expanding it beyond health, and designing specific programmes to meet the needs of girls and young women.

*"There is a lack of HIV **prevention services that integrate gender components** and target young women and girls." (Interview, Advocate, HIV and AIDS network)<sup>48</sup>*

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<sup>43</sup> See The Jamaica Observer, Wednesday, November 14, 2007, "Condom controversy"

<sup>44</sup> See Report Card (2006): Prevention Component 3, Pg. 4

<sup>45</sup> See Ibid

<sup>46</sup> See Ibid

<sup>47</sup> See Ibid

*“There are programs targeting young men who have sex with men. But there is also a need for **programmes targeting heterosexual young men and boys**. These males would be in a better position to provide support to females.”* (Interview, Advocate, HIV and AIDS network)<sup>49</sup>

*“There is a **need to go beyond ABC strategies**, particularly with young girls.”* (Interview, Representative, International Agency)<sup>50</sup>

*“A lot needs to be done in the area of VCT. **HIV/AIDS cannot be approached only from the health sector.**”* (Interview, Representative, International Agency)<sup>51</sup>

*“We **need an advertising campaign in schools** that distributes posters, flyers, and brochures, so that young women know that there are places to go if they do have questions or concerns about their health.”* (Interview, Advocate, HIV and AIDS network)<sup>52</sup>

*“**HIV prevention services are generic** and designed for the general population. Stratified and focused programmes for the specific needs of specific categories of girls and young women don’t exist. A lot needs to be done in terms of gender disaggregation and then in terms of age.”* (Interview, Representative, International Agency)<sup>53</sup>

## Changes in the Availability of Services

The National HIV/STI Programme M&E Plan (2008) outlines a number of national indicators to ‘help set the national health agenda and monitor programme effects.’ The following national focus indicators (prevention priority area) monitor issues of importance to research and advocacy on HIV prevention for girls and young women: “percentage of men and women aged 15 to 24 that are HIV infected, percentage of SW who are HIV infected, percentage of MSM who are HIV infected, number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.), number of persons trained to provide prevention services by client and service area, percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, percentage of young adults, 15 to 19 years old, who have never had sex, percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner, percentage of SW reporting using a condom at last sex act with client, percentage of men reporting using a condom the last time they had anal sex with a male partner.”<sup>54</sup>

The Ministry of Education has been making positive strides on actions for increased HIV prevention services for youth. Commitment was made, some years ago, to incorporate age-appropriate reproductive and sexual health education into the early childhood, primary and secondary school curricula, and today,

*“HFLE is currently in its third year of implementation since the programme was revised in 2005-2006. As at Oct. 2009, 647 primary and secondary schools are implementing the programme and some 289, 626 students are receiving HFLE. A Manual for Managing HIV/AIDS at the Early Childhood Level has been developed, and the programme is expected to be implemented at this level in by 2010/2011.”* (Health Promotions Education Officer, MOE, Region 3)

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<sup>48</sup> See Ibid

<sup>49</sup> See Ibid

<sup>50</sup> See Ibid

<sup>51</sup> See Ibid

<sup>52</sup> See Ibid

<sup>53</sup> See Ibid

<sup>54</sup> See Jamaica National HIV/STI Programme Monitoring and Evaluation System 2007-2012, March 2008, Pg. 16

The Ministry of Education also created a training system for increasing the number of educators who are experienced in the Health and Family Life Education Programme (HFLE). This strategy has contributed directly to an increase in the number of service providers in the education sector,

*“The Ministry trains approximately 700 teachers each year to facilitate implementation of the HFLE Programme. These teachers are required to train other teachers at the local school level to ensure quality delivery. A comprehensive teacher training manual and other learning materials have been developed and pre-tested to ensure quality in the delivery of information on HIV. The Ministry also has a cadre of Health Promotion Education Officers who monitor the implementation and delivery of HFLE in the 6 Ministry of Education regions.”* (Health Promotions Education Officer, MOE, Region 3)

Young people from St. Ann who participated in a focus group discussion (FGD) recently, identified the Youth Advocacy Movement (YAM) of the Jamaica Family Planning Association (FamPlan) as a programme that targets young people for HIV prevention education, advocacy, leadership and skills development. FamPlan (via YAM) was their primary source of information and services for HIV prevention. This was followed by the community, library, clinic and school. HIV prevention services delivered by school was strongly criticized,

*“They show mostly pictures, they don’t really talk about HIV and sex. They just tell you don’t do it. We do not get to share our opinion. Grade 10 and 11 students don’t get Guidance and Counselling—they assume the older kids should know.”* (FGD, FamPlan, Jamaica, November 2009)

The concerns raised by young people about the delivery of sex education have been reiterated by many different groups of persons since the commencement of research and advocacy on HIV prevention in 2006. As such, we sought clarity from a qualified expert,

*“Sex Education is currently provided under the Sex and Sexual Health Theme of the HFLE Programme which is offered to grades 1-6 at the Primary Level and grades 7-9 at the Secondary Level. HIV Prevention Education Programmes are designed from time to time for students above grade 9. In addition, Guidance Counsellors in the various institutions provide lessons on sexuality and sexual health based on the needs of the school.”* (Health Promotions Education Officer, MOE, Region 3)

Beth Jacobs Clinic at FamPlan, the hospital, clinic and school were identified as locations where voluntary counseling and testing (VCT) was available. FamPlan is also the source of their confidence about correctly using a male and female condom, as well as feelings of empowerment about being able to get condoms free and having the power over distribution in their communities. The condom advertisement, which gave instructions about correct use, *‘pinch leave an inch and roll,’* was identified as most useful to girls and young women.

## **Recommendations for Improvement**

Young people noted that the following four strategies are crucial for improving existing programmes and sites delivering HIV prevention services:

- **Empower women with life skills training**, including: condom negotiation, proper use of contraceptives, knowing and standing up for their sexual and reproductive health rights, promoting services to empower women and girls, and developing programmes that will promote the acceptance of self and promote self worth
- **Increase access to confidential services** (counselling and information) in schools by: de-stigmatizing traditional sites among students and offering/ providing confidential services to students
- **Thoroughly train all health care workers in customer services** by implementing and enforcing standards against discrimination and establishing a system where complaints can be logged and dealt with, as well as penalizing service providers for not adhering to the established protocol for service provision

- **Address irregularities among the different government agencies where it concerns adolescent sexuality management** by getting the different entities to agree on making the age of consent, age of marriage, and age to vote one single age in consideration for the age for the provision of all clinical services to adolescents

## Accessibility of HIV Prevention Services

### Overview

Accessibility to HIV prevention services takes into consideration concerns about location, user-friendliness and affordability. Any factor, which limits girls and young women from getting the required services for HIV prevention is examined in this component.

Several barriers were identified as curtailing girls and young women from accessing HIV prevention services in Jamaica:

“There are **multiple social, political and financial barriers** to girls and young women accessing sexual and reproductive health and HIV prevention services.”<sup>55</sup>

“**Access to services varies enormously** for different types of girls and young women. For example, generally, it tends to be easier for those that are married or live in urban areas and harder for girls or those living with HIV.”<sup>56</sup>

“The **cost of voluntary counselling and testing** varies.”<sup>57</sup>

“... Although widely available, the **cost of male condoms can prevent as many as 90% of sexually active 10-15 year olds from using them**. Meanwhile, the cost of female condoms, combined with concerns about their use, can also be a barrier.”<sup>58</sup>

Experts working in the health sector and young people saw the lack of user-friendliness of HIV prevention services and other factors as major hindrances to access:

“**Services need to speak to the Jamaican youth**, which is not an ordinary youth... Accessibility is about location. It’s also about the approach - whether it’s sexy and young enough.” (Interview, Representative, International Agency)<sup>59</sup>

“**Facility workers are unfriendly**. Normally the nurses discuss confidential information with people inside and outside the service centre.” (Focus group discussion, 15-24 year old girls and young women, Kingston)<sup>60</sup>

“...**The whole environment surrounding young girls is very difficult**. The issue of stigma and confidentiality are two fundamental issues that really affect the degree of accessibility of services. I think young girls are much more vulnerable than boys in terms of accessing services. The mainstream society thinks that young girls should not do these things.” (Interview, Representative, International Agency)<sup>61</sup>

“The **opening hours are a barrier** to students accessing the services.” (Interview, Clinician, STI Treatment Site)<sup>62</sup>

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<sup>55</sup> See Report Card (2006): Prevention Component 4, Pg. 5

<sup>56</sup> See Ibid

<sup>57</sup> See Ibid

<sup>58</sup> See Ibid

<sup>59</sup> See Report Card (2006), Pg. 5

<sup>60</sup> See Ibid

<sup>61</sup> See Ibid

<sup>62</sup> See Ibid

“**Knowledge of young women about the female condom is very inadequate** and they are also very expensive if you have to buy them in the supermarket.” (Interview, Chief Officer, national sexual and reproductive health organisation)<sup>63</sup>

## Changes in the Accessibility of Services

Data gathered from a focus group discussion with 12 participants in St. Ann on November 26, 2009, revealed that **young people (12-17 years) are very uncomfortable talking to leaders about HIV prevention issues**. Guidance counselors and teachers,

*“... Don’t know how to deliver information about HIV to youth—they have this piggish mentality, which makes children distrust them and are afraid of sharing problems. They are not confidential either...”*

(FGD participant, St. Ann, Jamaica, November 2009)

Young people in the FGD also had significant reservations about talking to their: mother and/ or father—because of fear of them becoming ‘*overprotective and restrictive*.’ Pastors were not seen as confidential and there was the fear of being preached about. Health workers were said to have similar attitudes to guidance counselors and teachers—“*they treat young people with a piggish approach, they lack confidentiality and they don’t explain prevention and contraceptives.*”

In addition to attitudinal changes of health workers, there is need to tailor services to match the needs of young people. **Long waiting hours, a lack of prioritization of services to youth and discrimination towards youth** were identified as particular challenges hindering girls and young women from accessing HIV prevention services. Young people were of the opinion that there was a need to increase awareness about HIV prevention and the national policies, using youth-friendly multimedia campaigns,

*“... Promoting HIV prevention with Kartel writing/ singing fitting songs—look at what he has already done promoting condoms. Influential youth leaders, like Usain Bolt, endorsing the campaign would also get more youth involved.”* (FGD participant, St. Ann, Jamaica, November 2009)

## Recommendations for Improvement

From the National Consultation on HIV Prevention (2008), young people suggested the following actions for improving access to HIV prevention services for girls and young women:

- **Increase the reach/ scope of services** by establishing a strong support framework for HIV prevention and creating strategies to increase compliance to standards
- **End overcrowding in clinics** by increasing the number of mobile clinics, implementing an appointment system in clinics, increasing the number of volunteers and health aids, conduct VCT in the communities, reorganizing physical setting to maximize space and comfort for the clients
- **Maintain a high level of confidentiality** across the health services sector by conducting on-going training and sensitization of staff, facilitating continuous evaluation of services and health care workers, encouraging and training clients and staff about the process for documenting and reporting breaches in confidentiality, sensitizing clients and staff about their rights by using signs, putting in place penalties for staff members that are found guilty of breaching confidentiality, creating a body to investigate reports of discrimination and stigma, implementing a referral system for clients who feel they are being discriminated against or treated unfairly, if they desire to change the service provider

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<sup>63</sup> See Ibid

- **Increase personal awareness and acceptance of responsibility for accessing services** by empowering youth to be self aware and informed of their rights and responsibilities to self
- **Reduce the distance travelled to access SRH services, especially in rural areas** by increasing mobile clinics, doing more work at the community level, closer collaboration between/ amongst groups that could provide services on at the community level
- **Increase the number of support groups** that speak to women about their own discriminatory practices, organize support groups for persons who are HIV positive, organize support groups for persons who are negative but have struggles protecting themselves
- **Address discrimination by service providers** towards married and unmarried clients by working with pharmacists to highlight the problem and train them with skills for recognizing and creating rights-friendly and youth-friendly spaces and attitudes
- **Increase parental involvement** by implementing parent education programmes, such as the delivery of health and education information through PTAs and collaborating with the SDC to mobilize parents at the community level

## Participation and Rights for HIV Prevention

### Overview

The participation and rights component examines how issues such as: human rights, representation, advocacy, and involvement in leadership improves actions on HIV prevention for girls and young women in Jamaica.

The Report Card (2006) recommended greater involvement of youth in national decision-making for improved actions on HIV prevention:

**“... The involvement of girls and young women in national decision-making is sometimes seen as 'token' rather than genuine.”**

**“At the community level, girls and young women report that there are few, if any, projects that bring together girls/boys or young women/young men to discuss HIV prevention.”**

Experts and young people were skeptical about the genuineness of Jamaica’s commitment to international conventions. They also expressed the need to strengthen and increase girls and young women’s empowerment for and participation in national decision-making, advocacy and leadership for HIV prevention.

**“Jamaica, like other countries that have signed international conventions, does so because it’s expedient. But when it comes to really changing any of their laws, or doing things, that is not so common.”** (Interview, Advocate, HIV and AIDS network)

**“There are not many women, let alone girls, involved in decision-making about HIV at the national level. There are no girls on the National AIDS Programme, National AIDS Committee or [the Global Fund] Country Coordinating Mechanism.”** (Interview, Representative, International Agency)

**“I haven’t seen or heard girls and young women in a public forum about HIV and AIDS, so maybe more needs to be done on that.”** (Interview, Chief Officer, national sexual and reproductive health organisation)

**“The organisation of people living with HIV is weak and is also not gender or youth focused.”** (Interview, Representative, International Agency)

## Changes in Participation and Rights

Young people who participated in the recent FGD (November 2009) **could not identify any youth who articulated the perspectives of young people on HIV prevention.** On account of this they could not tell if there were genuine attempts to seek and involve girls and young women in advocacy and leadership about HIV prevention nationally.

There was a strong conviction amongst FGD participants that **it is important to get the opinions and perspectives of girls and young women about HIV prevention,** because

*“They are the ones infected with and affected by HIV, so they need to be included in any national decision about its prevention—it is their lives that those decisions will impact on.”* (FGD participant, St. Ann, Jamaica, November 2009)

## Recommendations for Improvement

Strategies for addressing gaps in this component, included the need for youth to target a number of influential social leaders, who are largely male (the PM, government ministers, church leaders, DJs, and community leaders) and encourage them to support issues of concern to them, as well as endorsing the need for their inclusion in matters of national development.

- **Provide age-appropriate access to information and services** by training all teachers in SRH so that they will have the knowledge and skills to help youth, increasing the number of peer resources and educators, especially those who are PLWAs, implementing a standard public awareness campaign (like a World AIDS Day for schools)
- **Increase input from persons infected or affected by HIV in programme development** and to normalize the participation of youth in programme and country development by encouraging participation from vulnerable groups like children and PLWAs, putting positive messages in unique public venues (via concerts, t-shirts, bus stops, arm bands), identifying a prescribed text to support the SRH curriculum in schools, having a specially designated educator in schools to discuss SRH—who will organize extracurricular activities, Government endorsing the HIV prevention programme to show support and political will, promoting a national AIDS awareness competition, advertising information on exercise books, media support and endorsements, posting rights of children (e.g. murals) in visible and strategic locations like schools, community centres, and health facilities, displaying malicious intent/ disclosure laws so that individuals will know what their entitlements are in institutions that have a responsibility to keep personal and health information confidential
- **Increase knowledge and practice of HIV prevention** among girls and young women in rural and urban Jamaica by making available knowledge more accessible, increasing participation through grassroots efforts, introducing SRH issues at a younger age as children are being exposed at very young ages—We need a way to reach them in child-specific ways, diversifying the modes, methods, and content of messages to children.
- **Organize youth to advocate to the Prime Minister**, and the relevant government ministers, church leaders, DJs and other community leaders for the prevention of HIV for young women and girls by: advertising everywhere as constant/ consistent reminders, being in contact with people who are members of the Prime Minister’s network, going back to our respective organizations and telling people and spreading findings and messages about HIV prevention to the leadership, using popular tools (traditional media, chat rooms, and blogs) to increase support for HIV prevention on a national level, facilitating an HIV consortium for DJs to discuss their influence on adolescent sexuality, public opinion and potential to ‘preach positive messages’, and developing and implementing a training programme for ministers to help them manage and cope with HIV within their communities and congregation.
- **Implement projects aimed at bringing together males and females** for HIV prevention by: involving more men, working on HIV prevention issues at church—trying to take it to the larger community, through the PTA, SDC, Red Cross, police youth clubs, guidance counselors, and peer counselors, targeting boys in schools, developing positive lyrics to be recorded and aired on radio, training artists to have rap sessions at schools alongside peer educators, targeting non-traditional areas/ locations (e.g. sports events) to provide SRH information and services

## Lessons in HIV Prevention

AIDS is the "second leading cause of death in persons 15-24" while HIV infection "doubled in the age group 10-24 between 1995 and 2006."<sup>64</sup> The trend of HIV infections amongst girls and boys and young women and men is trending upwards with "1.1 percent of young women and men aged 15-24 infected in 2004, 1.5 percent infected in 2005 and 1.3 percent infected in 2007. Percentage of most-at-risk populations who were HIV infected: 9 percent of sex workers (2005), 3.3 percent of inmates (2006) and 25 – 30 percent (estimated) of MSM (2007)."<sup>65</sup> These facts underscore the importance of improving and increasing actions for HIV prevention for girls and young women in Jamaica. Actions that seek to improve the legal, policy, programme and funding aspects of HIV prevention for girls and young women will directly contribute to Jamaica's fulfillment of the Millennium Development Goals (MDGs) to: combat HIV/AIDS, promote gender equality and empower women, improve maternal health, and reduce child mortality.

FamPlan has been involved in HIV prevention for girls and young women since 2000, with the formation of the YAM. Since that time several strategies were undertaken to improve and increase actions on HIV prevention for girls and young women in Jamaica and St. Ann's Bay:

1. **Primary Research** targeting young people of various profiles and experts working in the area of HIV/AIDS nationally to understand the practical situation and identify issues that impact on HIV prevention for girls and young women
2. **Secondary Research** to gather statistical data, assemble news reports and national reports about legal issues, and identify appropriate laws to examine how their articulation impacts on access to HIV prevention services for girls and young women
3. **Advocacy** to national civil society leaders and the media to bring attention to the challenges relating to the six legal issues raised in the Report Card (2006) and influence them to champion for changes in HIV prevention for girls and young women in their respective organizations and on national boards and committees, etc.
4. **Awareness Raising** via national youth symposium and stakeholders meetings, education workshops and discussions to bring together various stakeholders to articulate challenges, solutions and opportunities for 'increasing and improving the programmatic, policy and funding actions taken on HIV prevention for girls and young women in Jamaica'
5. **Skills Building** activities that prepare members of YAM to deliver HIV prevention services at the youth-friendly clinic held on Saturdays
6. **Youth-friendly Clinic** with staff who are non-judgmental, willing to listen and give information to young people
7. **Involving Parents** as key stakeholders in HIV prevention for girls and young women
8. **Social Networking** with Jamaicans in different geographic locations about HIV prevention, in order to mobilize support for the issue and disseminate information broadly to stimulate individual action on HIV prevention
9. **Sourcing Grants** to fund projects and activities for improving HIV prevention for girls and young women

There are a number of obstacles to overcome in order to improve actions on HIV prevention for girls and young women in Jamaica. Legally, the issues of the age of consent for accessing HIV prevention services, the illegality of buggery and commercial sex work and the absence of HIV specific laws make it difficult to deliver HIV prevention services to different categories of girls and young women. Prohibitive laws also discourage users from accessing the services, because of fear of being caught and punished.

The quality of sex education and making condoms available to young people are seen as critical actions for improving HIV prevention for girls and young women, but they are contentious issues (like buggery, the age of consent, abortion and commercial sex work), which have very strong moral and religious support from a wide cross-section of Jamaicans.

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<sup>64</sup> The Sunday Gleaner, December 7, 2008

<sup>65</sup> See National HIV Programme, Jamaica- Country Progress Report to the Secretary General of the UN. MOH Jamaica, January 2008

Currently the Ministry of Education is reviewing its policies to speak to the creation of a referral system for youth who are deemed to be at-risk. Therefore, where the school is not able to deliver a particular HIV prevention service, because of moral or other reasons, there is a process through which access granted by way of referral.

A review of Jamaica's National HIV/STI Programme Monitoring and Evaluation Plan (2007-2012) provides critical information about key HIV prevention indicators. These indicators give a general idea what areas of HIV prevention are national priorities, so that organizational programming for HIV prevention can be aligned with national goals. Data on the variety, scope and range of services/ programmes that exist to meet the needs of different categories of women for HIV prevention for girls and young women in Jamaica was not obtained. This situation makes it extremely difficult for stakeholders to monitor and evaluate the changes, successes and threats to actions on HIV prevention for girls and young women.

The general absence of data on type, range, variety and scope of national HIV prevention programmes for young people is also a hindrance to the assessment of actions in the participation and rights prevention component. Young people who advocate for HIV prevention are, in many instances, unknown to the wider population of youth. There are also young leaders who are generally unaware of the issue of HIV prevention and/ or how it other laws, policies and programmes impact on its improvement. Critical debates, involving young people, such as the Gleaner editorial on the age of consent, did not make any mention of how that issue affects the delivery of HIV prevention services to young people.

The majority of the recommendations, of the Report Card, are still valid for improving actions on HIV prevention for girls and young women, as only a limited number of changes occurred since its publication in 2006. There is no specific HIV/AIDS law, adolescents under 16 years cannot access critical HIV prevention services and the national legal stance on sex work and buggery reduces access of some girls and young women to HIV prevention services and thereby increases their vulnerability to HIV/AIDS. There is also need for further promotion of universal access to antiretroviral therapy, increased involvement of young and older men in programmes to support HIV prevention for girls, awareness campaigns amongst parents and community leaders, opportunities for girls and young women to participate in decision making about HIV/AIDS, high quality comprehensive sex education and the promotion of models of HIV prevention for girls and young women.<sup>66</sup>

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<sup>66</sup> See Report Card, Jamaica, 2006

