AGE OF CONSENT: LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW

JAMAICA COUNTRY REPORT
FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
ACKNOWLEDGEMENT

The SRHR Africa Trust (SAT) wishes to acknowledge, individuals, organisations, and law firms that contributed to this report through their expertise, co-operation, and hard work.

Special thanks go to Rose Law Caribbean Law Firm in Jamaica that provided pro bono legal services to assist SAT with the underlying research for the review on the Age of Consent Legal, Ethical, Cultural and Social Review in Jamaica, working with Arnold & Porter Kaye Scholer LLP, and in particular to Catherine Young for coordinating the legal review in all the participating countries.

SAT wishes to thank Jerome Amir Singh (lead author), Faadiela Jogee and Samantha Chareka (co-authors) from the Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada for working on the ethical, cultural and social review. The ESC research and editorial support was provided by Faadiela Jogee and Samantha Chareka, CAPRISA.

SAT also wishes to thank civil society organisations and partners who attended the Age of Consent Validation Meeting that met to discuss and validate the draft Advocacy Toolkit. The meeting critically reviewed the draft reports, analysing the data collected for its accuracy and merits.

SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social, and Cultural (ESC) impacts on sexual reproductive health and rights (SRHR) and HIV.

Last but not least, SAT thanks TrustLaw at the Thomson Reuters Foundation for their continued collaboration with SAT on health and rights and for brokering the partnerships between SAT and the law firms. TrustLaw is the Thomson Reuters Foundation’s global pro bono legal programme, connecting law firms and corporate legal teams around the world with high impact NGOs and social enterprises working to create social and environmental change.
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JAMAICA

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW
# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
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<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>EHP</td>
<td>Essential Health Package</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
</tr>
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<td>MPR</td>
<td>Multiple-perpetrator Rape</td>
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<td>MSP</td>
<td>Multiple Sexual Partners</td>
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<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PLWHIV</td>
<td>People Living with HIV</td>
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<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
</tr>
<tr>
<td>SRHS</td>
<td>Sexual and Reproductive Health Services</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children's Fund</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YFS</td>
<td>Youth-friendly Services</td>
</tr>
</tbody>
</table>
# CONTENT PAGE

**FOREWORD**

**ACKNOWLEDGEMENT**

**DISCLAIMER**

**ACRONYMS**

**EXECUTIVE SUMMARY**

<table>
<thead>
<tr>
<th>Chapter One:</th>
<th>Introduction</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter Two:</td>
<td>Age of Consent to sexual intercourse</td>
<td>4</td>
</tr>
<tr>
<td>Chapter Three:</td>
<td>Access to contraception services and commodities</td>
<td>9</td>
</tr>
<tr>
<td>Chapter Four:</td>
<td>Age of Consent and HIV testing</td>
<td>11</td>
</tr>
<tr>
<td>Chapter Five:</td>
<td>Age of Consent and access to Antiretroviral Therapy (ART)</td>
<td>12</td>
</tr>
<tr>
<td>Chapter Six:</td>
<td>Age of Consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP)</td>
<td>13</td>
</tr>
<tr>
<td>Chapter Seven:</td>
<td>Age of Consent and access to safe abortions and/or postabortion care</td>
<td>14</td>
</tr>
<tr>
<td>Chapter Eight:</td>
<td>Age of Consent on access to Antenatal Care (ANC)</td>
<td>15</td>
</tr>
<tr>
<td>Chapter Nine:</td>
<td>Access to HPV vaccines and cervical cancer screening and treatment</td>
<td>16</td>
</tr>
<tr>
<td>Chapter Ten:</td>
<td>Conclusion</td>
<td>17</td>
</tr>
<tr>
<td>Chapter Eleven:</td>
<td>Recommended intervention on legal and policy framework</td>
<td>18</td>
</tr>
<tr>
<td>References</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Annex 1</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Annex 2</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The Age of Consent for sexual intercourse in Jamaica is 16 years. Sexual intercourse with a person under the age of 16 years is illegal. A defence is available to persons under 23 years of age where he or she believed the other person to be over 16 years.

The Sexual Offences Act does not specify gender in relation to non-consensual sex. Gay sex between men is prohibited and criminalised under the Offences Against the Person Act. The Offences Against the Person Act refers to male having sex with another male or buggery as an Unnatural Offence. There are no offences specifically relating to female gay sex, which is not illegal in Jamaica. There are no offences specifically relating to female gay sex, which is not illegal in Jamaica.

There are no age restrictions on access to contraceptives which are not a form of medical treatment so parental consent is not a legal requirement. Contraceptives which are a form of medical treatment are subject to the general rule that persons aged under 16 years require parental consent to access medical treatment.

Legislation does not stipulate an age for reporting of HIV status of a minor. However, since persons 16 years and over have the capacity to consent to surgical, medical and dental treatment, it follows therefore that such reports of a person under age 16 who are in the care and under the charge of their parents.

There are no specific provisions concerning access to Antiretroviral Therapy (ART). Access is subject to the general rule on access to medical treatment. The general rule states that at the age of 16 years, a person can access any surgical, medical or dental treatment without parental consent. Access to Pre-exposure Prophylaxis (PrEP)) or Post-exposure Prophylaxis (PEP) is generally defined according to the general rule on medical treatment would apply: a person of 16 years or older could access PEP without parental consent, and a person under 16 years could only access PEP with parental consent.

Abortion in Jamaica is illegal. There is no policy framework or legislation enabling access to Antenatal Care (ANC). In practice, ANC is provided regardless of the mother’s age and without parental consent. Women Centre of Jamaica Foundation Programme for Adolescent Mothers provides ante natal care.

The country does not have specific provisions regarding access to Human Papilloma Virus (HPV) vaccine or cervical cancer screening and treatment.
Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to a report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV, even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have, therefore, explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15-24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15.6% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘All In To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men, and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies, and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility, and acceptability. Adherence and quality must inform these services.
The SRHR Africa Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth attitudes survey

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / polices and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

Methodology

The Jamaica legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by Rose Law Caribbean Law Firm and the ethical, cultural, and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations, and policies exploring the ages for girls and boys separately where relevant, including where contradictions exist in laws, policies, and regulations on these issues.

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives, with and without parental consent
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent, with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent, with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent, with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent, with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent
9. Age of Consent to access HIV testing without parental consent.

The Ethical, Cultural and Social study component in this report seeks to highlight social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. Age of Consent and sexual debut.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing (HCT) and contraception access.

Jamaica’s analysis was conducted through a desk review of publically accessible sources, including works published by international agencies such as UNICEF, WHO, UNAIDS, UNFPA, and the World Bank, Jamaican Government reports, and non-governmental research outputs.
Country overview

Jamaica is the largest English-speaking Caribbean island, with a population of approximately 2.7 million people.1 The Jamaican population is predominantly of African descent, while Jamaicans of mixed ethnicity comprise the country's second largest grouping. African-descent Jamaicans represent 76.3% of the total population, followed by Afro-Europeans (15.1%), East Indian and Afro-East Indians (3.4%), Caucasian (2%), Chinese (1.2%) and other (0.8%).2 In Jamaica, an estimated 26% belongs to the Church of God, 12% Seventh-day Adventist, 11% Pentecostal, 7% Baptist, 3% Anglican, 2% Roman Catholic, 2% United Church, 2% Methodist, 2% Jehovah's Witnesses, 1% Moravian, 1% Brethren, 2% does not report a religious affiliation, and 8% belong to other groups.3 The latter includes approximately 29,000 Rastafarians, 1,500 Muslims (although Muslim groups estimate their numbers at 5,000), 1,800 Hindus, 500 Jews, and 270 Bahais. Census data indicates that 21% of the population has no religious affiliation.4 Administratively, Jamaica is divided into fourteen parishes, none of which are landlocked. The highest cumulative number of reported HIV cases are in urbanized parishes. 50% of the Jamaican population live in Kingston, St Lucia, St Andrew, St James, and St Catherine.5 These parishes account for 63% of reported cases of HIV. High tourism-based parishes also have a high cumulative number of reported cases of HIV. Jamaica’s population is relatively young, with adolescents constituting approximately 20% of the country's population.6

Country context

- Jamaica is classified as an upper-middle income country with a nominal GDP of $13.89 billion.7
- Jamaica’s population estimate in 2014 was approximately 2.7 million people.8
- Jamaica has an HIV prevalence rate of 1.7% with an estimated 32 000 people living with HIV.9,10 Of these, approximately 30% are unaware that they are infected.
- 40% of Jamaica women have been pregnant at least once before they reach 2011
- Adolescents constitute 18% of pregnancies in Jamaica.12
Chapter Two: Age of Consent to sexual intercourse

The Age of Consent to sexual intercourse in Jamaica is 16 years according to the Sexual Offences Act (SOA) Sections 8 and 10.

Under Section 10 of the act it is an offence for a person of any age to have sexual intercourse with a person under 16 years, subject to the provisions regarding children under 12 years described in the paragraph that follows. Under Section 10 (1) and 10 (3) a defence is available to persons under 23 years of age where the person believes the child to be over 16 years. This suggests that where both parties are under 16 years but over 12 years, sex is illegal if the defence is not applicable.

Under Section 8 SOA, it is an offence for an adult (a person aged 18 or over) to touch a person under 16 years, or incite a person under 16 years to touch themselves or another, for a sexual purpose (the scope of this offence is likely to include sexual intercourse).

Pursuant to Section 63 of the Child Care and Protection Act, a child under 12 years cannot be guilty of the offences listed above. Section 63 conflicts with Sections 10(1) and 10 (3) SOA but it is the opinion of council in Jamaica that Section 63 prevails where someone under the age of twelve is involved with one of these offences.

Legislation and policy framework


Section 2

‘adult’ means a person of or over the age of eighteen years.

Section 8

1. In this section, ‘child’ means a person under the age of sixteen years.
2. An adult commits an offence where he or she, for a sexual purpose, does any act specified in subsection (3).
3. The acts referred to in subsection (2) are-
   a. touching, directly or indirectly, with a part of his or her body or with an object, any part of the body of the child; or
   b. inviting, counselling or inciting a child to touch, directly or indirectly, with a part of the body or with an object, the body of-
      i. any person, including the body of the adult who so invites, counsels or incites; or
      ii. the child

Section 10

1. Subject to subsection (3), a person who has sexual intercourse with another person who is under the age of sixteen 16 years commits an offence.
2. Any person who attempts to have sexual intercourse with any person under the age of sixteen years commits an offence.
3. It is a defence for a person of twenty-three years of age or under who is charged for the first time with an offence under subsection (1) or (2), to show that he or she had reasonable cause to believe that the other person was of or over the age of sixteen years.
The Sexual Offences Act

Section 24.
It is hereby declared that, subject to section 63 of the Child Care and Protection Act, the common law presumption that a boy under the age of fourteen years is incapable of committing rape or any other offence involving vaginal or anal intercourse is abolished.

Child Care and Protection Act (http://www.moj.gov.jm/sites/default/files/laws/Child%20Care%20and%20Protection%20Act_0.pdf)

Section 63
It shall be conclusively presumed that no child under the age of twelve years can be guilty of an offence.

Definition of statutory rape

The Sexual Offences Act Sections 8 and 10 do not define the relevant acts as statutory rape, however the Age of Consent to sexual intercourse is 16 years and it is illegal for someone 12 years and older to have sexual intercourse with someone under the age of 16 years. A defence is available to persons under 23 years of age where the person believes the other person to be over 16 years.

Legislation and policy framework

See section above on Age of Consent to sexual intercourse.

Age of Consent and sexual debut

The legal age for sexual consent in Jamaica is 16 years of age. However, many adolescent males have sexual debut before this age. The Jamaican Reproductive Health Survey 2008-2009 indicated that among youth between 15-24 years of age, the mean age of first sexual intercourse among men was 14.5 years of age and 16.1 years of age among women. This is higher compared to the 2002 survey, which indicated that the mean age was 15.8 years for women and 13.5 years for men. 35% of males and 12% of females reported that they had started sexual intercourse before they were 15 years of age. Adolescent early sexual debut is heavily influenced by cultural sexual norms.

Gender norms

In Jamaica, there are blatant socially constructed roles of expected behaviours for males and females which negatively affect the sexual script of adolescents, making them vulnerable to early sexual debut, STI, and HIV infection.

Masculinity

In Jamaica, heterosexual sex is a defining element of masculinity. Culture prescribes that adolescent males debut sex at an early age as a sign of their manhood and also to prove that they are not homosexuals. If they do not engage in sexual activities they are labelled batty boys (a local derogatory term for homosexuals). Sex is a key component of the male sexual script. Since most adolescent male’s debut sex before the age of 15 years, their first sexual partner is often a sex worker. However, this is different for female adolescents. Females are culturally restrained, and are praised for abstinence. Virginity among females is highly valued, leading to young adolescent females engaging in alternative sexual behaviour such as oral and anal sex to preserve their virginity.

Multiple sex partners

Jamaican males are encouraged to demonstrate their sexual prowess from an early age by having multiple partners and children. Studies have reported that among adolescents who are sexually active, one third have had multiple sex partners. The Jamaican 2008 Knowledge, Attitudes, and Behaviour survey indicated that
multiple partnership is one of the risk factors fuelling Jamaica’s HIV epidemic.27 Multiple partnership among men is also intended to validate manhood and demonstrate one’s gender identity. Male adolescents are more likely to have multiple sex partners to enhance their status among their peers.28 The Jamaican Reproductive Survey 2008-2009 highlighted that marriage is relatively rare in Jamaica, but most females’ cohabitate or are in visiting unions (in such relations, the male and female have a sexual relationship but are not married and do not share a common residence).29 Such practices facilitate early sexual debut.

Parent absence

Increasing economic, social and psychological demands on parents in Jamaica has deprived children the security they need from adults.30 There are high rates of emigration out of Jamaica, with parents migrating overseas in search of a better standards of living. Approximately 16,330 people emigrated from Jamaica in 2009.31 In such instances, children are often left in the care of strangers or older siblings who are often children themselves.32 Such dynamics put children at risk of physical and sexual abuse, thus facilitating early sexual debut. Studies conducted in Jamaica have indicated that girls who do not reside with their fathers are three times more likely to become pregnant compared to their peers who reside with their fathers.33 Female adolescents also highlighted that it is important to have parental love otherwise they will seek it outside the home.34 Male adolescents indicated that the lack of parental love is linked to problem behaviour.35

Violence and abuse

Violence and abuse contributes to early sexual debut in Jamaica. Studies indicate that the first sexual experience of many girls is forced or coerced.36 To this end, the Caribbean Youth Health Survey highlighted that 47.6% of the adolescent girls reported that their first sexual experience was forced or coerced.37 Studies have demonstrated that partner violence also increases the risk of HIV infection and unwanted pregnancies. Studies in the Caribbean indicate that there is a 30% prevalence rate of intimate partner violence.38 Jamaica has one of the highest youth-perpetrated violence in the world. It also has high rates of rape, with 15-29 year olds being both the perpetrators and victims of violence.39 The 15-29 years age group is responsible for 80% of violent crimes in Jamaica.40 Jamaican authorities reported that in 2012 there were 833 cases of rape and 763 of carnal abuse which is higher than the previous year which had 738 and 637 respectively.41 Furthermore, sexual assault among children and adolescents was the common cause of hospitalisation, with adolescents accounting for 57% of the cases.42 70% of victims of sexual crimes were children and 16-25 year old males were arrested for 47% of the rape cases.

Ethical implications and recommendations

Notwithstanding the country’s legal and human rights obligations, the Jamaican Government has an ethical obligation to tackle the root causes of early sexual debut and sexual violence in the country. This will necessitate challenging entrenched socially-constructed gender norms and meaningfully confronting the social issues that impact on early sexual debut. Such an approach will require meaningful and sustained engagement on the part of several Government departments with communities, NGOs, and relevant international agencies. Such engagement should involve grassroots youth engagement and ongoing research support aimed at better understanding adolescent sexual norms and practices.

Country experiences in addressing barriers

The Jamaican Government has initiated several interventions aimed at protecting the rights of adolescents. These include establishing the Child Development Agency, the Office of the Children's Advocate, and enacting the Child Care and Protection Act.43 The country’s Ministry of National Security has also published a National Crime Prevention and Community Safety Strategy44 and established a National Forum on Youth Violence Prevention.45 The latter is intended to allow for “the sharing of best practices and the sensitisation of individuals and organisations as to the avenues through which they can contribute to violence prevention, or initiate preventative measures, within their own communities.”46 Despite such initiatives, the perpetration of sexual violence against adolescents remains unacceptably high in Jamaica and speaks to the need for the development of more effective strategies aimed at preventing and delaying early sexual debut in the country.
Homosexuality and transgender expression

Caribbean culture is heteronormative and homosexuality is rejected through the expression of violence and strong sociocultural disapproval. Buggery laws in Jamaica prohibit anal sex and it is punishable by a maximum term of 10 years in prison. Male same-sex intimacy is regarded as ‘gross indecency’. Homosexuality and transgender expression thus met with stigma and discrimination, which limits the ability to provide comprehensive quality services to MSM populations due to the fear of criminal punishment as a consequence of disclosure. The criminalization of anal sex among men has negatively impacted the health seeking behaviour of MSM. In 2008, 14.9% of Jamaican MSM men indicated that they had been physically abused, 48.8% were verbally abused and 14% were raped. The laws, policies and practices in Jamaica are based on moral judgements rather than on basic human rights, thus making it hard for the LGBTI community to access reproductive health services.

Religion in Jamaica is syncretic and serves as an instrument of resistance in arguments against sexual deviance. As noted earlier, Jamaica is a heavily Christian society. The evangelical communities organise marches and conferences at any hint of the state overturning the buggery laws. For instance, in 2013 when rumours circulated that Prime Minister Miller wanted to repeal the country’s buggery laws, 25,000 anti-gay rights religious leaders and demonstrators protested in the streets. The story of Sodom in the bible is a key point of reference for assaults on sexual deviant individuals and communities. Jamaica’s homophobic culture precedes the hate crimes and violence directed at the country’s LGBSI community. Dancehall music is also used as a medium to communicate homophobia, with many dancehall artist singing about murdering and threatening violence against homosexuals.

As a way to discourage homosexuality, fathers provide their sons with condoms and encourage them to engage in heterosexual sexual activities.

Exceptions for gay sex

The Sexual Offences Act does not specify gender in relation to non-consensual sex. However, gay sex between two men is illegal under the Offences Against the Person Act. The Offences Against the Person Act refers to male having sex with another male or buggery as an Unnatural Offence under Subsection 76-79. There are no offences specifically relating to female gay sex, which is not illegal in Jamaica.

Legislation and policy framework

**Offences Against the Person Act** (http://moj.gov.jm/sites/default/files/laws/Offences%20Against%20the%20Person%20Act_0.pdf)

- **Section 76.** Whosoever shall be convicted of the abominable crime of buggery, committed either with mankind or with any animal, shall be liable to be imprisoned and Kept to hard labour for a term not exceeding ten years.

- **Section 77.** Whosoever shall attempt to commit the said abominable crime, or shall be guilty of my assault with intent to commit the same, or of any indecent assault upon any male person, shall be guilty of a misdemeour, and being convicted thereof, shall be liable to be imprisoned for a term not exceeding seven years, with or without hard labour.

- **Section 78.** Whenever upon the trial of any offence punishable under this Act, it may be necessary to prove carnal knowledge, it shall not be necessary to prove the actual emission of seed in order to constitute a carnal knowledge, but the carnal knowledge shall be deemed complete upon proof of penetration only.

- **Section 79.** Any male person who, in public or private, commits, or is a party to the commission of, or procures or attempts to procure the commission by any male person of, any act of gross indecency with another male person, shall be guilty of a misdemeanour, and being convicted thereof shall be liable at the discretion of the court to be imprisoned for a term not exceeding two years, with or without hard labour.
**Ethical implications and recommendations**

Jamaica is a signatory to, amongst others, the Universal Declaration of Human Rights, the American Convention on Human Rights, and the UN Convention on the Rights of the Child. All these instruments prohibit unfair discrimination. The Jamaican Government has an ethical duty to promote dialogue on LGBTI rights. Schools should have discussions around identity and sexuality and promote tolerance. Hospitals and clinics should guarantee confidentiality. Healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to provide care to any person in need and that this duty supersedes the healthcare professional’s personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, policymakers, officials, and health professionals ought to note that they have a legal and ethical obligation to always act in the best interests of a child, regardless of that child’s sexual orientation.

**Country experiences in addressing barriers**

To curb the high rates of homophobia in Jamaica, a diversity policy was introduced by the Jamaican Constabulary Force in 2011. The policy aims to ensure that vulnerable groups can safely file police reports. The Ministry of National Security has also developed tools to monitor crime by providing data on violence against LGBTI people. Furthermore, a human rights programme called ‘Respect Jamaica’ was launched in 2014. The initiative attempts to prompt positive change by addressing discrimination according to sexual orientation, race, class, and colour. The initiative invites Jamaicans to stand in support of marginalised and vulnerable communities in the country. Despite these policies and interventions, violence based on sexual orientation and gender identity still persists. Of the 71 LGBTI people interviewed in a 2014 report, more than half indicated that they had experienced violence. Of the 19 reported crimes to the police, formal statements were only taken for 8. This speaks to the need for sustained, meaningful realisation of policies and law enforcement, without favour.
Chapter Three: Access to contraception services and commodities

The 2008-2009 Jamaica Reproductive Health survey reported that condoms, pills and injectable are the most widely used method of contraceptives in Jamaica. In the 2002-2003 Jamaican Reproductive Health survey 54% of males indicated that they purchase their supplies from small grocery stores, and 46% of the female adolescence depend on their partners to provide contraceptive methods. UNAIDS has highlighted that in the Caribbean region (Jamaica included) one in three adolescents do not have adequate knowledge on the prevention of HIV. Women also have limited ability to negotiate condom use due to gender norms which imply that women should be submissive and men should make all the important decisions in sexual engagement.

There are inconsistencies between policies and legal framework which impede access to reproductive health services for young people. For instance, the Reproductive Health Policy Guideline 2004, the Child Care and Protection Act 2004 have conflicting standpoints on adolescents’ access to contraceptives. Since the legal age of sexual consent is 16 years of age, health professionals cannot administer HIV testing to adolescents without a guardian’s consent.

There are also cultural barriers to comprehensive sexuality education aimed at adolescents. Some health professionals perceive the distribution of contraceptives to school children as sinful. On the other hand, to mitigate the chances of their daughters becoming pregnant, some mothers reportedly place oral contraceptive pills in their daughter’s tea. Stigma and discrimination prevents adolescents from accessing SRHS. The use of contraceptives by female adolescents is viewed as an indication that one is engaging in illicit sexual activities, a phenomenon that is condemned by parents and peers.

Jamaican adolescents also have erroneous knowledge about SRHS. For instance, some believe that oral contraceptives can protect one against STI’s, sex with a virgin can cure STI’s and they also believe that they can see and know when someone has HIV/AIDS.

The presence of misogynist gender norms in Jamaica, perpetuates gender inequalities and power imbalances in relationships. Women with HIV are also at risk for physical (57.4%) and sexual violence (23.4%) if they are seen in public treatment sites. This may deter adolescent females from accessing SRHS.

Jamaica has very high levels of poverty, unemployment, and underemployment, especially among the youth and women, which impact on vulnerability to HIV. Impoverished families do not have the material and psychological resources to protect their children from the pressures that accompany deprivation. People from these deprived areas also lack access to health and social welfare support. This leads to repeat pregnancies amongst adolescents in the region. Due to poverty women have children to guarantee economic support from the father. Children also act as a social identity for women, thus the restricted use of contraceptives. These factors lead to the marginalisation of these populations, often driving them underground making it harder for them to access HIV interventions and services.

Legal considerations

There are no specific restrictions in Jamaica on access to contraception and services and commodities. For contraceptives which are a form of medical treatment, the general rule on medical treatment therefore applies: a person of 16 years can access any surgical, medical or dental treatment without parental consent.

A person under 16 years can only access contraceptives which are a form of medical treatment with parental consent. There are no legal restrictions on the age at which a person can obtain barrier methods of contraception e.g. condoms.

Legislation and policy framework

Section 8.
(1) Where a minor has attained the age of sixteen years his consent in respect of any surgical, medical or dental treatment to himself shall be as effective as it would have been if he were of full age; and where a minor has, by virtue of the provisions of this section given an effective consent in respect of any such treatment, it shall not be necessary for consent to be obtained from the parent or guardian of that minor in respect of that treatment.

(2) In this section ‘surgical, medical or dental treatment’ includes any procedure undertaken for the purposes of diagnosis in respect of any surgical, medical or dental matter and any procedure ancillary to any such surgical, medical or dental treatment.

Ethical implications and recommendations

The promotion of gender equality in Jamaica will be central to facilitate adolescent access to SRHS and the effective adoption of birth control methods. Female adolescents should be encouraged to access SRHS, and more should be done to tackle sexual violence in the country, which sometimes serves as a deterrent to accessing SRHS. Moreover, the Jamaican Government should do more to tackle youth unemployment, poverty, entrenched gendered norms, and social support and welfare, as these factors particularly impact on adolescent access to SRHS. Health workers should be reminded that health authorities have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values. Authorities should facilitate HCT, contraception, and MMC access in places where adolescents and young persons will feel free and comfortable to access such services. Staff must be trained to provide services in a non-judgmental and child-friendly manner.

Country experiences in addressing barriers

The Jamaican Ministry of Health designed a number of interventions targeted at adolescents. For example, they implemented the safer sex week which is observed every year since its implementation. During this period a number of community initiatives are initiated in different communities. In 2015 during the safer sex week they provided free HIV testing and contraceptives to some parishes. The Ministry of Health also designed 2 interventions targeted at adolescents, namely Hold on, hold-off in-school and the out of school youth intervention. These programs are for in and out of school adolescents respectively. Jamaica has a comprehensive sexuality education manual which gives guidelines on delivering comprehensive sexuality education. The manual “serve as a national model for comprehensive sexuality education which will help promote, protect, and secure programmes and policies that advance sexual and reproductive health and rights; ensure that an abundance of accurate, balanced, useful, and accessible information about human sexuality is available; and assure that all people are able to receive comprehensive education about sexuality that helps them integrate information and skills into their lives.”

However, although the Government is trying to implement different strategies to provide information about SRHS, adolescents might not be able to attain adequate information from these programs. This could be due to teachers’ inadequacy and unwillingness to discuss sexual information. Furthermore, the interventions might not reach the targeted group.

Legislation does not stipulate an age for reporting of HIV status of a minor. However, since persons 16 years and over have the capacity to consent to surgical, medical and dental treatment, it follows therefore that such reports of a person under age 16 years who are in the care and under the charge of their parents would be directed to the parents.
Chapter Four: Age of Consent and HIV testing

There are no specific provisions in Jamaica regarding access to HIV testing. The general rule on medical treatment therefore applies: a person of 16 years or older can access medical treatment without parental consent, and a person under 16 years can only access ART with parental consent.

Legislation and policy framework

The legislation that governs Age of Consent and HIV testing in Jamaica is the *Age of Majority Act, Section 8.*

Age of Consent to report the HIV status direct to adolescents

Legislation does not stipulate an age for reporting of HIV status of a minor. However, since persons 16 years and over have the capacity to consent to surgical, medical and dental treatment, it follows therefore that such reports of a person under age 16 years who are in the care and under the charge of their parents would be directed to the parents.
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

There are no specific provisions in Jamaica regarding access to ART. The general rule on medical treatment therefore applies: a person of 16 years or older can access medical treatment without parental consent. A person under 16 years can only access ART with parental consent.

Legislation and policy framework

*Law Reform (Age of Majority) Act, Section 8.*
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

There are no prohibitions for both Pre and Post-exposure Prophylaxis access. With respects to consent, the general rule on medical treatment applies - a person of 16 years or older could access PrEP or PEP without parental consent, and a person under 16 years could only access PrEP or PEP with parental consent.

Legislation and policy framework on access to PEP

There is no legislation or policy enabling PEP in place. However, with respect to consent the Law Reform (Age of Majority Act, Section 8 applies.
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

Jamaica has legislation the Offences Against the Person Act disenabling access to safe abortions as abortion is illegal at any age.

Legislation and policy framework

Offences Against the Person Act (http://moj.gov.jm/sites/default/files/laws/Offences%20Against%20the%20Person%20Act_0.pdf)

Section 72. Every woman, being with child, who with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent; and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her, or cause to be taken by her, any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and, being convicted thereof, shall be liable to be imprisoned for life, with or without hard labour.

Section 73. Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour, and, being convicted thereof, shall be liable to be imprisoned for a term not exceeding three years, with or without hard labour.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

There is no policy framework or legislation enabling or disenabling access to ANC in place however antenatal care is given regardless of age of mother. No parental consent is required at that point. Women Centre of Jamaica Foundation Programme for Adolescent Mothers provides Antenatal Care.
Chapter Nine: Access to HPV vaccine, and cervical cancer screening and treatment

There are no specific provisions in Jamaica regarding access to HPV vaccine or cervical cancer screening and treatment. The general rule on medical treatment therefore applies: a person of 16 years or older can access medical treatment without parental consent, and a person under 16 years can only access ART with parental consent.

Legislation and policy framework

Howard Reed (Age of Majority) Act, Section 8
Chapter Ten: Conclusion

Authorities, policymakers, scientists, civil society should engage with communities on the social and cultural factors that facilitate early sexual debut, sexual coupling patterns, and the health risks implicit therein. Furthermore, authorities should take tangible measures to sensitize health professionals regarding their ethical duties in respect of all patients, including homosexual and transgender adolescents. To his end, health professionals should be reminded that their professional ethics duties supersede personal moral biases. Authorities should work towards gender equality, and devise strategies to encourage and facilitate SRHS access to adolescents, mindful of sexual coupling and gender norms. Authorities should also work towards reducing institutionalized discrimination against MSM. To this end, they should recall that Jamaica is bound by various international human rights instruments and obliged to uphold the rights of all people, including MSM adolescents.

A limitation of this work is that data sources were limited to publically-accessible documents in English, and not based on original qualitative or quantitative research. Relevant studies may have been missed if they were not included in the databases reviewed for this report.
## Chapter Eleven: Recommended intervention on legal and policy framework

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<tr>
<th>Area</th>
<th>Category of regulation</th>
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<tr>
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<td>Definition of statutory rape</td>
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<td>Exceptions on Age of Consent - For example ‘gay sex’</td>
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<tr>
<td>Address of various policy and legislation inconsistencies</td>
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Annex 1

KEY QUESTIONS IN ESC REVIEW

i. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents males and females.

ii. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

iii. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

iv. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

v. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

vi. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?
2. Is there a definition of statutory rape? Please define.
3. Are there exceptions to question (1)? For example gay sex?
4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.
5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’) At what age? Please specify if there are different ages with and without parental consent.
6. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent, with and without parental consent.
7. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
8. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.
9. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent, with and without parental consent.
10. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
11. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.
12. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent, with and without parental consent.
13. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent, with and without parental consent.
14. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent.
15. What is the Age of Consent to access HIV testing without parental consent?
16. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/ policy requirements to report the status to her/his parents?
17. Please explain any inconsistencies between the answers above.