NATIONAL SEXUAL AND REPRODUCTIVE HEALTH POLICY: PUBLIC CONSULTATIONS REPORT

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National SRH Policy Consultation Report

Introduction

In accordance with the development of a Sexual and Reproductive Health Policy, The National Family Planning Board - Sexual Health Agency arranged a series of 13 public consultations to solicit feedback from citizens island-wide on key issues which would be included in the policy. The 13 public consultations held between May to July 2016 saw the engagement of a total of 517 participants.

Presentations and discussions on sexual and reproductive health issues were conducted along with presentations around HIV and the National HIV Policy. These discussions were documented and formatted into a combined report highlighting the main positions expressed by members of the public on issues around the HIV Policy and many emerging and controversial sexual and reproductive health and rights issues.

The following represents the composition of participants by parish.

Table 1: Respondent's Parish

Parish	Frequency	Percentage
Portland	27	5.2%
Manchester	37	7.2%
Clarendon	39	7.5%
Trelawny	33	6.4%
Hanover	37	7.2%
St. James	26	5%
Westmoreland	47	9.1%
KSA	54	10.4%
St. Mary	37	7.2%
St. Thomas	49	9.5%
St. Catherine	49	9.5%
St. Ann	45	8.7%
St. Elizabeth	37	7.2%
Total	517	100%

The feedback was presented as qualitative and quantitative data which was incorporated into the Sexual and Reproductive Health Policy Situational Analysis.

Content of the Presentations

The discussions on sexual and reproductive health were guided by a series of PowerPoint presentations which tackled SRH issues and questions posed by the facilitator. The presentations varied between parishes based on time constraints and the SRH areas which

respondents were keen to discuss, however, all information was pulled from the general presentation located in Appendix 1.

The key issues which were tackled and which garnered the most responses were around:

- Sexual and reproductive rights for adolescents
- The definition of rape and marital rape
- Termination of pregnancy/Abortion
- Anal sex/The Buggery Laws

Consultation Outcomes

Maternal Mortality

Discussions which took place on maternal mortality during public consultations focused on hospital conditions and the availability of services and assistance. Some participants in public consultations believed that when women died during pregnancy, childbirth or soon after childbirth the responsibility for the death was on both the women and a faulty healthcare system which allowed women to die in these circumstances.

One woman was noted as saying "Both [the health care system and the women must be blamed], 50/50", a second woman responded, "Some [women] should be on bed rest, but can't. Some stubborn."[1] It was expressed that maternal mortality was a concern and should be addressed by the SRH Policy and these issues persisted due to poor hospital care, including negligent staff.[2]

Fertility

It was clear from the public consultations that there was need for additional public information on fertility. In response to the query: "Do you think that we provide enough services for persons who cannot have children?" Two men said they have never heard about any such services.[3] Persons remained unsure of what fertility treatments entailed and where they were provided.

Reproductive Cancers

Issues have been raised with the timeliness of pap smear exams at public clinics with persons noting that it takes too long to book an appointment and even longer for results to be returned which discourages the frequent practice for most women, especially in the rural

[1] Public Consultation Report - Hanover
[2] Public Consultation Report - Trelawney
[3] Public Consultation Report - Hanover

areas.[4] It was also noted that there was negative information surrounding pap smears and not a lot of information on alternative ways of protection.[5]

It was expressed that the cost of pap smears was prohibitive. One woman commented that the examinations were expensive and the "*Results are too hard to get. Should be free. Should be done at the health center. Even if it's not free, it should be accessible. If you do it privately you get the results quickly. If you do it publicly, then it takes long to get.*"[6]

Personal breast exams were found to be common among women as opposed to scheduled mammograms.[7]

People Living with HIV (PLHIV)

In public consultations, it was noted that stigma and discrimination was a major barrier for PLHIV. Rumours surrounding PLHIV and services that are offered at the different health facilities must be dispelled. One person pointed out that HIV medication was given to patients in a brown paper bag and the fact that this was known by the public allowed further stigmatisation.[8]

It was noted that PLHIV were often discriminated against which may be due to a lack of education. Additionally, while PLHIV have access to treatment and care it is not easily accessible to all persons based on their socio-economic standings. It was also noted that there is anti-discriminatory law to protect PLHIV. It was stressed that there should be sensitivity to person's privacy and status in health care facilities, highlighting the significance of discretion and confidentiality.[9]

The Situation of Women

In public consultations a number of issues regarding women was raised. One major issue was that in many instances woman taking charge of their sexuality is seen as taboo. Additionally it was raised that there were instances where healthcare providers discriminated against older pregnant women. It was noted that while male condoms are available and easily accessible, contraceptive pills, female condoms and injections are not as readily available for women and are more expensive thus acting as a barrier for many women to manage their own sexual and reproductive health.

[4] Public Consultation Report - Mandeville & Clarendon
[5] Public Consultation Report - Clarendon
[6] Public Consultation Report - Hanover
[7] Public Consultation Report - Mandeville
[8] Public Consultation Report - Clarendon
[9] Ibid

Mention was made that spousal and marital rape laws needs revising as it adversely impacted women. It was noted that doctors may not be entirely knowledgeable about LBT women's needs and that the cost of fertility treatments should be subsidized to allow women greater access.[10]

The Situation of Adolescent and Youth

In public consultations it was noted that youth and adolescents face issues around parental consent which acts as a barrier to accessing information and services. Young people were noted as not having sufficient funds to allow them easy access to condoms and given their age and the prevailing ideology held by many adults that young people should not be engaging in sex, there is a level of fear held by young persons about accessing healthcare facilities and dealing with healthcare professionals.[11] It was noted that there should be more provisions for the youth; more age appropriate education and access to sexual and reproductive health information and services.[12]

On whether or not sexual and reproductive health information should be provided to young people, there was much contention.
The majority of participants (91.8%) shared that young people should have access to sexual and reproductive health services and commodities (including condoms and other contraceptive devices).

It was argued that it should be provided by a young female who said: *"I would have wanted to have access to commodities because my parent really didn't know when I started having sex, and in my own privacy, I would have wanted to know I could have kept myself protected at a young age".*[13]
It was noted that correct information deters them from early engagement: *"We should not wait until the internet teaches them, their peers, social media, the music or our culture, but we must take the initiative to give them the 'correct' information from early so that as they get older they are able to sift through what is correct and what is not."*

It was added that aside from information and preventive products, parents or the other agents of socialization, i.e. church leaders, teachers and guidance counsellors, need to talk to young people in a social and accepting manner in order to empower them and teach them how to respect the different genders and each other's sexuality and to identify what

[10] Ibid
[11] Public Consultation Report - Portland
[12] Public Consultation Report - Mandeville
[13] Public Consultation Report - St. Ann

characteristics one should look for in a partner and what a healthy relationship looks like.[14] This emphasizes the notion that conversations with adolescents and youth around sexual and reproductive health will reasonably contemplate how they navigate relationships, appreciate their reproductive and sexual development and understand their sexuality.

It was stressed that parents have a role to play in relation to the sexual and reproductive health of their children. They should establish a relationship with their children that allows honest and open conversation and should not treat sex as a 'taboo' or 'dirty' topic. Participants noted that parents need to face the reality that socializing of young persons is happening through the media and through their peers, accordingly, parents have a responsibility to take the initiative and have the conversations with their children, answer their questions and help them to make informed decisions.[15]

The issue of myths which are still held by persons in Jamaica and how these incorrect beliefs impact the sexual and reproductive health of young girls was also raised. One participant noted that: 'There is a mythical belief among some men that if they have sex with a virgin or a very young girl they will be cured of HIV or any other transmitting disease. *"… so man a rape likkle pickney and nuff incest a gwan"*. She added "*I believe that children in the age group 10-15 need to be informed. They need guidance, they need sessions like these that open them eyes and make them prepared for sexual advancement from these perpetrators. They need interaction with members of the HIV community who can come out and openly share their experiences, especially if these persons are from their age groups."*[16]

Condoms in Schools

During public consultation, the issue of condoms in schools was notably controversial. One person who was opposed to the provision of condoms noted that Guidance Counsellors had the responsibility to provide guidance, not to provide students with condoms and stressed that their child should not be provided with condoms.

Where participants agreed that condoms should be provided by the school, it was stated that parents must be contacted by the Guidance Counsellor prior to the issuance of any condom to a child under the age of consent.[17] It was noted that some things need to be put into perspective for children having sex including who the child was having sex with. It was suggested that other agencies should get involved at this stage, to find out if the child is being

[14] Ibid
[15] Ibid
[16] Public Consultation Report - St. Mary
[17] Public Consultation Report - St. Ann

molested and where there is concern that the sexual activity is against the child's will, the police should be contacted.

Some participants note that when parents are included in assessing the situation when it involves underage sexual activity, they are hesitant to cooperate and the information trail dissolves because of the fear that their child would be locked up or punished for engaging in sex with another young person. It was noted that both the boy and the girl who are underage and involved in sexual activity should be subject to the same treatment before the law.

Some participants held the controversial belief that in cases where the sexual activity was between an underage child and an older man, consideration for punishing both should be an option especially where the girl is the 'instigator'.[18]

On the issue of providing condoms to 16 –19 year olds the views were varied ranging from no condoms in schools in any circumstance, stressing that any conversation around sexual activity and the distribution of condoms was the parents' responsibility and not that of the school. The opposite was noted where one person stated that they were not concerned where young persons got condoms: *"I don't care where they get it… it's not a gun"* and added that young people were sexually active often without the knowledge of their parents, accordingly, the state must take responsibility to protect them from sexually transmitted infections through the provision of condoms.[19]

For some participants, the issue which was raised was who would provide the condoms to the children and not that they would get them. They felt that the health centre was the appropriate place for the provision of condoms and not the schools, for fear of the perception that the school was promoting sex.[20]

One notable discussion occurred where one pastor believed that condom distribution in schools would be giving students permission to engage in sexual activity. He went on to say that knowledge of sexual activity among students is no reason to endorse it by giving them condoms.[21] Another pastor, a woman, who was also a parent noted that she had no objection to the school issuing condoms to her child. In fact, she wished they would. She reasoned that it protected her investment in books, school fee, school resources and lunch money, and the least the school could do was to provide students with condoms and sex education sessions.[22]

[18] Ibid
[19] Public Consultation Report St. Elizabeth
[20] Ibid
[21] Public Consultation Report – Clarendon
[22] Ibid

A few other parents agreed, stating that when the school discusses sex with resources and materials provided for the students, it made it easier for them as parents to continue the conversation at home, instead of having to initiate one. One parent shared her (pleasant) surprise at how knowledgeable her eight-year-old son was about sex: "*My son came home and shared what he had learnt about good sexual practices, and the consequences of bad sex practices, accompanied by brochures given to him during the discussion at his primary school on Boys' Day".*

A former school principal identified what she saw as the real problem. It was not the school either discussing sexual education material or even distributing condoms; but with parents and the Parent-Teacher Association. She decried the parents:

"… who created trouble and havoc, and sometimes war, showing great resistance and resentment for the teachers who introduce sex to their children through the Family Life Classes that are part of the school's curriculum"? "Many of them don't even want the word sex to be mentioned to their children".

One senior male had the last word in support of condom distribution in schools adding that he believed more conversations with students about protection was necessary and should accompany condom distribution.

In St. James there was a consensus that sexuality education should be taught. Some were however concerned about the "agenda" [of homosexuality] being introduced to/ promoted among children. Others felt the children already knew about sex and sexuality and needed the appropriate guidance.[23]

In St. Mary, the following was noted in relation to young people and the creation of controlled environments for safe discussions and the delivery of commodities:

"Based on where we are as a society, sex starts long before 16, so it makes sense that we provide them with the necessary information and access to commodities in a controlled environment."

Another participant noted that students should be allowed access to condoms in schools at the age of 16 because that is the age of consent. The reality is that there are young persons in 10-19 age group that are sexually active, it therefore means that the laws and policy should stop being reactionary and more pro-active in an effort to curtail an issue before it is full-blown out of control. Accordingly, policies should contemplate the provision of access to commodities for safe sex to protect the sexual and reproductive health of young people.

[23] Public Consultation Report – St. James

A participant who identified herself as a mother noted that that the government should put condoms in schools, because despite the wishes of parents that their children are delaying sexual activity, they are having sex regardless. Accordingly we should provide condoms to young people and provide regular counselling and workshops that will help to inform them.

The Situation with Men

Public consultations noted that boys sometimes suffer from stigma and discrimination when issues arise in relation to their sexual and reproductive health. In Jamaican society men are discriminated against if they are gay or perceived to be gay based on how they look, speak and act. Respondents noted that men are not keen on penile exams and there is often not enough conversation between fathers and sons about diseases and the importance of regular doctor visits, especially because the fathers hardly visit the doctor for their own check-ups.[24] It was noted that men experience discrimination and stigma through culture and certain value systems of the country; Especially in instances *"If you are a certain age and don't have a child"; "if you don't have a wife or girlfriend"; "if a male is still a virgin at a certain age"*[25]All of these things adversely impact how boys develop and how they navigate sexual relationships and their sexuality.

On the issue of getting men tested for sexually transmitted diseases and other reproductive illnesses , a number of men put the responsibility on women to encourage their partners and men in their lives to get tested, male participants also noted that men can influence and encourage each other to get tested and to adopt healthy practices. Two men noted "*This is where the partnership comes in. If the woman cares about the man, then she should encourage him."* Another man stated, *"When you are brave enough to get tested and tell your male friends it helps when you talk to your male friends about the benefits."*[26]

Abortion

During public consultations, abortion was examined broadly as well as in specific situations to determine the opinions of participants. The general consensus seemed to be that in instances where the pregnancy was as a result of rape or incest, women should be allowed to terminate the pregnancy. A similar amount of support was shown for instances where women would need abortions because of issues with their health. Where the proposed reason for the abortion was the health of the child, there were concerns about what illnesses in the foetus would be cause for termination and there were calls for this to be clearly defined, including the seriousness of the illness. There was less support for termination in instances where the

[24] Public Consultation Report - Portland
[25] Ibid
[26] Public Consultation Report - Hanover

woman was seeking an abortion due to financial hardship and little support for instances where women would seek abortions on demand.

It was noted that there is a need to fully explain the procedure of abortion and types of abortion that are available so that citizens can better understand the issue and can give an educated opinion on the topic – existing laws, policies, etc.[27] It was also said that there is need to revise laws & policies affecting youth, such as on Abortion and Age of Consent.[28]

Some participants noted that women should be allowed to make the decision on their own and to determine what they wanted since the issue was more than carrying a child for nine months but rather it was about caring for a child for 18 years. Participants noted that there are too many unwanted children in Jamaica because mothers were unable to take care of them.[29] Participants widely agreed that termination of pregnancy whether legally or illegally obtained should be accompanied with counseling to the woman.[30]

A Doctor and Medical Health representative who were present at one consultation were in favour of legalising abortions because there were unhealthy side effects when persons were forced to resort to "backdoor" practices. The number of women whose lives are lost or their reproductive health is severely damaged because of botched abortion attempts remains high.

Participants noted that abortions are very costly - as doctors who performed black market abortions were taking a financial and medical risk. They added that it could expose women to grave medical risk when done in rooms that were unsuitable for medical procedures and stressed that disaster would be preventable if the procedure was made legal and affordable and provided in a medical facility such as a hospital where the patient could access other medical care and even counselling before and after the procedure. This would greatly reduction to the large amount of cases that the health facilities had because of "patched work" and "botched up" abortion procedures.[31]

In St. Ann it was said that the law should specify up to what stage of pregnancy a woman is allowed to terminate the pregnancy. Before the foetus is considered a human being, we have to take into consideration the development stages of the foetus, and though the debate is that if the foetus cannot live on its own outside of the mother's womb then it is not human, some argue that at certain stages brains and other relevant aspects of the foetus are developed.

[27] Public Consultation Report – Portland
[28] Public Consultation Report – Clarendon
[29] Public Consultation Report – Westmoreland
[30] Public Consultation Report – Kingston
[31] Public Consultation Report – St. Thomas

The reasoning behind abortions was discussed with participants noting that some women seek to terminate the pregnancy out of ignorance, for some young women it is because of the fear of telling their parents, or anger and revenge. It was noted that termination of pregnancy should be done only after the woman has received counselling or guidance and that women should be informed of the possibility that they would not be able to have a child after the procedure, the trauma and guilt of the action, and in some circumstances complicated health issues[32]

From the discussions, it was clear that Abortion is an issue which needs to be addressed by the SRH Policy. The following responses were gathered from the Consultations:

Abortion in the case of Rape or Incest

71.3% of the 363 respondents who completed this aspect of the research tool distributed at the island wide public consultations said they would support the provision of health services to allow the legal termination of pregnancy where the pregnancy is as a result of rape or incest.

Members of the public had this to say: *"Laws should be amended for these persons who wish to have their pregnancy terminated. But since it is currently illegal, all the medical centers in Lucea should be locked down!"*(Man). *"If woman is pregnant by rape or incest then the law should be changed."* (Woman).[33] Many persons felt that abortions should be allowed in the case of incest and rape.[34]

Most persons indicated that women should be allowed to terminate their pregnancy in instances of rape & incest.[35] It was evenly divided as to whether a mother should be allowed to have an abortion legally should she be raped or be the victim of incest. 88% in St Thomas agreed that women should be allowed, while others (mostly men) deemed it hypocritical and cowardly; *"you won't commit murder, but you take the easy way and kill the child before it is born, it is the same murder."*[36]

Abortion in the case of risk the mother's health or a sick child

The majority of persons engaged felt that a policy on termination of pregnancy should not generally allow persons to abort a child; the choice should be exercised only where there is danger to the mother's health or the child's health. 90% persons in Westmoreland agreed that

[32] Public Consultation Report – St. Ann
[33] Public Consultation Report – Hanover
[34] Public Consultation Report – St. Thomas, Kingston
[35] Public Consultation Report – Kingston
[36] Public Consultation Report – St. Thomas

it should be allowed for these special circumstances. Many participants supported the idea that if a woman was made to carry the pregnancy full term and the child is born with health issues or a disability that the family is not prepared for financially, the government should provide aid in the maintenance of the child.[37]

Of the 366 persons who responded to the research tool, 86.3% found that women should be able to terminate pregnancies where there was a risk to the health of the mother.

In addition, of the 377 persons who responded to whether abortions should be allowed in instances where there was a health risk to the child, 77.7% were in favour.

Abortion in the case of economic hardship

The provision of abortion services in instances where the women was unable to provide for the child gained the least amount of support with the majority believing that abortion services should not be provided in these circumstances. Only 27.7% of the 358 respondents were in agreement with the provision of abortions in these circumstances. Those against (both women and men), argued that economic hardship was not acceptable as a reason for termination. [38]

Abortion on Demand

Similar low numbers were recorded when persons were asked if abortions should be provided to women in situations where the pregnancy was unwanted or mistimed. Only 26.3% of the 350 persons who replied were in favour of this.

In Hanover, one man commented, "Overall abortion should be legal." However he was faced with disagreement.[39] Many individuals in the various consultations believed that abortion should be allowed in all circumstances, noting that it was the woman's body and she should be allowed to do what she believed was in her best interest. However, this was never in the majority.

Men's Role in Decisions about Abortion

In a number of the consultations it was noted that men should be included in the decision. "*We need to bring the man into the picture; the man needs to also understand about sowing his seed. We need to take a strong stance against men who flash around the island.*" *(man)*. However, this was not a popular view. Most felt it was the woman's decision.[40] In St. Ann it

[37] Public Consultation Report – Westmoreland & St. Thomas
[38] Public Consultation Report – Hanover
[39] Public Consultation Report – Hanover
[40] Public Consultation Report – Hanover

was said that men should be involved in the decision making process when it comes to termination of pregnancy. While women should have the right to do what they want with their body, too often they make these decisions without informing the child's father, and in some instances the man might want him "yute".

A male expressed the view that both the man and the woman should decide about termination as both contributed to the pregnancy. Most felt it was the woman's decision as it was her body.[41]

One woman expressed that "If you have a penis, you should not have a say in this issue".[42]

Ethical and Religious Considerations

It was established that women were entitled do whatever they chose with their bodies, but it must be remembered that the child had a right to life as well.[43]

In the consultation held in Kingston, the pastoral group which was in attendance raised a number of questions including:

1. How is that current data being collected about botched abortions? Where does the NFPB get its information about these harmful abortions?
2. What happens when persons begin to use abortion as a contraceptive method, how will the policy take that into consideration? Should they decide to bring this to the public as something that should be legalized or decriminalized?
3. Are there any specific statistics to the rate of illegal abortions that are taking place in Jamaica yearly?

They suggested that the relevant agencies conduct scientific research and disaggregate the data, to insert in the policy the substantive proof of the harm of botched terminations, for those who are against it, like pastors. In this way they may understand the extent of the problem, as do the NGOs and Government organizations.

Where abortions are being considered for the child's health they said that it must be ensured that the rate of error is a factor in diagnosis of whether a child will be born with a deformity or not. The policy should list the defects that are considered for abortion.

Other questions which were raised in St. Ann:

[41] Public Consultation Report – St. James
[42] Public Consultation Report – St. Thomas
[43] Public Consultation Report – Westmoreland

"Where are the limits? Where do we draw the line? What do we consider significant disability for children? Will there be a distinct set of variables that will be used to determine and isolate a case qualified for abortion?'

Marital Rape

It was widely held that the law on marital rape needs to be revised.[44]

Participants noted that there are loopholes in the law that are allowing Jamaica men to rape. There was a strong position that it doesn't matter the circumstance, no means no.[45] The consensus in St. James was that the law needs to be reviewed, the conditions under which it should be allowed are too narrow. It was said that "... if a husband takes it and the wife doesn't want it? [This is] Abuse" (a male participant).[46]

Controversial, but the majority were in favour of this being fully recognized more than in the present law. A dissenting voice stubbornly held unto religious reason: "Bible says we are one, the two fleshes become one, and there is no denying and saying no."[47]

The discussion in St. Mary outlined the religious view which was that The Bible makes it clear that if a husband need [sex], the woman must consent, and she is subjected to that time off for her menstrual cycle and if she would like to abstain for purposes of religion she must seek to come to some agreement with her husband, so on that premise there is no room for 'marital rape' to even be considered an issue for discussion. In that same session it was said that the law should be amended to relieve women's suffering. The law needs to be amended as soon as possible because women are suffering in marriages in which they have no right over their bodies.

It was noted that some women are physically or mentally unable to have sex, some are on medication, and the medication or even the stress of their life, and a trauma in their life has rendered them in a place where either their sex drive is turned off or they are just not mentally in a place to participate, enjoy or partake in sex and these things are breaking up marriages.

It was raised that some husbands are requesting anal sex and the question was raised what if a woman is not interested in this type of sexual practice, if she says no, and her husband takes it, there is no recourse for the wife? It was asked, "While the church is saying to wives to submit to their husband, isn't the basic human right of freedom of choice being violated?"

[44] Public Consultation Report - Clarendon
[45] Public Consultation Report - Trelawney
[46] Public Consultation Report - St. James
[47] Public Consultation Report - Kingston

Those in support of broadening marital rape legal protection conclude that the policy should be here to fix societal ills; the purpose should be to help women in relationships who are being raped and are not supported legally.

On the issue of the definition of rape not protecting men from being raped by women, a number of participants noted that the definition should be broadened. Participants noted that *"Arousal or an erection does not mean anything and women take advantage of that"* and *"A woman can force herself unto a man"*[48] A man commented on the definition of rape, "*Dat nuh mek nuh sense."*

Others: "*As long as someone is forced (into sex) it is considered rape (woman). "Rape is rape from any perspective. Once consent is not there it is rape. If it nuh go suh under the law, they need to be changed (man)." "…we are becoming a more aggressive people. … we need to look at all the evidence to determine whether someone is forced.*[49]

The Buggery Law

In public consultations the issues of the buggery law and anal sex were raised and discussed at length as they were particularly contentious.

The majority of male participants in the public consultation in St. Ann were in favour of keeping the clauses outlawing anal sex as they were. Some women argued for decriminalizing anal sex; they considered the possibility of sexual exploration between heterosexual couples, which should not be subjected to this "law", as what they did inside their bedroom should be of no importance to the law/government.[50]

Participants noted their belief that pornography was to be blamed for the increase in anal sex activity, whether publicly or privately. Additionally they thought that some men believed that anal sex offered them greater sexual pleasure because of the tighter entrance and some women resorted to it to prevent pregnancy, notably Christian girls, who also sought to maintain their virginity.[51]

In St. Elizabeth when the facilitator spoke on the issue of the definition of rape not including forced anal sex, when asked if that was something that needs to change, many voices were heard saying "Yes". And persons stated that "Any form of forced sex" was deemed rape.[52] A similar stance was taken in St. Catherine where two women said *"No man should be raped, no*

[48] Public Consultation Report - St. Mary
[49] Public Consultation Report - Hanover
[50] Public Consultation Report – St. Ann
[51] Public Consultation Report – St. Ann
[52] Public Consultation Report – St. Elizabeth

boy should be raped, therefore the law should be changed.", *"They (perpetrators of forced buggery against other men) should be punished the same way."*

In Manchester it was suggested that there should be a distinction in the law that identifies when anal sex is not considered a criminal offence and when it does not. Participants noted that the law should only be considered criminal in the case of rape (non-consensual sexual encounter) and in the cases of a minor and while it should not be removed entirely, it should be amended to reflect that there is a difference in persons now who are engaging in the act, whether male or female for explorative purposes, as opposed to rape or sexual grooming which should then be deemed as a criminal offence.[53]

In Kingston and St. Andrew, the session was highly sensitive and tense as the pastoral advocacy group were in attendance with an agenda to let their voices be heard to retain the buggery law. The suggestions stemming from that consultation included that the Offence Against the Person Act and the Sexual Offences Act need not be revised to include a validation of anal sex as a healthy, legitimate alternative to heterosexual intercourse. It was said that this is to respect the moral principles that inform the Jamaican legal system and the positions that Jamaica has taken with regard to these activities.[54]

They stressed that efforts should be made to use culture, social media and non-literature methods to get information across, engage youth and marginalized persons into the process and have a hotline to address issues and allow the vulnerable to talk and express their needs and concerns and train all MOH workers, Healthcare providers and workers, security guards, in 'good' practices. They stressed that we could sensitize communities but ensure that we do not promote homosexuality and anal sex as okay as this is against Jamaica's religious (Christian) principles. [55]

It was added by members of the pastoral group - "Do sensitization around HIV with community groups to reduce stigma and discrimination; however, the truth must be communicated". *"Jamaica has taken the view that anal sex and homosexuality is not an acceptable healthy alternative, thus, we advocate to accurately sensitize along these lines, based on our Judeo-Christian moral principles".*[56]

The majority of respondents at the island wide public consultation (262 out of 452) believed that anal sex should not be decriminalized. While the minority, 41.6% believed that it should be decriminalized.

[53] Public Consultation Report - Manchester
[54] Public Consultation Report – Kingston and St. Andrew
[55] Public Consultation Report – Kingston and St. Andrew
[56] Public Consultation Report – Kingston and St. Andrew

Respondents were asked, "Do you think the Charter of Rights should be revised to include freedom from discrimination of health, sexual orientation or neither?" They were allowed to select multiple options, and so 357 (61.2%) indicated that freedom from discrimination on the basis of health should be included in the Charter of Rights, while 191 (32.8%) expressed a similar perspective. On the other hand, 35 (6.0%) indicated that neither should be included in the Charter of Rights.

Transgender People

In the discussion in Clarendon it was noted that LGBT persons faced discrimination because of Jamaican culture. They said that churches add to this discrimination through their religious value system with the teaching of Sodom & Gomorrah, "them fi bun in fyah". Participants noted that churches have double standards; one moment they are teaching that we should embrace all persons regardless of their circumstances while they discriminate against a person who is seen as a member of the LGBT community, always trying to find a way to change or correct the person. A participant shared a belief that persons from different socio-economic backgrounds interact differently with LGBT persons for example inner-city communities are highly homophobic, while persons in a middle class family socialize with persons from the community and are accordingly more comfortable and tolerant.[57]

It was said that Jamaicans generally are socialized differently with persons from different socio-economic backgrounds interacting differently with LGBT persons for example inner-city communities are highly homophobic, while persons in a middle class family socialize with persons from the community. So their children or family members are generally tolerant or comfortable with LGBT persons.[58] It was said that there should be a certain level of acceptance; and LGBT persons should not be treated with scant regard. Transgender persons need to be able to access important health information so they can transition safely.[59]

Age of Consent

It was raised that in some instances young persons are engaging in sexual activity below the age of consent, and the health facilities, workers, guidance counsellors and teachers of the Family Life course in schools cannot engage these individuals about good sexual practices or even provide them with resources that could help them because of the barriers which exist.[60] A few persons agreed that the age of consent should be lowered, and the general consensus appeared to be that the age of consent should remain at 16 but there must be training to help persons to make better life choices and abstinence must be promoted[61]

[57] Public Consultation Report – Clarendon
[58] Public Consultation Report - Clarendon
[59] Public Consultation Report - Portland
[60] Public Consultation Report - Clarendon
[61] Public Consultation Report - Westmoreland

In Kingston, the majority of persons wanted the age of consent increased as it is in correlation to nothing else such as the age to enter the working world and the age to start alcohol consumption. Some of the sentiments shared include: "*When you tell them they are allowed to have sex, and they are big now, which house them stay into? If you not providing jobs for them, and them nuh legal yet fi vote so when them get pregnant, a we same parents wey a beg unuh fi lowa di age, a guh haffi luk afta di pregnant pickney and the new born?*"
It was said that the policy should reflect that children who engage in sexual activity below 16 should be held accountable.

It was noted that we must look at the moral conditions of these nations who have reduced their age of consent to 16 and below. "*We will not accept the sexual imperialism of the 1st world countries. We will deal with teenage pregnancy here outside of reducing the age of consent.*" The suggested alternatives included pushing education and finding where the gap are and do what we need to do to fix those areas.

Similarly in St. Mary it was noted that most 16 year old children are still living with parents, and should they get pregnant for a man over the age of 30, the man should be held accountable because a child at the age of 16 is not deemed responsible enough to make certain decisions including working an voting and accordingly they should not be considered responsible enough to make decisions regarding sex and the possibility of procreating. It was said that the age of consent should be raised to 18.

It was noted that students between the age of 16 and 18 are either in 4th or 5th at the educational level, preparing to participate in their external exams, if we are saying that the age of consent should remain at 16 years old and they are allowed to have sex at this age, then we are not mindful of the impact that this has on our educational system and our possible economic capabilities as a country. Lawmakers did not take this into consideration when they were doing this, they should have seen the correlation with cripple the society at its knees when we made such a decision. The amendment should reflect our postmodern cultural situation.

They flagged that it should take parents into consideration noting that if a 16 year old child gets pregnant, the responsibility will fall on the parents. It was noted that we have to make policies and laws based on our own cultural situation in relation to what's happening in reality on the ground.

Make policy and laws proactive - not reactive - based on situation analysis. It was argued that the age of consent at 16 promotes a different psychological mentality among our young people: *'Dem start act like dem a big man and ooman".*

In St. Thomas it was the consensus that young people should be provided with information as early as possible, even below the current age of consent, then they will be equipped with information that they will become useful for them later on.

In St. Catherine, in opposition to raising the age of consent it was said that: "*I don't think it should be raised, because there will be a lot of 17 year old boys in prison. Raising the age of consent won't stop them from having sex." "It is irrelevant"* - was one position - "*because parents are the ones who should be instilling and teaching their children."*

"*In an ideal world children would receive information from their parents. But [many] parents do not want to talk to talk to their children about sex. Some do not even have the correct information to pass on."* A female commented that, "Children should be informed from birth." She called on participants to "expose your children."
"The Age Of Consent does not send anyone to have sex. It is a choice. If you work as a parent, to inform your child you should have no problem." (Female). "You have to teach them values from they are small."

Notably while the consensus was that the age of consent to information and condoms should be lowered and children should be provided with age appropriate information form birth upwards, there were mixed responses about the provision of condoms.

In St. Ann it was said that the age of consent should remain at 16 because even if it is raised to 18, it will not deter young people from having sex nor will it reduce sexual activity among the younger populous or reduce the spread of HIV; what should happen is that society needs to be re-sensitized, empowered with information to assist them in the nurturing of their children.

They noted that parents should be a part of the solution. It was raised that consideration should be taken of broken homes, parents who themselves are young and inexperienced, the dysfunctional families, the homeless and those children who are within this age group that are not be guided for lack of parenting. Participants called for attention to be paid to children in residential care and to determine how they are being sensitized about these policies and questioning who would provide them with the relevant guidance.

Appendix

THE SEXUAL AND REPRODUCTIVE HEALTH POLICY – Presentation

WHAT IS A POLICY

- A policy is a deliberate system of principles used to guide decisions and achieve specific outcomes
- It's a broad course of action or statement of guidance adopted by the government in pursuit of national objectives

WHY IS POLICY IMPORTANT

- National policies, strategies, and plans play an essential role in defining a country's vision, priorities, budgetary decisions and course of action for improving the lives of its people.
- Policies, strategies and plans are not ends in themselves. They are part of the larger process that aims to align country priorities with the real needs of the population, generate buy-in across government, development partners, civil society and the private sector, and make better use of all available resources – so that all people in all places have access to what they need.

WHAT IS A SEXUAL AND REPRODUCTIVE HEALTH POLICY

- A Sexual and Reproductive Health Policy would be used to enhance the SRH status of Jamaicans and contribute towards realization of their full potential in national development.
- The Policy will bring sexual and reproductive health and rights issues into the mainstream of health and development.
- The Policy will examine the prevailing social, economic, cultural and demographic context of sexual and reproductive health of Jamaicans and noting how these things affect their health and development.
- The Policy will outline principles, objectives, priority areas and actions for SRH. The management and coordination, provision of ASRH services, roles and responsibilities of various sectors and stakeholders, research and utilization of evidence-based interventions as well as monitoring and evaluation are spelt out in the policy implementation framework section.
- The vision, mission and goals of a SRH policy
- A SRH Policy is to address the social and economic development of Jamaicans by improving their sexual and reproductive health and well-being and upholding their rights

- The vision of the policy will be to create a healthy and well-informed population with universal access to quality SRH information and services that are sustainable and provided through an efficient and rights based support system
- The Mission is to provide, facilitate and support an integrated and well-coordinated sexual and reproductive health system upholding the rights of women, men, youth, adolescents and children
- The Goal is to guide an evidence-based framework for the implementation of a well-coordinated and integrated sexual and reproductive health and rights programmes to attain the highest level of health and well-being for Jamaicans

The Objectives of the SRH Policy will be:

- To inform and guide the actions of policy makers and programmes
- To facilitate the mobilization and appropriate allocation of resources
- To guide the integration of SRH services
- To guide appropriate monitoring and evaluation of SRH programmes

Guiding principles of a SRH policy

Human Rights Based Approach and Equity: Everyone is entitled to fundamental human rights and freedoms including the right to health and accordingly shall have access to health services without distinction of ethnicity, age, gender, sexual orientation, disability, religion, political belief, HIV status, economic status, social condition or geographical location.

Gender Sensitivity: Gender issues shall be mainstreamed in the planning and implementation of all health programmes

Client centeredness: Service provision will consider the client's personal circumstances, preferences, values, and lifestyle

Quality of care: Provision of the highest quality and evidence based SRH services to all individuals in all health service delivery levels

Evidence-based decision making: Interventions shall be based on proven and cost-effective national and international best practices.

Universal Coverage to Comprehensive SRH services: The policy will ensure that all people have access to needed services of sufficient quality which does not expose them to financial hardship

WHAT IS REPRODUCTIVE HEALTH

From 1994 after the International Conference on Population and Development onwards, sexual and reproductive health and rights have been treated as fundamental rights of all

citizens, regardless of gender, sexual orientation or age and steps have been taken to ensure there is accessible, affordable and appropriate sexual and reproductive health information, services and commodities.

Reproductive health involves a constellation of methods, techniques and services that contribute to the overall well-being of individuals by preventing and solving reproductive problems. It also speaks to people enjoying safe sex lives and the capability to reproduce and the freedom to decide if and when to do so.

WHAT IS SEXUAL HEALTH

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

FACTORS WHICH AFFECT SEXUAL AND REPRODUCTIVE HEALTH

- Gender Roles
- Gender inequality and inequity between women and men and those who assume stereotypical feminine and masculine behaviors and roles is an underlying determinant of HIV risk and vulnerability in Jamaica. Social vulnerability for males is related to cultural norms Same comment as before of the dominant heterosexual masculine identity which is associated with having multiple sex partners, virility, having many children, having sex without using a condom and poor health seeking behavior
- Population, Poverty and Inequality
- The poverty rate in Jamaica stood at 16.5% (PIOJ 2011)
- The gap in income distribution also widened evidenced by an increased Gini Coefficient from 37.9 in 2000 (comparable to the UK at 36.8 and lower than the US at 45.0 at the time) to 59.9 in 2011 according to an IMF report (2011).
- This inequality contributes chiefly to the heightened vulnerability of the most-at-risk populations, including women for whom the unemployment rate stands at 17.7% compared to 9.3% of men and youths aged 14-24 for whom the unemployment rate was 30.9% with it being 23.4% for males and 41.0% for females in July 2015.

KEY CONCERNS FOR THE SRH POLICY

Family planning

- The goal of the Family Planning Programme in Jamaica is to continue increasing the number of planned pregnancies and achieve a Contraceptive Prevalence Rate of 75%
- Jamaica has achieved a relatively high contraceptive prevalence rate of 72% and a low unmet need for family planning of 7.2%
- Mistimed and unwanted pregnancies – The 2008 RHS reported that 66.2 per cent of the 15-19 years cohort stated that their pregnancy was mistimed and 14.6 per cent indicated pregnancy was unwanted.
- The majority of unintended pregnancies among contraceptive users occur because of inconsistent or incorrect contraceptive use. This is where underused family planning (FP) methods such as Implants, the Injection, IUDs and Tubal Ligation prove to be invaluable

Fertility

- The Total Fertility Rate (represents the number of children who would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates) for Jamaica has been declining since 1975 when it was recorded as 4.5. The UNFPA State of the World Population (SWOP) Report 2015 indicated that the 2010-2015 Jamaican TFR was 2.1.
- TFR estimates for more developed regions which stood at 1.7 and less developed regions which was estimated to be 2.6

Infertility

- Infertility has been defined clinically as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.
- Primary infertility occurs where there is the absence of a live birth for women who desire to have a child and who are exposed to the risk of pregnancy, that is, in unions and not using contraceptives.
- Secondary infertility is the absence of a live birth for women who desire to have a child and are exposed to the risk of pregnancy for at least five years since last live birth
- Medical practitioners in Jamaica have for some time been offering assisted reproductive technology (ART), such as fertility drugs and intrauterine insemination.

Teenage pregnancy

- In the year 2008, 18.8 per cent of pregnancies to women in the 15-19 age group were planned, 66.2 per cent were mistimed and 14.6 per cent were unwanted. The rate of teenage pregnancy in Jamaica continues to be of great concern.
- Jamaica currently has a teenage pregnancy rate of 7.2 per 100,000.

Reproductive organ cancers

- Cervical cancer is the second most common cancer among women worldwide as well as women in Jamaica.
- Cervical cancer is also ranked as the second most frequent cancer among women between 15 and 44 years of age
- It is approximated that 392 women in Jamaica are diagnosed with cervical cancer and 185 women die from the disease annually
- Primary prevention of cervical cancer focuses mainly on modification of sexual behavior, the HPV vaccine, and eradication of cigarette smoking, while secondary prevention occurs through screening, and using the Pap test.
- In Jamaica in 2014 it was estimated that there were 1,400 cancer related deaths in women with 19.7 percent of these deaths being attributed to breast cancer.
- People living with HIV
- It is estimated that the population of persons living with HIV (PLHIV) in Jamaica in 2013 is 30,265 and of this population, 16,766 were in need of antiretroviral (ARV) treatment
- Since the inception of Universal Access to ARV treatment in 2004, approximately 1,000 to 1,500 new persons are placed on treatment each year. It is estimated that at the end of 2013 approximately 10,982 persons with HIV were started on ARV treatment

The situation of women

- Women and girls constitute 50.7% of the Jamaican population but are often disproportionately affected by reproductive ill-health and issues of inequality in access to power and resources. Therefore, special attention must be placed on women's health, rights and empowerment in any dialogue aimed at advancing development.
- In 2008 it was found that 12% of women reported having been physically forced to have sexual intercourse at some time in her life.
- Although women experience many of the same forms of violence, intersections of: gender, HIV status, disability, lesbian, trans-gender or intersex or women who live in poverty can be subject to particularized and exacerbated forms of violence and discrimination

The situation of youth & adolescents

- Almost half of adolescent females (48.8%) said their first sexual encounter was forced or unwanted, compared to 4.4% of males
- 52.6% of male youth (15-24 years) reported no condom use at last sex. Three out of four males and 1 in 5 females 15-24 years reported having multiple partners.

- Transactional sex i.e. the exchange of sex for gifts and money was also reported by 42.6% of sexually active youth 15-24 years.
- Issues peculiar to adolescents
- There is no single policy position covering the sexual and reproductive health rights of adolescents. This leads to inconsistencies in the ways in which adolescents' right to information and services are treated by different agencies
- The Reproductive Health Policy Guidelines for Health Professionals outlines the procedure for the provision of contraceptive advice, counselling and treatment to persons under 16 years of age by a health provider. The guidelines stipulate that health professionals should first provide counselling, try to persuade the minor to involve a parent or guardian and then promote abstinence.
- The Sexual Offences Act (2009) determines the age of consent to be 16 years. This means that anyone who attempts to or has sexual intercourse with someone under the age of sixteen years commits a crime. In sexual relationships where both partners are under 16, both of them are considered to be both perpetrators and victims of a crime, under the Sexual Offences Act, as sex under age 16 is technically illegal
- Many of the programmes providing SRH information, services or treatment to adolescents do not have national reach. This leads to inconsistencies in the levels of access to ASRH services provided to minors.
- Life skills education programmes that include sexual and reproductive health information have proven to be effective in delaying the onset of sexual intercourse and, among sexually experienced youth, in increasing the use of condoms and decreasing the number of sexual partners. Evaluation shows that life skills programmes can contribute to the reproductive and sexual health of young people around the world.

The situation of men

- The Sexual and Reproductive Health behavior of males is a concept that is of great concern in Jamaica. The behavior of males in this respect has far reaching implications for their reproductive health and that of their partners. Having multiple partners for example or having unprotected sex will increase the chances of contracting a sexually transmitted infection, having an unintended pregnancy with a partner or both.
- Men are hesitant to get rectal examinations and this affects the likelihood of prostate cancer being undiagnosed
- Informational and cultural barriers account for the poor health seeking behaviors among men in regard to prostate cancer screening.
- SRH approaches must address men as partners and reflect the view that men can improve – and impede – women's contraceptive use and reproductive health. SRH

programmes must view men as allies and resources in efforts to improve contraceptive prevalence rates and other dimensions of reproductive health.

- We should emphasize men as agents of positive change. And acknowledge the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights.
- The programmes must move toward gender equity by shaping the way services are and look to reinforce gender equity rather than specifying which reproductive health services should be provided and to whom

The situation of men who have sex with men

- The MSM population in Jamaica is estimated to be 33,000
- The HIV prevalence rate among this group is estimated to be 32%
- Issues of the frequency of condom usage with their male partners as well as with their female partners (for MSM who identify as bisexual or who engage in sex with women) continue to affect the HIV prevalence rate
- Steps should be taken to ensure an enabling environment for the recognition and protection of the human rights of MSM and transgender people
- Measures to reduce social vulnerability, combat stigma and discrimination and empower MSM to practice safe sex are critical.

The situation of sex workers

- Sex work is the provision of sexual favors for money or its equivalent. Sex workers may be male, female or transgendered.
- Individuals may occasionally or opportunistically exact a gift or fee for sexual favor without perceiving themselves as a sex worker or they may engage full time in the explicit commercial provision of sex services
- There is little documentation of male and transgender sex workers in Jamaica. It is estimated that approximately 15,000 female sex workers (SW) operate in Jamaica at any given time
- A survey of SW operating in bars, clubs and on the street in 2008 found that condom use with clients (97%) was significantly higher than condom use with non-paying partners (23%) and 56% of this population had at least one STI
- The Sex Work Association of Jamaica (SWAJ) *reports that its members are regularly harassed, extorted and abused by police officers and private citizens who act under the laws which in the Sexual Offences Act which criminalize adult consensual sex work*

The situation of drug users

- Substance abuse has been a grave social problem as well as a notable cause of morbidity and health expenditure in Jamaica. This problem results in social, economic, and personal problems ranging from emotional and physical illness, through family dysfunction, to lost productivity, and health costs. Drug users might trade sex for drugs or for money to buy drugs.

The situation of persons with disabilities

- Persons with disability are as sexually active as persons without disabilities but their sexual and reproductive rights and needs are often neglected
- When SRH matters are attended to, it is often focused on preventing women with disabilities from getting pregnant, which is sometimes imposed by family members and health professionals, without the consent of the disabled person, as has been seen with forced sterilization and abortions.
- SRH services are often inaccessible to persons with disabilities for many reasons, including physical barriers, the lack of disability-related clinical services, lack of accessible information and communication, stigma and discrimination and negative health care providers' attitudes.

The situation of prisoners

In 2010 there was a record of high levels of HIV prevalence among inmates - 5.4% among male inmates and 2.3% among female inmates

The nature of our laws, namely the buggery laws, prevents condoms from being distributed in prisons.

Abortion

- The abortion debate has been on the table for the past 40 years in Jamaica. Abortion is illegal as stipulated in section 72 of the Offences against the Person Act, with a maximum penalty of life in prison.
- Abortion remains illegal with issues arising for how health care practitioners treat with botched abortions.