

Baseline Assessment - Jamaica

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV Services

2018

Geneva, Switzerland

Disclaimer

Toward the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics, 2017-2022*, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in this paper do not necessarily reflect the views of the Global Fund.

Acknowledgements

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Acronym List

| | |
|--------|--|
| AIDS | Acquired immunodeficiency syndrome |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral |
| BCC | Behavior change communication |
| CBO | Community based organization |
| CCM | Country Coordinating Mechanism |
| HIV | Human immunodeficiency virus |
| HTC | HIV testing and counseling |
| JASL | Jamaica AIDS Support for Life |
| J-FLAG | Jamaica Forum for Lesbians, All-Sexuals and Gays |
| JFJ | Jamaicans for Justice |
| LGBTI | lesbian, gay, bisexual, transgender and intersex |
| MoH | Ministry of Health |
| MoE | Ministry of Education |
| MSM | Men who have sex with men |
| MTCT | Mother-to-child transmission |
| NGO | Nongovernmental Organization |
| PANCAP | Pan Caribbean Partnership Against HIV/AIDS |
| PLHIV | People living with HIV |
| PMTCT | Prevention of mother-to-child transmission |
| STI | Sexually transmitted infection |
| SUFJ | Stand Up for Jamaica |
| SW | sex worker(s) |
| TB | Tuberculosis |
| TGF | The Global Fund |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |

UNICEF

United Nations Children's Fund

USAID

United States Agency for International Development

WHO

World Health Organization

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Executive Summary

Introduction

Since the adoption of its strategy, Investing to End Epidemics, 2017-2022, the Global Fund to Fight AIDS, Tuberculosis and Malaria has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria¹. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. It is envisioned that the expanded programs will increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

In addition to including attention to breaking down human rights barriers to health in all of its allocations to countries, the Global Fund is providing intensive support over the next five years to a set of 20 priority countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers². Based on criteria involving needs, opportunities, capacities and partnerships in country, Jamaica has been selected as one of the countries to receive intensive support. This baseline assessment is the first component of the package of support to Jamaica and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV services. This assessment: (a) establishes a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) sets out a costed comprehensive program aimed at reducing these barriers; and (c) recommends next steps in putting this comprehensive program in place.

The comprehensive programs proposed are based on the seven key program areas identified by UNAIDS and the Global Fund for HIV programs. These are set out in the respective program sections below.

Methodology

In October 2017 a literature review of formal and informal literature on the HIV response in Jamaica was conducted, followed by an in-country assessment. This assessment involved a total of 19 key informant interviews, including 16 in-person and three phone interviews, with 23 key informants. Eight focus group discussions were conducted with 72 individuals representing the following key and vulnerable populations: people living with HIV (men and women), female sex workers, men who

¹ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

² *Ibid*, Key Performance Indicator 9.

have sex with men, youth representatives, women of trans experience³, and people with disabilities (some of whom were living with HIV). The interviews and focus group discussions were carried out in Kingston, Montego Bay, and St. Ann. A standard assessment protocol, developed to be used across the twenty country assessments and standard tools for the key informant interviews and focus group discussions were used. An Inception Workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review. Following the fieldwork, a multi-stakeholder meeting will be held to confirm the activities proposed for comprehensive response.

Summary of Baseline Findings

Key and vulnerable populations

The key and vulnerable populations most affected by HIV in Jamaica include: people living with HIV, female sex workers, men who have sex with men, people who use drugs, prisoners, people with disabilities, women of trans experience, and adolescents. These populations are in agreement with the key and vulnerable populations identified by Jamaica's Ministry of Health.

Barriers to HIV services

The most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

- a) Stigma and discrimination based on HIV status alone, or in addition to stigma and discrimination based on membership within a key or vulnerable population experienced in the community and at health facilities (i.e. inefficient and discriminatory practices in healthcare facilities, which is heightened for members of key and vulnerable populations);
- b) Gender inequality, including gender-based violence, and harmful gender norms contribute to the gendered transmission of the epidemic;
- c) Punitive laws and policies that hinder key and vulnerable population access to HIV services—the 2013 HIV and AIDS Legal Assessment Report prepared for UNDP Jamaica identified some problematic laws that should be updated or removed to remove rights-related barriers to health services access;
- d) Harmful police practices against key populations—specifically men who have sex with men and female sex workers; and
- e) Structural barriers that impede access to health services (e.g. lack of clear appointment times in clinics often leave patients waiting for hours before being

³ 'Women of trans experience' is the terminology preferred by the community in Jamaica and will be used in place of 'transgender women' or 'transwomen' throughout this report.

seen, causing many PLHIV to face the difficult choice of missing work or forgoing treatment in order to remain at work).

The ways that these barriers impact key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address barriers to HIV services—from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Jamaica to remove human rights-related barriers to services and provides a summary of the proposed elements of a comprehensive program⁴, based on the seven program areas set out in the Global Fund HIV, Human Rights and Gender Equality Technical Brief⁵.

The seven program areas are:

PA 1: Programs to reduce HIV-related stigma and discrimination

PA 2: Programs to train health care workers on human rights and ethics related to HIV

PA 3: Programs to sensitize lawmakers and law enforcement agents

PA 4: Programs to provide legal literacy (“know your rights”)

PA 5: Programs to provide HIV-related legal services

PA 6: Programs to monitor and reform laws, regulations and policies related to HIV

PA 7: Programs to reduce discrimination against women and girls in the context of HIV

Currently, several non-government and community-based organizations, as well as government entities, are working to some extent to address human rights-related barriers to HIV. However, the programs they implement do not fully cover each program area and lack the resources to be implemented at scale. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones would be appropriate to take to scale.

Summary of existing/recent programs and proposed elements of a comprehensive program

PA 1: Stigma and discrimination reduction

Current and recent initiatives to reduce HIV-related stigma and discrimination include: (1) social marketing and mass media campaigns that have mostly targeted the general

⁴ Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at *the right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

⁵ *Technical Brief HIV, Human Rights and Gender Equality*, Global Fund to Fight AIDS, TB and Malaria (April 2017)

population to raise awareness and enhance knowledge around HIV; (2) community outreach and stigma-reduction trainings for sensitization to key and vulnerable population issues. This has included curriculum development, which was followed by extensive facilitator training of NGOs and CBOs staff who then conducted extensive stigma-reduction training with a variety of stakeholders throughout Jamaica to reduce harmful attitudes and behaviors.

It is proposed that these interventions continue with refinements for some activities and at greater scale for others, as follows:

- Increase engagement of churches and other faith-based organizations to lead efforts to reduce stigma, discrimination and violence against key and vulnerable populations in the context of HIV and train leaders to broaden HIV awareness.
- Increase mass media campaigns, advocacy, and engagement of key populations to help reduce stigma and discrimination related to HIV status (e.g. reducing fears and ignorance about how HIV is transmitted and raising awareness about existing laws and policies that protect the rights of people living with HIV).
- Institutionalize pre-service training on HIV, human rights, including stigma and discrimination reduction, as part of education curricula for teachers, health professionals, police, judiciary, social workers, and law enforcement officers.
- Develop and implement training for CBOs on strategic litigation and legal support (i.e. strategically filing/bringing cases to court that can catalyze social reform).
- Repeat the national PLHIV stigma index on a 3-5-year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services.

PA 2: Training of healthcare providers on human rights and medical ethics

Current and former initiatives to train healthcare providers on human rights and medical ethics have included: training and sensitization workshops for healthcare workers that reached over 1,500 healthcare workers and frontline staffs over the past three years. Trainings focused on improving procedures and on stigma reduction to improve treatment and care for people living with HIV in Jamaica's healthcare facilities.

It is proposed that these interventions be refined as follows:

- Adapt successful in-service stigma-reduction curricula for healthcare workers, expanding content to include human rights and medical ethics, for use in pre-service training. Offer as a required course in medical and nursing colleges, to solidify stigma-free care in Jamaican health institutions and ensure sustainability of prior investments in stigma-reduction over the last decade. .
- Institutionalize routine (i.e. annual), in-service trainings on HIV, human rights and key population, including stigma reduction, nondiscrimination and medical ethics, for current health facility staff, including non-health care provider staff like receptionists and data clerks. Engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up.

- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health care towards people living with HIV and other key populations to support health facility administrators to identify and address any issues.
- Routine healthcare setting-based surveys should be done among providers and exit interviews with key population clients throughout the country with the help of proper guidelines executed for this.

PA 3: Sensitization of lawmakers and law enforcement agents

Current and recent initiatives to sensitize lawmakers and law enforcement agents have included trainings and orientation programs to educate officers and members of the judiciary on appropriate practices when engaging with people living with HIV and members of key and vulnerable populations while on duty. These programs also sensitize police to rights and services for people living with HIV and other vulnerable groups in Jamaica.

It is proposed that these interventions be refined as follows:

- Institutionalize curricula to sensitize law enforcement agents, prison warders and senior policy makers. This includes updating existing training curricula and introducing the pre-service trainings in police academies and law schools.
- Update and institutionalize the online HIV-sensitization course developed by UNDP (i.e. online HIV-sensitization course for members of the judiciary needs to be updated with new terminology, e.g. ‘test and treat’).
- Implement in-service training on human rights for law enforcement officers; support in-service trainings for police, members of judiciary, prison staff on HIV policies and key populations; support responsible and supportive policing and respective for diversity.
- Adopt routine measurement of knowledge, attitudes, and behaviors of police, correctional officers, and members of the judiciary; introduce follow-up trainings. Support routine assessments of law enforcement agents’ knowledge, attitudes and behaviors towards PLHIV and other key populations and support police administrators to identify and address any issues, including the data captured from SIDney and JADS.
- Support community-based advocacy and joint activities with law enforcement to address key challenges affecting communities; support key population networks to engage with law enforcement to prevent harmful policing practices, such as arbitrary arrests and other forms of harassment, violence, and extortion against sex workers and peer educators for carrying condoms.

PA 4: Legal Literacy (“know your rights”)

Current and recent initiatives to increase legal literacy have included training on legal matters to empower people living with HIV in their rights and opportunities to seek justice; these trainings create avenues for detailed plans of action to seek redress in cases of HIV-related stigma and discrimination.

It is proposed that current efforts be refined as follows:

- Support legal literacy and patient's rights education through conducting awareness campaigns and workshops among people living with HIV and other key populations towards mobilizing around health rights, freedom from discrimination and violence and other relevant rights'
- Integrate 'Know-your rights' trainings in the training for key population peer educators and support the peer educators conducting human rights awareness raising outreach;
- Update the current training and education materials for peer educators on HIV and update to include 'know-your rights' and other legal and human rights literacy materials. Disseminate widely through various community groups, including community networks and CBOs who can then tailor the packages to reflect appropriate and relevant content to each key population.

PA 5: HIV-related legal services

Current and recent initiatives around HIV-related legal services include development of redress platforms such as the Shared Incidence Database (SIDney), which provides an integrated platform to record, analyze and exchange information to impact policy and programs and empower individuals and CSOs to pursue redress and legal remedies, as well as the Jamaica Anti-Discrimination System for HIV (JADS), which collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress.

It is proposed that current efforts be refined as follows:

- Implement mechanisms to monitor stigma, discrimination and violence related to HIV and linkages to redress in the form of mainstream adoption of SIDney and JADS. A specific recommendation is to streamline the reporting protocols and systems among CSOs that report to both systems.
- Train and support paralegals and lawyers to provide legal advice and support to people living with HIV and members of key population who report discrimination via the SIDney and JADS systems.
- Develop a comprehensive community-based paralegal system that will engage community paralegals from the communities of people living with HIV and other key populations to provide peer legal advice and support. This could also include providing extensive legal and human rights literacy trainings to peer educators to act as a community paralegals.
- Support organizations providing legal aid and legal services for key and vulnerable populations; this could include supporting pro-bono lawyers and/or law clinics based in law schools to provide HIV-related legal services.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

Current and recent initiatives around monitoring and reforming laws have included development and implementation of a National HIV Workplace Policy (2012). Additionally, NGOs and CBOs are engaged in various forms of justice system reform.

It is proposed that current efforts be refined as follows:

- Support joint advocacy efforts, which can include joint efforts with the Public Defenders Office, to pass a comprehensive anti-discrimination law
- Facilitate a process to begin updating the 2013 Legal Environment Assessment in Jamaica to capture any recent changes to problematic laws and policies in the last five years, this could include supporting an audit, in consultation with civil society and other stakeholders, of discriminatory legal provisions and provisions which are open to discriminatory application. Fund advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws.

PA 7: Reducing discrimination, gender-based violence and inequalities against women in the context of HIV

Current and recent initiatives to reduce discrimination, gender-based violence and inequalities against women and girls in all their diversities in the context of HIV have included awareness campaigns to facilitate communication around gender-based violence and harmful gender norms, programs to address gender-based violence through counseling and mentoring, as well as support groups for survivors of sexual violence, child abuse, and domestic abuse.

It is proposed that these interventions be continued on a larger scale and refined and added to as follows:

- Increase programs that seek to address socio-cultural dynamics that create barriers to accessing HIV services (i.e. systematically incorporate gender and relational perspectives into program activities to ensure adequate access and support for women).
- Support advocacy for economic opportunities for women and legal support for women, including through peer-para legals.
- Support community-based advocacy and mobilization against illegal police practices toward female, male and sex workers with trans experience (trans sex workers) and discriminating health care practices toward women including women living with HIV, adolescent girls and young women, generally.
- Support community-based advocacy and mobilization to reduce GBV and support redress for survivors of violence.
- Integrate gender-sensitization training, including recognizing gender-based violence and effective referrals to appropriate medical and legal services, into pre-service training for health care providers, law enforcement officers and lawmakers.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence.

2016 Investments and proposed comprehensive program costs—HIV (forthcoming)

- AIDS Healthcare Foundation (AHF)

- Health Policy Plus (HP+)
- Jamaica AIDS Support for Life (JASL)
- Jamaicans for Justice (JFJ)
- Caribbean Vulnerable Communities Coalition (CVCC)
- National Family Planning Board (NFPB)
- Jamaica Network of Seropositives (JN+)
- JFLAG/Equality for All (JFLAG)
- Jamaica Coalition of Positive women (JCW)

| Funding source | 2016 allocation (USD) |
|--|------------------------------|
| UNAIDS | 5,605 |
| The Global Fund to Fight AIDS, TB and Malaria | 438,815 |
| AIDS Healthcare Foundation | 107,794 |
| UN Women | 4,962 |
| International Community of Women Living with HIV | 32,935 |
| Women's Global Network for Reproductive Rights | 460 |
| CARICOM | 36,792 |
| SRT | 85,034 |
| Open Society Foundation | 81,522 |
| DRL | 91,218 |
| ViiV Positive Action | 196,501 |
| MAC AIDS | 133,758 |
| Comic Relief | 36,792 |
| UN Trust Fund | 160,190 |
| UDF | 222,570 |
| European Union | 254,507 |
| Swede | 11,140 |
| Robert Carr Fund | 254,000 |
| Canadian Institutes of Health Research | 44,853 |

| | |
|----------------------------|----------------------|
| Elton John AIDS Foundation | 25,472 |
| USAID | 317,081 |
| Total | USD 2,742,031 |

| HIV Human Rights Barriers Program Area | 2016 (USD) |
|--|----------------------|
| PA 1: Stigma and discrimination reduction for key populations | 905,165 |
| PA 2: Training for health care workers on human rights and medical ethics related to HIV | 241,306 |
| PA 3: Sensitization of law-makers and law enforcement agents | 9,786 |
| PA 4: Legal literacy (“know your rights”) | 801,072 |
| PA 5: HIV-related legal services | 90,468 |
| PA 6: Monitoring and reforming laws, regulations and policies relating to HIV | 246,142 |
| PA 7: Reducing discrimination against women in the context of HIV | 404,013 |
| Relevant activities that cannot be classified under the 7 program areas | 44,080 |
| Total | USD 2,742,031 |

The costing for the 5-year comprehensive program is set out in the following table:

| HIV Human Rights Barriers Program Area | Total (USD) |
|--|--------------------|
| PA 1: Stigma and discrimination reduction for key populations | 4,074,860 |
| PA 2: Training for health care workers on human rights and medical ethics related to HIV | 101,000 |
| PA 3: Sensitization of law-makers and law enforcement agents | 565,900 |
| PA 4: Legal literacy (“know your rights”) | 1,848,000 |
| PA 5: HIV-related legal services | 159,800 |

| | |
|---|----------------------|
| PA 6: Monitoring and reforming laws, regulations and policies relating to HIV | 1,645,000 |
| PA 7: Reducing discrimination against women in the context of HIV | 1,163,200 |
| Total | USD 9,557,760 |

Priorities for scaling up towards comprehensive programs to reduce barriers to HIV services

The full list of programs and activities proposed in the comprehensive response is summarized in Annex 1.

Given the nature of barriers in Jamaica, it is recommended that the early focus be on activities to update or develop curricula on stigma and discrimination reduction and human rights for key duty bearers and integrate these curricula into the appropriate professional training schools and colleges. While Jamaica is not in the projections for transition, as an upper middle-income country, it is not only about ensuring a comprehensive rights-based response, but also about doing so in a sustainable manner. Standardization and institutionalization of such trainings will help to ensure sustainability and will solidify the investments made in stigma-reduction and human rights training in Jamaica over the past two decades. In addition, the continued support and mainstreaming of systems to capture experiences of stigma and discrimination and support redress should be prioritized (e.g. SIDney and JADS). As recommended in the *2013 HIV and AIDS Legal Environment Assessment in Jamaica*, and reiterated by multiple stakeholders interviewed for this assessment, NGO advocacy efforts should be scaled up to expand access to justice for key and vulnerable populations. KIIs and focus group discussions pointed out that as part of the broader efforts to increase access to justice, the advocacy support for the development and passage of an anti-discrimination law as well as the completion of the process of creating and integrating a National Human Rights Commission should continue. Alongside efforts to expand knowledge of rights among key and vulnerable populations and access to appropriate and quality legal services, the anti-discrimination law will provide an effective legal remedy in prohibiting discrimination; and where discrimination does occur, the National Human Rights Commission would investigate and conciliate complaints. The development or updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized to ensure that networks and patient advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation and beyond.

Efforts should also focus on developing and implementing appropriate monitoring tools for the various duty bearers (i.e. health workers, police, prison staff, teachers, lawyers, members of the judiciary, etc.) with a feedback mechanism for institutional administrators to ensure appropriate action and support following the trainings. In

addition, this phase of the response would also include outreach and engagement with pro bono lawyers and paralegals, who have already begun being recruited and trained with the SIDney system, to support clients utilizing the monitoring and redress platform.

Next Steps

The Global Fund will utilize this baseline assessment to assist the government, civil society, including community-based organizations, other stakeholders, technical partners and donors in Jamaica to develop a five-year, comprehensive program to remove human rights-related barriers to services. The Global Fund Technical Review Panel (TRP) has recently recommended the Jamaica funding request including a matching fund application to proceed to grant making. Data from the baseline assessment will be used to inform this process and grant implementation. However, beyond the Global Fund processes, the outcomes of the baseline assessment will support the country to develop a 5-year strategic plan to implement a comprehensive human rights response in the context of HIV.

1. Findings of baseline assessment and costing

1.1 Introduction

This report comprises the baseline assessment conducted in Jamaica to support scaling up of programs to remove human rights-related barriers to HIV services. Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “introduce and scale up programs that remove human rights barriers to accessing HIV service”; and to “scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities”.¹ The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9—“Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation”. This KPI measures “the extent to which comprehensive programs are established to reduce human rights barriers to access with

a focus on 15-20 priority countries”.⁶ Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Jamaica as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, is the first component of the package of support the country will receive.

The outcomes of this assessment in Jamaica are to: (a) establish a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) set out a costed, comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

The programs recognized by UNAIDS and other technical partners as effective in removing human rights-related barriers to HIV services are: (a) stigma and discrimination reduction; (b) training for healthcare providers on human rights and medical ethics; (c) sensitization of lawmakers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people in the right combination* under each of the program areas set out above, at the *right level of investment* to remove human rights-related barriers and increase access to HIV services.

The findings of this baseline assessment will be used by Jamaica, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to services in the country. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

1.2 Methodology

Conceptual framework

The conceptual framework for the baseline assessments (and Global Fund Strategic Objective 3) is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV services; (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV; (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers; (d) If these interventions and activities are

⁶ 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35.07a – Revision 1, April 2016

funded, implemented and taken to sufficient scale in country, they will remove or at least significantly reduce these barriers; (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the HIV epidemic; and (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Jamaica has identified:

- a) Human rights-related barriers to HIV services;
- b) Key and vulnerable populations most affected by these barriers;
- c) Existing programs to address these barriers; and
- d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:

- a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with HIV due to a combination of biological, socioeconomic and structural factors;
- b) Access to relevant services is significantly lower for the group than for the rest of the population—meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
- c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization—which increase vulnerability and risk and reduced access to essential services.⁷

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV because of their particular context, e.g. adolescent/women and girls, and people with disabilities.⁸

The design, outcomes and costs of existing programs to reduce these barriers were analyzed and a set of initiatives have been proposed in order to make up a comprehensive program to address human rights-related barriers at scale.

⁷ The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva

⁸ Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017; 95:159-161.

Steps in the assessment process

- a) *Desk Review* - A comprehensive search to assess human rights-related barriers to HIV services in Jamaica, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Popline, and Embase to identify peer-reviewed literature. A total of 32 articles and documents were identified and reviewed through the literature search. The grey literature was also reviewed: data were extracted from a range of documents identified through a combination of google searches, the USAID publications clearinghouse, and documents and reports recommended by Global Fund and key informants. We also conducted a key word search of the publications section of websites for CBOs and NGOs in Jamaica. Overall, 29 documents were reviewed in depth: 20 on human rights-related barriers and 9 on interventions to address these barriers, including reports and presentations. The legal and policy environment data extraction was based on an assessment of the legal and policy environment carried out in 2010, as well as primary analysis of relevant laws, policies and strategies that post-dated the 2010 assessment. Finally, to garner additional insights about barriers and programs, as well as suggestions for the in-country data collection, a telephone interview was conducted with the CCM and Global Fund representatives and emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV in Jamaica.
- b) *Preparation for in-country work* - From the Desk Review and support from our partner Jamaica AIDS Support for Life, a list of key informants and types of focus groups was developed to guide data collection in country. The Permanent Secretary of the Ministry of Health of Jamaica granted formal approval to begin the assessment. Ethical approval was not required for this assessment.
- c) *In country work*—an inception meeting introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized the findings of the Desk Review. This was followed by key informant interviews and focus group discussions with members of key and vulnerable populations in Kingston, St. Ann and Montego Bay (areas of Jamaica that have been particularly affected by the HIV epidemic). A total of 19 key informant interviews, including 16 in-person and three phone interviews, with 23 key informants. Eight focus group discussions were conducted with 72 individuals representing the following key and vulnerable populations: people living with HIV, female sex workers, men who have sex with men, youth representatives, women of trans experience, and people with disabilities.
- d) *Data collection*—Data were collected on the following areas:
 - Human rights-related barriers to HIV services
 - Key and vulnerable populations most affected by these barriers
 - Programs carried out presently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers

- Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
 - Funding of all such programs (for the 2016 and 2017 financial years); and
 - Costing of effective⁹ programs carried out presently or in the past.
- e) *Data analysis*—The in-country data were analyzed to explore agreement with or divergence from the Desk Review findings and to add data on barriers and affected populations missing from the Desk Review. This information, together with data on funding in 2016 and 2017, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV services in Jamaica.
- f) *Multi-stakeholder meeting*— a multi-stakeholder meeting will be held to confirm the activities proposed for comprehensive response.
- g) *Finalization and next steps*—Upon finalization, this assessment will be provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-stakeholder meeting to consider best how to scale up programs to reduce human rights barriers to HIV services in Jamaica.

Costing methodology

Three sets of costing processes will be undertaken for this assessment:

First, all donors and funders who were identified to have financed any activities in the program areas for HIV were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful in overall terms for HIV, in that most donors were able to state what program areas the funds were directed to, but did not provide details of the funded activities or their reach.

Second, specific implementers were approached and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). The expenditure lists and donors for HIV are summarized in Annex 3. Individual costing sheets for services provided by each of the organizations were prepared.

Third, a Prospective Costing of the comprehensive program was carried out. The results of this process are provided in Annex 4. For each type of intervention, an intervention-level cost was assembled.

The unit costs for activities included in the prospective costing of the 5-year comprehensive response were premised on the unit cost of the budgetary sheet of the main HIV country proposal submitted to GFATM (under allocation), with the envisioned grant starting from 16 March 2018 and ending on 15 March 2021. This costing was based on the practicing rates of the Principal Recipients (i.e. the standard unit costs for

⁹ Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

activities like training, counselling etc.). Preparation of budget for the main HIV country proposal was done through a wide, participatory process, in which all representatives of key populations in the CCM consensually agreed on unit costs and scale of each of the activities in the budget. This approach was taken to encourage use of the same unit costs for other prospective costing activities, which was also consensually agreed by CCM members.

These costs were used to construct calculation tables (see HIV calculation tables in Annex 4). In these calculations, the number of services to be provided/people to be reached/trained were multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every few years, such the PLHIV Stigma Index, and others require capacity building or other activities in the first year that are not needed in later years. Comment boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets, for each of five years as well as a five-year total. These are the budgets that are used to construct the five-year totals provided at the end of the HIV of this report.

Limitations

With regards to the retrospective costing, it should be noted that the tool for data collection was sent to a wide range of organizations, including key population networks, UN agencies, CBOs and INGOs involved in the response to HIV. This often involved visiting these organizations repeatedly for orientations on the tool and follow up as well as telephone conversations. Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate. Though unit costs for many outputs have been calculated, it was not possible for a number of activities, as it was difficult to separate out the expenditures incurred for each of these activities because many headings including salary, utilities, transportations, and communications were shared by other interventions also. Moreover, many interventions also have multiple outputs at the same time. Further costing considerations are described in detail in Annex 5.

2. Summary of baseline findings

2.1 Overview of epidemiological context and key and vulnerable populations

According to UNAIDS, Jamaica had an estimated 1,700 new infections and 1,300 AIDS-related deaths in 2016¹⁰. There were 30,000 people living with HIV in 2016, among whom 35% were accessing antiretroviral therapy. Among pregnant women living with

¹⁰ <http://www.unaids.org/en/regionscountries/countries/jamaica>

HIV, over 95% were accessing treatment or prophylaxis to prevent transmission of HIV to their children. Less than 100 new HIV infections occurred due to mother-to-child transmission. Among people living with HIV, approximately 21% had achieved viral suppression.

| Population | 2016 HIV and AIDS estimates (# of cases) |
|---|---|
| Children aged 0 to 14 living with HIV | <500 |
| Men aged 15 and over living with HIV | 19,000 |
| Women aged 15 and over living with HIV | 11,000 |
| Adults aged 15 and over living with HIV | 30,000 |

Source: UNAIDS

| Population | 2016 HIV and AIDS estimates (population size and prevalence) |
|------------------------------------|---|
| Men who have sex with men | 33,000 (32.8%) |
| Sex workers (both male and female) | 18,696 (2.8%) |
| People of trans experience | Not known |

Of those living with HIV in Jamaica, as of 2017, approximately 13% are unaware of their status.¹¹ Underreporting of HIV data in Jamaica is likely, especially in terms of number of persons with advanced HIV (Jarrett, 2017). Transmission in Jamaica is largely occurring through heterosexual sex, with youth at particularly high risk (Hutchinson et al., 2007). Less than 1% of people living with HIV in Jamaica inject drugs, making transmission through needle sharing less of a concern (Ministry of Health Jamaica, 2016). While HIV exists across the island, urban areas tend to have a higher prevalence, and the most densely populated parishes on the island have the highest cumulative number of advanced HIV cases (Ministry of Health Jamaica, 2016). In addition to the urbanized parishes, parishes with significant tourism-based economies have the next highest level of cumulative number of reported AIDS cases since the start of the epidemic (Ministry of Health Jamaica, 2016)

¹¹ Global Fund HIV Program Continuation Application (Jamaica)

The HIV epidemic has concentrations across a number of key and vulnerable populations. According to UNAIDS¹², the prevalence among sex workers and men who have sex with men in 2016 was 2.8% and 32.8%, respectively. The prevalence among men who have sex with men may vary based on other factors, as suggested by recent research that found higher rates among men who have sex with men who are also sex workers (41.1%), men who have sex with men with adverse life events or low literacy (38.5%), and transgender men who have sex with men (52.9%) (Figuroa et al., 2015). While size estimates and prevalence among women of trans experience are not available at the national level in Jamaica, research studies have reported prevalence as high as 25.2% (Logie et al., 2016)..

In a study on knowledge and attitudes of HIV among sex workers in Jamaica, it was found that male sex workers generally had more correct information about HIV and other STIs in comparison with female sex workers (Duncan et al., 2010). Research suggests that sex workers of trans experience face high rates of incarceration, rape and other sexual violence, as well as homelessness (Logie, Wang, et al., 2017). Two thirds of women of trans experience in one study reported transactional sex of some sort. The findings of the study pointed towards a high level of violence and stigma for women of trans experience across structural, interpersonal and intrapersonal factors in Jamaica that operate separately as well as in tandem to elevate HIV risk (Logie, Wang, et al., 2017).

In Jamaica, men who have sex with men may not self-identify as homosexual, and may also have sex with women. Same-sex sexual activity is stigmatized in Jamaica, and rejection can occur via extreme social and violent means. The noticeable lack of legal protections for men who have sex with men in the Caribbean compounds this problem (Avrett, 2011) (Figuroa et al., 2013). However, recent investments have been made through key population funds supported by USAID and the Global Fund to support programming with men who have sex with men and other sexual and gender minorities in Jamaica, including programs to provide legal support and monitoring of human rights violations.

The HIV prevalence among incarcerated populations in Jamaica has been reported as double that of the general population: 3.3% (Rodríguez-Díaz & Andrinopoulos, 2012). The high prevalence in prisons may not be attributable only to sexual activity within prisons, as new admissions also report a high prevalence, signifying that members of key populations are imprisoned at the higher rate. (Rodríguez-Díaz & Andrinopoulos, 2012).

Recent information on adolescents is rather difficult to obtain, particularly as there is no DHS data for Jamaica. According to UNICEF, however, adolescent boys and girls are among the most at risk for HIV infection. Among adolescents, unprotected sex is common and normalized, with many reporting that they had had sex before the age of 15. A recent secondary data analysis of the 2012 Knowledge, Attitudes, Behaviors and

¹² <http://www.unaids.org/en/regionscountries/countries/jamaica>

Practices Survey presented at the 2017 National HIV/STI Program Annual Retreat by Dr. Jarrett noted that:

- One-third of participants had sex by the age of 14 years, and nearly half by the age of 16 years;
- Having sex early may set the stage for continued engagement in high risk behaviors such as multiple partnerships, and possibly transactional sex, for girls;
- Providing developmentally appropriate interventions may reduce sexual risk behavior among adolescents; and
- Access to SRH provides opportunities to not only improve health outcomes, delay initiation, but also, importantly, identify and addresses instances of sexual abuse (personal communication, Nicholas Oliphant)

For adolescent women with multiple partners, 43% reported not using a condom at last sex. Girls between the ages of 10-19 are three times as likely to be infected as their male counterparts¹³. Additionally, cross-generational relationships are common within Jamaica, with late-adolescent girls often having sexual relationships with older men (Anderson KK, Tureski K, Rogers S, 2012). This puts them at risk for HIV, due to general lack of condom use, and for having sex with men who tend to have multiple partners (Wood, 2010)(Anderson KK, Tureski K, Rogers S, 2012; Darlington, Basta, & Obregon, 2012). Men who have sex with men are also vulnerable to cross-generational relationships, where it is common for older males, who generally have sexual and emotional control of the relationship, to resist condom use. Men in cross-generational relationships with men also reported cases of aggression and violence, and forced sex was not uncommon in one study (one in five focus group discussion members experienced forced sex) (Anderson KK, Tureski K, Rogers S, 2012).

For orphans and other vulnerable children, a lack of socioeconomic opportunities limits HIV testing, treatment, and retention. Often from low-income families, children lost their parents and other vulnerable children face challenges accessing educational opportunities, nutritional support, and information on sexual and reproductive health. For children living with HIV, the transition from childhood to adulthood is difficult. Many children living with HIV are unaware of their status and disclosure is difficult for parents and caregivers. Lack of disclosure and ability to communicate about HIV within families influences children's willingness to continue taking on ART, or adhere to ART, after learning their serostatus in adolescence for OVC living with HIV who learn of their serostatus after (World Learning, 2013).

¹³ www.unicef.org/jamaica/hiv_aids.html

2.2 Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

2.2.1 Protective laws (with challenges of enforcement)

The Jamaican Constitution was drafted in 1962 by a bipartisan joint committee and approved by the United Kingdom, coming into legal power with the Jamaica Independence Act of 1962. This constitution provides the rights to life, liberty, security of person, freedom of movement, and ensures freedom from inhumane treatment or punishment for all citizens. It also guarantees equal treatment under the law regardless of race, political opinion, place of origin, color, creed, or sex (Jamaica Information Service, 1990).

A legislative assessment as part of an initiative of UNDP Jamaica, with funding support from UNAIDS, and in partnership with the Enabling Environment Component of the National HIV/STI Programme (NHP) of the Ministry of health, was conducted in 2013. The assessment aimed to build capacity for reform of outdated, inconsistent and discriminatory HIV-related laws in Jamaica, to promote programming aimed at improving access to justice for people living with HIV, and to monitor progress in addressing HIV-related discrimination (UNAIDS, National HIV/STI Programme, & UNDP, 2013). Problematic laws will be discussed in the section on human rights-related barriers to HIV services.

Although Jamaica has several HIV-related policies, there is no broad, HIV-specific law in Jamaica. The following Acts and Policies are the main regulations pertaining to HIV and AIDS:

Acts and Policies

- Plan of Action for Orphans and Other Children Made Vulnerable by HIV/AIDS, 2003: Details social programs, education and infrastructural plans in strategies to assist children affected by HIV.
- Management of HIV/AIDS in Schools Policy, 2004: Sets non-discrimination standards for students living with HIV and calls for education strategies in schools.
- National HIV/AIDS Policy, 2005: Denotes infrastructural requirements to combat HIV/AIDS through prevention and treatment. It provides protections for the rights of people living with HIV, and seeks an environment with reduced HIV stigma and discrimination, and proper access to information, treatment, and support. (Objective 3.2.5)
- Draft Strategic Framework for HIV/AIDS for Incarcerated Populations in Jamaica, 2009: Details efforts to increase prevention, testing, and treatment of HIV among incarcerated populations. Proposes inclusion of peer educators on stigma and discrimination and calls for increased advocacy in legislative systems for HIV prevention and care. (Objectives 1 and 2)

- National HIV/AIDS Workplace Policy, 2012: Imposes anti-discrimination obligations on employers of people living with HIV.
- National HIV/AIDS Strategic Plan, 2014-2019: Envisions comprehensive and multi-sectoral approach to prevention, testing, and treatment of HIV, as well as addressing larger societal issues associated with the disease.

In 2011, the Charter of Fundamental Rights and Freedoms was passed, which prohibits discrimination on the grounds of sex, race, place of origin, social class, color, religion, or political opinion (Government of Jamaica, 2011). Although this is a major achievement, civil society organizations have expressed concern that there remains no comprehensive anti-discrimination law to protect the human rights and equal treatment of LGBT persons and persons living with HIV, as well as no protection of health status expressly protected in the Charter. This has very significant implications, as there is no constitutionally enforceable responsibility on the Government to provide access to health-related education and information, including sexual and reproductive health, among other health needs. Additionally, there is no Human Rights Commission where persons can access redress for discrimination or human rights abuses as stipulated under the Paris Principles by Resolution 1992/54 by the UN General Assembly¹⁴. As such, there is no standardized way to report about and address human rights abuses, especially as they relate to HIV and SRH (KII01). Mechanisms such as the Shared Incident Database (SIDney) and the Jamaica Anti-Discrimination System for HIV (JADS) aim to improve documentation and reporting of human rights violations against key populations across Jamaica but have their own limitations that will be addressed in the HIV-related legal services section.

The response to HIV, led by the Ministry of Health and the National Family Planning Board, is guided by a National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014-2019. The plan provides a blue print for achieving the vision of an integrated program while supporting the achievement of the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) and the Fast-Track strategy to end the AIDS epidemic by 2030. The Plan plays an important role in Jamaica's National Development Plan—Vision 2030 Jamaica—into which HIV and Population and Development goals and strategies have been integrated (Planning Institute of Jamaica, 2009).

Furthermore, in 2012, the Ministry of Labour and Social Security developed a National Workplace Policy on HIV and AIDS as part of a commitment to the 2011 United Nations High Level Meeting Political Declaration on HIV and AIDS. The Policy includes specific provisions that protect the rights of workers regardless of their HIV status (Ministry of Labour and Social Security, 2012). Rights and responsibilities of government, employers and workers are outlined in reference to the International Labour Organization Code of Practice on HIV and AIDS on the World of Work and the Platform of Action on HIV and AIDS in the Caribbean signed in Barbados on May 17, 2002 (International Labour Office,

¹⁴ IACHR, Hearing on “Monitoring the Report of the Commission on the Situation of Human Rights in Jamaica,” 153rd Regular Session, October 28, 2014

2001). It notes that employers are responsible for ensuring that policies and programs are designed and implemented to prevent the spread of the epidemic and protect workers from stigmatization and discrimination.

Key informants emphasized the significance of the Policy but noted the need for the development of a confidentiality protocol as an addition to the Policy (KII05). Key informants mentioned that, as of now, workers filing the complaint bear the responsibility of coming forward and are hesitant to do so for fear of losing confidentiality (KII05).

Jamaica's National Integrated Strategic Plan for Sexual and Reproductive Health and HIV 2014-2019 (NISP) has as Strategic Priority 3: the creation of an enabling environment and the protection of human rights (Ministry of Health Jamaica, 2014). The main outcome associated with this strategic priority is a strengthened policy and legal framework for sexual and reproductive health and HIV prevention, treatment and care services.

Challenges of enforcement and other gaps:

While significant gains have been made in reducing the transmission of HIV among Jamaicans generally, the national HIV response has not been as successful at creating an enabling policy and legal environment to support the efforts being made to eliminate new HIV infections. Five years after the 2013 UNDP HIV and AIDS Legal Assessment Report for Jamaica, there are still only a handful of unevenly implemented policies and legal provisions working at cross-purposes. For example, the 2011 Charter of Fundamental Rights and Freedoms guarantees a broad right to equitable and humane treatment by public authorities including in hospitals, however, laws which perpetuate stigma around key populations such as gay, bisexual and other men who have sex with men and female sex workers only serve to keep members of these communities away from accessing healthcare services.

Key informants indicated that the problem is that in many cases, and most often with regard to key and vulnerable populations, these groups have insufficient knowledge of protective laws or of their rights, as well as insufficient access to legal support, so they generally do not advocate for their rights under these laws or seek redress for violations through the justice system (FGD01). This shows that it is not just a problem of needing to reform laws, but also a problem of lack of legal literacy and support.

For example, although the National HIV/AIDS Workplace Policy (2012) prohibits HIV screening of job applicants and HIV screening for continued employment, the practice still exists. A challenge related to employment is the fear of disclosing HIV status if an employer requires a health exam. One key informant described how some people would choose to leave a job rather than disclose or take the physical exam (KII03).

2.2.2 Political Environment

Many countries in the Caribbean have taken steps in recent years to address HIV-related concerns, as well as steps to counter violence and discrimination against key and

vulnerable populations. Throughout the Caribbean, the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP) developed a framework for a proposed anti-discrimination law, which prohibits the discrimination of people living with HIV, gender and sexual minorities, disabled people or orphans from basic services. The Organization of American States passed Resolution 2721, which criminalized violence, discrimination, and other violations of human rights on the basis of sexual orientation and gender identity. The Caribbean Forum on Gender Equality allowed government representatives to address sexual violence, intimate partner violence, and other forms of gender-based violence. There was also an urge to recognize gender-based violence as a public health issue.

Many key informants referred to a problem of lack of accountability at multiple levels throughout Jamaica's response to HIV.

2.3 Human rights barriers to access, uptake and retention in HIV services

The major human rights-related barriers identified in the desk review and confirmed in discussions with key stakeholders and members of key populations, included:

- a) Stigma and discrimination based on HIV status alone or in addition to stigma and discrimination based on membership within a key or vulnerable population;
- b) Gender inequality, including gender-based violence, and harmful gender norms that contribute to the gendered transmission of the epidemic (e.g. social norms that condone men having multiple sexual partners, yet expect women to be monogamous);
- c) Punitive laws and policies create barriers that hinder key and vulnerable populations to access HIV services—the 2013 HIV and AIDS Legal Assessment Report prepared for UNDP Jamaica, among other things, identified some problematic laws that should be updated or removed to remove rights-related barriers to health services access;
- d) Harmful police practices against key populations—specifically men who have sex with men and female sex workers; and
- e) Access to health services is impeded by structural barriers (e.g. lack of clear appointment times in clinics often leave patients waiting for hours before being seen, causing many PLHIV to face the difficult choice of missing work or forgoing treatment in order to remain at work; these factors may affect their willingness to attend follow-up appointments).

2.4 Stigma and discrimination

Stigma and discrimination compromises the health and wellbeing of people living with HIV and has negative impacts on the uptake of HIV testing, prevention behaviors, and disclosure (Rogers et al., 2014). Because of actual and feared stigmatization by the community as well as service providers, individuals may avoid (or fail to return to) services – particularly public services. A common theme that came out in the focus groups was that key populations and people living with HIV have a strong preference for

NGO-organized services, precisely because they feel they are more likely to be protected from stigma and discrimination (FGD01, FGD02, FGD03, FGD04, FGD05).

According to many key informants, much of the stigma and discrimination related to HIV is grounded in limited understanding of and misconceptions about HIV. Interviews and focus groups described inadequate, somewhat outdated, levels of knowledge about HIV among the general population, as well as among key populations, particularly about how HIV is transmitted (KII05, KII06, KII09, KII10).

Stigma and discrimination based on key and vulnerable population status

In Jamaica, men who have sex with men and sex workers are two key populations that have been most affected by HIV, and are also among the most stigmatized populations on the island. Experiences of stigma contribute to vulnerabilities to infection and transmission, as well as to the likelihood of violence for people living with HIV (Rogers et al., 2014) (FGD02).

In places where same-sex sexual activity is more often condemned, such as in Jamaica, disclosure of HIV status is less likely due to fear of unintended disclosure of sexual orientation. Other psychosocial reasons for non-disclosure range from fear of abandonment, rejection, and discrimination, to fear of violence. One study found that in Jamaica, 55% of participants had disclosed their HIV status to a family member and 51% had disclosed to their sexual partners. Worldwide, disclosure rates vary from 42% to 100%, meaning Jamaica falls on the lower side of this equation. In Jamaica, instances of intolerance, homophobia, and cultural attitudes about gender and traditional sexual relationships make it difficult for people to accept a person living with HIV in their communities, which could account for the low disclosure rates (Clarke et al., 2010).

Stigma and discrimination likely influence adherence to antiretroviral treatment. People not wanting others in their community to know that their HIV status often means deferring, ignoring, or brushing off doses in order to conveniently take pills in private, which limits efficacy, can lead to drug resistance, and increases the likelihood of forgetting the dosage altogether (Harvey et al., 2008). Displacement and ostracization from one's community was a common theme across the focus group discussions of people living with HIV, particularly against men and women with same-sex partners and people of trans experience (KII02, FGD01, FGD02).

“In the communities, people make assumptions about our sexuality and some treat us differently.” (FGD02)

Some participants expressed that they do not talk to their families, have been beaten, and/or have been thrown out of the house (FGD02).

In Jamaica, reports of verbal and physical abuse due to sexual orientation are rampant; men and women often become homeless after coming out to their communities and families (White, Sandfort, Morgan, Carpenter, & Pierre, 2016) (FGD01, FGD02).

Same-sex couples often report that HIV-related stigma associated with gay people in Jamaica discourages them from testing, seeking treatment, and care in the context of HIV (Avrett, 2011). It also makes them less likely to disclose their HIV status to their partners. In one study conducted with men who have sex with men in Jamaica, almost 60% of those with HIV did not disclose their HIV status to their partners, and half of the men were uncomfortable disclosing their HIV status to anyone. Half of the men who participated in the study encountered abuse – mostly verbal, but sometimes physical – associated with their sexual orientation. Many felt rejected and marginalized due to their sexual orientation, which likely influenced their willingness to disclose their HIV status due to fear of experiencing further marginalization and violence (Figueroa et al., 2013).

Men who have sex with men also report institutional stigma and discrimination from educational establishments, especially in teacher-student power dynamics, and in church, where stigma and discrimination can manifest through sermons, avoidance and shunning behaviors from other congregants or from religious officials (KII06) (C-Change, FHI-360, & USAID, 2012).

Women of trans experience also face high rates of stigma, likely due to a number of social and structural factors, that fuel experiences of stigmatization, violence, and other abuse. Sex workers of trans experience in particular face high levels of incarceration, rape, and homelessness. The findings of a study on women of trans experience point to a high level of violence and stigma for women of trans experience across all socio-demographic factors in Jamaica (Figueroa et al., 2013).

With regards to disabilities, Jamaica was the first country to ratify the Convention on the Rights of Persons with Disabilities (CRPD), which signifies its commitment to ensuring equal rights for all persons living with disabilities. This requires adoption of “appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications...and to other facilities and services open or provided to the public, both in urban and in rural areas.”

“They don’t look out for persons like us, with a disability.” (FGD05)

HIV-related information on persons with disabilities in Jamaica is almost nonexistent. Data on prevalence among this highly vulnerable group is not measured (Ministry of Health Jamaica, 2014). Common misconceptions affecting public health planning and people with disabilities include the belief that people with disabilities are sexually inactive and do not require HIV or sexual reproductive health services.

Direct impacts of stigma on accessing services

Visibility of HIV services

Key and vulnerable populations, including men who have sex with men, people with disabilities, among others, experience higher burdens and more intense forms of stigma and discrimination, including social exclusion. People living with HIV who identify themselves as also belonging to other key and/or vulnerable populations, experience a type of intersectional stigma. The association of HIV with same-sex sexual activity inhibits HIV testing. Many men who have sex with men avoid testing for fear of a positive result, not only for reasons of health, but also for an unintentional “outing” of sexual preference and sexual history, as well as stigma from family, friends, and the LGBTI community. Despite recent data that most new infections arise from heterosexual sex, the common stereotype linking HIV with same-sex sexual activity puts additional pressure on men who have sex with men who become infected by HIV. Some become ashamed for contributing to the stereotype that has been so harmful to their communities (Logie, Lacombe-Duncan, Brien, et al., 2017).

The fear of being seen utilizing services and, hence, “branded” in the community is a particularly acute problem where facilities offer distinct hours for HIV-related services (KII16). One group described instances where people living with HIV were made to sit in a separate section of the clinic in order to wait to obtain services (FGD01). These breaches in confidentiality procedures cause people living with HIV to feel as though visiting a healthcare facility may put their privacy at risk, and may avoid engaging with healthcare facilities again for testing and treatment (Logie, Lacombe-Duncan, Brien, et al., 2017).

Health worker attitudes and actions

While anticipated stigma related to being seen at health care facilities while accessing HIV services may be a major barrier to utilizing services, another significant barrier to access, as well as uptake and retention, is the stigma and discrimination experienced within facilities (KII02, KII06, KII12, FGD01, FGD02, FGD03, FGD04). Progress has been made to sensitize healthcare providers to the needs of key populations. For example, the University of the West Indies HIV/AIDS Response Programme (UWI HARP) established in 2001 led the development of the Caribbean HIV/AIDS Regional Training Network (CHART) and the Caribbean Health Leadership Institute (CHLI)¹⁵. While CHART had a mandate to provide health care training to healthcare providers, the Caribbean Health Leadership Institute (CHLI) provided leadership training to health care leaders across the length and breadth of the Caribbean. The CHART Regional Coordinating Unit was established in June 2003 to coordinate the development of training for healthcare professionals working in the field of HIV through the CHART network.

Despite these efforts, research suggests that underlying stereotypes, prejudices and discriminatory attitudes towards people living with HIV and key populations persist and act as a barrier to HIV service access. A Common theme across the key stakeholder interviews and focus groups was the expression of experiences, either firsthand or by

¹⁵ <http://www.moh.gov.jm/national-hiv-sti-tb-programme/structure-overview-of-the-nhp/sub-recipients/university-of-the-west-indies-hiv-aids-response-programme-uw-harp/>

word of mouth, of mistreatment by not only healthcare providers but also general staff at health clinics (FGDo1, FGDo2, FGDo4). There was debate about whether people felt more confident going to NGOs, which concluded with agreement that both public facilities and NGO spaces may have some of the same structural barriers, such as the risk of being seen by community members while seeking services, but key informants felt that the general welcoming environment at NGOs promoted patients' return (FGDo1, FGDo2).

Stigma and lack of confidentiality in healthcare facilities is a common concern for people living with HIV, especially members of key and vulnerable populations. This typically grows out of common society-based stigma that has also affected healthcare workers and providers, and occurs sometimes subtly and sometimes outright. Healthcare providers may subconsciously discriminate against or mistreat LGBTI populations in the pursuit of testing, treatment, and care for HIV. Instances such as having people living with HIV sit in a separate section of the clinic may breach confidentiality procedures, and causes people living with HIV to feel as though visiting a healthcare facility may put their privacy at risk (Logie, Lacombe-Duncan, Brien, et al., 2017). This was supported by focus group discussions where participants described that in some clinics, there were signs that indicated where persons coming for HIV services should sit (FGDo1). Experiencing this kind of mistreatment once may lead people living with HIV and key populations to avoid engaging with healthcare facilities again for testing and treatment (Logie, Lacombe-Duncan, Brien, et al., 2017).

Nurses who administer HIV care often unknowingly perpetuate stigma and discrimination that is carried out in society. Many nurses believe that they treat people living with HIV in an equal manner to other patients, although research and detailed accounts from people living with HIV in Jamaica have indicated that this may not be the case (Mill et al., 2013) (Rogers et al., 2014). Through the Key Population Challenge Fund project, Health Policy Project delivered two-day stigma-reduction trainings between February and April 2015 to three health facilities in Jamaica. Just over 10 percent of the total trained healthcare facility staff members were interviewed as part of an assessment in preparation for additional programmatic roll-out and evaluation of stigma and discrimination reduction activities. The results showed that stakeholders recognized that key population-related stigma and discrimination is a problem and a barrier to care (USAID, PEPFAR, & Health Policy Plus, 2016). Many people living with HIV described being told by healthcare providers that they should not have sex, even if taking anti-retroviral medication and using condoms (KII04, FGDo4). One participant said they were taken to bible class after disclosing their sexuality to a government social worker (FGDo1). Lack of legislation related to trans identity affects how people of trans experience seek health care because there is nothing mandating the healthcare worker to register the person according to the gender the person identifies with (KII02). In these cases, it falls under the healthcare worker's discretion to identify the patient's gender. Others expressed concern over generally poor customer service. One person explained,

“The first barrier is walking into the clinic. How do you declare [the purpose of visit] to a receptionist with bad customer service when you don’t know what level of training they have; they’re rude and turn you to another window.” (FGD01)

“There is a tendency to treat key pops as numbers, so that becomes a barrier because they feel like they’re not being treated as a person.” (KII02)

Despite healthcare workers’ agreement that key populations deserve to receive high quality care, research suggests that their underlying stigmas are often expressed towards men who have sex with men, sex workers, and people living with HIV. In one study, stigmatizing attitudes were shown to increase depending on whether clients identified with more than one key population group, and was shown to be higher in non-clinical staff, and staff who worked at general health care facilities, as opposed to ones specially providing care to gender and sexual minorities and/or sex workers. Additionally, staff untrained in stigma reduction displayed much higher levels of stigma (Rogers et al., 2014). In one focus group of men who have sex with men, a participant described his hesitation to disclose his sexual orientation to the healthcare provider because of previous experiences of judgmental behavior.

“I’ve always been curious. Why do they need to know my orientation if I’m not coming for that?” (FGD02)

Stigma in Prisons

Negative societal attitudes towards same-sex relationships can often result in a denial of the fact that same-sex activities exist in the prison system. Recent research conducted by Stand Up for Jamaica (SUFJ) in partnership with Caribbean Vulnerable Communities (CVC) confirms the stigma and discrimination faced by LGBT and MSM inmates in the Jamaican prison system (Stand Up for Jamaica, 2016). Due to its association with homophobia, HIV testing within incarcerated populations is not common.

The Tower Street Adult Correctional Facility, commonly referred to as General Penitentiary (GP) and the St. Catherine Adult Correctional Facility, houses self-identified, and prisoners perceived, as LGBT and men who have sex with men in a segregated part of both prisons known as the “special block” or “special” (Stand Up for Jamaica, 2016) (KII18).

There are many limitations around providing HIV services in prisons. It has been argued that the distribution of condoms is a tacit embrace of homosexual lifestyles and as such, the Government feels pressure to oppose the introduction of condoms within prisons, as it may prove politically and ethically problematic (KII18). The church has been opposed to any initiative that would provide condoms for prisoners. Correctional officers have also been opposed to any initiative, which would provide condoms for prisoners. In 1997, when prevention efforts only included dissemination of condoms and HIV information throughout the prison, violence overtook two of the general penitentiaries. A strike by the wardens and violent riots by inmates resulted in sixteen prisoners being killed, largely due to the linkage of condom distribution as an HIV prevention effort and the fear of being ‘branded’ as homosexuals by the wider community. The Commissioner, who

was determined to be too liberal for the role, soon resigned (Stand Up for Jamaica, 2016). After this event, HIV prevention and treatment efforts were halted for fear of more violent backlash (Andrinopoulos K, Kerrigan D, Figueroa JP, Reese R, 2010).

Fear of stigma by fellow prisoners, as well as prison guards and staff, affects the likelihood of inmates testing for HIV and accessing treatment if positive. For some, a combination of stigma surrounding the disease, lack of social support and knowledge, and lack of self-efficacy limits testing probability, fueling HIV transmission in prisons (Andrinopoulos K, Kerrigan D, Figueroa JP, Reese R, 2010).

2.5 Gender inequality and discrimination against women

Some gender norms and gender-related practices can end up harming both men and women, and increasing their vulnerabilities to HIV.

Female sex workers are one of the groups found to be most at risk of becoming infected with HIV in Jamaica. Much of this risk can be attributed to the limited agency and decision-making power that female sex workers have in relation to their work in terms of condom use, sexual behaviors, or financial and personal decision-making. Some research on decision-making factors for female sex workers has indicated that interactions between the environmental and structural elements of sex work contribute to this problem. In addition, individual-level factors such as risk perception, perceived relationship, intimacy, perceived control, and affirmation of self all contribute to sexual decision-making likelihood. However, other factors, like violence, socioeconomic vulnerability, and policy and legal frameworks also exacerbate this problem (Bailey A, 2016; Bailey AE, 2017).

Violence is common from clients of sex workers, many of whom heavily resist condom use and secure condom-less sex through violent and coercive means (FGD03). Violence is also commonly reported against female sex workers in the forms of kidnapping, abuse, beatings, stabbings, being robbed, gang-raped, and deserted in remote areas (Eldemire-Shearer & Bailey, 2008)(Logie, Wang, et al., 2017). Police harassment against men who have sex with men and women of trans experience is widespread and in a context where same-sex sexual relationships and practices are criminalized, it is likely that men who have sex with men and women of trans experience have little to no recourse to justice when police are perpetrating violence (Logie, Lacombe-Duncan, Kenny, et al., 2017). Women of trans experience who are mislabeled as male can also receive up to two years of imprisonment with possible hard labor if convicted of “being a male person who is party to the commission of any act of gross indecency with another male person”(Reisner, Radix, & Deutsch, 2016).

Men and boys

Masculinity and risk-taking are highly entangled in Jamaica’s youth culture. Having multiple female partners at a young age, often thought of as a rite of passage, is one aspect of a manifestation of norms of masculinity (Walcott et al., 2015). If these young men are unable to carry out this masculinity challenge, it may result in a perception of

homosexuality and, as a result, intense homophobia from their communities that could escalate to violence and stigmatization. Because many young people in Jamaica are pushed into early and regular sexual activity, heterosexual sex increases risk for both young men and young women. Condoms may even be avoided as a way to promote pregnancy, which is seen as physical proof of masculinity (Walcott et al., 2014). Because of this, safe sex, partner reduction, abstinence, and other common safe sex methods may be purposefully avoided in some cases (Plummer, 2013). One key informant felt that boys were being left behind:

“Ministry of Education feels alone in this fight; we don’t provide treatment, we rely on health sector to do that but they (boys) keep falling through the cracks; there is no other entity to refer to them for support. Especially if it’s males who are not MSM. They need a lot of psychosocial support and the only people we can turn to is Eve for Life but they primarily work with adolescent girls. Adolescent males—not enough support for them.” (KII11)

Intimate partner violence is common against women assumed of being unfaithful to their partners. About a quarter of Jamaican men have a favorable attitude toward intimate partner violence and display behaviors and attitudes that put them at high risk for unsafe sexual practices (Gibbison, 2007). It can be argued that women who engage in sexual relationships with these men are at a higher risk for contracting HIV and other STIs, as well as being a victim of gender-based violence (Gibbison, 2007) (FGD01).

Girls between the ages of 13 and 15 have a higher prevalence of HIV than boys of their age, indicating that the inter-generational sex and power dynamics inherent in those relationships further increase the vulnerability of young women and girls¹⁶. Cross-generational relationships in Jamaica can be risky relationships for the younger men and women who engage in these partnerships. Because these types of relationships are considered common, some of the power dynamics tend to go unchecked, creating elevated risk of HIV infection and sexual violence. In one study on cross-generational relationships, a majority of the respondents were in more than one sexual relationship and believed that marriage was becoming less common. A high number of the sexual partnerships studied involved men over the age of 25 and younger women, though cross-generational relationships in Jamaica exist across all age groups, genders and sexual orientations (Anderson KK, Tureski K, Rogers S, 2012). Despite high levels of satisfaction for most respondents in cross-generational relationships, instances of physical and sexual abuse were reported. And while importance seemed to be placed on HIV testing and condom use for those in the partnerships, issues of power, economic instability, and infidelity influence how gender and age affect HIV transmission in the cultural context of Jamaica (Anderson KK, Tureski K, Rogers S, 2012).

¹⁶ Kashyap, A. *Speech at the Opening Ceremony of Global Validation & Lessons Learned Workshop of Support for Gender Equality in the Context of HIV/AIDS*. UN/UNDP Jamaica. July 30, 2013

People of trans experience

People of trans experience are also still largely invisible from discussions as well as interventions and policies. When asked if they could rank which key and/or vulnerable populations receive the most stigma and discrimination, however, members of one focus group came to the consensus that people of trans experience receive the brunt of the intersectional stigma and violence associated with living with HIV as well as with being of trans experience (FGDO1). There is no case law in Jamaica that deals with the status of people of trans experience (Murray, Long, & Nelson, n.d.). While Jamaica's legislative environment does not formally outlaw transgender identity or sex change procedures, there are no policies to deal with any aspect of the transgender experience, such as change of name, stigma as a result of gender non-conformity, or access to medically assisted gender reassignment. Interactions with the formal system and the results of these engagements are therefore unpredictable¹⁷. The USAID-funded Health Policy Project has implemented a pilot study to train physicians in the field on transgender health issues and vulnerabilities, however this intervention has not been evaluated (USAID & Health Policy Project, 2011)

2.6 Punitive laws, policies and practices

Many countries in the Caribbean have taken steps in recent years to address HIV-related concerns, as well as steps to counter violence and discrimination against key and vulnerable populations. Throughout the Caribbean, the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP) developed a framework for a proposed anti-discrimination law, which prohibits the discrimination of people living with HIV, gender and sexual minorities, disabled people and orphans from basic services. The Organization of American States passed Resolution 2721, which criminalized violence, discrimination, and other violations of human rights on the basis of sexual orientation and gender identity. The Caribbean Forum on Gender Equality allowed government representatives to address sexual violence, intimate partner violence, and other forms of gender-based violence. There was also an urge to recognize gender-based violence as a public health issue.

Although the Jamaican Constitution provides the rights to life, liberty, security of person, freedom of movement, and ensures freedom from inhumane treatment or punishment for all citizens, there is not a fully comprehensive HIV/AIDS law or general anti-discrimination law. Nor is there any national human rights commission. Legal protections in the context of HIV are scarce and there are currently no legally-enforceable protections in schools for children affected by HIV (UNAIDS et al., 2013).

The Child Care and Protection Act of 2004, section 9(1), considers healthcare providers to be exposing the minor to age-inappropriate information should they provide contraceptive advice and reproductive health services to young people under the age of 16 without parental consent. This is so despite the Reproductive Health Policy Guidelines for Health Professionals 2004, which permits health professionals to provide

¹⁷ Jamaica AIDS Support for Life, Issues Affecting Transgender People in Jamaica (JASL, 2012) 4 accessed at <http://jasforlife.org/html/wp-content/uploads/2012/01/Issues-Transgender.pdf>

counseling on contraceptive advice and treatment where the minor is adamant regarding sexual intercourse without the use of contraception and if physical and mental health is at risk. This puts healthcare providers, as well as minors who may be living with HIV, in a difficult position when negotiating access care. For adolescents, barriers to healthcare services limits communication about safe practices and avenues for testing and treatment. Reservations occur for adolescents who do not wish to disclose to their peers and family members (Crawford, McGrowder, & Crawford, 2009)(UNAIDS et al., 2013). It has also been noted in the Legal and Policy Assessment conducted by UNAIDS in 2013 that religious influences in policy and legislation act as a barrier to prevention and treatment efforts, some of which have a heavy influence on government policy in Jamaica, especially within the Ministry of Education, where comprehensive and age-appropriate sexual education has been limited due to its controversial nature in social and religious circles (UNAIDS et al., 2013) (KII11).

Jamaica's laws do not criminalize the status of being homosexual but rather outlaw conduct. The Jamaican Offenses Against the Person Act (also referred to as the 'buggery law') prohibits anal sex between men, in public or in private, punishable by 10 years in prison with hard labor¹⁸. The law also makes "gross indecency" between two men, the acts of which are not defined, a misdemeanor punishable by 2 years in prison. Moreover, there is no law that prevents discrimination against an individual on the basis of his or her sexual orientation, gender identity, or gender expression, and many focus group participants described violent encounters with police based on these factors.

"I don't know why they say the police are here to serve and protect." (FGD02)

The criminalization of same-sex sexual acts may fuel violence towards men who have sex with men and women of trans experience. Criminalization of such activity facilitates high levels of violence towards men who have sex with men and people of trans experience (Betron, Gonzalez-figueroa, Agency, & Development, 2009)(Figueroa et al., 2013). It also leads to stigma in healthcare facilities, limiting disclosure of sexual orientation for men who have sex with men and other LGBTI populations, which could impede the likelihood of testing for HIV (Logie, Lacombe-Duncan, Brien, et al., 2017). Some men who have sex with men experienced issues of nonverbal stigma and discrimination from healthcare workers, including being knowingly gossiped about, body language that communicated disrespect, and avoidance (C-Change et al., 2012).

Illegal police practices

Through the Sexual Offences Act, sex work is criminalized in Jamaica, making it illegal to live off of the earnings of sex work with a potential fine of up to \$500,000 Jamaican dollars (\$5000 USD) and imprisonment. The criminalization of sex work puts sex workers in a position of weakness, where they may be reluctant to report crimes against themselves or others for fear of arrest and interrogation. This can also put sex workers and clients of sex workers at higher risk of HIV, because sex workers may be less likely to

¹⁸ Jamaica Offenses Against the Person Act (1864), Section 76.

carry condoms and other safe sex materials, as they could be deemed as evidence of sex work if they are arrested (Sex Work Association of Jamaica, 2016). Additionally, the Town and Communities Act makes it possible to be charged with loitering in a public place, which is a common cause of arrest among sex workers. Discussion with representatives of sex workers revealed several instances of illegal practices at the hands of law enforcement.

“Police come with their big bright light and tell us to go and entertain them. Police make us not respect them because they are breaking the law when they extort. Prefer they arrest and charge us. They sometimes curse out sex workers and say they will go for gun. They are not protecting. When they extort, they make the clients think that we set them up.” (FGD03)

“They just lock us up in the night and then let us go in the morning. We want the police to be trained to know how to deal with us. We would like sex workers to have security.” (FGD03)

It has also been noted in the Legal and Policy Assessment conducted by UNAIDS in 2013 that religious influences in policy and legislation act as a barrier to prevention and treatment efforts, some of which have a heavy influence on government policy in Jamaica.

2.7 Poverty and other barriers

Poverty has a particular impact on access to treatment services, such as being late or having issues with absenteeism at work because of the need to pick up medication during work hours (Kalichman et al., 2015) (KII05, FGD04). This includes sex workers, whose high mobility and potentially inconsistent work hours may limit access to services. There is often no time outside of work hours for working people to access treatment services (FGD03). Moreover, time away from work to access services would constitute lost income, which many cannot afford. Thus, many people living with HIV are faced with either choosing to be absent from work in order to pick up their medication or forgoing treatment in order to remain at work (FGD01; KII05).

As discussed above, many people living with HIV may find it uncomfortable to seek care and treatment from a clinic within their neighborhood because of the risk of being seen by someone in their community (Logie, Lacombe-Duncan, Brien, et al., 2017) (KII02, KII06). Thus, transportation costs can be higher for those who may choose to access facilities further away from their home (KII02, KII05, FGD01).

People with disabilities also stressed the importance of incorporating wheelchair-accessible ramps and sign language interpreters into the healthcare system in order to address some of the specific barriers to access they face (FGD05).

2.8 Programs to address barriers to HIV services—from existing programs to comprehensive programs

Overview

This section describes existing or recent programs in Jamaica to reduce human rights-related barriers to services under the seven program areas set out in the Global Fund Technical Brief, as well as the comprehensive program that, if put in place at scale, would help to minimize these barriers to service access. Several non-government and community-based organizations, as well as government entities have been working to address human rights-related barriers to HIV. Jamaica has institutions and civil society organizations that can all be strengthened and engaged to significantly reduce these barriers. However, this will require increased and sustained investment in interventions and activities that provide important human rights-related knowledge and skills to officials and to the populations of those affected by HIV.

There have been many pilot projects, but few of them have been evaluated and taken to scale. Institutionalization of some activities, such as training of members of the judiciary in stigma reduction, is underway but for many other effective or promising interventions led by individual CBOs, their sustainability is highly dependent on external funding. Programs to reduce stigma and discrimination among healthcare workers have yet to be institutionalized in medical education more broadly, including for other key sectors, such as law enforcement.

The funding for HIV programming in Jamaica is currently financed by the Government as well as by two main external sources, the Global Fund and the United States government. The US government, through PEPFAR, funds HIV-related prevention, care and treatment activities for key populations, particularly female sex workers and men who have sex with men. The Global Fund provides additional funding to many of these activities as well as supports activities led by civil society organizations.

Jamaica's classification as an upper middle-income country by the World Bank has affected the country's ability to qualify for international aid from some sources, which has implications for the sustainability of various government programs, including health (Planning Institute of Jamaica, 2004) (The World Bank, 2013). Medium term cost projections estimate that the cost of implementation of the HIV response between 2017 and 2023 will be approximately J\$17.2 billion or US \$15.4 million (Ministry of Health Jamaica, 2014). Currently, the Government of Jamaica supports the pediatric component of the HIV program. The Government has been gradually absorbing ART procurement since 2016. In 2017, it has funded 50% of the national need for ART and by 2019, it plans to fund 100% of the ART needs in the country.

However, funding from external sources is on the decline, and matching funds from the Government of Jamaica are expected to reduce due to limitations in its loan agreement with the International Monetary Fund (IMF). Therefore, a major concern is the potential loss of gains due to challenges in the wider health system, including a severe shortage of human resources (Tomblin Murphy et al., 2016), which limits the full integration and expansion of HIV and SRH services necessary to achieve and maintain sustainability. Furthermore, staff shortages may worsen if the Government is unable to absorb the costs of human resources currently paid by donors.

Nonetheless, the Government of Jamaica has started absorption of HIV/AIDS treatment costs incrementally and well in advance of transitioning from Global Fund funding (UNAIDS & Curatio International Foundation, 2017). To ensure smooth and full transition of HIV national response from external support to country ownership, Ministry of Health and Planning Institute of Jamaica requested UNAIDS to support the transition preparedness process. Strong ownership by the Government, as well as cooperation by the country's stakeholders and the donor communities, provides a solid foundation for a sustained HIV national response.

Many key informants referred to the important role that NGOs have played in working with key populations, especially in providing a safe and comfortable environment to seek services (KII02, FGD01, FGD03). Some key informants believe that some of the current problems related to violence and hostility towards key populations has come mainly from a lack of understanding and awareness of how HIV is transmitted.

Many of the interventions described empower and engage key population representatives to be strong advocates for increased access to services and support among law enforcement and health care providers for this access. A summary description of existing or recent interventions to address human rights-related barriers to HIV services for each Program Area is presented below.

PA 1: Stigma and discrimination reduction for key populations

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon.

| Stigma and discrimination reduction for people living with HIV and other key and vulnerable populations | | | | | |
|--|---|--|---|------------------|--|
| Program | Description | | | | Limitations |
| Campaigns and social marketing | Includes mass media campaigns and other campaigns to raise awareness, enhancement knowledge, and reduce stigma and discrimination against people living with HIV and key populations. Working with the media to create more sensitive and fact-based reporting, promoting information sharing, expanding local awareness and including KP perspectives. | | | | Short-term/done on an ad hoc basis; lack of funding |
| Implementer | Population targeted | # trained | Region(s) | Timeframe | Recommended scale-up |
| National AIDS Programme | General population | Not identified | Not identified | Not identified | Private sector engagement in the national response should be scaled up through strategic partnerships with CSOs. Also needs to be expanded into workplace initiatives. More training needed with media personnel about ethics and sensitization when investigating and writing about issues with PLHIV and other key populations. This includes assisting CSOs with dedicated communications. |
| Scotia Bank/ Government of Jamaica | Jamaican Youth | 91 public schools participated | Not identified | 2006-2007 | |
| Panos Caribbean | Men who have sex with men, journalists | 10 MSM advocates, 30 media workers trained | Not identified | 2013-2015 | |
| Pan-Caribbean Partnership Against AIDS (PANCAP), funded by the Global Fund and German Financial Cooperation | Caribbean Social Marketing Programme (CARISMA) targeted the general population | Not identified | 13 Caribbean countries, including Jamaica | 2005-2012 | |
| JFLAG | General population | Not identified | Not identified | 2013 | |

| | | | | | | |
|--|--|--|---|-----------------------|---|-----------------------------|
| Jamaica AIDS Support for Life (JASL) | General population | Not identified | Island-wide | Jan 2017- Jan 2018 | | |
| Program | Description | | | | Limitations | |
| Community Outreach/Trainings | Stigma-reduction trainings and sensitization to key population issues. Could involve holding a series of national community conversations/consultations; sensitization training for students; voluntary counseling and testing training; activities that focus on documenting cases of discrimination, reducing or removing the barriers of stigma and discrimination; post-incarceration follow-up to empower and facilitate reintegration into society; health and wellness programs; training of FBOs on HIV basics and stigma reductions; empowering PLHIV to serve as community leaders; and training healthcare workers and national leaders on key population issues and GBV. | | | | Some duplication of efforts; lack of standardization. | |
| Implementer | Population targeted | # trained | Clients reached | Region(s) | Timeframe | Recommended scale-up |
| Health Policy Plus (HP+) | Healthcare workers, community leaders | Not identified | Not identified | Not identified | 2014 | |
| National HIV/AIDS Policy/ Ministry of Health Jamaica | General population, PLHIV | Not identified | Not identified | Not identified | Not identified | |
| Ministry of Health | FBOs | Not identified | Not identified | Not identified | 2011 | |
| CVC/COIN and SUFJ | Incarcerated populations | 20 prison workers sensitized, 45 inmates trained as peer educators | 100 MSM provided with HIV and human rights education, 1000 inmates interact | Not identified | 2013-2015 | |

| | | | | | | |
|--|--|----------------|---|---|--------------|--|
| | | | with peer educators on a regular basis during project duration. | | | |
| UNDP is prime recipient, Caribbean Vulnerable Communities/ El Centro de Orientacion e Investigacion Integral (CVC) are the implementers; via investment by the Global Fund | General population | Not identified | | Eight countries in the Caribbean, including Jamaica | 2017-2019 | |
| United Theological Program of the West Indies supported by Christian Aid | Students | Not identified | Not identified | UWT | 2004-present | |
| Pan Caribbean Partnership against HIV and AIDS (PANCAP) supported by UNAIDS | Stakeholders—parliamentarians/ judiciary, civil society, private sector, FBOs, media workers and youth | Not identified | Not identified | Island-wide | 2013-2014 | |
| PANCAP supported by the Global Fund | Key populations | Not identified | Not identified | Island-wide | 2016 - 2019 | |

| <i>Program</i> | <i>Description</i> | | | | <i>Limitations</i> |
|----------------------------------|---|-------------------------------|-------------------------|-------------------------|--|
| PLHIV Stigma Index | A process led by and for PLHIV to gather data on the experiences of PLHIV in Jamaica, including stigma and discrimination in the community and health care settings. The data generated are used to inform advocacy efforts by civil society. | | | | Only one survey has been conducted. |
| <i>Implementer</i> | <i>Population targeted</i> | <i>Clients reached</i> | <i>Region(s)</i> | <i>Timeframe</i> | <i>Recommended scale-up</i> |
| Jamaica Network of Seropositives | PLHIV | 540 (255 men; 285 women) | Country-wide | 2012 | Repeat national PLHIV stigma index on a 3-5 year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services. |

Current Programs

Jamaica has institutions, policies, and civil society organizations that can all be strengthened and engaged to significantly reduce stigma and discrimination based on HIV status. However, this will require increased and sustained investment in interventions and activities that provide important human rights-related knowledge and skills to officials and to the populations of those affected by HIV.

There are many interventions in place in Jamaica that involve an element of stigma and discrimination reduction. These range from interventions specifically and explicitly dedicated to stigma and discrimination reduction to those interventions that accomplish these objectives more generally through increased participation, representation and mobilization of key populations and their representatives.

Campaigns and Social Marketing

In countries where the health infrastructure is underfunded, a social marketing approach has become an important component of efforts to improve national health.

The National Family Planning Board (NFPB) and the AIDS Healthcare Foundation (AHF) collaborated this past World AIDS Day to focus on engaging youth as a means to educate and raise awareness of HIV/AIDS among the younger generation. The Jamaica Forum for Lesbians, All-Sexuals and Gays (J-FLAG) launched the We Are Jamaicans campaign on YouTube in 2013 to allow LGBT Jamaicans and allies to talk about LGBT identity, community and rights, as well as discrimination and violence¹⁹. This was the first time there was a campaign with several LGBT Jamaicans openly sharing their personal experiences living in Jamaica and the campaign generated much excitement among a wide cross section of people. The videos have been viewed hundreds of thousands of times on YouTube and the campaign was also featured in Caribbean Beat, the inflight magazine for Caribbean Airlines. So far there have been no evaluations of whether these campaigns have influenced stigma and discrimination experienced by PLHIV and key populations.

The National AIDS Programme has conducted mass social marketing campaigns to reduce stigma and discrimination, including radio announcements, reaching even those in prisons. One such campaign that was launched in 2017 by the Ministry of Health was to encourage people living with HIV to take their medication and to continue to do so for life²⁰. The campaign, which has been dubbed, ‘Test and Start: Get on yu meds and get on wid life’, goes further to encourage persons to get tested for HIV in order to know their status and, if confirmed positive, to commence antiretroviral treatment. Information on the impact of these campaigns is lacking.

Limitations/Challenges

¹⁹ jflag.org/programmes/we-are-jamaicans/

²⁰ jis.gov.jm/campaign-launched-persons-living-hiv-take-medication-life/

Key informants noted that social marketing and mass media campaigns are helpful in reaching large numbers of the general population and should be a key part of the response to reduce HIV-related stigma and discrimination. The main limitation with mass media campaigns is that they are often short-term. There is a lack of funding to sustain regular roll outs amid ever-growing social media avenues of distribution. Although some measurement criteria are being developed, another limitation of social marketing programs is the difficulty in measuring impact and effectiveness.

Community Outreach/Trainings

In healthcare facilities, Jamaica Key Population Challenge Fund (KPCF) has employed a participatory stigma and discrimination reduction training for healthcare workers and all other members of staff at healthcare facilities. This training involved facilitators guiding facility staff through interactive exercises and other method-learning sessions to create an environment of empathy and understanding for people living with HIV and members of key populations that arrive as patients in their facilities. Issues of gender and sexual diversity, confidentiality, and social norms and practices were all addressed throughout the training.

To build awareness and reduce stigma and discrimination in the context of HIV in Jamaica, Scotia Bank of Jamaica created a nation-wide public school debate initiative, which prompted students to discuss and compete on the topic of HIV.

Panos Caribbean, a regional organization that has been working to help empower the most marginalized and vulnerable persons in the region since 1986 on issues such as child rights, HIV and gender, created a handbook for journalists for responsible reporting on HIV and AIDS.

In response to the problems of HIV-related stigma and discrimination, the Caribbean Vulnerable Communities/El Centro de Orientación e Investigación Integral (CVC/COIN) and Stand Up for Jamaica (SUFJ) offered a health and wellness program designed for incarcerated MSM populations. As a post incarceration follow-up for the MSM population who received the wellness training, SUFJ and CVC/COIN offered a three-day workshop to support, empower and facilitate reintegration into society. The follow-up research was conducted to determine the extent to which the two interventions positively affected this group's knowledge levels, behavior and coping skills. A finding from the follow-up research highlighted the fact that the health and wellness program had increased the awareness of the inmates in regard to healthy lifestyle choices and how to access social benefits (Alvaranga, 2016).

JFLAG puts on what is known as the "LGBT Speakers' Bureau"—a cadre of LGBT persons and allies who are trained to share information about their experiences. Members of the Bureau are provided with a number of opportunities to share with a wide range of stakeholders on the human rights situation and lived realities of LGBT Jamaicans, and how the legislative framework affects the community (KII02). The majority of these sessions were facilitated through Peace Corps and the US Embassy.

Faith-based organizations (FBOs) in Jamaica have a long history of responding to public health crises and the emotional, social and economic needs that arise out of these crises. Their prominence in Jamaica makes them potentially well positioned to serve the needs of people affected by HIV and AIDS and to serve as efficient mechanisms for information distribution and awareness raising (KII09). However, many key informants critiqued the often judgmental and socially conservative stances towards HIV, and expressed that the Church and FBOs can often become places of exclusion rather than refuge (KII01, KII06, KII17). Despite this, FBOs are already actively engaged in the implementation of initiatives and programs around HIV. In 2015 with support from the WHO, the Jamaican Council of Churches carried out a mapping exercise, which indicated some key pointers of the response and some of the gaps within the national HIV response (KII19). The United Theological Program of the University of the West Indies provides sensitization training to students, who are going to be future pastors across the Caribbean, as well as voluntary counselling and testing (VCT) training (KII19). All graduates of the program are then prepared to provide VCT training to their members and the program has developed a manual for preachers to integrate into sermons. Additionally, the steering committee of the Jamaica Council of Churches, which includes religious leaders and one member of a key population, developed a strategic framework and proposal to collaborate with AIDS Healthcare Foundation. This partnership was driven by the need to address policy gaps within religious organizations that would help to align the HIV response with that of the government's (Pan Caribbean Partnership Against HIV and AIDS (PANCAP), 2017) (KII14).

PANCAP received a grant from the Global Fund in 2016 for a project to remove barriers to accessing HIV and sexual and reproductive health services for key populations in the Caribbean. The overarching goal of the grant program is to contribute to the removal of barriers that impede access to HIV and sexual and reproductive health services for key populations, thereby promoting the achievement of regional HIV targets. One of the barriers to be addressed includes harmful societal norms and high levels of stigma and discrimination (Pan Caribbean Partnership Against HIV and AIDS (PANCAP), 2016).

Limitations/Challenges

Duplication of efforts by many civil society organizations as well as lack of standardization have been cited as limitations of stigma reduction trainings. Many key informants and focus group participants emphasized the need for expanded standardized stigma and discrimination reduction training beyond healthcare providers, teachers, and law enforcement to include social service providers such as bus drivers, desk clerks, data analysts, etc. (KII02, KII06). Social marketing and mass media campaigns are also done on an ad hoc basis around commemorative holidays and have not been consistent.

PLHIV Stigma Index

The PLHIV Stigma Index is a process that was developed by and for people living with HIV to generate data for advocacy and empower communities to advocate for their rights using the data. With support from UNAIDS, the Jamaican Network of Seropositives conducted the PLHIV Stigma Index in Jamaica in 2012. The study, conducted among 540 people living with HIV throughout the country (255 men and 285 women), found that 11.8% of men and 19.4% of women reported experiencing discrimination because of their HIV status at least once in the past 12 months.²¹

Limitations/Challenges

Data on stigma, discrimination and rights violations is not being collected routinely from PLHIV and key populations, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts that have been implemented over the last 15 years. Investments in routine data collection efforts, like conducting the PLHIV Stigma Index every 3-5 years are needed to support national goals to achieve the 90-90-90 targets by 2020. Outside of the Index, there are two different mechanisms to capture experiences of stigma and discrimination. The JADS system, facilitated by JN+, is for specific HIV-related discrimination and redress while the SID system, facilitated by CVCC, collects data on broader human rights violations. However, these systems are currently in the process of being linked together and rolled out across Jamaica. More detail on these mechanisms will be discussed in the HIV-related legal services section.

Recommendations to reach comprehensive programming

The following recommendations are made to move towards comprehensive programming in stigma and discrimination:

- Support for continued and expanded sensitization and education campaigns on the transmission of HIV, ART/viral suppression, and how people living with HIV cannot transmit HIV if virally suppressed (KII04).
- Scale up community public education and media campaigns to increase comprehensive knowledge about HIV as well as awareness about human rights could help correct continued myths and misperceptions about HIV, and increase knowledge about ART, as well as seek to build a general appreciation for human rights as they relate to the public beyond those who identify with a key or vulnerable population group. Given the prevailing notion that human rights is a “western” concept, it may be most strategic to use examples from progressive country contexts of the global South, e.g. South Africa.
- Use different media platforms, such as social media outlets, as an opportunity to expand to different types of audiences, especially youth.
- While there have been some training efforts with health care workers to reduce stigma in the context of services, there has been little programming targeting

²¹ PLHIV Stigma Index Jamaica. 2012.

<http://www.stigmaindex.org/sites/default/files/reports/Jamaica%20%20People%20living%20with%20HIV%20Stigma%20Index%20report%202012pdf.pdf>

- more general populations that still interface with people living with HIV, such as social service providers and clinic security officers.
- Engage traditional and religious leaders in campaigns to reduce fears and misconceptions about transmission and promoting acceptance.
 - Utilize mass media strategies to share stigma reduction messages to reach rural areas.
 - Institutionalize stigma-reduction and awareness of human rights barriers to health services within medical, judicial and teacher-training colleges was widely recommended. Funding for regular support groups for people living with HIV and other key populations is another opportunity to foster resilience and reduce internalized and anticipated stigma.
 - Repeat the national PLHIV stigma index on a 3-5 year basis to provide updated data for assessing impact of programs to remove human rights barriers. This will help to better understand the climate around HIV-related stigma, it would be useful to re-implement the *Stigma Index*, which has not been carried out since 2012²². This could also help to understand changes in stigma over time, which would be useful given the range of interventions to tackle stigma and discrimination that have been implemented to date.
 - Private sector engagement in the national response should be scaled up through strategic partnerships with CSOs. Also needs to be expanded into workplace initiatives.
 - Fund data analysts to look at trends and impact of programming to help inform better implementation of programs and position NGOs for stronger funding applications.
 - Support projects aimed at de-stigmatization within FBOs and training FBO leaders themselves in order to broaden HIV awareness and strengthen the national HIV response.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

The table below provides an overview of current programmatic efforts to train health care workers on human rights and medical ethics related to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

²²<http://www.stigmaindex.org/jamaica>

| Training for health care providers on human rights and medical ethics | | | | | | |
|--|--|---|---|-------------------------|-------------------------|--|
| <i>Program</i> | <i>Description</i> | | | | | <i>Limitations</i> |
| Training and sensitization workshops for healthcare workers | Widespread training in procedures and stigma reduction to improve treatment and care for people living with HIV in Jamaica's healthcare facilities. Some trainings are HIV-specific, and others include sensitization to issues that affect key populations. Trainings include sensitization techniques to limit stigma faced by patients in routine healthcare. The objectives include addressing patient rights as well as the rights and needs of healthcare providers. | | | | | In-service trainings are not implemented routinely; different NGO facilitators leads to some overlap/redundancy. Limited evaluation data on attitudes and behaviors of health workers is available to assess impact/change over time. More focus can be given to train healthcare workers on matters of confidentiality, as this was a common theme expressed from the field work. |
| <i>Implementer</i> | <i>Population targeted</i> | <i># trained</i> | <i>Clients reached</i> | <i>Region(s)</i> | <i>Timeframe</i> | <i>Recommended scale-up</i> |
| JFLAF, MOH, NFPB | Healthcare workers; frontline staff such as male and female orderlies, security personnel, receptionists, and porters. | 250 healthcare workers: This included 53 frontline staff. | 325 people who use public health services have also participated in sensitization sessions. | Not identified | 2015 | A standard curriculum that all implementers could use for training health workers at all levels (and others working in health facilities). It should cover stigma, discrimination, gender-based violence, and human rights relevant to people living with HIV, key populations, and vulnerable |

| | | | | | | |
|--------------------------|--|--|---|--|----------------------------|---|
| JFLAG | Service users, healthcare workers, civil society, policy and decision makers | 166 HCW trained, 26 persons trained in social media. | 161 HCW sensitized, 85 service workers sensitized, 234 service users sensitized | Not identified | 2016, 2017 | populations. Existing training curricula could be used as the basis. Improve planning and mobilization of staff to attend trainings, focus on sustainability of stigma and discrimination reduction in healthcare facilities, improve monitoring and evaluation of stigma and discrimination reduction (Recommendation from report) |
| JFLAG | Various key populations and healthcare workers | 50 community members | 300 HCW | Not identified | 2017 | |
| Health Policy Plus (HPP) | Clinical and non-clinical healthcare facility staff | HPP delivered two-day stigma-reduction trainings in consultation with government and civil society organizations | 169 total participants | St. Jago Park Health Center in South East Region, Port Antonio Health Centre in North East Region, and Mandeville Health Center in Southern Region | February 2015 – April 2015 | |

Current Programs

Training and sensitization workshops for healthcare workers

There have been various initiatives to reduce stigma and discrimination in health facilities by sensitizing and training health care workers to be key population-friendly – particularly in relation to interacting with female sex workers and men who have sex with men. Several of these trainings have incorporated, or are now seeking to incorporate, human rights perspectives and content. Often these trainings provide spaces for participants to address their personal perceptions and biases (KII02).

In healthcare facilities, Jamaica Key Population Challenge Fund (KPCF) has employed a participatory stigma and discrimination reduction training for healthcare workers and all other members of staff at healthcare facilities. This training involved facilitators guiding facility staff through interactive exercises and other method-learning sessions to create an environment of empathy and understanding for people living with HIV and members of key populations that arrive as patients in their facilities. Issues of gender and sexual diversity, confidentiality, and social norms and practices were all addressed throughout the training

Limitations/Challenges

Training efforts for health care workers have been limited to relatively small cohorts of staff. There is a need for more systematic efforts, as several key informants spoke of the challenge of “too many chefs in the kitchen”, referring to the overlap in trainings given by different NGOs to the same health care worker cohort (KII02, KII08). Focus has also been on nurses, however, there is a need to increase training for others in the health system that will interface with people living with HIV, including receptionists, data clerks, security officers, etc.

Another limitation is that the right to health is not included in the Constitution, which would have otherwise been the fundamental basis for which to hold healthcare workers accountable to providing care.

Recommendations to reach comprehensive programming

- Incorporate HIV-related human rights sensitization into the existing curricula in pre-service training, e.g. medical, and nursing schools; embed HIV sensitization in a broader focus on human rights, stigma, and discrimination. While there would be initial costs related to securing buy-in for these institutional approaches, incorporating content into existing curricula, and building capacity to implement, the long-term costs would be relatively minimal and the broader human rights focus would have impacts in the context of HIV and beyond.
- Scale-up in-service training of health workers as well as other people working in health facilities (e.g. receptionists, data clerks). As general poor customer service was cited as a major barrier to retention in care, these trainings should work to

provide a paradigm shift in the way healthcare workers view their patients to enable a safe environment for those seeking care (KII05, KII06, KII07).

“Healthcare workers need to do their work out of love...even if the laws are no good, if the humanity is there, the treatment will be better.” (FGD01)

- Routine assessments of knowledge, attitudes and practices of healthcare towards people living with HIV and other key and vulnerable populations should be carried out to support health facility administrators to identify and address any issues.
- Standardize curriculum that all implementers could use for training health workers at all levels (and others working in health facilities). It should cover stigma, discrimination, gender based violence and human rights relevant to people living with HIV, key populations and vulnerable populations. Existing training curricula could be used as the basis. This provides a strong foundation to more systematically provide rights-based training at a larger scale and across different sectors – to move beyond individuals to systems.

“Modifying existing curricula is getting at low-hanging fruit. It’s feasible. We can do it.” (KII07)

- Invest in mainstream health services beyond that of NGOs, particularly adequate training for health care professionals. In the long-term, healthcare providers should generally be capable of providing services that are welcoming, responsive, non-stigmatizing and non-discriminatory.

PA 3: Sensitization of law-makers and law enforcement agents

The table below provides an overview of current programmatic efforts on the sensitization of law-makers and law enforcement agents as well as for scale-up. The content of the table is then further elaborated upon.

| Sensitization of law-makers and law enforcement agents | | | | | |
|--|---|--|------------------|------------------|---|
| Program | Description | | | | Limitations |
| Trainings and orientation programs | Educate officers and members of the judiciary on appropriate practices when engaging with people living with HIV and members of key and vulnerable populations while on duty. Sensitizes police of rights and services for people living with HIV and other vulnerable groups in Jamaica. Covers common complaints against police system by sex workers, people who use drugs, and men who have sex with men: stigma and discrimination, abuse, arbitrary arrest, torture, and rights violations. | | | | Challenges include harmful policies that allow for police practices that counteract the impact of national and programmatic efforts to reduce HIV in Jamaica, such as arrest for carrying condoms. |
| Implementer | Population targeted | # trained | Region(s) | Timeframe | Recommended scale-up |
| Jamaican Constabulary Force (implemented by JASL, CVC and Jamaicans for Justice) | Law Enforcement agents/ PLHIV | 58 in-service police officers | Not identified | 2016 | A range of trainings exist, primarily targeting the police. It will be important to scale-up training for members of the judiciary. Standardized messages should be provided to: pre-service police, in-service police, law school students, in-service lawyers and judges, pre-service prison officers, in-service prison officers, parliamentarians (if possible). All of the organizations involved in ongoing training could usefully collaborate to help |
| Judicial Education Institute of Jamaica (JEIJ) | Judiciary | Aims to strengthen judicial system by training and sensitizing the judiciary | Not identified | 2017- | |
| Sex Worker Association of Jamaica | Police Officers | Aims to sensitize police officers in Jamaica regarding the human rights of sex workers | Not identified | Not identified | |

| | | | | | |
|--|------------------------------------|---|--|------------------------------|---|
| Judicial Reform and Institutional Strengthening (JURIST) Project | Judiciary | Gender sensitive adjudication training workshop for judges – two 2-day workshops for Supreme Court and Court of Appeal Judges | Not identified | Not identified | inform these training curricula and to carry out the trainings. |
| Stand Up for Jamaica (SUFJ) and Jamaicans for Justice (JFJ) | National Police College of Jamaica | Provides courses in human rights at the National Police College of Jamaica. | Formerly known as Jamaica Police Academy, this college is run by the Jamaica Constabulary Force and is located in Twickenham Park, St. Catherine Parish. | November 2015 – October 2017 | |

Current Programs

Trainings and Orientation Programs

After it had been determined that HIV-related stigma was a pervasive problem within the justice system, especially in terms of police abuse of key populations (Logie, Lacombe-Duncan, Brien, et al., 2017)(C-Change et al., 2012) the Jamaican Constabulary Force published an educational document about HIV transmission, infection, treatment, and stigma. Local CSOs, including JASL, Caribbean Vulnerable Communities, and Jamaicans for Justice provided trainings and lectures, and prepared police for first aid certification exams with components on HIV and AIDS. JCF also developed a diversity policy that guides members of the force in their professional dealings with persons of minority groups such as lesbians, gays and people of trans experience.

At the request of the Chief Justice in September of 2014, UNDP held two workshops in 2015 for members of the judiciary to review the National HIV Workplace Policy (2012). UNDP is currently in the process of developing an online HIV-sensitization course for members of the judiciary. This course would aim to give members of the judiciary a basic understanding of HIV and acquaint them with the rights of people living with HIV.

Additionally, UNDP produced an HIV-sensitization course for the police training college to ensure, for example, that people in jail who are on medication are kept on medication.

In October 2017, the Judicial Education Institute of Jamaica (JEIJ) was launched. JEIJ aims to strengthen the administration of justice via access to training and sensitization programs in order to build public trust and confidence in the judicial system.

The Judicial Reform and Institutional Strengthening (JURIST) Project is a five-year regional Caribbean judicial reform initiative funded under an arrangement with the Government of Canada. The Project is being implemented on behalf of Global Affairs Canada (GAC) and the Conference of Heads of Judiciary of CARICOM, by the Caribbean Court of Justice (CCJ), which was appointed by the Conference as its Regional Executing Agency (REA). The Project is working with judiciaries in the region to support their own efforts to improve court administration and strengthen the ability of the courts and the judiciary to resolve cases efficiently and fairly. In December of 2017 in collaboration with the Caribbean Association of Judicial Officers (CAJO) and UN Women, JURIST hosted Part 1 of a three-part Gender Sensitive Adjudication Training. The objective of the workshop was to strengthen the capacity among judicial officers to train other judicial officers on how to practically use gender equality protocols to achieve more gender sensitive adjudication.

The Ministry of Labor is currently proposing a collaboration with UNAIDS to create a more practical training in which judges will train other judges. This would include adding sessions on recognizing and mitigating gender-based violence, as well as sessions to sensitize around HIV issues.

Limitations/Challenges

One of the biggest limitations, as explained in some of our key informant interviews, is funding (KII01). Mobilization of resources for governance-related projects has been a challenge. Furthermore, it has proven difficult to train judges unless done by another judge (KII07, KII10), making it very difficult to focus the conversation unless it becomes an institutional process mandated by the chief justice (judicial education institute) (KII10).

Recommendations to reach comprehensive programming

- Develop curriculum for law and law enforcement students on stigma and discrimination, human rights and GBV in the context of HIV. This should be done through a consultative process with the Ministries of Education, Health, administrators of local police training colleges, and representatives of key and vulnerable populations. Training of trainers should be rolled out to build capacity for facilitation.
- Standardized messages should be provided to: Pre-service police and in-service police; law school students and in-service lawyers and judges; pre-service prison officers and in-service prison officers as well as parliamentarians, if possible. All of the organizations involved in ongoing training should collaborate to help inform these training curricula and to carry out the trainings with changes and updates made to tailor to the realities, challenges, and opportunities of the different professions.
- Integration of this developed curriculum into the required curriculum of police training colleges and law schools, with changes and updates made to tailor to the realities, challenges, and opportunities of the different professions. In-service trainings for police, judges, and prison staff would continue with the updated curriculum, to ensure sufficient coverage of the information among law enforcement agents and lawmakers.
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and other key populations and support police administrators to identify and address any issues.
- Institutionalization of curricula to sensitize law enforcement agents, parliamentarians, and members of the judiciary in a standardized and comprehensive way moving forward is an opportunity to combat the challenge of restricted funding. There have been suggestions to update the existing training curriculums and introduce the trainings while in police academies and law schools—before the officers and members of the judiciary enter the system (KII16). Integration of these courses where the funding already exists, for example, within sexual and reproductive health, has been noted as one way to circumvent the challenge of funding limitations. The Justice Training Institute (JTI), the training arm of the Ministry of Justice, in consultation with and at the request of the Chief Justice is also mandated to organize and coordinate

- seminars, workshops and training programs for Judges of the Supreme Court, Court of Appeal, Resident Magistrate’s Court, and Justices of Peace.
- Expand and revise terminology within the UNDP online HIV-sensitization course for members of the judiciary as needed, e.g. “test and treat” and “key populations” (KII10). Although, ultimately, the Chief Justice has the final say in making the online course mandatory, the goal of the course is to integrate it into the general orientation to the judiciary.
 - Conduct routine assessments of law enforcement agents’ knowledge, attitudes and behaviors towards people living with HIV and other key populations to provide administrators with the information they need to identify and address any issues among their employees.
 - Support organizations working with prisoners and prison officials to develop health information trainings for inmates.

PA 4: Legal Literacy (“know your rights”)

The table below provides an overview of current programmatic efforts in the area of HIV legal literacy as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Legal Literacy (“know your rights”)

| Program | Description | | | | Limitations |
|--|---|--|----------------------------------|------------------|---|
| Training on legal matters | Provides tools to empower people living with HIV in their rights and opportunities to seek justice; creates avenues for community organizations to interact with the legal system; details plans of action to seek redress in cases of HIV-related stigma and discrimination. | | | | It is particularly difficult to create, implement and support “know-your-rights” campaigns when such major rights are missing from the Constitution, such as the right to health. |
| Implementer | Population targeted | Number trained/client s reached | Region(s) | Timeframe | Recommended scale-up |
| CVC via UNDP in partnership with the Global Fund | Key population peer leaders, youth, CSOs | 25 participants trained in Shared Incident Database training, 15 youth leaders trained regionally, 11 key population peer leaders trained. | Island-wide | Not identified | This work is generally small-scale and fragmented. All legal literacy work should be linked to efforts to increase access to legal services. |
| CVC and Sex Worker Association of Jamaica via UNDP in partnership with the Global Fund | Sex Workers | 10 participants | Kingston, Ocho Rios, Montego Bay | Not identified | |

| | | | | | |
|---|---|---|----------------|----------------|--|
| Sex Worker Association of Jamaica | Sex Workers | Not identified | Not identified | Not identified | |
| National Council on Drug Abuse (NCDA) | People who use drugs | Not identified | Kingston | Not identified | |
| Eve for Life | Women and members of their families, couples and children. | 130 women sensitized on rights and opportunities in the context of HIV and GBV to seek justice | Not identified | 2016-2017 | |
| JASL | Men who have sex with men, sex workers, PLHIV and key populations | 85 HCW trained, 39 policy-makers engaged, 15 women of trans experience trained in leadership and advocacy | Not identified | Not identified | |
| Jamaica Network of Sero-positives (JN+) | PLHIV | Not identified | Not identified | Not identified | |
| Jamaican Information Service | General population | Not identified | Not identified | 2016 | |

| | | | | | |
|---|--|----------------|----------------------------|-------------|--|
| PANCAP with support from PEPFAR and USAID | One regional organisation and several local community service organizations (CSOs) that specifically focus their efforts on key populations. | Not identified | Countries funded by PEPFAR | 2014 - 2018 | |
|---|--|----------------|----------------------------|-------------|--|

Current Programs

Training on Legal Matters

Through a grant from UNDP, the CVC has developed a legal literacy manual with country-specific information and Shared Incident Database (SIDney) protocol. SIDney is one of several interventions being implemented as part of a three-year, CVC/COIN Caribbean Civil Society Grant funded by the Global Fund. As of September 2017, 11 key population peer leaders were trained in legal literacy; a capacity-building session with the Sex Worker Association of Jamaica (SWAJ) (Sex Work Association of Jamaica, 2016) was held with 10 participants and a training of the Shared Incident Database was conducted with 25 participants²³. Through this UNDP grant, the CVC has been able to provide small grants to CSOs to improve documentation and reporting of human rights violations against key populations via the Shared Incident Database. SID provides an integrated platform to record, analyze and exchange information to impact policy and programs and empower individuals and civil society organizations to pursue redress and legal remedies where possible. A pool of lawyers has been trained with the SID system to review cases and litigate on behalf of the client *pro bono*.

The Pan Caribbean Partnership against HIV and AIDS (PANCAP) launched its PEPFAR- and USAID-funded Local Capacity Initiative (LCI) Project in April 2015²⁴. This three-year project seeks to build the capacity of one regional organization and several local community service organizations (CSOs) that specifically focus their efforts on key populations. Through the LCI, the organizations will become more sustainable as they continue to strive towards the overall goal of reducing the transmission of HIV in the Caribbean. PANCAP and the UWI HEU Centre for Health Economics have collaborated to implement the project. The project is aligned with the Caribbean Regional Strategic Framework for HIV and AIDS (CRSF), 2014-2018.

Through this initiative, which was informed by the epidemiology of HIV in the Caribbean, PANCAP provides grants to local CSOs in countries funded by PEPFAR for activities such as policy and advocacy, program implementation and/or building a financially diverse organization.

Limitations/Challenges

It is particularly difficult to create, implement and support 'know-your-rights' campaigns when such major rights are missing from the Constitution, such as the right to health. However, these campaigns are not only about high level constitutional rights, but also includes due process, obligations and responsibility of law enforcement agents to stand up against arbitrary arrests, extortion, etc. It is also about the medical ethics and rights as patients: non-discrimination, medical confidentiality, informed consent, etc. Thus,

²³ www.undp-globalfund-capacitydevelopment.org/en/results/regional-grants/cvccoin-caribbean-regional-hiv-project/

²⁴ <https://pancap.org/pancap-work/local-capacity-initiative/>

even where laws and regulations and their enforcement contribute to HIV risk or constitute barriers to health services, people can still assert their rights supported by national policies (e.g. National HIV/AIDS Workplace Policy, 2012) as well as to life, protection from violence and bodily harm, among others, as these rights are afforded by the Constitution.

Another limitation to engagement in legal literacy has been the perception that human rights are solely focused on the rights of key and vulnerable populations (KII02, KII03). One key informant noted,

“Advocacy is seen as having a ‘gay agenda’.” (KII02)

Therefore, advocates have begun to shift away from explicit discussion of issues perceived as “gay issues”, such as the ‘buggery law’, and are moving toward an expanded and more general conversation about human rights (KII16, KII17).

“Key population issues should be mainstreamed. Their human rights are everyone’s human rights.” (KII08)

Some key informants and group discussions expressed that another challenge has been the idea that human rights is a “Western concept” (KII01, KII02, KII10). Addressing these misconceptions is an opportunity not only to move toward a more accepting and safe environment for key and vulnerable populations, but to create an environment where the general population is aware of and can advocate for their rights as well (KII06).

“What I would love is how to create demand for human rights. JFLAG has done well. The LGBT community is now demanding the stuff that they have a right to. How do we get everybody in Jamaica to understand that the community has to demand human rights? Demand will drive supply. Quality services for all, that needs to be our message.” (KII03)

Recommendations to reach comprehensive programming

- Legal literacy work is generally small-scale and fragmented. All legal literacy work should be linked to efforts to increase access to legal services to ensure literacy efforts do not exist in a vacuum.
- Support existing institutions to engage in broad human rights education for the public, conduct general campaigns for HIV-related rights and reduction of stigma and discrimination. One of the main trends seen in the fieldwork was that human rights are not a familiar concept to the general public. Many key informants described the misconception that human rights only refer to key and vulnerable populations, rather than rights that every human has. Furthermore, human rights are seen as “foreign” concepts pushed by Western countries to promote a “gay agenda”—many key informants spoke about the need to adopt a broader approach to communicating about human rights so as to move away from this narrow framing (KII02, KII03, KII06, KII08, KII09, KII10). *“To allow for*

- human rights discourse to be recognized as routine—sexual and reproductive health has to be recognized as regular human rights discourse.” (KII08)*
- Implement better systems of accountability when service providers and others continue to stigmatize and discriminate (KII03, KII06, KII16, KII12, FGD01). These can take the form of patients’ rights training, training on how to go about submitting a complaint, and community-based monitoring. NGOs already doing this work should be supported. *“We can train ad nauseam but training without accountability is fruitless.” (KII15)*
 - Support the implementation of awareness campaigns (e.g. awareness of policies and resources that support people living with HIV such as the SIDney system, National HIV/AIDS Workplace Policy, etc.) and workshops among people living with HIV and other key populations toward mobilizing around health rights and needs. *“People should know that the workplace policy doesn’t allow an employer to screen for HIV. This sensitization should target the public, not just key pops.” (KII05)*
 - Support NGOs already engaged in ‘know-your-rights’ education and legal literacy interventions to develop the capacity of key population members to propagate information via peer education.
 - Support key population networks to organize and engage with law enforcement agents to prevent harmful policing practices.
 - Finally, as Such campaigns could also constitute an opportunity to raise awareness about the National HIV Workplace Policy (2012) and the Shared Incident Database, including the protections and responsibilities they confer.

PA 5: HIV-related legal services

The table below provides an overview of current programmatic efforts to provide HIV-related legal services as well as recommendations for scale-up. The content of the table is then further elaborated upon.

| HIV-related legal services | | | | | |
|---|--|---------------------------------------|------------------|------------------|---|
| Program | Description | | | | Limitations |
| Reporting systems | Databases to capture experiences of discrimination and other human rights violations experienced by PLHIV and key populations. | | | | Recently implemented; not fully utilized yet; clients often not willing to seek redress after reporting due to fear of accidental disclosure of their HIV status. |
| Implementer | Population targeted | Number trained/clients reached | Region(s) | Timeframe | Recommended scale-up |
| CVCC (Shared Incident Database) | PLHIV and key populations | Not identified | Caribbean-wide | Ongoing | Key supporting activities will need to be considered to making this intervention successful: <ul style="list-style-type: none"> ▪ Legal Case Management Software ▪ Institutional strengthening for JN Plus to effectively administer case review via a Case Management Panel ▪ Expand network of lawyers and other officers ▪ Improve synergy between CSOs to enhance reporting protocols |
| JN+ (Jamaica Anti-Discrimination System for HIV (JADS)) | PLHIV | Not identified | Country-wide | Ongoing | |

| Training on legal matters | Provides tools to empower people living with HIV in their rights and opportunities to seek justice; creates avenues for community organizations to interact with the legal system; details plans of action to seek redress in cases of HIV-related stigma and discrimination. Collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress. Promotes human rights and participates in human rights litigation in collaboration with human rights lawyers and civil society organizations. | | | | |
|---|--|--|----------------------------|-------------------------|---|
| <i>Implementer</i> | <i>Population targeted</i> | <i>Number trained/clients reached</i> | <i>Region(s)</i> | <i>Timeframe</i> | <i>Recommended scale-up</i> |
| CVC | Not identified | Not identified | Not identified | Not identified | There are different models to support a community based legal support system, and therefore a framework has to be created that will include various activities such as: reporting protocols between and among CSOs; geographic scope; advisory committees, etc. |
| JN+/ GOJ via funding from USAID and MOH | People living with HIV | Not identified | Not identified | Not identified | |
| Faculty of Law at the University of the West Indies (UWI) | Lawyers | Not identified | English-speaking Caribbean | Not identified | |
| JASL | People living with HIV | Not identified | Kingston | Not identified | |

| | | | | | |
|--|--|---|----------------------|----------------|--|
| Eve for Life | Women and members of their families, couples and children. | 130 women sensitized | Not identified | 2016-2017 | |
| JASL | Men who have sex with men, sex workers, PLHIV and key populations | 85 HCW trained, 39 policy-makers engaged, 15 women of trans experience trained in leadership and advocacy | Not identified | Not identified | |
| PANCAP in partnership with Knowledge 4 Health (K4Health) | Policy makers, health care professionals, civil society organizations, and all entities involved in the eradication of the virus | Not identified | Across the Caribbean | 2016-2018 | |

Current Programs

Reporting systems

The Shared Incident Database (SID) aims to strengthen evidence-based advocacy for more just policies and programs in the Caribbean HIV response. SID provides an integrated platform to record, analyze and exchange information to impact policy and programs and empower individuals and civil society organizations to pursue redress and legal remedies where possible. The tool captures incidents of human rights violations not only of key populations, but of the general population as well. The system is organized in a way that enables the user to pull out the profile of an incident at any level, e.g. by nurse's name, by location, etc. One of the goals of SID is to move toward strategic litigation. A cross-Caribbean regional pool of lawyers has been trained with the SID system to review cases and litigate on behalf of the client *pro bono*. The Global Fund and the Robert Carr Foundation, among others, fund this training. Beyond benefiting CSOs, the SID could also reassure those who wish to report abuse that there is a reliable, secure and trustworthy means of doing so—that a network of organizations exists that is equipped and willing to assist with follow up.

Established in 2007 with funding from USAID and the Ministry of Health, the National HIV-Related Discrimination Reporting and Redress System (NHDRRS), now the Jamaica Anti-Discrimination System for HIV (JADS) is a system that collects and investigates complaints of HIV-related discrimination across Jamaica and refers them to the appropriate entities for redress. The Jamaican Network of Seropositives (JN+) with the Ministry of Health manages JADS. The Health Policy Plus (HP+) project, and its predecessor Health Policy Project, has been supporting the Jamaica Network of Seropositives (JN+) and the Ministry of Health, a JN+ redress partner, to strengthen and evaluate their redress systems. JADS redress is limited to government partners right now, specifically the Ministry of Labour. In August, HP+ provided training to public sector healthcare workers and JN+ redress officers on the Ministry's Complaint Management System and the importance of addressing stigma and discrimination in healthcare facilities. In October 2017, HP+ organized an additional training for JN+ redress officers and presented them with locking file cabinets, improving the system's ability to protect confidentiality.

Unlike SIDney, JADS system does not have an electronic platform. Through this system, JN+ collects cases of HIV-related discrimination and refers them to the Ministry of Health/Ministry of Labour to investigate, mediate, or provide damages to people who have experienced discrimination. The redress system was first conceived under a Global Fund grant to strengthen prevention, treatment, and policy efforts in Jamaica. While the principal recipient of the Global Fund grant is the Ministry of Health (MOH), JN+, as a sub-recipient, created and manages JADS. Notably, the difference between the two systems is that SID collects broader human rights complaints with the goal of strategic litigation, while JADS is HIV/AIDS-specific and offers redress. Efforts are being made currently to link JADS-reported incidents to the SID system.

Limitations/Challenges

There are several limitations to the JADS redress system. According to stakeholder interviews, complaints are not always resolved quickly and complainants may lose trust in the system and stop reporting cases when redress options are not timely or do not occur (KII02, KII05). As JN+ does not have any in-house capacity to provide redress, they must refer cases to other organizations—a process which may take time. Stakeholders mentioned a perceived weakness in confidentiality protections as one of the key reasons that people living with HIV do not report discrimination (KII02, KII04, FGDO1). Many people living with HIV expressed fear that reporting would put them at further risk for discrimination or involuntary status disclosure should confidentiality be broken.

The SID system does not allow JN+ to directly manage or edit cases once they are submitted. As a result, it does not provide the integrated case management system that JN+ needs. JADS redress is limited to government partners right now, specifically the Ministry of Labour. A comprehensive system would expand to pro bono or private lawyers and senior paralegals. Also, redress would expand to effectively utilize trained PLHIV community paralegals.

Training on Legal and human rights literacy

The Pan Caribbean Partnership against HIV&AIDS, PANCAP, has formed a partnership with the Knowledge for Health (K4Health) Program to significantly enhance the capacity of the PANCAP Coordinating Unit (PCU) and to aid all PANCAP members in knowledge generation and sharing with regard to the new World Health Organization (WHO) guidelines for ‘Test and Start’. The K4Health Project, based in Baltimore, United States, is funded by the [U.S. Agency for International Development](#) (USAID) [Bureau for Global Health, Office of Population and Reproductive Health](#) and implemented by the [Johns Hopkins Center for Communication Programs](#) (CCP). The goal of the project is to present information that is vital to HIV testing and early treatment in concise, well-packaged communication products that can be easily accessed and utilized by policy makers, health care professionals, civil society organizations, and all entities involved in the eradication of the virus.

The new partnership between the two entities will help to enhance the availability and access to vital information regarding the new treatment eligibility. For example, K4Health will be instrumental in revamping and relaunching the PANCAP website with fact sheets, policy documents, brochures, and other communication products which will concisely illustrate the importance of commencing early HIV treatment after a positive diagnosis as well as other issues related to advocacy around stigma and discrimination.

Recommendations to reach comprehensive programming

- Mainstream adoption of the Shared Incident Database provides an efficient and streamlined opportunity to provide supporting data for and facilitate the work of

- those advocating safer and healthier conditions for the region's most vulnerable (KII03).
- The Office of the Public Defender of Jamaica could act as an important future partner to improve the JADS redress system. To increase trust in the system, development of a privacy and confidentiality statement could provide assurances for complainants and describe sanctions for privacy breaches (KII05). To strengthen internal systems, communication should be continued with the CVC about SID regarding how best to connect cases between JN+ and the SID system.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

The table below provides an overview of current programmatic efforts to monitor and reform laws, regulations and policies relating to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

| Monitoring and reforming laws, regulations and policies relevant to HIV | | | | | |
|--|---|--|-------------------------|-------------------------|--|
| <i>Program</i> | <i>Description</i> | | | | <i>Limitations</i> |
| Advancing and advocating for improved legal and political environment | Provide training to public sector healthcare workers and officers on confidentiality, engage in advocacy initiatives including the repeal of punitive laws and other policies and legislations that infringe on the rights of persons living with HIV and key groups, work with change agents across all levels of the society to help bring about positive changes in state mechanisms, especially in the justice system, advance a holistic framework for PLHIV to manage their health, and advocate for high-quality HIV services and prevent onward HIV transmission. | | | | Without a comprehensive HIV and AIDS law, an anti-discrimination law or human rights act/commission to legally enforce non-discrimination, existing and future HIV and AIDS policies and strategic plans will not have the desired result of ensuring equal access to prevention, care, treatment, and support by key populations, as well as the full enjoyment of PLHIV in all aspects of social, cultural, civil, and political life. |
| <i>Implementer</i> | <i>Population targeted</i> | <i>Number trained/clients reached</i> | <i>Region(s)</i> | <i>Timeframe</i> | <i>Recommended scale-up</i> |
| Ministry of Labour and Social Security | General population | Not identified | Nation-wide | Implemented 2012 | It is noted that UNDP undertook a comprehensive legal assessment in 2013. Therefore, given that not much legislative changes would have occurred, this activity should be refocus towards monitoring of joint |
| Jamaica Network of Seropositives (JN+), MOH | People living with HIV | Not identified | Not identified | Not identified | |

| | | | | | |
|--|------------------------|----------------|----------------|----------------|---|
| JASL | People living with HIV | Not identified | Not identified | Not identified | advocacy efforts and their impact. |
| Jamaicans for Justice | Not identified | Not identified | Not identified | Not identified | To effectively implement law reform and advocacy, funding of legal and policy support across organizations have to be considered. Organizations include: Equality for All Foundation, Jamaicans for Justice, Jamaica AIDS Support for Life, Jamaican Network of Seropositives that will need support for Legal Officers, as well as Policy staff, including community paralegals. |
| JN+ via Global Network of People Living with HIV (GNP+) and UNAIDS | People living with HIV | Not identified | Not identified | 2011- | |
| Ministry of Justice | General population | Not identified | Not identified | Not identified | |
| Eve for Life | Girls and Women | Not identified | Not identified | Not identified | |
| | | | | | |

Current Programs

Advancing and advocating for improved legal and political environment

There has been increasing recognition of and commitment to enabling legal environments in the HIV context. Jamaica the Political Declaration on HIV/AIDS in 2001, 2006, and 2011, committing to protecting the human rights of people living with HIV, women and girls, and key and vulnerable populations. Additionally, the country has adopted several policy initiatives, including National HIV/AIDS Policy and National HIV/AIDS Workplace Policy.

A National HIV Workplace Policy was put into place in 2012 that developed an internal HIV policy for using International Labor Organization (ILO) recommendations. The policy assists in developing a caring, supportive, and responsible working environment that will protect all workers; reduce HIV and AIDS-related stigma and discrimination; and assist in reducing HIV and AIDS transmission. The ten guiding principles from the ILO Code of Practice on HIV and AIDS are used as the foundation for the development of strategies and objectives. In 2016, the Jamaican Information Service (JIS) aired a documentary on television on the HIV policy to raise awareness.

Another important monitoring activity has been the submission of alternative or shadow reports. Submitting a shadow report to a UN treaty body committee is an important tool for NGOs as they can highlight issues not raised by their governments or point out where the government may be misleading the committee from the real situation. A coalition of five leading human rights organizations—Jamaicans for Justice (JFJ), the Caribbean Vulnerable Communities Coalition (CVC), the Jamaica Youth Advocacy Network (JYAN), the Jamaica Forum for Lesbians, All-Sexuals and Gays (J-FLAG) and Stand Up for Jamaica—submitted a report for review at the 118th session of the Human Rights Committee regarding the implementation of the provisions of the International Covenant on Civil and Political Rights (ICCPR) related to a list of issues Jamaica adopted at its 116th Session (Jamaicans for Justice (JFJ), Caribbean Vulnerable Communities Coalition (CVCC), Jamaica Youth Advocacy Network (JYAN), J-FLAG, & Stand Up for Jamaica (SUFJ), 2016). Another coalition of civil society organizations including J-FLAG, Women’s Empowerment for Change (WE-Change), The Colour Pink Foundation, TransWave, Center for Human Rights at Northwestern University School of Law and Global Initiatives for Human Rights of Heartland Alliance submitted a shadow report for consideration at the 18th Session of the Human Rights Committee regarding human rights violations against lesbian, gay, bisexual and people of trans experience in Jamaica (J-FLAG et al., 2016).

Ministry of Labor is currently working on a 5-year national plan to look at strengthening the primary healthcare facilities’ dealing with issues like HIV. It aims to be a general plan that does not put HIV as the area of focus but simply takes steps toward ensuring the primary healthcare facilities will address issues like customer service.

Limitations/Challenges

Funding is a major restriction to monitoring and reforming laws and policies. Without enacting legislation, there is no basis for implementation.

“Policies are nice guideline docs for government employees; but in terms of teeth and push and ensuring there’s an avenue for redress, policies won’t cut it.” (KII10)

Key informants cited misinformed parliamentarians as another challenge (KII05, KII10).

Recommendations to reach comprehensive programming

- Identify a human rights point person, e.g. the Public Defender. This person could support the process to begin replacing or updating the problematic laws and policies identified in the 2013 Legal Environment Assessment in Jamaica. Several respondents note the importance of ensuring that supportive laws and policies are implemented and that old, harmful laws are identified and updated. Although law reform is a difficult endeavor, identifying key policies or regulations that could be improved or better implemented is key. This can be done in coordination with U-RAP, which promotes human rights and participates in human rights litigation in collaboration with human rights lawyers and civil society organizations.
- Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws.
- Passing a comprehensive anti-discrimination law was one of the consistently mentioned suggestions throughout all the interviews, as well as the need for the establishment of a national human rights commission (KII01, KII02, KII05, KII07, KII08, KII16). This human rights commission is slated to be situated in the public defender’s office.
- It is important to note that there were mixed opinions regarding where this Human Rights Commission should be housed. This will have to be sorted and agreed upon by national stakeholders and civil society groups. Another critique of the Human Rights Commission is the concern that it will not be able to defend rights that are not part of the constitution and would have little jurisprudence (KII10). Funding for joint advocacy efforts to push for constitutional reform to address the lack of a comprehensive anti-discrimination legislation, for example, will be an important step to ensuring the utility of the Commission.
- Training in strategic litigation and legal support for CSOs. Although there were some conflicting opinions about the suitability of this tactic in the Jamaican context, one recommendation that came from key informants was the process of strategic litigation (KII08, KII13). The purpose of strategic litigation being to use the authority of the law to advocate for social change by setting legal precedent and expanding jurisprudence.

PA 7: Reducing discrimination against women in the context of HIV

The table below provides an overview of current programmatic efforts to reduce HIV-related gender discrimination, harmful gender norms and violence against women and

girls in all their diversity as well as recommendations for scale-up. The content of the table is then further elaborated upon.

| Reducing Discrimination Against Women in the context of HIV | | | | | |
|--|--|---|---|-------------------------|--|
| <i>Program</i> | <i>Description</i> | | | | <i>Limitations</i> |
| Community awareness campaigns | The campaign used a variety of methods to facilitate culturally sensitive discussions about safe sex, women's sexuality, and changing gender norms, including small group discussions and community dialogues. Stigma and reduction components promoted women's empowerment and encourage HIV disclosure in health care facilities. Drawing on gender-focused research on violence to raise awareness, promote gender equality and reduce gender-based violence, training with a focus on gender-based violence and sexual diversity, documenting experiences of women at all ages and encounters with domestic violence and providing support in the form of group sessions, legal literacy, and advocacy sessions for women. | | | | It may be challenging to maintain gains in HIV knowledge over a longer time period following discussions/dialogues. Current efforts are only focused on adult women. |
| <i>Implementer</i> | <i>Population targeted</i> | <i>Number trained/client s reached</i> | <i>Region(s)</i> | <i>Timeframe</i> | <i>Recommended scale-up</i> |
| Woman, Inc. via funding from Health Policy Plus (HP+) | Healthcare workers, community leaders, women | In total 87 patients answered screening questions about experiences with violence and were subsequently linked to relevant resources that could provide help. | Kingston (Kingston's Comprehensive Health Centre) | July 2013- October 2013 | Consider staff rotation and other health system issues in project planning. Plan for multiple trainings to address rotation, attrition and transfers. |

| | | | | | |
|--|---|---|----------------|----------------|--|
| RENEWAL/ Woman's Inc. Kingston | Women and girls | Not identified | Not identified | Not identified | |
| AIDS Healthcare Foundation Jamaica with Bureau of Gender Affairs and MCGES | General population | >30,000 people | Not identified | 2017 | |
| Exposing the Link/ Woman's Inc. Kingston | Women and girls | Not identified | Not identified | Not identified | |
| Eve for Life Jamaica | Women and girls | Not identified | Not identified | Not identified | |
| Jamaica AIDS Support for Life | Sex workers, LBT women, women with disabilities and women living with HIV | Sex workers (977), LBT women (159), women with disabilities (29), and women living with HIV (848) | Not identified | Not identified | |
| Jamaica Community of Positive Women (JCW+) | Girls and Women with HIV | Not identified | Not identified | Not identified | |

| | | | | | |
|---|--|----------------|----------------------------------|---|--|
| Stand Up for Jamaica | Young women in the March Pen Road community of St. Catherine Parish | Not identified | Not identified | Not identified | |
| Palladium Group via funding from Health Policy Plus (HP+) and the Global Fund | Key facility staff members and peer navigators received the training | Not identified | Jamaica and the Caribbean region | 2016-2017 with annual extensions funded by PEPFAR | |
| Partnership between the Bureau of Gender Affairs and the Planning Institute; the Ministries of Youth and Culture, Education and National Security; the Inter-American Development Bank and the World Bank | Youth ages 10-29 | Not identified | Not identified | 2013- | |

Current Programs

Community Awareness Campaigns

Woman Inc., an organization that focuses on projects to promote the equality of women in Jamaican society, while not primarily focusing on issues of HIV and AIDS, has implemented projects through their public education initiative that explore women and HIV in Jamaica. In 2012, the USAID and PEPFAR-funded Health Policy Project (HPP) supported Woman Inc. to assess strategies for integrating GBV screenings and referrals into clinical HIV/STI care (Health Policy Project & Futures Group, 2014). Healthcare personnel deemed the referral component a major strength of the project, noting that they were previously unaware of GBV resources available in Kingston. Additionally, the project, “RENEWAL”, established support groups for survivors of sexual violence, and also held public forums, wherein “Women and HIV and AIDS” was a forum topic. Another project, known as “Exposing the Link” was established to educate the general public about the links between gender-based violence and HIV. Margaret Sanger International of New York City sponsored this project.²⁵

Initiated by the United Nations Secretary General’s Campaign UNITE to End Violence Against Women, campaigns like “Orange Day”—a day to raise awareness and take action to end violence against women and girls celebrated on the 25th of each month—calls upon activists, government entities and civil society to mobilize people and highlight issues relevant to preventing violence against girls and women. Orange Day has highlighted sustainable development goal (SDG) 3: “Ensure healthy lives and promote well-being for all at all ages”, focusing on HIV and AIDS as one of the thematic areas as well as SDG 5, recognizing gender equality and the empowerment of women as a key priority.

In an effort to promote gender equality, reduce discrimination and reduce gender-based violence in Jamaica, Health Policy Plus (HP+) is supporting the government’s national response to the HIV epidemic by training and working with healthcare workers and community leaders to understand the issues faced by key populations and their experiences of gender-based violence, and create an environment of safety for survivors of gender-based violence in the context of HIV.²⁶

Another organization that works to alleviate the burden of gender inequality in the context of HIV is called Eve for Life, which provides psychosocial support to women and children affected by HIV, as well as ensures adequate health services and care, fosters positive attitudes towards people living with HIV, promotes education for healthy sexual attitudes, beliefs, and behaviors, as well as disseminates accurate HIV information, and addresses gender-based violence.²⁷

Jamaica AIDS Support for Life also works with women who experience violence within the context of HIV and AIDS. *Expanding Gains to Decrease and Prevent Violence*

²⁵ NGO Caribbean Development Foundation. (2009). Woman’s Inc. – Kingston. <http://www.ngocaribbean.org/index.php/womans-inc-kingston/>

²⁶ Health Policy Plus. (2016). Jamaica. <http://www.healthpolicyplus.com/jamaica.cfm>

²⁷ Eve for Life. (2012). About Us. <http://www.eveforlife.org/about-us>

against Women in the Context of HIV and AIDS, a three-year project funded by the UN Trust Fund addressed several forms of violence faced by women, including: intimate partner, physical, sexual, financial violence, among others.

The Next GENDERation Initiative draws on the World Bank's gender-focused research on youth and violence, globally and in Jamaica, and includes a national awareness raising campaign. The current phase of the Initiative focuses on activities under three pillars: 1) National Awareness Campaign: a participatory youth campaign; 2) Multi-sectoral Dialogue on gender roles, gender equality, agency and their impact on violence among young people, through round table discussions and the Steering Committee Interactions; 3) Development of a Note on a gender social norms and youth violence in Jamaica based on research, broad-based dialogue and good practices. Next GENDERation collaborates with other relevant campaigns including Unite for Change.

Limitations/Challenges

The Jamaica Charter of Fundamental Rights and Freedoms does not protect against discrimination on the basis of sexual orientation or gender identity. The effect of this is that discriminatory treatment in employment, education, healthcare and housing at the hands of non-state actors is allowed to happen with impunity.

Rape, according to the Sexual Offences Act, only occurs in limited circumstances. For example, marital rape exists only in instances where divorce proceedings have started, where they have separated, where there is a separation agreement, where a protection order has been issued against the husband and where the husband has an STI²⁸.

Working at broader community and societal levels is not only necessary to address barriers facing key populations – it is also crucial given the fact that heterosexual sexual transmission is the most commonly reported mode of transmission in Jamaica (UNAIDS & Ministry of Health Jamaica, 2012). Certainly, there are many factors driving this statistic, but at the core are harmful gender norms and power dynamics that perpetuate risky ideals of masculinity such as early sexual debut, multiple sexual partnerships, and unprotected sex. Gender norms put women and girls at risk and include the pressure to conform to men's sexual requests and be unquestioning of the sexual honesty of their male sexual partners (KII01). Values and norms related to constructs of masculinity and femininity; sexual relationships in terms of gender inequalities as well as sexual and physical abuse all impact sexual risk behaviors and sexual and reproductive health outcomes (Kempadoo, Taitt, UNIFEM, & IDRC, 2006). Programs that address harmful manifestations of masculinity and gender norms are limited.

Recommendations to reach comprehensive programming

²⁸ Sexual Offences Act (2009), s. 5

- Integrate gender across all program areas to ensure that gender dynamics and issues relating to gender-based violence are considered throughout the response to human rights-related barriers to accessing HIV services– seeking, for example, to ensure adequate access and supports for women (KII13), but also striving to more systematically engage their male partners.
- Support advocacy on raising the issue on gender-based violence and move toward a comprehensive legal and policy framework against gender-based violence (e.g. inclusion of forced sex within marriage as a form of rape).
- Support advocacy for economic opportunities for women and legal support for women vulnerable to HIV because of abuse (e.g. market driven skills training, linkage to employment, income generating schemes).
- Continue current programs that support women from key populations and vulnerable groups experiencing gender-based violence. Additionally, the gender integration and mainstreaming plans in the SRH and HIV programs of the NISP 2014-2019 provide additional opportunity to strengthen an existing activity.
- Support networks of women living with HIV, female sex workers, women of trans experience and women who use drugs to advocate and organize against mistreatment by police and health care providers.
- Mobilize women’s groups and support networks to combat violence and support survivors to seek redress and services from one-stop crisis management centers.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce GBV. Community dialogues should be organized to promote gender equality at every level, from the national to the grass-roots level.

2.8 Investments to date and costs for a comprehensive program

In 2016 a total of USD **2,742,031** was invested in Jamaica to reduce human rights-related barriers to HIV services.

Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

| Funding source | 2016 allocation (USD) |
|--|------------------------------|
| UNAIDS | 5,605 |
| The Global Fund to Fight AIDS, TB and Malaria | 438,815 |
| AIDS Healthcare Foundation | 107,794 |
| UN Women | 4,962 |
| International Community of Women Living with HIV | 32,935 |

| | |
|--|----------------------|
| Women's Global Network for Reproductive Rights | 460 |
| CARICOM | 36,792 |
| SRT | 85,034 |
| Open Society Foundation | 81,522 |
| DRL | 91,218 |
| ViiV Positive Action | 196,501 |
| MAC AIDS | 133,758 |
| Comic Relief | 36,792 |
| UN Trust Fund | 160,190 |
| UDF | 222,570 |
| European Union | 254,507 |
| Swede | 11,140 |
| Robert Carr Fund | 254,000 |
| Canadian Institutes of Health Research | 44,853 |
| Elton John AIDS Foundation | 25,472 |
| USAID | 317,081 |
| Total | USD 2,742,031 |

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

| HIV Human Rights Barriers Program Area | 2016 |
|--|-------------|
| PA 1: Stigma and discrimination reduction for key populations | 905,165 |
| PA 2: Training for health care workers on human rights and medical ethics related to HIV | 241,306 |

| | |
|---|----------------------|
| PA 3: Sensitization of law-makers and law enforcement agents | 9,786 |
| PA 4: Legal literacy (“know your rights”) | 801,072 |
| PA 5: HIV-related legal services | 90,468 |
| PA 6: Monitoring and reforming laws, regulations and policies relating to HIV | 246,142 |
| PA 7: Reducing discrimination against women in the context of HIV | 404,013 |
| Total | USD 2,742,031 |

2.9 Costing for 5-year comprehensive program—HIV

Table to be completed once costing is complete

| HIV Human Rights Barriers Program Area | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
| PA 1: Stigma and discrimination reduction for key populations* | 813,500 | 808,000 | 796,000 | 766,400 | 920,960 | 4,074,860 |
| PA 2: Training for health care workers on human rights and medical ethics related to HIV* | 22,000 | 27,500 | 39,500 | 0 | 12,000 | 101,000 |
| PA 3: Sensitization of law-makers and law enforcement agents* | 125,800 | 97,500 | 109,500 | 107,150 | 125,950 | 565,900 |
| PA 4: Legal literacy (“know your rights”)* | 360,500 | 350,000 | 350,000 | 385,000 | 402,500 | 1,848,000 |
| PA 5: HIV-related legal services* | 43,200 | 38,000 | 33,500 | 33,050 | 28,050 | 159,800 |
| PA 6: Monitoring and reforming laws, regulations and policies relating to HIV* | 320,000 | 360,000 | 305,000 | 330,000 | 330,000 | 1,645,000 |
| PA 7: Reducing discrimination against women in the context of HIV | 221,600 | 215,600 | 221,600 | 248,400 | 256,000 | 1,163,200 |
| Total (USD) | 1,906,600 | 1,896,600 | 1,855,100 | 1,870,000 | 2,075,460 | 9,557,760 |

Other interventions

The table below provides an overview of other interventions that are addressing broader right-to-health issues in the context of HIV such as accessibility, acceptability, availability, and quality of services. These programs do not fall under the seven human rights program areas, but are critical to the success of a comprehensive response to remove human rights-related barriers to HIV services and continued funding for these programs from other sources is recommended. The content of the table is then further elaborated upon.

| Other Programs: HIV | | | | | | |
|--|---|------------------|--|--------------------------|---|-----------------------------|
| Program | Description | | | | Limitations | |
| Increasing accessibility, acceptability, availability, and quality of services | Reducing risk of transmission in geographically marginalized and low socioeconomic areas where healthcare may not be readily available through community-based HIV testing and care, preventive services, increased capacity and advocacy, and enhancing of the HIV care continuum. | | | | | |
| Implementer | Population Targeted | Region(s) | Intervention | # trained/ Output | Timeframe | Recommended scale-up |
| FHI 360/LINKAGES Project Jamaica | People living with HIV, sex workers, men who have sex with men, people of trans experience, | Island-wide | LINKAGES works to strengthen the MoH and CSO response to help prevent HIV transmission among key populations and retain them in care and treatment services. | Not identified | 2016-2017 with annual extensions funded by PEPFAR | |

| | | | | | | |
|--|-------------------------|--|---|---------------------------|------|--|
| | clients of sex workers. | | | | | |
| Ministry of Youth and Culture with support from UNICEF | Youth | | <p>Development of non-traditional materials and approaches promoting safer sex and HIV prevention for adolescents. A</p> <p>“Youth in Action” forum to discuss topics of youth and HIV.</p> | 500 young people attended | 2004 | |
| The PACT— Coalition of more than 25 youth organizations ad networks working on HIV supported by UNAIDS | Youth | | Launched a youth-led campaign to respond to barriers that put young people at risk of HIV. | Not identified | 2017 | |

| | | | | | | |
|---|---------------------------------|--|--|-----------------------|-------------------------------------|--|
| <p>Stand Up for Jamaica (SUFJ) funded by the European Union</p> | <p>Incarcerated populations</p> | <p>Tower Street, Fort Augusta, and St Catherine Adult Correctional Centres</p> | <p>SUFJ, through its human rights advocacy, provides support to inmates who face stigma and discrimination based on the conditions of incarceration, their sexuality and/or their HIV status. SUFJ is currently working on a campaign to raise awareness of SRH within prisons (KII18). They've done workshops with MSM prisoners through the use of peer educators. Technical training of inmates and warders as teachers responsible for education activities of professional labs.</p> <p>Peer Educator Leadership Training for inmates</p> <p>Partnering with the Restorative Justice Unit</p> | <p>Not identified</p> | <p>November 2015 – October 2017</p> | |
|---|---------------------------------|--|--|-----------------------|-------------------------------------|--|

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | <p>within the Ministry of Justice to sensitize inmates and correctional officers about restorative justice</p> <p>Psychological support for inmates and their families</p> | | | |
|--|--|--|--|--|--|--|

Current Programs

Increasing accessibility, acceptability, availability, and quality of services

The LINKAGES program is currently being implemented in Jamaica, with support from USAID/PEPFAR and additional funds from the Global Fund. The activity helps to accelerate the ability of the government and organizations, to plan and implement services that reduce HIV transmission among key populations and their sexual partners and extend the lives of those already living with HIV²⁹.

Organizations like the Jamaica Youth Advocacy Network are tapping into the National Secondary Students' Council (NSSC) to train as youth advocates (KII17). These youth advocates work with mayors of different parishes and hold leadership roles that place them in position to dialogue with policy makers.

The first youth policy was drafted in the 1980s, and commitments to youth were institutionalized in the form of the creation of the National Centre for Youth Development (NCYD) in 2000 as the Youth Division of the then Ministry of Local Government, Youth and Community Development and transferred to the Ministry of Education, Youth and Culture in 2001. The NCYD was created to facilitate youth development in Jamaica by serving as an institutional focal point to ensure coordination and collaboration on youth related programming and research.

The most recent National Youth Policy came out in 2015 under the Ministry of Youth and Culture, and includes “Improved Health Access and Services to Ensure the Holistic Wellbeing of Young People” as one of its policy goals (Ministry of Youth and Culture, 2015). UNICEF, in the area of HIV prevention, is providing support for workshops and the development of materials to disseminate the National HIV/AIDS Schools Policy³⁰. UNICEF also supported the development of non-traditional materials and approaches promoting safer sex and HIV prevention for adolescents. A youth and HIV forum, dubbed “Youth in Action” and mounted by UNICEF in collaboration with the National AIDS Committee and other partners in 2004, attracted over 500 young people.

The PACT, a coalition supported by UNAIDS of more than 25 youth organizations and networks working on HIV, launched a youth-led campaign in 2017 to respond to the barriers that put young people at risk of HIV. Launched through a Twitter chat at the World Health Assembly, #uproot is a campaign running until the end of 2020 that is developed and powered by and for young people everywhere. It aims to increase the visibility of the root causes of risk and vulnerability, including inequities, violence, exclusion and stigma and discrimination, that jeopardize young people’s health, access to HIV and sexual and reproductive health services and rights and the sustainability of the AIDS response. The campaign will focus its efforts on three strategic areas—challenging harmful legal and policy barriers that deter young people from accessing services,

²⁹ www.usaid.gov/sites/default/files/documents/1862/FACT_SHEET-HEALTH-June_2017_FINAL.pdf

³⁰ https://www.unicef.org/jamaica/adolescents_development_participation.html

supporting youth participation in the HIV response and strengthening innovative partnerships between networks of young people.

The Local Capacity Initiative (LCI) was established by the U.S. Government in 2013 to strengthen sustainability of national HIV and AIDS responses through increased advocacy capacity of local civil society organizations. Stand Up for Jamaica (SUFJ), a human rights organization that supports and lobbies on behalf of incarcerated people who face stigma and discrimination based on the conditions of incarceration, their sexuality and/or their HIV status, completed a Local Capacity Initiative project focused on HIV and AIDS in Jamaican prisons—a project implemented by CARICOM’s Pan Caribbean Partnership Against HIV/AIDS (PANCAP). One outcome of the project was *Barriers Behind Bars*, a report that compares global best practices for providing HIV healthcare to LGBT (male) inmates with what happens in Jamaica. The research was funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).

SUFJ, through its human rights advocacy, provides support to inmates who face stigma and discrimination based on the conditions of incarceration, their sexuality and/or their HIV status. SUFJ is currently working on a campaign to raise awareness of SRH within prisons (KII18). They’ve done workshops with MSM prisoners through the use of peer educators:

“When you teach people to empower themselves and deliver messages to others, it’s more sustainable.” (KII18)

MSM prisoners and those suspected of being MSM are not allowed to attend the main school. In response to the backlash and out of concern for the safety of the LGBT and MSM prison population, SUFJ began providing a separate school at the Tower Street Adult Correctional Center for known and suspected MSM that focuses on providing them with English literacy and numeracy (Caribbean Vulnerable Communities Coalition, 2016) (KII18).

Limitations/Challenges

Jamaica has made many notable achievements in the fight against HIV, which include a robust treatment program and improved HIV prevention programs that are evidence-based that increasingly focus on the key drivers of the HIV epidemic. The largest component of HIV spending is on prevention geared towards “communication for social and behavioral change” targeting the general or young population (The World Bank, 2013). Sex workers and their clients, men who have sex with men and people who use drugs are also targeted.

However, as was evident throughout the assessment, there are significant continued barriers and gaps that are not being adequately addressed by current programming, many of which implicate human rights concerns as well as affect populations beyond men who have sex with men and sex workers. The recommendations below map out various opportunities to enhance existing efforts and ensure a comprehensive and rights-

based response to Jamaica's HIV epidemic – these recommendations should thus be viewed as complementary to and in synergy with existing programming.

While human rights matching funds can only be used to fund the human rights-related components of this work, it might be possible to use this to leverage additional funds to also expand HIV prevention and treatment services along these lines.

Moving to more comprehensive programming

The following recommendations cut across the UNAIDS program areas underpin the recommendations for the comprehensive package of services to address human rights barriers to accessing HIV services in Jamaica. Prior to laying out specific recommendations according to the UNAIDS human rights program areas, each of these recommendations is explained below.

- **Integrate HIV services into general health system** by introducing staggered appointment times so as not to overcrowd the health facility as well as removal of signs that differentiate waiting room areas for those seeking HIV-specific care. Additionally, strict dress codes outlined at the entrance to some hospitals and other public agencies should be re-examined so as not to create a barrier to services (KII03).
- **Outreach to adolescents** by building the work of the National Centre for Youth Development (NYCD) to include HIV-related programming where relevant and appropriate; adopt youth-specific HIV management to cater to the particular needs of youth; support and strengthen teachers' ability to deliver the Health and Family Life Education (HFLE) subject material as well as build the capacity of guidance counselors to address sensitive issues such as HIV status, sexual orientation, sexual history and gender identity; develop a system of feedback to the Ministry of Education when a student is referred to the health system that would allow the MOE to keep track of and measure students' access to services and their outcomes (KII11).
- **Mainstream attention to people with disabilities** by supporting advocates to hold organizations accountable for producing information materials that accommodate blind and deaf audiences (KII02); improve wheel chair-accessibility (KII01, FGD05); collect additional data to provide a comprehensive understanding of the specific vulnerabilities and barriers that people with disabilities face in accessing services, including those with mental disabilities.
- **Expand treatment facilities and key population-supportive programming beyond Kingston.** The use of data to prioritize geographical areas where interventions are most required is critical but must be balanced with a need for continuity and access to a minimum package of services for the whole population. Although treatment facilities for STIs are available with at least one facility in each parish, some key informants described how the concentration of funding in "priority" districts had left

other districts without organizations, information, or services for people living with HIV as well as other key and vulnerable populations (KII02, FGDO1). Others described the difficulties clients faced with retention to their treatment once they left Kingston.

3. Limitations, Measurement Approach and Next Steps

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions that have been conducted to address the human rights-related barriers to HIV services in Jamaica have been missed. However, the inclusion of the inception meeting as part of the assessment, as well as being able to touch base with key informants with any questions or clarifications allowed for several opportunities for program implementers and funding agencies to share documentation about programs that were missing from the review.

Another limitation is that only eight focus group discussions with key population representatives were conducted during the fieldwork and, thus, views from all the different geographical regions in Jamaica are not represented.

It was not possible to apply the tool to assess the effectiveness of the program approaches identified, namely because so few were evaluated in a manner that would enable such an assessment. However, details on the programs identified were gathered, including implementer perceptions of what worked well and what could be improved, which informed the comprehensive response proposed.

Measurement approach for assessing impact of scaled up programs to remove human rights related barriers to services

Qualitative Assessment

In order to understand how the comprehensive response is influencing human rights-related barriers to HIV services, it will be critical to conduct midline and endline qualitative assessments. Such assessments will provide more nuanced understanding of the various approaches being implemented and will help to understand the combined influence of the structural community-level and individual-level interventions being proposed.

Quantitative Assessment

While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Jamaica should consider strategically evaluating some of the interventions. For example, it will be important to determine if the stigma and human rights training for police leads to fewer criminal charges brought against female sex workers. Likewise, it would be important to evaluate the influence of awareness raising and “know your rights” campaigns for workers living with HIV, particularly regarding the National Workplace Policy on HIV and AIDS, to see if this

information helped them to improve access to treatment, counseling, care and support. In addition to evaluations of specific programs, the impact of the comprehensive response can be assessed with several outcome and impact-level indicators. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 5. Data sources included: the 2012 PLHIV Stigma Index and the 2016 indicators reported to UNAIDS as a part of Global AIDS Monitoring (GAM). Outcome indicators are proposed for people living with HIV, key populations, the general population, healthcare workers, institutions and financing.

Measurement Limitations

It will not be possible to directly link the activities supported under the comprehensive response with key outcomes and impacts, however, comparison of baseline values with values collected at midline and endline, and examination of the findings of the repeated qualitative assessments, will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV services has influenced Jamaica's progress towards reaching the 90-90-90 targets for HIV.

Next steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights-related barriers to HIV services. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in-country where a summary of the key points of this assessment will be presented for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV services.

4. Setting priorities for scaling up interventions to reduce human rights-related barriers to HIV services

Given the nature of barriers in Jamaica, it is recommended that the early focus be on activities to update or develop curricula on stigma and discrimination reduction and human rights for key duty bearers and integration these curricula into the appropriate professional training schools and colleges, including routine measurement and assessment of knowledge of in-service duty bearers. In addition, the continued support and mainstreaming of systems to capture experiences of stigma and discrimination and support redress should be prioritized (e.g. SIDney and JADS). Through the KIIs and focus group discussions, the completion of the process of creating and integrating a National Human Rights Commission was identified as one of the advocacy focus, so that the office can coordinate the comprehensive response, ensure consultations and collaboration across various stakeholders (i.e. key population networks, CBOs,

government ministries, etc.); and support the process of replacing or updating the problematic laws and policies identified in the 2013 HIV and AIDS Legal Environment Assessment in Jamaica. However, this process may require continual effort over the 5-year period and should not hinder implementation or scale-up of the other activities. The development or updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized to ensure that networks and patient advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation and beyond.

The response should also focus on training-of-trainers and training of instructors/professors, followed by rollout of routine training/re-training of key duty bearers both pre-service and in-service. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty bearers (i.e. health workers, police, prison staff, teachers, lawyers, members of the judiciary, etc.) with a feedback loop for institutional administrators to ensure appropriate action and support following these trainings. In addition, this phase of the response would also include outreach and engagement with pro bono lawyers and paralegals to support clients utilizing SIDney and/or JADS systems. The PLHIV Stigma Index should be implemented in year three or four, with additional funding support to PLHIV networks to conduct follow on advocacy and awareness-raising activities in the final year of the comprehensive response.

The capacity of the community-based organizations, public institutions and government agencies to implement the proposed comprehensive response is fairly strong for HIV. Jamaica has a vibrant civil society that provides crucial programming and services to key and vulnerable populations, which complement and bolster the national response to addressing human rights barriers to accessing HIV services. As the Government continues to transition away from external funding sources and expand its commitment to integrating HIV services into general SRH services, coordination efforts will be critical to ensure that government, civil society, and key population networks work together to collectively address the human rights barriers identified. Once the finalized response is agreed, the implementation capacity needs can be revisited and informed by specific recommendations.

5. List of Annexes

Annex 1: Chart—Comprehensive programs to reduce human rights-related barriers to HIV services

Annex 2: Calculations for retrospective costing of programs to remove human rights-related barriers to HIV services

Annex 3: Calculations for costing the comprehensive response

Annex 4: Costing considerations

Annex 5: Baseline indicators and values for comprehensive response

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